

**Data Element Name:** *ABG Done*

**Collected For:** PN-1

**Definition:** An analysis of the pH, concentration and pressure of oxygen, carbon dioxide, and hydrogen ions in the blood. It is used to assess acid-base balance and ventilatory status in a wide range of conditions. Arterial blood gas (ABG) determination is performed on arterial, rather than venous blood. Documentation of arterial blood gas analysis performed within 24 hours of arrival may be used for this measure. If no ABG was performed within 24 hours after arrival, then the results up to 24 hours prior to arrival may be used.

**Suggested Data**

**Collection Question:** Is there documentation an arterial blood gas (ABG) was done within 24 hours before or after hospital arrival?

**Format:**                      **Length:** 1  
**Type:** Alphanumeric  
**Occurs:** 1

**Allowable Values:**      Y (Yes) ABG was done within 24 hours before or after hospital arrival.  
                                       N (No) ABG not done or unable to determine from medical record documentation.

**Notes for Abstraction:** None

- Suggested Data Sources:**
- Consultation notes
  - Emergency department record
  - History and physical
  - Laboratory report
  - Respiratory therapy notes
  - Vital signs graphic record

**Guidelines for Abstraction:**

Inclusion	Exclusion
<ul style="list-style-type: none"> <li>• ABG</li> <li>• arterial blood gas</li> </ul>	<ul style="list-style-type: none"> <li>• Tests performed after the first 24 hour period</li> </ul>

**Data Element Name:** *Abstraction Date*

**Collected For:** All Records (CMS ONLY)

**Definition:** The date the medical record was abstracted.

**Suggested Data Collection Question:** What is the date the medical record was abstracted?

**Format:**                   **Length:** 10 – MM-DD-YYYY (includes dashes)  
                                   **Type:** Date  
                                   **Occurs:** 1

**Allowable Values:**       MM = Month (01-12)  
                                   DD = Day (01-31)  
                                   YYYY = Year (2000-9999)

**Notes for Abstraction:** Enter the date (i.e., today’s date) in MM-DD-YYYY format.

**Suggested Data Sources:** None

**Guidelines for Abstraction:**

Inclusion	Exclusion
None	None

**Data Element Name:** *Abstractor Identification (ID) Number*

**Collected For:** All Records (CMS ONLY)

**Definition:** Documentation of the abstractor identification (ID) number.

**Suggested Data Collection Question:** What is your abstractor ID number?

**Format:**                   **Length:** up to 20 characters  
                                   **Type:**    Alphanumeric  
                                   **Occurs:**  1

**Allowable Values:**       The information is determined by the user.

**Notes for Abstraction:**   None

**Suggested Data Sources:**  Not Applicable

**Guidelines for Abstraction:**

Inclusion	Exclusion
None	None

**Data Element Name:** *ACEI Clinical Trial*

**Collected For:** AMI-3, HF-3

**Definition:** Documentation the patient was participating in clinical trial testing alternatives to angiotensin converting enzyme inhibitors (ACEIs) as first-line heart failure therapy at hospital discharge.

**Suggested Data Collection Question:** Was the patient participating in clinical trial testing alternatives to angiotensin converting enzyme inhibitors (ACEIs) as first-line heart failure therapy at discharge?

**Format:** **Length:** 1  
**Type:** Alphanumeric  
**Occurs:** 1

**Allowable Values:**  
 Y (Yes) Participating in clinical trial testing alternatives to ACEI for heart failure therapy at discharge.  
 N (No) Not participating in clinical trial testing alternatives to ACEI for heart failure therapy at discharge or unable to determine from medical record documentation.

**Notes for Abstraction:** If there is documentation in the record that at the time of hospital arrival the patient was participating in a clinical trial testing alternatives to ACEI for heart failure, it may be presumed that the patient will continue in that trial after discharge.

- Suggested Data Sources:**
- Consultation notes
  - Discharge instruction sheet
  - Discharge summary
  - Emergency department record
  - History and physical
  - Nursing admission assessment
  - Progress notes

**Guidelines for Abstraction:**

<b>Inclusion</b>	<b>Exclusion</b>
None	None

**Data Element Name:** *ACEI Prescribed at Discharge*

**Collected For:** AMI-3, HF-3

**Definition:** Documentation that an angiotensin converting enzyme inhibitor (ACEI) was prescribed at hospital discharge. ACEIs widen or dilate blood vessels to improve the amount of blood the heart pumps thus lowering blood pressure. This helps to decrease the amount of work the heart has to do and helps prevent deterioration in heart function over time.

NOTE: Refer to Appendix C, Table 1.2 for a comprehensive list of ACEIs.

**Suggested Data**

**Collection Question:** Was an angiotensin converting enzyme inhibitor (ACEI) prescribed at discharge?

**Format:**                      **Length:** 1  
                                      **Type:** Alphanumeric  
                                      **Occurs:** 1

**Allowable Values:** Y (Yes) ACEI prescribed at discharge.  
N (No) ACEI not prescribed at discharge or unable to determine from medical record documentation.

**Notes for Abstraction:** None

**Suggested Data Sources:**

- Discharge instruction sheet
- Discharge summary
- Nursing discharge notes
- Physician orders sheet
- Transfer sheet

**Guidelines for Abstraction:**

<b>Inclusion</b>	<b>Exclusion</b>
<p>Refer to Appendix C, Table 1.2 for a comprehensive list of ACEIs</p>	<p><b>Angiotensin II inhibitors/angiotensin receptor blockers (ARBs)</b></p> <ul style="list-style-type: none"> <li>• Atacand</li> <li>• Atacand HCT</li> <li>• Avalide</li> <li>• Avapro</li> <li>• Benicar</li> <li>• Candesartan</li> <li>• Candesartan/hydrochlorothiazide</li> <li>• Cozaar</li> <li>• Diovan</li> <li>• Diovan HCT</li> <li>• Eprosartan</li> <li>• Eprosartan/hydrochlorothiazide</li> <li>• Hyzaar</li> <li>• Irbesartan</li> <li>• Irbesartan/hydrochlorothiazide</li> <li>• Losartan</li> <li>• Losartan/hydrochlorothiazide</li> <li>• Micardis</li> <li>• Micardis HCT</li> <li>• Olmesartan</li> <li>• Olmesartan/hydrochlorothiazide</li> <li>• Tasosartan</li> <li>• Telmisartan</li> <li>• Telmisartan/hydrochlorothiazide</li> <li>• Teveten</li> <li>• Teveten HCT</li> <li>• Valsartan</li> <li>• Valsartan/hydrochlorothiazide</li> <li>• Verdia</li> </ul>

**Data Element Name:** *Admission Date*

**Collected For:** All Records

**Definition:** The month, day, and year of admission for inpatient care.

**Suggested Data**

**Collection Question:** What is the date the patient was admitted to inpatient care?

**Format:**                   **Length:** 10 – MM-DD-YYYY (includes dashes)  
**Type:**                    Date  
**Occurs:**                 1

**Allowable Values:**   MM =     Month (01-12)  
                                   DD =     Day (01-31)  
                                   YYYY =  Year (2000-9999)

**Notes for Abstraction:** Because this data element is critical in determining the population for all measures, the abstractor should NOT assume that the UB-92 claim information for the admission date is correct. If the abstractor determines through chart review that the UB-92 date is incorrect, she/he should correct and override the downloaded value. If the abstractor is unable to determine the correct admission date through chart review, she/he should default to the UB-92 admission date.

- Suggested Data Sources:**
- Emergency department record
  - Face sheet
  - History and physical
  - Nursing admission assessment
  - Physician orders
  - UB-92, Field Location: 17

**Guidelines for Abstraction:**

Inclusion	Exclusion
None	<ul style="list-style-type: none"> <li>• Admit to observation</li> <li>• Arrival date</li> </ul>

**Data Element Name:** *Admission Diagnosis of Infection*

**Collected For:** All SIP Measures

**Definition:** An admission diagnosis suggestive of preoperative infectious disease.

**Suggested Data**

**Collection Question:** Did the patient have an admission diagnosis suggestive of preoperative infectious disease?

**Format:**                      **Length:** 1  
    **Type:** Alphanumeric  
    **Occurs:** 1

**Allowable Values:**      Y (Yes) The patient had an admission diagnosis suggestive of preoperative infectious disease.  
    N (No) The patient did not have an admission diagnosis suggestive of preoperative infectious disease or unable to determine from medical record documentation.

**Notes for Abstraction:**      None

- Suggested Data Sources:**
- Admitting physician orders
  - Admitting progress notes
  - History and physical
  - UB-92, Field Location: 76

**Guidelines for Abstraction:**

Inclusion	Exclusion
Refer to Appendix A, Table 5.09 for a list of ICD-9-CM Principal or Admission Diagnosis Codes suggestive of preoperative infection	None

<b>Data Element Name:</b>	<i>Admission Source</i>
<b>Collected For:</b>	All Records (used in algorithm for AMI-1, AMI-6, AMI-7, AMI-7a, AMI-8, AMI-8a, AMI-9, AMI-T1b [CMS Optional Test Measure], PN-1, PN-2, PN-3b, PN-5, PN-5a, PN-5b, PN-6, PN-6a, PN-6b, PN-7)
<b>Definition:</b>	The source of inpatient admission for the patient.
<b>Suggested Data Collection Question:</b>	What was the source of inpatient admission for the patient?
<b>Format:</b>	<b>Length:</b> 1 <b>Type:</b> Alphanumeric <b>Occurs:</b> 1
<b>Allowable Values:</b>	<ol style="list-style-type: none"><li>1      Physician referral The patient was admitted to this facility upon recommendation of his or her personal physician, or Normal Delivery (if Admission Type = 4) A baby delivered without complications.</li><li>2      Clinic referral The patient was admitted to this facility upon recommendation of this facility's clinic physician, or Premature Delivery (if Admission Type = 4) A baby delivered with time and/or weight factors qualifying it for premature status.</li><li>3      HMO referral The patient was admitted to this facility upon recommendation of a health maintenance organization physician, or Sick baby (if Admission Type = 4) A baby delivered with medical complications, other than those relating to premature status.</li></ol>

- 4      Transfer from a hospital  
The patient was admitted to this facility as a hospital transfer from an acute care facility where he or she was an inpatient,  
or  
Extramural Birth (if Admission Type = 4)  
A newborn born in a non-sterile environment.
- 5      Transfer from Skilled Nursing Facility  
The patient was admitted to this facility as a transfer from a skilled nursing facility where he or she was an inpatient.
- 6      Transfer from Another Health Care Facility  
The patient was admitted to this facility as a transfer from a health care facility other than an acute care facility or a skilled nursing facility. This includes transfers from nursing homes, long term care facilities and skilled nursing facility patients that are at a non-skilled level of care.
- 7      Emergency Room  
The patient was admitted to this facility upon recommendation of this facility's emergency room physician.
- 8      Court/law Enforcement  
The patient was admitted to this facility upon the direction of a court of law or upon the request of a law enforcement agency representative.
- 9      Information Not Available  
The means by which the patient was admitted to this hospital is not known.
- A      Transfer from a Critical Access Hospital  
The patient was admitted to this facility as a transfer from a Critical Access Hospital where he or she was an inpatient.

**Notes for Abstraction:**

- Because this data element is critical in determining the population for many measures, the abstractor should NOT assume that the UB-92 claim information for the admission source is correct. If the abstractor determines through chart review that the UB-92 admission source is incorrect, she/he should correct and override the downloaded value.
- If unable to determine admission source, select “9”.

- Suggested Data Sources:**
- Emergency department record
  - Face sheet
  - History and physical
  - Nursing admission notes
  - Progress notes
  - UB-92, Field Location: 20

**Guidelines for Abstraction:**

<b>Inclusion</b>	<b>Exclusion</b>
None	If patient was transferred from an emergency department of another hospital, do not use “ 7”. This is only for patients admitted upon recommendation of <b>this</b> facility's emergency department physician

**Data Element Name:** *Admission Type*

**Collected For:** All Records

**Definition:** The code indicating priority/type of admission.

**Suggested Data Collection Question:** What was the priority/type of admission?

**Format:**                   **Length:** 1  
                                  **Type:** Alphanumeric  
                                  **Occurs:** 1

- Allowable Values:**
- 1      Emergency  
       The patient requires immediate medical intervention as a result of severe, life threatening, or potentially disabling conditions. Generally, the patient is admitted through the emergency room.
  
  - 2      Urgent  
       The patient requires immediate attention for the care and treatment of a physical or mental disorder. Generally, the patient was admitted to the first available and suitable accommodation.
  
  - 3      Elective  
       The patient's condition permits adequate time to schedule the availability of a suitable accommodation.
  
  - 4      Newborn  
       Use of this code necessitates the use of special Source of Admission codes -- see data element Admission Source.
  
  - 5      Trauma Center  
       Visit to a trauma center/hospital as licensed or designated by the state or local government authority authorized to do so, or as verified by the American College of Surgeons and involving a trauma activation.
  
  - 9      Information not available

**Notes for Abstraction:** None

- Suggested Data Sources:**
- Emergency department record
  - Face sheet
  - History and physical
  - Progress notes
  - UB-92, Field Location: 19

**Guidelines for Abstraction:**

<b>Inclusion</b>	<b>Exclusion</b>
None	None

**Data Element Name:** *Adult Smoking Counseling*

**Collected For:** AMI-4, HF-4, PN-4

**Definition:** Documentation in the medical record that smoking cessation advice or counseling was given during this hospital stay for patients 18 years of age and older.

JCAHO NOTE: This data is only populated if the Adult Smoking history is entered Y (Yes) .

**Suggested Data  
Collection Question:**

Was the adult patient given smoking cessation advice or counseling during this hospital stay?

**Format:**

**Length:** 1  
**Type:** Alphanumeric  
**Occurs:** 1

**Allowable Values:**

Y (Yes) Patient received smoking cessation advice/counseling during hospital stay.  
N (No) Smoking cessation advice/counseling not given or unable to determine from medical record documentation.

**Notes for Abstraction:**

- If the patient refused smoking cessation advice or counseling during this hospital stay, select “Yes”.
- If the patient has a history of cigarette smoking within the year prior to the arrival date but the patient does not currently smoke, they should be advised to continue not smoking. For these patients, if this advice/counseling was not done, select “No”.
- If the patient is prescribed Wellbutrin/bupropion, it should not be assumed that this is a smoking cessation aid unless specifically noted as such. It is sometimes used as an antidepressant unrelated to smoking.

- Suggested Data Sources:**
- Consultation notes
  - Discharge instruction sheet
  - Discharge summary
  - Emergency department record
  - History and physical
  - Medication administration record
  - Nursing notes
  - Progress notes
  - Teaching sheet

**Guidelines for Abstraction:**

<b>Inclusion</b>	<b>Exclusion</b>
<p><b>Cigarette smoking cessation advice/ counseling</b></p> <ul style="list-style-type: none"> <li>• direct discussion with patient about stopping smoking (e.g., “advised patient to stop smoking”)</li> <li>• prescription of smoking cessation aid (e.g., Habitrol, NicoDerm, Nicorette, Nicotrol, Prostep, Zyban) during hospital stay or at discharge</li> <li>• prescription of Wellbutrin/bupropion during hospital stay or at discharge, if prescribed as smoking cessation aid</li> <li>• referral to smoking cessation class/program</li> <li>• smoking cessation brochures/ handouts/ video</li> </ul>	<p>None</p>

**Data Element Name:** *Adult Smoking History*

**Collected For:** AMI-4, HF-4, PN-4

**Definition:** Documentation that the adult patient has smoked cigarettes anytime during the year prior to hospital arrival. Adult is defined as 18 years of age or older.

**Suggested Data**

**Collection Question:** Did the adult patient smoke cigarettes anytime during the year prior to hospital arrival?

**Format:**                   **Length:** 1  
                                  **Type:** Alphanumeric  
                                  **Occurs:** 1

**Allowable Values:**    Y (Yes) There is documentation that the adult patient smoked cigarettes anytime during the year prior to hospital arrival.  
                                  N (No) There is documentation that the adult patient did not smoke cigarettes anytime during the year prior to hospital arrival, smoking history was not addressed or unable to determine from medical record documentation.

JCAHO NOTE: If the ICD-9-CM Other Diagnosis Code 305.1 exists, then default the allowable value to Y (Yes).

**Notes for Abstraction:**

- In some cases smoking history documentation in one medical record source may further clarify the patient's smoking history documented in another medical record source. Examples:
  - Progress note states “history of smoking” and the nursing admission assessment notes “quit 2 years ago” – select “No”.
  - Discharge summary states smoker without specifying the type of tobacco and the ED record specifies the type of tobacco as cigar – select “No”.
- In cases where conflicting information about the patient's smoking history is documented, “Yes” should be selected. Example:
  - “Current smoker” per H&P, but consultation notes state patient “quit 2 years ago” - select “Yes” (one source suggests the patient currently smokes, the other suggests the patient does not currently smoke).
- If there is documentation of current smoking or tobacco use, or a history of smoking or tobacco use, and the type of product is not specified, assume this refers to cigarette smoking.
- Do not include documentation of smoking history referenced as a “risk factor” (e.g., “risk factor: tobacco”, “risk factor: smoking”, “risk factor: smoker”), where current smoking status is indeterminable.
- If there is a history of smoking and documentation indicates the patient quit, but the timeframe in which the patient quit is not clear, select “No”. Examples:
  - Nursing admission assessment documents patient as “ex-smoker” or “former smoker”, or simply notes pt. “quit smoking” - select “No”.
  - “History of tobacco abuse” per H&P, and consultation note states “non-smoker” - select “No” (not a case of conflicting information).

**Suggested Data Sources:**

- Consultation notes
- Discharge summary
- Emergency department record
- History and physical
- Nursing admission assessment
- Progress notes
- Respiratory therapy notes

**Guidelines for Abstraction:**

<b>Inclusion</b>	<b>Exclusion</b>
<p><b>Cigarette smoking within one year prior to hospital arrival</b></p> <ul style="list-style-type: none"> <li>• + smoker, type of product not identified</li> <li>• + tobacco use, type of product not identified</li> <li>• history of cigarette use without mention of a time frame, if no indication that patient quit</li> <li>• history of smoking (type of product not identified), without mention of a time frame, if no indication that patient quit</li> <li>• history of smoking within one year prior to arrival, type of product not identified</li> <li>• history of tobacco use (type of product not identified), without mention of a time frame, if no indication that patient quit</li> <li>• history of tobacco use within one year prior to arrival, type of product not identified</li> <li>• recent smoker</li> </ul>	<p><b>Cigarette smoking within one year prior to hospital arrival</b></p> <ul style="list-style-type: none"> <li>• chewing tobacco use only</li> <li>• cigar smoking only</li> <li>• cigarette smoking within one year prior to arrival or any of the other inclusion terms described using one of the following qualifiers: cannot exclude, cannot rule out, may have, may have had, may indicate, possible, suggestive of, suspect or suspicious</li> <li>• illegal drug use only (e.g., marijuana)</li> <li>• oral tobacco use only</li> <li>• pipe smoking only</li> <li>• remote smoker (smoked in the past, but greater than one year ago)</li> </ul>

**Data Element Name:** *Antibiotic Administration Date*

**Collected For:** PN-3b, PN-5, PN-5a, PN-5b, PN-6, PN-6a, PN-6b, SIP-1, SIP-2, SIP-3,

**Definition:** The date (month, day, and year) for which an antibiotic dose was administered. An antibiotic may be defined as any drug, such as penicillin or streptomycin, containing any quantity of any chemical substance produced by a microorganism or made synthetically (i.e.,quinolones) which has the capacity to inhibit the growth of or destroy bacteria and other microorganisms. Antibiotics are used in the prevention and treatment of infectious diseases.

**Suggested Data Collection Question:** What was the date of administration for the antibiotic dose?

**Format:** **Length:** 10 – MM-DD-YYYY (includes dashes)  
**Type:** Date  
**Occurs:** 75

**Allowable Values:** MM = Month (01-12)  
DD = Day (01-31)  
YYYY = Year (2000-9999)

**Notes for Abstraction:** SIP: Document the date EACH antibiotic DOSE was administered from arrival through the first 48 hours after the surgery end time.

For EACH antibiotic name, enter an Antibiotic Administration Route, Date, Time, and whether it is a Prophylactic Antibiotic.

PN: Document the initial (first time) month, day, and year, for which the patient received each antibiotic administered during the first 36 hours after hospital arrival, or the initial antibiotic administered if antibiotics were not administered within the first 36 hours.

If an antibiotic is given more than one time during the first 36 hours after hospital arrival, only record the antibiotic name once. Enter the first administration date and time associated with each antibiotic name.

For EACH antibiotic name enter an Antibiotic Administration Route, Date, Time.

- Suggested Data Sources:**
- Emergency room record
  - ICU flowsheet
  - IV flowsheet
  - Medication administration record
  - Nursing notes

For SIP, in addition to the above data sources, the following data sources are also suggested:

- Anesthesia record
- Operating room record
- PACU/recovery room record

**Guidelines for Abstraction:**

<b>Inclusion</b>	<b>Exclusion</b>
None	None

**Data Element Name:** *Antibiotic Administration Route*

**Collected For:** PN-6, PN-6a, PN-6b, SIP-1, SIP-2

**Definition:** Method of administration of a dose of medication. Medications may be administered in a variety of ways depending upon how they are supplied and prescribed. Methods of administration are listed below as allowable values.

**Suggested Data**

**Collection Question:** What was the route of administration for the antibiotic dose?

**Format:** **Length:** 2  
**Type:** Alphanumeric  
**Occurs:** 75

**Allowable Values:**

- 1 PO/NG/PEG tube (Oral)
- 2 IV (Intravenous)
- 3 IM (Intramuscular)
- 4 Inhalation
- 5 Abdominal/peritoneal/chest irrigation
- 6 Mixed in cement
- 7 Intracoronary (IC)
- 8 Enema/rectally
- 9 Other
- 10 UTD

**Notes for Abstraction:**

SIP: Document the route of EACH antibiotic DOSE administered from arrival to the hospital through the first 48 hours after the surgery end time.

For EACH antibiotic name enter an Antibiotic Administration Route, Date, and Time, and whether it is a Prophylactic Antibiotic.

PN: Document the route of administration for the initial start date and time of each antibiotic administered during the first 36 hours after hospital arrival, or the initial antibiotic administered if antibiotics were not administered within the first 36 hours.

If an antibiotic is administered more than once by the same route during the first 36 hours after hospital arrival, only record the antibiotic name once. Enter the first administration date, time, and route associated with each antibiotic name.

If the route of administration of an antibiotic changes during the first 36 hours after arrival, record the antibiotic name once for each route by which it was administered.

Example:

- A patient arrives at the hospital at 07:15 on 05-05-2004. Zithromax IV is given in the ER at 09:30 on 05-05-2004. On 05-06-2004 at 09:00 Zithromax PO is recorded as given on the MAR. Enter: Zithromax 05-05-2004 09:30 IV, and Zithromax 05-06-2004 09:00 PO

For EACH antibiotic name enter an Antibiotic Administration Route, Date, Time.

**Suggested Data Sources:**

- Emergency department record
- ICU flowsheet
- IV flowsheet
- Medication administration record
- Nursing notes

For SIP, in addition to the above data sources, the following data sources may also be utilized:

- Anesthesia record
- Operating room record
- PACU/recovery room record

**Guidelines for Abstraction:**

Inclusion	Exclusion
<p><b>SIP</b></p> <ul style="list-style-type: none"> <li>• abdominal irrigation</li> <li>• chest irrigation</li> <li>• enema/rectally</li> <li>• feeding tubes (NG/PEG)</li> <li>• IM</li> <li>• inhalation</li> <li>• intracoronary (IC)</li> <li>• IV</li> <li>• mixed in cement</li> <li>• orally (PO)</li> <li>• other</li> <li>• peritoneal irrigation</li> </ul> <p><b>PN</b></p> <p>Include any antibiotics given:</p> <p><u>Intramuscular:</u></p> <ul style="list-style-type: none"> <li>• Injected</li> <li>• IM</li> <li>• I.M.</li> <li>• Z-track</li> </ul> <p><u>Intravenous:</u></p> <ul style="list-style-type: none"> <li>• Bolus</li> <li>• Infusion</li> <li>• IV</li> <li>• I.V.</li> <li>• IVPB</li> <li>• IV piggyback</li> <li>• Parenteral</li> </ul> <p><u>PO/NG/PEG tube:</u></p> <ul style="list-style-type: none"> <li>• any kind of feeding tube e.g., percutaneous endoscopic gastrostomy, percutaneous endoscopic jejunostomy, gastrostomy tube</li> <li>• by mouth</li> <li>• gastric tube</li> <li>• G-tube</li> <li>• Jejunostomy</li> <li>• J-tube</li> <li>• nasogastric tube</li> <li>• PO</li> <li>• P.O.</li> </ul> <p>Refer to Appendix C, Table 2.1 for a comprehensive list of Antimicrobial Medications</p>	<ul style="list-style-type: none"> <li>• eardrops</li> <li>• eyedrops</li> <li>• mouthwash</li> <li>• nasal sprays</li> <li>• peritoneal dialysate (antibiotic added to)</li> <li>• swish and spit</li> <li>• swish and swallow (S/S)</li> <li>• topical antibiotics</li> <li>• troches</li> <li>• vaginal administration</li> <li>• wound irrigation</li> </ul>

**Data Element Name:** *Antibiotic Administration Time*

**Collected For:** PN-3b, PN-5, PN-5a, PN-5b, PN-6, PN-6a, PN-6b, SIP-1, SIP-2, SIP-3

**Definition:** The time (military time) for which an antibiotic dose was administered.

**Suggested Data Collection Question:** What was the time of administration for the antibiotic dose?

**Format:**

**Length:** 5 – HH:MM (includes colon)  
**Type:** Time  
**Occurs:** 75

**Allowable Values:** HH = Hour (00-23)  
MM = Minutes (00-59)

Military Time – A 24-hour period from midnight to midnight using a 4-digit number of which the first two digits indicate the hour and the last two digits indicate the minute.

Converting clock time to military time:

With the exception of Midnight and Noon:

- If the time is in the a.m., conversion is not required
- If the time is in the p.m., add 12 to the clock time hour

For example:

Midnight - 00:00    Noon - 12:00

5:31 am - 05:31    5:31 pm - 17:31

11:59 am - 11:59    11:59 pm - 23:59

**Notes for Abstraction:** SIP: Document the time EACH antibiotic DOSE was administered from arrival through the first 48 hours after the surgery end time.

For EACH antibiotic name enter an Antibiotic Administration Route, Date, Time, and whether it is a Prophylactic Antibiotic.

PN: Document the initial (first time) time for which the patient received each antibiotic administered during the first 36 hours after hospital arrival, or the initial antibiotic

administered if antibiotics were not administered within the first 36 hours.

If an antibiotic is given more than one time during the first 36 hours after hospital arrival, only record the antibiotic name once. Enter the first administration date and time associated with each antibiotic name.

For EACH antibiotic name enter an Antibiotic Administration Route, Date, Time.

**Suggested Data Sources:**

- Emergency room record
- ICU flow sheet
- IV flow sheet
- Medication administration record
- Nursing notes

For SIP, in addition to the above data sources, the following data sources are also suggested:

- Anesthesia record
- Operating room record
- PACU/recovery room record

**Guidelines for Abstraction:**

<b>Inclusion</b>	<b>Exclusion</b>
None	None

<b>Data Element Name:</b>	<i>Antibiotic Allergy</i>
<b>Collected For:</b>	PN-6, PN-6a, SIP-2
<b>Definition:</b>	Documentation that the patient has an allergy, sensitivity, or intolerance to penicillin, beta lactams, or cephalosporins. An allergy can be defined as an acquired, abnormal immune response to a substance, (allergen) that does not normally cause a reaction.
<b>Suggested Data Collection Question:</b>	Did the patient have any allergies, sensitivities or intolerance to beta-lactam/penicillin antibiotic or cephalosporin medications?
<b>Format:</b>	<b>Length:</b> 1 <b>Type:</b> Alphanumeric <b>Occurs:</b> 1
<b>Allowable Values:</b>	Y (Yes) Documentation that the patient has an antibiotic allergy to beta-lactam, penicillin, or cephalosporins (e.g., either history or current finding). N (No) No documentation that the patient had an allergy to beta-lactam, penicillin, or cephalosporins or unable to determine from medical record documentation.
<b>Notes for Abstraction:</b>	If the patient was noted to be allergic to “cillins”, “penicillin”, or “all cillins”, select “Yes”.  If one source in the record documents “Allergies: penicillin” and another source in the record documents “penicillin causes upset stomach”, select “No” for this variable because upset stomach is an exclusion.
<b>Suggested Data Sources:</b>	<ul style="list-style-type: none"><li>• Consultation notes</li><li>• Emergency department record</li><li>• History and physical</li><li>• ICU flowsheets</li><li>• Medication administration record</li><li>• Nursing admission assessment</li><li>• Nursing notes</li></ul>

**Suggested Data Sources  
continued:**

- Physician orders
- Progress notes

For SIP, in addition to the above data sources, the following data sources may also be utilized:

- Anesthesia record
- Operating room notes
- PACU/recovery room record
- Pre-anesthesia assessment

**Guidelines for Abstraction:**

<b>Inclusion</b>	<b>Exclusion</b>
<p><b>Symptoms include</b></p> <ul style="list-style-type: none"> <li>• adverse drug event</li> <li>• adverse effect</li> <li>• adverse reaction</li> <li>• anaphylaxis</li> <li>• anaphylactic reaction</li> <li>• rash</li> <li>• hives</li> </ul> <p>Refer to Appendix C, Table 4.0 Antibiotic Allergy Table</p>	<p><b>Medications which cause any of the following</b></p> <ul style="list-style-type: none"> <li>• diarrhea</li> <li>• gastric upset</li> <li>• GI distress</li> <li>• nausea or vomiting</li> <li>• stomach upset</li> </ul>

<b>Data Element Name:</b>	<i>Antibiotic Name</i>
<b>Collected For:</b>	PN-3b, PN-5, PN-5a, PN-5b, PN-6, PN-6a, PN-6b, SIP-1, SIP-2, SIP-3
<b>Definition:</b>	The name of the antibiotic dose administered any time after hospital arrival.
<b>Suggested Data Collection Question:</b>	What is the name of the antibiotic administered any time after hospital arrival?
<b>Format:</b>	<b>Length:</b> 244 <b>Type:</b> Alphanumeric <b>Occurs:</b> 75
<b>Allowable Values:</b>	Name of any antibiotic, see Appendix C, Table 2.1  Not Otherwise Specified (NOS) If the specific name of the antibiotic is not on Table 2.1, please select “Antibiotic Not Otherwise Specified (NOS)” on Table 2.1, as the antibiotic name. This entry will then be treated as any other antibiotic entry.
<b>Notes for Abstraction:</b>	<b>SIP:</b> Document the name of EACH antibiotic DOSE administered from arrival <b>through the first 48 hours</b> after surgery end time.  For EACH antibiotic name, enter an Antibiotic Administration Route, Date, Time, and whether it is a Prophylactic Antibiotic.  <b>PN:</b> Document the name of each antibiotic administered PO, NG, PEG, IV, and/or IM <b>during the first 36 hours</b> after hospital arrival, or the initial antibiotic administered if antibiotics were not administered within the first 36 hours.  If an antibiotic is administered more than once by the same route during the first 36 hours after hospital arrival, only record the antibiotic name once. Enter the first administration date, time and route associated with each antibiotic name.

If the route of administration of an antibiotic changes during the first 36 hours after arrival, record the antibiotic name once for each route by which it was administered:

Example:

- A patient arrives at the hospital at 07:15 on 05-05-2004. Zithromax IV is given in the ER at 9:30 on 05-05-2004. On 05-06-2004 at 09:00 Zithromax PO is recorded as given on the MAR.  
Enter: Zithromax 05-05-2004 09:30 IV, and Zithromax 05-06-2004 09:00 PO

For EACH antibiotic name, enter an Antibiotic Administration Route, Date, Time.

**Suggested Data Sources:**

- Emergency department record
- ICU flowsheet
- IV flowsheet
- Medication administration record
- Nursing notes

For SIP, in addition to the above data source, the following data sources may also be utilized:

- Anesthesia record
- Operating room record
- PACU/recovery room record

**Guidelines for Abstraction:**

<b>Inclusion</b>	<b>Exclusion</b>
Refer to Appendix C, Table 2.1 for a comprehensive list of Antimicrobial Medications	None

**Data Element Name:** *Antibiotic Received*

**Collected For:** PN-3b, PN-5, PN-5a, PN-5b, PN-6, PN-6a, PN-6b

**Definition:** Documentation that the patient was on an intravenous (IV), intramuscular (IM), oral (PO), or nasogastric (NG) antibiotic. An antibiotic may be defined as any drug, such as penicillin or streptomycin, containing any quantity of any chemical substance produced by a microorganism or made synthetically (i.e.,quinolones) which has the capacity to inhibit the growth of or destroy bacteria and other microorganisms. Antibiotics are used in the prevention and treatment of infectious diseases.

**Suggested Data**

**Collection Question:** Did the patient receive an intravenous (IV), intramuscular (IM), oral (PO) or nasogastric (NG) antibiotic?

**Format:**                      **Length:** 1  
   **Type:** Alphanumeric  
   **Occurs:** 1

- Allowable Values:**
- 1 Antibiotic received only prior to arrival and not during hospital stay.
  - 2 Antibiotic received prior to arrival and during hospital stay.
  - 3 Antibiotic received only during hospital stay (any point in time from the patient's arrival to the hospital to the point of discharge).
  - 4 Antibiotic not received, or unable to determine from medical record documentation.

NOTE: Due to the difficulty and/or lack of medical record documentation regarding the start time and date of the outpatient antibiotic, this specific information is not required for this measure set.

**Notes for Abstraction:** None

- Suggested Data Sources:**
- Emergency department record
  - History and physical
  - Medication administration record
  - Nursing admission assessment
  - Physician admitting notes
  - Progress notes

**Guidelines for Abstraction:**

Inclusion	Exclusion
<p><b>PN</b>            Include any antibiotics given:  <u>Intramuscular:</u></p> <ul style="list-style-type: none"> <li>• Injected</li> <li>• IM</li> <li>• I.M.</li> <li>• Z-track</li> </ul> <p><u>Intravenous:</u></p> <ul style="list-style-type: none"> <li>• Bolus</li> <li>• Infusion</li> <li>• IV</li> <li>• I.V.</li> <li>• IVPB</li> <li>• IV piggyback</li> <li>• Parenteral</li> </ul> <p><u>PO/NG/PEG tube:</u></p> <ul style="list-style-type: none"> <li>• any kind of feeding tube e.g., percutaneous endoscopic gastrostomy, percutaneous endoscopic jejunostomy, gastrostomy tube</li> <li>• by mouth</li> <li>• gastric tube</li> <li>• G-tube</li> <li>• Jejunostomy</li> <li>• J-tube</li> <li>• nasogastric tube</li> <li>• PO</li> <li>• P.O.</li> </ul> <p>Refer to Appendix C, Table 2.1 for a comprehensive list of Antimicrobial Medications</p>	<ul style="list-style-type: none"> <li>• eardrops</li> <li>• eyedrops</li> <li>• mouthwash</li> <li>• nasal sprays</li> <li>• peritoneal dialysate (antibiotic added to)</li> <li>• swish and spit</li> <li>• swish and swallow (S/S)</li> <li>• topical antibiotics</li> <li>• troches</li> <li>• vaginal administration</li> <li>• wound irrigation</li> </ul>

**Data Element Name:** *Antibiotics During Stay*

**Collected For:** All SIP Measures

**Definition:** Documentation the patient received antibiotics during this hospital stay. This refers to the time period from arrival through the first 48 hours after the surgery end time. An antibiotic may be defined as any drug, such as penicillin or streptomycin, containing any quantity of any chemical substance produced by a microorganism or made synthetically (i.e., quinolones) which has the capacity to inhibit the growth of or destroy bacteria and other microorganisms. Antibiotics are used in the prevention and treatment of infectious diseases.

**Suggested Data**

**Collection Question:** Is there documentation the patient received antibiotics during this hospital stay?

**Format:**                      **Length:** 1  
    **Type:** Alphanumeric  
    **Occurs:** 1

**Allowable Values:**      Y (Yes) Documentation the patient received antibiotics during this hospital stay.  
    N (No) There is no documentation the patient received antibiotics during this hospital stay.

**Notes for Abstraction:** None

- Suggested Data Sources:**
- Anesthesia record
  - Emergency department record
  - ICU flowsheet
  - IV flowsheet
  - Medication administration record
  - Nursing notes
  - Operating room record
  - PACU/recovery room record

**Guidelines for Abstraction:**

Inclusion	Exclusion
Refer to Appendix C, Table 2.1 for a comprehensive list of Antimicrobial Medications	None

**Data Element Name:** *Antibiotics Prior to Arrival*

**Collected For:** PN-5, PN-5a, PN-5b, SIP-1, SIP-2, SIP-3

**Definition:** Documentation in the medical record that the patient received antibiotics within 24 hours prior to hospital arrival. An antibiotic may be defined as any drug, such as penicillin or streptomycin, containing any quantity of any chemical substance produced by a microorganism or made synthetically (i.e., quinolones) which has the capacity to inhibit the growth of or destroy bacteria and other microorganisms. Antibiotics are used in the prevention and treatment of infectious diseases.

**Suggested Data**

**Collection Question:** Did the patient receive antibiotics within 24 hours prior to arrival?

**Format:**                      **Length:** 1  
   **Type:** Alphanumeric  
   **Occurs:** 1

**Allowable Values:**      Y (Yes) Documentation that the patient received antibiotics within 24 hours prior to hospital arrival.  
   N (No) No documentation that the patient received antibiotics within 24 hours prior to hospital arrival or unable to determine when the antibiotics were received from medical record documentation.

**Notes for Abstraction:**      SIP: The intent of this question is to identify patients undergoing treatment for an infection. If the patient received antibiotics prior to arrival, answer “Yes”.

   PN: In order to answer “Yes”, there must be clear documentation to support the receipt of antibiotics within 24 hours prior to arrival. This may include the exact time of administration, or phrases such as “this morning”, “this afternoon”, or similar documentation that is obviously within 24 hours of arrival. For PN, if unable to determine when the antibiotics prior to arrival were received, answer “No”.

**Suggested Data Sources:**

- Any source documenting antibiotic administrations
- Emergency department record
- EMT/Ambulance records
- ICU flowsheet
- IV flowsheet
- Medication administration record
- Nursing notes

For SIP, in addition to the above data sources, the following data sources may also be utilized:

- Consultation notes
- History and physical
- Nursing admission assessment
- Pre-anesthesia assessments
- Pre-operative assessments

**Guidelines for Abstraction:**

<b>Inclusion</b>	<b>Exclusion</b>
<p><b>SIP</b></p> <ul style="list-style-type: none"> <li>• abdominal irrigation</li> <li>• chest irrigation</li> <li>• enema/rectally</li> <li>• feeding tubes (NG/PEG)</li> <li>• IM</li> <li>• inhalation</li> <li>• intracoronary (IC)</li> <li>• IV</li> <li>• mixed in cement</li> <li>• orally (PO)</li> <li>• other</li> <li>• peritoneal irrigation</li> </ul> <p><b>PN</b> Include any antibiotics given:</p> <p><u>Intramuscular:</u></p> <ul style="list-style-type: none"> <li>• Injected</li> <li>• IM</li> <li>• I.M.</li> <li>• Z-track</li> </ul> <p><u>Intravenous:</u></p> <ul style="list-style-type: none"> <li>• Bolus</li> <li>• Infusion</li> <li>• IV</li> <li>• I.V.</li> <li>• IVPB</li> <li>• IV piggyback</li> <li>• Parenteral</li> </ul>	<ul style="list-style-type: none"> <li>• eardrops</li> <li>• eyedrops</li> <li>• mouthwash</li> <li>• nasal sprays</li> <li>• peritoneal dialysate (antibiotic added to)</li> <li>• swish and spit</li> <li>• swish and swallow (S/S)</li> <li>• topical antibiotics</li> <li>• troches</li> <li>• vaginal administration</li> <li>• wound irrigation</li> </ul>

**Guidelines for Abstraction (cont.):**

<b>Inclusion</b>	<b>Exclusion</b>
<p><u>PO/NG/PEG tube:</u></p> <ul style="list-style-type: none"><li>• any kind of feeding tube e.g., percutaneous endoscopic gastrostomy, percutaneous endoscopic jejunostomy, gastrostomy tube</li><li>• by mouth</li><li>• gastric tube</li><li>• G-tube</li><li>• Jejunostomy</li><li>• J-tube</li><li>• nasogastric tube</li><li>• PO</li><li>• P.O.</li></ul> <p>Refer to Appendix C, Table 2.1 for a comprehensive list of Antimicrobial Medications</p>	

<b>Data Element Name:</b>	<i>Arrival Date</i>
<b>Collected For:</b>	AMI-1, AMI-6, AMI-7, AMI-7a, AMI-8, AMI-8a, AMI-T1b (CMS optional test measure), PN-3a, PN-3b, PN-5, PN-5a, PN-5b, PN-6, PN-6a, PN-6b
<b>Definition:</b>	The earliest documented month, day, and year the patient arrived at the hospital.
<b>Suggested Data Collection Question:</b>	What was the <b>earliest</b> documented date the patient arrived at the hospital?
<b>Format:</b>	<b>Length:</b> 10 – MM-DD-YYYY (includes dashes) <b>Type:</b> Date <b>Occurs:</b> 1
<b>Allowable Values:</b>	Enter the earliest documented date MM = Month (01-12) DD = Day (01-31) YYYY = Year (2000-9999)
<b>Notes for Abstraction:</b>	<ul style="list-style-type: none"><li>• Review only the acceptable sources to determine the earliest date the patient arrived at the hospital. This may differ from the admission date.</li><li>• When reviewing ED records do NOT include any documentation from external sources (e.g., ambulance records, physician office record, laboratory reports or ECG/EKGs) obtained prior to arrival. The intent is to utilize any documentation which reflects processes that occurred in the ED or hospital.</li><li>• Do not include addressographs/stamps.</li><li>• If the patient is in an outpatient setting of the hospital (e.g., undergoing dialysis, chemotherapy, or an outpatient procedure) and is subsequently admitted to the hospital, use the date the patient presents to the ED or arrives on the floor for inpatient care as arrival date.</li></ul>

**Suggested Data Sources: ONLY ACCEPTABLE SOURCES:**

- Any ED documentation (includes ED vital sign record, ED/Outpatient Registration form, or triage record)
- Face sheet
- Nursing admission assessment/admitting note
- Observation record
- Procedure notes
- Vital signs graphic record

**Guidelines for Abstraction:**

<b>Inclusion</b>	<b>Exclusion</b>
None	None

<b>Data Element Name:</b>	<i>Arrival Time</i>
<b>Collected For:</b>	AMI-7, AMI-7a, AMI-8, AMI-8a, PN-3a, PN-3b, PN-5, PN-5a, PN-5b, PN 6, PN-6a, PN-6b
<b>Definition:</b>	The earliest documented time (military time) the patient arrived at the hospital.
<b>Suggested Data Collection Question:</b>	What was the <b>earliest</b> documented time the patient arrived at the hospital?
<b>Format:</b>	<b>Length:</b> 5 - HH:MM (includes colon) <b>Type:</b> Time <b>Occurs:</b> 1
<b>Allowable Values:</b>	Enter the earliest documented time of arrival HH = Hour (00-23) MM = Minutes (00-59)  Military Time – A 24-hour period from midnight to midnight using a 4-digit number of which the first two digits indicate the hour and the last two digits indicate the minute.  Converting clock time to military time: With the exception of Midnight and Noon: <ul style="list-style-type: none"><li>• If the time is in the a.m., conversion is not required</li><li>• If the time is in the p.m., add 12 to the clock time hour</li></ul> For example: Midnight - 00:00    Noon - 12:00 5:31 am - 05:31    5:31 pm - 17:31 11:59 am - 11:59    11:59 pm - 23:59

**Notes for Abstraction:**

- Review only the acceptable sources to determine the earliest time the patient arrived at the hospital. This may differ from the admission time.
- When reviewing ED records do NOT include any documentation from external sources (e.g., ambulance records, physician office record, laboratory report, or ECG/EKGs) obtained prior to arrival. The intent is to utilize any documentation which reflects processes that occurred in the ED or hospital.
- Do not include addressographs/stamps.
- If the patient is in an outpatient setting of the hospital (e.g., undergoing dialysis, chemotherapy or an outpatient procedure) and is subsequently admitted to the hospital, use the time the patient presents to the ED or arrives on the floor as the arrival time.

**Suggested Data Sources: ONLY ACCEPTABLE SOURCES:**

- Any ED documentation (includes ED vital sign record, ED/Outpatient Registration form, or triage record)
- Face sheet
- Nursing admission assessment/admitting note
- Observation record
- Procedure notes
- Vital signs graphic record

**Guidelines for Abstraction:**

<b>Inclusion</b>	<b>Exclusion</b>
None	None

<b>Data Element Name:</b>	<i>ASA Score</i>
<b>Collected For:</b>	All SIP Records – (CMS Optional Data Element)
<b>Definition:</b>	Documentation of the American Society of Anesthesiologists (ASA) physical status score.
<b>Suggested Data Collection Question:</b>	What was the patient’s American Society of Anesthesiologists (ASA) physical status score?
<b>Format:</b>	<b>Length:</b> 1 <b>Type:</b> Alphanumeric <b>Occurs:</b> 1
<b>Allowable Values:</b>	<ol style="list-style-type: none"><li>1 The ASA physical status score is documented as 1.</li><li>2 The ASA physical status score is documented as 2.</li><li>3 The ASA physical status score is documented as 3.</li><li>4 The ASA physical status score is documented as 4.</li><li>5 The ASA physical status score is documented as 5.</li><li>6 The ASA physical status score is documented as 6.</li><li>7 UTD</li></ol> <p>An ASA physical status score other than those listed above is documented (including “0”), or there is no score recorded on the priority sources, or the documentation is illegible, or unable to determine from medical record documentation.</p>
<b>Notes for Abstraction:</b>	If “0” is documented, choose “UTD”.
<b>Suggested Data Sources:</b>	<ul style="list-style-type: none"><li>• Anesthesia record</li><li>• Pre-anesthesia assessment performed prior to surgery</li></ul>

**Guidelines for Abstraction:**

<b>Inclusion</b>	<b>Exclusion</b>
<ul style="list-style-type: none"><li>• ASA PS</li><li>• ASA score</li><li>• physical score</li><li>• physical status</li><li>• PS</li><li>• PS score</li></ul> <p>Additional inclusions if related to anesthesia:</p> <ul style="list-style-type: none"><li>• risk status</li><li>• status</li><li>• score</li></ul>	None

**Data Element Name:** *Aspirin Prescribed at Discharge*

**Collected For:** AMI-2

**Definition:** Documentation that aspirin was prescribed at discharge. Aspirin is primarily a pain reliever. Aspirin also reduces the tendency of blood to clot by blocking the action of a type of blood cell involved in clotting. Aspirin reduces the risk of having a heart attack and improves chances of surviving a heart attack.

NOTE: Refer to Appendix C, Table 1.1 for a list of aspirin medications.

**Suggested Data**

**Collection Question:** Was aspirin prescribed at discharge?

**Format:**                      **Length:** 1  
**Type:**                      Alphanumeric  
**Occurs:** 1

**Allowable Values:**      Y (Yes) Aspirin prescribed at discharge.  
                                       N (No) Aspirin not prescribed at discharge or unable to determine from medical record documentation.

**Notes for Abstraction:**    None

- Suggested Data Sources:**
- Discharge instruction sheet
  - Discharge summary
  - Nursing discharge notes
  - Physician orders
  - Transfer sheet

**Guidelines for Abstraction:**

Inclusion	Exclusion
Refer to Appendix C, Table 1.1 for a comprehensive list of Aspirin and Aspirin-Containing Medications	None

**Data Element Name:** *Aspirin Received Within 24 Hours Before or After Hospital Arrival*

**Collected For:** AMI-1

**Definition:** Aspirin received within 24 hours before or 24 hours after hospital arrival. Aspirin is primarily a pain reliever. Aspirin also reduces the tendency of blood to clot by blocking the action of a type of blood cell involved in clotting. Aspirin reduces the risk of having a heart attack and improves chances of surviving a heart attack.

NOTE: Refer to Appendix C, Table 1.1 for a list of aspirin medications.

**Suggested Data**

**Collection Question:** Was aspirin received within 24 hours before or 24 hours after hospital arrival?

**Format:**                      **Length:** 1  
   **Type:** Alphanumeric  
   **Occurs:** 1

**Allowable Values:**      Y (Yes) Aspirin received within 24 hours before or 24 hours after hospital arrival.  
   N (No) Aspirin not received within 24 hours before or 24 hours after hospital arrival or unable to determine from medical record documentation.

**Notes for Abstraction:**

- Do not assume that the patient took aspirin within 24 hours prior to arrival based solely on aspirin being listed as a pre-arrival or home medication. Documentation must indicate that the patient actually took aspirin within the 24 hour timeframe.
- When unable to determine for certain whether aspirin was received within 24 hours prior to arrival (e.g., last dose noted as 02-27-2004 and patient arrived at hospital on 02-28-2004 at 09:00), select “No”.

**Suggested Data Sources:**

- Ambulance record
- Emergency department record
- History and physical
- Medication administration record
- Nursing admission assessment
- Transfer sheet

**Guidelines for Abstraction:**

<b>Inclusion</b>	<b>Exclusion</b>
Refer to Appendix C, Table 1.1 for a comprehensive list of Aspirin and Aspirin-Containing Medications	None

**Data Element Name:** *Beta Blocker Prescribed at Discharge*

**Collected For:** AMI-5

**Definition:** Documentation that a beta blocker was prescribed at discharge. Beta blockers are agents which block beta-adrenergic receptors, thereby decreasing the rate and force of heart contractions, and reducing blood pressure. Over time beta blockers improve the heart's pumping ability.

NOTE: Refer to Appendix C, Table 1.3 for a list of beta blockers.

**Suggested Data**

**Collection Question:** Was a beta blocker prescribed at discharge?

**Format:**                      **Length:** 1  
    **Type:** Alphanumeric  
    **Occurs:** 1

**Allowable Values:**        Y (Yes) Beta blocker prescribed at discharge.  
    N (No) Beta blocker not prescribed at discharge or unable to determine from medical record documentation.

**Notes for Abstraction:**    None

- Suggested Data Sources:**
- Discharge instruction sheet
  - Discharge summary
  - Nursing discharge notes
  - Physician order sheet
  - Transfer sheet

**Guidelines for Abstraction:**

<b>Inclusion</b>	<b>Exclusion</b>
Refer to Appendix C, Table 1.3 for a comprehensive list of Beta Blocker medications	None

**Data Element Name:** *Beta Blocker Received Within 24 Hours After Hospital Arrival*

**Collected For:** AMI-6

**Definition:** Beta blocker was received within 24 hours after hospital arrival. Beta blockers are agents which block beta-adrenergic receptors, thereby decreasing the rate and force of heart contractions, and reducing blood pressure. Over time beta blockers improve the heart's pumping ability.

NOTE: Refer to Appendix C, Table 1.3 for a list of beta blockers.

**Suggested Data**

**Collection Question:** Was a beta blocker received within 24 hours after hospital arrival?

**Format:**                      **Length:** 1  
    **Type:** Alphanumeric  
    **Occurs:** 1

**Allowable Values:**      Y (Yes) Beta blocker received within 24 hours after hospital arrival.  
    N (No) Beta blocker not received within 24 hours after hospital arrival or unable to determine from medical record documentation.

**Notes for Abstraction:** None

- Suggested Data Sources:**
- Emergency department record
  - History and physical
  - Medication administration record
  - Nursing admission assessment

**Guidelines for Abstraction:**

Inclusion	Exclusion
Refer to Appendix C, Table 1.3 for a comprehensive list of Beta Blocker medications	None

<b>Data Element Name:</b>	<i>Beta Blockers</i>
<b>Collected For:</b>	All SIP Records – (CMS Optional Data Element)
<b>Definition:</b>	Documentation of the timeframes the patient received beta blockers. Beta blockers are antihypertensive drugs that limit the activity of epinephrine, a hormone that increases blood pressure.
<b>Suggested Data Collection Question:</b>	During which of the following timeframes did the patient receive beta blockers?
<b>Format:</b>	<b>Length:</b> 1 <b>Type:</b> Alphanumeric <b>Occurs:</b> 1
<b>Allowable Values:</b>	<i>All that apply:</i> 1 Preoperatively: The patient received beta blockers in the preoperative setting. 2 Intraoperatively: The patient received beta blockers in the intraoperative setting. 3 Postoperatively: The patient received beta blockers in the postoperative setting. 0 None of the above: The patient did not receive beta blockers during any of the above listed timeframes or unable to determine from medical record documentation.
<b>Notes for Abstraction:</b>	None

- Suggested Data Sources:**
- Discharge summary
  - ICU flow sheets
  - Medication administration record
  - Nursing notes
  - PACU/recovery room record
  - Physician orders
  - Procedure reports/notes
  - Progress notes

**Guidelines for Abstraction:**

<b>Inclusion</b>	<b>Exclusion</b>
Refer to Appendix C, Table 1.3 for a comprehensive list of Beta Blocker medications	None

<b>Data Element Name:</b>	<i>Birth Weight</i>
<b>Collected For:</b>	PR-2 (used for risk adjustment) (JCAHO ONLY)
<b>Definition:</b>	The weight (in grams) of a neonate at the time of delivery.  NOTE: 453.5 grams = 1 pound 28.35 grams = 1 ounce It is recommended that each system provide the ability to enter birth weight in either grams or pounds. However, all birth weights must be converted to grams prior to indicator calculation. Values of less than 150 grams should be verified.
<b>Suggested Data Collection Question:</b>	What was the weight of the neonate at delivery?
<b>Format:</b>	<b>Length:</b> 4 <b>Type:</b> Alphanumeric <b>Occurs:</b> 1
<b>Allowable Values:</b>	150 through 7200 grams  NOTE: When converting from pounds and ounces to grams, do not round to the nearest pound before converting the weight to grams. Round to the nearest whole number after the conversion to grams.  NOTE: Birth weights less than 150 grams need to be verified for data quality. Neonates with birth weights less than 150 grams are not likely to be born live and therefore would not be part of the population.
<b>Notes for Abstraction:</b>	None

- Suggested Data Sources:**
- Delivery record
  - History and physical
  - Nursing note
  - Nursery record
  - Physician progress note

**Guidelines for Abstraction:**

<b>Inclusion</b>	<b>Exclusion</b>
None	None

**Data Element Name:** *Birthdate*

**Collected For:** All Records

**Definition:** The month, day, and year the patient was born.

NOTE: Patient's age (in years) is calculated by Admission Date minus Birthdate. The algorithm to calculate age must use the month and day portion of admission date and birthdate to yield the most accurate age.

**Suggested Data**

**Collection Question:** What is the patient's date of birth?

**Format:** **Length:** 10 – MM-DD-YYYY (includes dashes)  
**Type:** Date  
**Occurs:** 1

**Allowable Values:** MM = Month (01-12)  
 DD = Day (01-31)  
 YYYY = Year (1880-9999)

**Notes for Abstraction:** Because this data element is critical in determining the population for all measures, the abstractor should NOT assume that the UB-92 claim information for the birthdate is correct. If the abstractor determines through chart review that the UB-92 date is incorrect, she/he should correct and override the downloaded value. If the abstractor is unable to determine the correct birthdate through chart review, she/he should default to the UB-92 date of birth.

- Suggested Data Sources:**
- Emergency department record
  - Face sheet
  - Registration form
  - UB-92, Field Location: 14

**Guidelines for Abstraction:**

Inclusion	Exclusion
None	None

<b>Release Notes:</b> Data Element - Version 1.0
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**Data Element Name:** *Blood Culture Collected After Arrival*

**Collected For:** PN-3a, PN-3b

**Definition:** Documentation in the medical record that a blood culture was collected after hospital arrival (at any time from the point of the patient's arrival to the hospital to the point of discharge). This includes blood cultures drawn in the emergency room or in observation beds, as well as after the patient's admission to inpatient status. A blood culture can be defined as a culture of microorganisms from specimens of blood to determine the presence and nature of bacteremia.

**Suggested Data Collection Question:** Did the patient have blood cultures collected after hospital arrival?

**Format:**                      **Length:** 1  
**Type:** Alphanumeric  
**Occurs:** 1

**Allowable Values:** Y (Yes) A blood culture was collected after hospital arrival.  
 N (No) Blood culture not done or unable to determine from medical record documentation.

**Notes for Abstraction:** None

- Suggested Data Sources:**
- Emergency department record
  - History and physical
  - Laboratory report
  - Microbiology report
  - Nursing notes
  - Progress notes

**Guidelines for Abstraction:**

<b>Inclusion</b>	<b>Exclusion</b>
<ul style="list-style-type: none"> <li>• BC</li> <li>• blood cultures</li> <li>• blood cultures collected on patients in observation beds</li> </ul>	<ul style="list-style-type: none"> <li>• Cultures collected prior to arrival</li> </ul>

**Data Element Name:** *Blood Cultures Prior to Arrival*

**Collected For:** PN-3a, PN-3b

**Definition:** Documentation in the medical record that a blood culture (a culture of microorganisms from specimens of blood to determine the presence and nature of bacteremia) was collected within 24 hours prior to hospital arrival.

**Suggested Data**

**Collection Question:** Did the patient have blood cultures collected within 24 hours prior to hospital arrival?

**Format:**                      **Length:** 1  
    **Type:** Alphanumeric  
    **Occurs:** 1

**Allowable Values:**        Y (Yes) Documentation that the patient had blood cultures collected within 24 hours prior to hospital arrival.  
    N (No) The patient did not have blood cultures collected within 24 hours prior to hospital arrival or unable to determine from medical record documentation.

**Notes for Abstraction:**    None

- Suggested Data Sources:**
- Emergency department record
  - History and physical
  - Laboratory report
  - Nursing notes
  - Progress notes
  - Transfer forms

**Guidelines for Abstraction:**

Inclusion	Exclusion
<ul style="list-style-type: none"> <li>• BC</li> <li>• blood cultures done in the physician's office</li> <li>• blood cultures PTA</li> </ul>	<ul style="list-style-type: none"> <li>• Cultures collected more than 24 hours prior to arrival</li> </ul>

<b>Data Element Name:</b>	<i>Blood Sugar</i>
<b>Collected For:</b>	All SIP Records – (CMS Optional Data Element)
<b>Definition:</b>	Documentation of a blood sugar level of greater than or equal to 200 ( $\geq 200$ ) intraoperatively or within 48 hours postoperatively.
<b>Suggested Data Collection Question:</b>	Did the patient have a blood sugar level of greater than or equal to 200 ( $\geq 200$ ) intraoperatively or within 48 hours postoperatively?
<b>Format:</b>	<b>Length:</b> 1 <b>Type:</b> Alphanumeric <b>Occurs:</b> 1
<b>Allowable Values:</b>	<ol style="list-style-type: none"><li>1 Yes-above: The patient had a blood sugar level greater than or equal to 200 (<math>\geq 200</math>) intraoperatively or within 48 hours postoperatively.</li><li>2 No-below: The patient had a blood sugar level less than 200 (<math>&lt; 200</math>) intraoperatively or within 48 hours postoperatively.</li><li>3 UTD: Unable to determine if a blood sugar was performed during the intraoperative or 48 hours postoperative timeframe.</li><li>0 No-not performed: A blood sugar was not performed intraoperatively or within 48 hours postoperatively.</li></ol>
<b>Notes for Abstraction:</b>	None
<b>Suggested Data Sources:</b>	<ul style="list-style-type: none"><li>• Consultation notes</li><li>• Diabetic flow sheet</li><li>• Laboratory report</li><li>• Nursing graphic sheets</li><li>• Nursing notes</li><li>• PACU/recovery room record</li><li>• Progress notes</li></ul>

**Guidelines for Abstraction:**

<b>Inclusion</b>	<b>Exclusion</b>
<ul style="list-style-type: none"><li>• blood sugar</li><li>• fasting glucose</li><li>• finger stick glucose</li><li>• glucometer results</li><li>• glucose</li><li>• non-fasting glucose</li><li>• random glucose</li><li>• serum glucose</li></ul>	None

<b>Data Element Name:</b>	<i>Bowel Prep</i>
<b>Collected For:</b>	All SIP Records – (CMS Optional Data Element)
<b>Definition:</b>	Documentation a bowel preparation was done prior to the colon surgery. Bowel prep may be defined as the process used to clean the colon and rectum with enemas and a special drink. It is used before surgery of the colon, a colonoscopy or barium x-ray. It is sometimes called lavage.
<b>Suggested Data Collection Question:</b>	Was a bowel preparation done prior to the colon surgery?
<b>Format:</b>	<b>Length:</b> 1 <b>Type:</b> Alphanumeric <b>Occurs:</b> 1
<b>Allowable Values:</b>	Y (Yes) A bowel preparation was done prior to the colon surgery. N (No) A bowel preparation was not done prior to the colon surgery or unable to determine from medical record documentation.
<b>Notes for Abstraction:</b>	Select “No” if the surgical procedure of interest was not a colon procedure.
<b>Suggested Data Sources:</b>	<ul style="list-style-type: none"><li>• Emergency room record</li><li>• ICU flow sheet</li><li>• Nursing notes</li><li>• Operative notes</li><li>• Pre-op checklist</li><li>• Procedure notes</li></ul>

**Guidelines for Abstraction:**

<b>Inclusion</b>	<b>Exclusion</b>
<ul style="list-style-type: none"><li>• cleansing enema</li><li>• Colyte</li><li>• enema</li><li>• enemas until clear</li><li>• Fleets phosphosoda</li><li>• Go-Lytely</li><li>• Mag citrate</li><li>• Phosphosoda</li><li>• X-prep</li></ul>	<ul style="list-style-type: none"><li>• Barium enema</li></ul>

<b>Release Notes:</b> Data Element - Version 1.0
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**Data Element Name:** *Case Identifier*

**Collected For:** All Records (JCAHO REQUIRED)

**Definition:** A measurement system-generated number that uniquely identifies an episode of care. This identification number should be used by the performance measurement system (PMS) in order to allow the health care organization to link this Case Identifier to a specific record for purposes of ORYX<sup>®</sup>.

A patient identifier is required for data submitted to the QIO data warehouse.

**Suggested Data**

**Collection Question:** What is the unique measurement system-generated number that identifies this episode of care?

**Format:**                      **Length:** 9  
    **Type:** Numeric  
    **Occurs:** 1

**Allowable Values:** Value greater than (0) assigned by the system.

**Notes for Abstraction:** None

**Suggested Data Sources:** Unique measurement system generated number

JCAHO NOTE: A PMS may have its own case identifier. We are not requesting that systems change their internal processes; rather this identifier is needed for ORYX verification and risk adjustment data.

**Guidelines for Abstraction:**

Inclusion	Exclusion
Refer to Appendix I, Patient ID	None

**Data Element Name:** *Comfort Measures Only*

**Collected For:** All PN Measures

**Definition:** Physician/nurse practitioner/physician assistant documentation the patient was receiving comfort measures only. Commonly referred to as “palliative care” in the medical community and “comfort care” by the general public. Palliative care includes attention to the psychological and spiritual needs of the patient and support for the dying patient and the patient's family. Usual interventions are not received because a medical decision was made to limit care to comfort measures only. Comfort Measure Only are not equivalent to the following: Do Not Resuscitate (DNR), living will, no code, no heroic measure.

**Suggested Data**

**Collection Question:** Is there physician/nurse practitioner/physician assistant documentation the patient was receiving comfort measures only?

**Format:** **Length:** 1  
**Type:** Alphanumeric  
**Occurs:** 1

**Allowable Values:** Y (Yes) There is physician/nurse practitioner/physician assistant documentation that the patient was receiving comfort measures anytime during the hospital stay.  
N (No) There is no documentation the patient was receiving comfort measures only or unable to determine from medical record documentation.

JCAHO NOTE: If the ICD-9-CM Other Diagnosis code V66.7 (encounter for palliative care) exists, then default the allowable value to Y(Yes).

**Notes for Abstraction:** None

**Suggested Data Sources:    PHYSICIAN/NURSE PRACTITIONER/PHYSICIAN ASSISTANT DOCUMENTATION ONLY**

- Admitting physician orders
- Consultation notes
- Emergency department record
- History and physical
- Physician admitting note
- Physician orders
- Progress notes

**Guidelines for Abstraction:**

<b>Inclusion</b>	<b>Exclusion</b>
<ul style="list-style-type: none"> <li>• comfort measures only</li> <li>• hospice care</li> <li>• maintain treatment for comfort, terminal care</li> <li>• physician documentation that care is limited at family's request or due to patient's age or chronic illness</li> <li>• palliative care</li> <li>• supportive care only</li> <li>• V66.7 encounter for palliative care</li> </ul>	<ul style="list-style-type: none"> <li>• chemical code only</li> <li>• DNR</li> <li>• do not cardiovert</li> <li>• do not defibrillate</li> <li>• do not intubate (DNI)</li> <li>• living will</li> <li>• NCR</li> <li>• no antiarrhythmic therapy</li> <li>• no artificial respirations</li> <li>• no cardiac monitoring</li> <li>• no chest compressions</li> <li>• no code</li> <li>• no Code 99</li> <li>• no heroic or aggressive measures</li> <li>• no intubation and/or ventilation</li> <li>• no invasive procedures</li> <li>• no other protocols associated with advanced cardiac life support</li> <li>• no resuscitative medications</li> <li>• no resuscitative measures (NRM)</li> <li>• no vasopressors</li> </ul>

**Data Element Name:** *Compromised*

**Collected For:** PN-6, PN-6a, PN-6b

**Definition:** For the purposes of PN-6, PN-6a and PN-6b, “*Compromised*” includes 2 concepts:

1. The patient has a clinical condition that could cause an impaired immune system or put the patient at a higher risk for infection.
2. A prior hospitalization within 14 days. The intent is to exclude possible nosocomial infections.

Documentation that the patient had:

1. Any of the following compromising conditions:
  - HIV positive
  - AIDS
  - Cystic fibrosis
  - Systemic chemotherapy within last three months
  - Immunosuppressive therapy within last three months
  - Leukemia documented in the past three months
  - Lymphoma documented in the past three months
  - Radiation therapy in the past three months
2. A prior hospitalization within 14 days. The patient was discharged from an acute care facility for inpatient care to a non-acute setting (e.g., home, SNF, ICF, or rehabilitation hospital), before the second admission to the same or different acute care facility.

**Suggested Data**

**Collection Question:** Is there documentation the patient had a compromising condition?

**Format:**

**Length:** 1  
**Type:** Alphanumeric  
**Occurs:** 1

**Allowable Values:**

- 1 One of the following compromising conditions; HIV/AIDS, cystic fibrosis, systemic chemotherapy, radiation therapy, immunosuppressive therapy, or leukemia/lymphomas
- 2 Prior hospitalization within 14 days
- 3 Both 1 and 2
- 4 None of the above

**Notes for Abstraction:** None

- Suggested Data Sources:**
- Admission face sheet
  - Consultant notes
  - Discharge summary
  - Emergency room record
  - History and physical
  - Nurse admission notes

**Guidelines for Abstraction:**

<b>Inclusion</b>	<b>Exclusion</b>
<ul style="list-style-type: none"><li>• Acquired Immune Deficiency Syndrome</li><li>• AIDS related complex</li><li>• ARC</li><li>• Cystic Fibrosis (CF) (Documentation of, or reflected by ICD-9-CM codes 277.00, 277.01, 277.02, 277.03, or 277.09)</li><li>• HIV + lymphocytic leukemia</li><li>• HIV positive</li><li>• myelogenous leukemia</li><li>• myeloma</li><li>• myelodysplasia</li><li>• organ transplant</li><li>• prednisone therapy</li><li>• radiation therapy</li></ul> <p>Refer to Appendix C, Table 2.2 for a comprehensive list of Immunosuppressive medications</p>	None

**Data Element Name:** *Contraindication to ACEI at Discharge*

**Collected For:** AMI-3, HF-3

**Definition:** Contraindications/reasons for not prescribing angiotensin converting enzyme inhibitors (ACEIs) include: ACEI allergy, moderate or severe aortic stenosis, or other reasons documented by physician, nurse practitioner, physician assistant for not prescribing ACEI at discharge. ACEIs widen or dilate blood vessels to improve the amount of blood the heart pumps and lower blood pressure. This helps decrease the amount of work the heart has to do and helps prevent deterioration in heart function over time.

NOTE: Refer to Appendix C, Table 1.2 for a list of ACEIs.

**Suggested Data**

**Collection Question:** Is one or more of the following potential contraindications/reasons for not prescribing an angiotensin converting enzyme inhibitor (ACEI) at discharge documented?

**Format:**                      **Length:** 1  
   **Type:** Alphanumeric  
   **Occurs:** 1

**Allowable Values:**        Y (Yes) Documentation that the patient has one or more of the following potential contraindications/reasons for not prescribing an ACEI at discharge:

- ACEI allergy
- Moderate or severe aortic stenosis
- Other reasons documented by physician, nurse practitioner, or physician assistant for not prescribing ACEI at discharge

   N (No) There is no documentation of potential contraindications/reasons for not prescribing ACEI at discharge or unable to determine from medical record documentation.

**Notes for Abstraction:**

- **This data element should be answered independently and irrespective of whether the patient was prescribed ACEI at discharge.**
- When there is documentation of an ACEI “allergy” or “sensitivity”, regard this as documentation of an ACEI allergy regardless of what type of reaction might be noted. Do not attempt to distinguish between true allergies/sensitivities and intolerances, side effects, etc. (e.g., “Allergies: ACEIs – Cough” – select “Yes”).
- Documentation of an allergy/sensitivity to one particular ACEI is acceptable (e.g., “Allergic to Vasotec”). Allergy documentation does NOT need to refer to the entire class of ACEIs.
- Moderate or severe aortic stenosis includes both a current finding of moderate or severe aortic stenosis AND a history of moderate or severe aortic stenosis without mention of repair or replacement, valvuloplasty, or commissurotomy.
- When determining whether there is a reason documented by a physician, nurse practitioner, or physician assistant for not prescribing an ACEI at discharge:
  - Reasons must be explicitly documented (e.g., “K+5.5 – No ACEI”) or clearly implied (e.g., “Severe hypotension with ACEIs in past”, “Hx ACEI-induced cough”, “ACEIs contraindicated”, “Intolerant of ACE inhibitors”, “Problems with ACEIs in past”, “c/o severe cough, will dc Vasotec”, “Pt. refusing all medications”, “Terminal care, no further treatment”). If reasons are not mentioned in the context of ACEIs, do not make inferences (e.g., Do not assume that an ACEI is not prescribed because of the patient's chronic renal disease, or because the patient was prescribed ARBs).
  - Reasons do NOT need to be documented at the time of discharge or otherwise associated specifically with discharge prescription. Documentation of contraindications anytime during the hospital stay are acceptable (e.g., ACEI held mid-hospitalization “due to acute renal failure” - select “Yes”, even if documentation indicates that the acute renal failure had resolved by the time of discharge).
  - Disregard documentation of a temporary hold, discontinuation, or initiation of an ACEI which is made conditional (e.g., “Hold Captopril if cough persists”, “Stop Vasotec if BP < 90 systolic”, “Consider ACE therapy after BP stabilizes”).

- Suggested Data Sources:**
- Consultation notes
  - Diagnostic test reports
  - Discharge instruction sheet
  - Discharge summary
  - Emergency department record
  - History and physical
  - Medication administration record
  - Nursing notes
  - Physician orders
  - Progress notes

**Guidelines for Abstraction:**

<b>Inclusion</b>	<b>Exclusion</b>
<p><b>Moderate/severe aortic stenosis (AS)</b></p> <ul style="list-style-type: none"> <li>• aortic stenosis described as 3+, 4+, or critical</li> <li>• aortic stenosis, degree of severity not specified</li> <li>• aortic valve area of &lt; 1.0 square cms</li> </ul> <p>Refer to Appendix C, Table 1.2 for a comprehensive list of ACEIs</p>	<p><b>ACEI allergy</b></p> <ul style="list-style-type: none"> <li>• ACEI allergy described using one of the following qualifiers: cannot exclude, cannot rule out, may have, may have had, may indicate, possible, suggestive of, suspect, or suspicious</li> </ul> <p><b>Moderate/severe aortic stenosis (AS)</b></p> <ul style="list-style-type: none"> <li>• aortic insufficiency only</li> <li>• aortic regurgitation only</li> <li>• aortic stenosis described as 1+ or 2+</li> <li>• moderate/severe aortic stenosis, or any of the other moderate/severe aortic stenosis inclusion terms, described using one of the following qualifiers: cannot exclude, cannot rule out, may have, may have had, may indicate, possible, suggestive of, suspect, or suspicious</li> <li>• subaortic stenosis</li> </ul>

**Data Element Name:** *Contraindication to Aspirin at Discharge*

**Collected For:** AMI-2

**Definition:** Contraindications/reasons for not prescribing aspirin at discharge include: aspirin allergy, active bleeding on arrival or during hospital stay, Coumadin/warfarin prescribed at discharge, or other reasons documented by physician, nurse practitioner, physician assistant for not prescribing aspirin at discharge. Aspirin is primarily a pain reliever. Aspirin also reduces the tendency of blood to clot by blocking the action of a type of blood cell involved in clotting. Aspirin reduces the risk of having a heart attack and improves chances of surviving a heart attack.

NOTE: Refer to Appendix C, Table 1.1 for a list of aspirin medications.

NOTE: Refer to Appendix C, Table 1.4 for a list of warfarin medications.

**Suggested Data**

**Collection Question:** Is one or more of the following potential contraindications/reasons for not prescribing aspirin at discharge documented?

**Format:**                      **Length:** 1  
**Type:**                        Alphanumeric  
**Occurs:**                      1

**Allowable Values:**        Y (Yes) Documentation that the patient has one or more of the following potential contraindications/reasons for not prescribing an aspirin at discharge:

- Active bleeding on arrival or anytime during hospital stay
- Aspirin allergy
- Coumadin/warfarin prescribed at discharge
- Other reasons documented by physician, nurse practitioner, or physician assistant for not prescribing aspirin at discharge.

N (No) There is no documentation of potential contraindications/reasons for not prescribing aspirin at discharge, or unable to determine from medical documentation.

**Notes for Abstraction:**

- **This data element should be answered independently and irrespective of whether the patient was prescribed aspirin at discharge.**
- When there is documentation of an aspirin “allergy” or “sensitivity”, regard this as documentation of an aspirin allergy regardless of what type of reaction might be noted. Do not attempt to distinguish between true allergies/sensitivities and intolerances, side effects, etc. (e.g., “Allergies: ASA – Upsets stomach – select “Yes”).
- Documentation of an allergy/sensitivity to one particular type of aspirin is acceptable (e.g., “Allergic to Empirin”). Allergy documentation does NOT need to refer to the entire class of aspirin-containing medications.
- When determining whether there is a reason documented by a physician, nurse practitioner, or physician assistant for not prescribing aspirin at discharge:
  - Reasons must be explicitly documented (e.g., “Chronic hepatitis – No ASA”) or clearly implied (e.g., “GI bleeding with aspirin in past”, “ASA contraindicated”, “Intolerant of aspirin”, “Problems with aspirin in past”, “c/o upset stomach, will dc ASA”, “Pt. refusing all medications”, “Terminal care, no further treatment”). If reasons are not mentioned in the context of aspirin, do not make inferences (e.g., Do not assume that aspirin is not being prescribed because of the patient's history of PUD).
  - Reasons do NOT need to be documented at the time of discharge or otherwise associated specifically with discharge prescriptions: Documentation of contraindications anytime during the hospital stay are acceptable (e.g., aspirin held mid-hospitalization “due to rectal bleeding” - select “Yes”, even if documentation indicates that the rectal bleeding has resolved by the time of discharge.
  - Disregard documentation of a temporary hold, discontinuation, or initiation of aspirin which is made conditional (e.g., “Hold ASA if OB+ stool”, “Stop aspirin if blood in urine recurs”, “Consider aspirin therapy after GI upset resolved”).
- For documentation of OB+ stools, do not overlook laboratory reports and nursing notes as potential sources.
- When determining whether there is post-procedure bleeding noted as abnormal or which required medical intervention, do NOT consider sandbags applied to the groin area post-PCI or cardiac catheterization as medical intervention. This is standard post-PCI/cardiac cath treatment.

- Suggested Data Sources:**
- Consultation notes
  - Discharge instruction sheet
  - Discharge summary
  - Emergency department record
  - History and physical
  - Laboratory reports (OB+ stools)
  - Medication administration record
  - Nursing notes
  - Physician orders
  - Progress notes

**Guidelines for Abstraction:**

<b>Inclusion</b>	<b>Exclusion</b>
<p>Refer to Appendix C, Table 1.1 for a comprehensive list of Aspirin and Aspirin-Containing medications</p> <p>Refer to Appendix C, Table 1.4 for a comprehensive list of Warfarin medications</p> <p>Refer to Appendix H, Table 1.1 Bleeding Inclusion Table for additional inclusion criteria</p>	<p><b>Bleeding</b></p> <ul style="list-style-type: none"> <li>• anemia not due to gastrointestinal bleeding</li> <li>• bleeding hemorrhoid</li> <li>• bleeding, or any of the other terms in the Bleeding Inclusion Table, described using one of the following qualifiers: cannot exclude, cannot rule out, may have, may have had, may indicate, possible, suggestive of, suspect, or suspicious</li> <li>• sputum described as “pink” or “red tinged”</li> </ul> <p><b>Aspirin Allergy</b></p> <ul style="list-style-type: none"> <li>• aspirin allergy described using one of the following qualifiers: cannot exclude, cannot rule out, may have, may have had, may indicate, possible, suggestive of, suspect, or suspicious</li> </ul>

**Data Element Name:** *Contraindication to Aspirin on Arrival*

**Collected For:** AMI-1

**Definition:** Contraindications/reasons for not prescribing aspirin on arrival include: aspirin allergy, active bleeding on arrival or within 24 hours after arrival, Coumadin/warfarin as pre-arrival medication, or other reasons documented by physician, nurse practitioner, or physician assistant for not giving aspirin on arrival. Aspirin is primarily a pain reliever. Aspirin also reduces the tendency of blood to clot by blocking the action of a type of blood cell involved in clotting. Aspirin reduces the risk of having a heart attack and improves chances of surviving a heart attack.

NOTE: Refer to Appendix C, Table 1.1 for a list of aspirin medications.

NOTE: Refer to Appendix C, Table 1.4 for a list of warfarin medications.

**Suggested Data**

**Collection Question:** Is one or more of the following potential contraindications or reasons for not prescribing aspirin present on arrival?

**Format:**                      **Length:** 1  
**Type:**                        Alphanumeric  
**Occurs:**                      1

**Allowable Values:**        Y (Yes) Documentation that the patient has one or more of the following potential contraindications/reasons for not prescribing an aspirin on arrival:

- Active bleeding on arrival or within 24 hours after arrival
- Aspirin allergy
- Coumadin/warfarin prescribed as pre-arrival medication
- Other reasons documented by physician, nurse practitioner, or physician assistant for not prescribing aspirin on arrival

N (No) There is no documentation of contraindications/reasons for not prescribing aspirin on arrival or unable to determine from medical record documentation.

**Notes for Abstraction:**

- **This data element should be answered independently and irrespective of whether the patient was prescribed aspirin on arrival**
- When unable to determine for certain whether bleeding occurred either on arrival or within 24 hours after arrival, select “No”.
- When there is documentation of an aspirin “allergy” or “sensitivity”, regard this as documentation of an aspirin allergy regardless of what type of reaction might be noted: Do not attempt to distinguish between true allergies/sensitivities and intolerances, side effects, etc. (e.g., “Allergies: ASA – Upsets stomach” – select “Yes”).
- Documentation of an allergy/sensitivity to one particular type of aspirin is acceptable (e.g., “Allergic to Empirin”): Allergy documentation does NOT need to refer to the entire class of aspirin-containing medications.
- When determining whether Coumadin/warfarin was a pre-arrival medication:
  - Refer to the patient’s medication regimen just prior to acute care treatment. Include Coumadin/warfarin if the patient was on it at home, the nursing home, a transferring psychiatric hospital, etc. Do NOT include Coumadin/warfarin taken in the ambulance en route to the hospital.
  - Include cases where there is documentation that the patient was prescribed Coumadin/warfarin at home but there is indication it was on temporary hold or the patient has been non-compliant/self-discontinued their medication (e.g., refusal, side effects, cost).
- When determining whether there is a reason documented by a physician, practitioner, or physician assistant for not prescribing aspirin on arrival:
  - Reasons must be explicitly documented (e.g., “Chronic hepatitis – No ASA”) or clearly implied (e.g., “GI bleeding with aspirin in past”, “ASA contraindicated”, “Intolerant of aspirin”, “Problems with aspirin in past”, “Pt. refusing all medications”, “Terminal care, no further treatment”). If reasons are not mentioned in the context of aspirin, do not make inferences (e.g., Do not assume that aspirin is not being prescribed because of the patient's history of PUD).
  - Disregard documentation of a temporary hold, discontinuation, or initiation of aspirin which is made conditional (e.g., “Hold ASA if OB+ stool”, “Stop aspirin if blood in urine recurs”, “Consider aspirin therapy after GI upset resolved”).

**Notes for Abstraction Continued:**

- For documentation of OB+ stools, do not overlook laboratory reports and nursing notes as potential sources.
- When determining whether there is post-procedure bleeding noted as abnormal or which required medical intervention, do NOT consider sandbags applied to the groin area post-PCI or cardiac catheterization as medical intervention. This is standard post-PCI/cardiac cath treatment.

**Suggested Data Sources:**

- Consultation notes
- Discharge summary
- Emergency department record
- History and physical
- Laboratory reports (OB+ stools)
- Medication administration record
- Nursing notes
- Physician orders
- Progress notes
- Transfer sheet

**Guidelines for Abstraction:**

<b>Inclusion</b>	<b>Exclusion</b>
<p>Refer to Appendix C, Table 1.1 for a comprehensive list of Aspirin and Aspirin-Containing medications</p> <p>Refer to Appendix C, Table 1.4 for a comprehensive list of Warfarin medications</p> <p>Refer to Appendix H, Table 1.1 Bleeding Inclusion Table for additional inclusion criteria</p>	<p><b>Bleeding</b></p> <ul style="list-style-type: none"> <li>• anemia not due to gastrointestinal bleeding</li> <li>• bleeding hemorrhoid</li> <li>• bleeding, or any of the other terms in the Bleeding Inclusion Table, described using one of the following qualifiers: cannot exclude, cannot rule out, may have, may have had, may indicate, possible, suggestive of, suspect, or suspicious</li> <li>• sputum described as “pink” or “red tinged”</li> </ul> <p><b>Aspirin Allergy</b></p> <ul style="list-style-type: none"> <li>• aspirin allergy described using one of the following qualifiers: cannot exclude, cannot rule out, may have, may have had, may indicate, possible, suggestive of, suspect, or suspicious</li> </ul>

**Data Element Name:** *Contraindication to Beta Blocker at Discharge*

**Collected For:** AMI-5

**Definition:** Contraindications/reasons for not prescribing beta blockers at discharge include: beta blocker allergy, bradycardia (heart rate less than 60 beats per minute [bpm]) on day of discharge or day prior to discharge while not on a beta blocker, second or third degree heart block on ECG on arrival or during hospital stay, systolic blood pressure less than 90 mm Hg on day of discharge or day prior to discharge while not on a beta blocker, or other reasons documented by physician, nurse practitioner, or physician assistant for not prescribing beta blocker at discharge. Beta blockers are agents which block beta-adrenergic receptors, thereby decreasing the rate and force of heart contractions, and reducing blood pressure. Over time beta blockers improve the heart's pumping ability.

NOTE: Refer to Appendix C, Table 1.3 for a list of beta blockers.

**Suggested Data**

**Collection Question:** Is one or more of the following potential contraindications/ reasons for not prescribing a beta blocker at discharge documented?

**Format:**                      **Length:** 1  
   **Type:** Alphanumeric  
   **Occurs:** 1

**Allowable Values:** Y (Yes) Documentation that the patient has one or more of the following potential contraindications/reasons for not prescribing a beta blocker at discharge:

- Beta blocker allergy
- Bradycardia (heart rate less than 60 beats per minute [bpm]) on day of discharge or day prior to discharge while not on a beta blocker
- Second or third degree heart block on ECG on arrival or during hospital stay and does not have a pacemaker
- Systolic blood pressure less than 90 mm Hg on day of discharge or day prior to discharge while not on a beta blocker
- Other reasons documented by physician, nurse practitioner, or physician assistant for not prescribing a beta blocker at discharge.

N (No) There is no documentation of contraindications/reasons for not prescribing to beta blocker at discharge or unable to determine from medical record documentation.

**Notes for Abstraction:**

- **This data element should be answered independently and irrespective of whether the patient was prescribed a beta blocker at discharge.**
- When there is documentation of a beta blocker “allergy” or “sensitivity”, regard this as documentation of a beta blocker allergy regardless of what type of reaction might be noted: Do not attempt to distinguish between true allergies/sensitivities and intolerances, side effects, etc. (e.g., “Allergies: Beta blockers – Impotence” – select “Yes”).
- Documentation of an allergy/sensitivity to one particular beta blocker is acceptable (e.g., “Allergic to Lopressor”): Allergy documentation does NOT need to refer to the entire class of beta blockers.
- Documentation of “bradycardia” alone is not acceptable. Bradycardia must be substantiated by documentation of a heart rate of less than 60 beats per minute [bpm] on the day of discharge or the day prior to discharge.
- When determining whether there is second or third degree heart block on ECG on arrival or during hospital stay AND does not have pacemaker:
  - Consider this true if there are findings of second or third degree heart block on the ECG AND this same ECG does NOT show pacemaker findings.
  - Disregard pacemaker findings if documentation suggests the patient has a non-functioning pacemaker.
  - Heart block or pacemaker findings do not have to be taken from ECG interpretations: Any notation of second or third degree heart block or pacemaker findings on an ECG report or other source is acceptable with or without physician, nurse practitioner, or physician assistant signature

**Notes for Abstraction continued:**

- Consider the patient “on a beta blocker” if the patient received a beta blocker on the day of discharge or the day prior to discharge.
- When determining whether there is a reason documented by a physician, nurse practitioner, or physician assistant for not prescribing a beta blocker at discharge:
  - Reasons must be explicitly documented (e.g., “COPD - No BBs”) or clearly implied (e.g., “Severe hypotension with beta blockers in past”, “BBs contraindicated”, “Intolerant of beta blockers”, “Problems with beta blockers in past”, “c/o drowsiness, will dc beta blocker”, “Pt. refusing all medications”, “Terminal care, no further treatment”). If reasons are not mentioned in the context of beta blockers, do not make inferences (e.g., Do not assume that a beta blocker is not being prescribed because of the patient's history of Peripheral Vascular Disease [PVD]).
  - Reasons do NOT need to be documented at the time of discharge or otherwise associated specifically with discharge prescription: Documentation of contraindications anytime during the hospital stay are acceptable (e.g., beta blocker held mid-hospitalization “due to hypotension” - select “Yes”, even if documentation indicates that the hypotension had resolved by the time of discharge).
  - Disregard documentation of a temporary hold, discontinuation, or initiation of a beta blocker which is made conditional (e.g., “Hold Lopressor if pulse drops below 60”, “Stop propranolol if HR < 50”, “Consider beta blocker therapy after BP stabilizes”).

**Suggested Data Sources:**

- Consultation notes
- Discharge summary
- ECG/EKG reports
- Emergency department record
- History and physical
- Medication administration record
- Nursing notes
- Physician orders
- Progress notes
- Vital signs graphic record

**Guidelines for Abstraction:**

<b>Inclusion</b>	<b>Exclusion</b>
<p><b>2nd/3rd degree heart blocks (HB)</b>  <b>Note: The following inclusive terms may stand alone or be modified by “variable” or “intermittent”</b></p> <ul style="list-style-type: none"> <li>• 2:1 atrioventricular (AV) block</li> <li>• 2:1 atrioventricular (AV) conduction</li> <li>• 2:1 heart block (HB)</li> <li>• 3:1 atrioventricular (AV) block</li> <li>• 3:1 atrioventricular (AV) conduction</li> <li>• 3:1 heart block (HB)</li> <li>• atrioventricular (AV) dissociation</li> <li>• complete heart block</li> <li>• heart block</li> <li>• high degree heart block (HB)</li> <li>• Mobitz Type 1 or 2</li> <li>• second degree atrioventricular (AV) block</li> <li>• second degree heart block (HB)</li> <li>• third degree atrioventricular (AV) block</li> <li>• third degree heart block (HB)</li> <li>• Wenckebach</li> </ul> <p><b>Pacemaker findings</b></p> <ul style="list-style-type: none"> <li>• atrial pacing</li> <li>• AV pacing</li> <li>• dual chamber pacing</li> <li>• paced rhythm</li> <li>• paced spikes</li> <li>• ventricular pacing</li> </ul> <p>Refer to Appendix C, Table 1.3 for a comprehensive list of Beta Blockers</p>	<p><b>Beta blocker allergy</b></p> <ul style="list-style-type: none"> <li>• beta blocker allergy described using one of the following qualifiers: cannot exclude, cannot rule out, may have, may have had, may indicate, possible, suggestive of, suspect, or suspicious</li> </ul> <p><b>2nd/3rd degree heart blocks (HB)</b></p> <ul style="list-style-type: none"> <li>• 2nd/3rd degree heart blocks (HB), or any of the other 2nd/3rd degree heart block inclusion terms, described using one of the following qualifiers: cannot exclude, cannot rule out, may have, may have had, may indicate, possible, suggestive of, suspect, or suspicious</li> <li>• atrial flutter</li> <li>• atrioventricular (AV) block</li> <li>• atrioventricular (AV) conduction block</li> <li>• first degree atrioventricular (AV) block</li> <li>• first degree heart block (HB)</li> <li>• intraventricular conduction delay (IVCD)</li> </ul>

**Data Element Name:** *Contraindication to Beta Blocker on Arrival*

**Collected For:** AMI-6

**Definition:** Contraindications/reasons for not prescribing beta blockers on arrival include: beta blocker allergy, bradycardia (heart rate less than 60 beats per minute [bpm]) on arrival or within 24 hours after arrival while not on a beta blocker, heart failure on arrival or within 24 hours after arrival, second or third degree heart block on ECG on arrival or within 24 hours after arrival and does not have a pacemaker, shock on arrival or within 24 hours after arrival, systolic blood pressure less than 90 mm Hg on arrival or within 24 hours after arrival, or other reasons documented by physician, nurse practitioner, or physician assistant for not prescribing a beta blocker on arrival. Beta blockers are agents which block beta-adrenergic receptors, thereby decreasing the rate and force of heart contractions, and reducing blood pressure. Over time beta blockers improve the heart's pumping ability.

NOTE: Refer to Appendix C, Table 1.3 for a list of beta blockers.

**Suggested Data**

**Collection Question:** Is one or more of the following potential contraindications/reasons for not prescribing a beta blocker present on arrival?

**Format:**                      **Length:** 1  
   **Type:** Alphanumeric  
   **Occurs:** 1

**Allowable Values:** Y (Yes) Documentation that the patient has one or more of the following potential contraindications/reasons for not prescribing a beta blocker on arrival:

- Beta blocker allergy
- Bradycardia (heart rate less than 60 beats per minute [bpm]) on arrival or within 24 hours after arrival while not on a beta blocker
- Heart failure on arrival or within 24 hours after arrival
- Second or third degree heart block on ECG on arrival or within 24 hours after arrival AND does not have a pacemaker
- Shock on arrival or within 24 hours after arrival

- Systolic blood pressure less than 90 mm Hg on arrival or within 24 hours after arrival
- Other reasons documented by physician, nurse practitioner, or physician assistant for not prescribing a beta blocker on arrival

N (No) There is no documentation of a contraindication/ reason for not prescribing beta blocker on arrival or unable to determine from medical record documentation.

**Notes for Abstraction:**

- **This data element should be answered independently and irrespective of whether the patient was prescribed a beta blocker on arrival.**
- When there is documentation of a beta blocker “allergy” or “sensitivity,” regard this as documentation of a beta blocker allergy regardless of what type of reaction might be noted. Do not attempt to distinguish between true allergies/sensitivities and intolerances, side effects, etc. (e.g., “Allergies: Beta blockers – Impotence” – select “Yes”).
- Documentation of an allergy/sensitivity to one particular beta blocker is acceptable (e.g., “Allergic to Lopressor”). Allergy documentation does NOT need to refer to the entire class of beta blockers.
- When determining whether there is bradycardia (heart rate less than 60) on arrival or within 24 hours after arrival while not on beta blocker:
  - Documentation of “bradycardia” alone is not acceptable. Bradycardia must be substantiated by documentation of a heart rate of less than 60 beats per minute [bpm] on arrival or within 24 hours of arrival.
  - Consider the patient “on a beta blocker” if one of the following conditions is met:
    - A beta blocker is noted as a part of the patient’s medication regimen just prior to acute care treatment. This includes beta blockers the patient was on at home, the nursing home, a transferring psychiatric hospital, etc., regardless of whether there is an indication that it was on temporary hold or the patient has been non-compliant/self-discontinued their medications (e.g., refusal, side effects, cost). Do NOT include beta blockers taken in the ambulance en route to the hospital. or
    - The patient received a beta blocker in the hospital within 24 hours after hospital arrival.
- When determining whether there is heart failure on arrival or

**Notes for Abstraction  
continued:**

within 24 hours after arrival, do NOT use chest x-ray reports. However, physician, nurse practitioner, or physician assistant references to chest x-ray findings are acceptable, provided the finding documented is one of the listed Inclusion terms.

- When determining whether there is a second or third degree heart block on ECG on arrival or within 24 hours after arrival AND does not have pacemaker:
  - Consider this true if there are findings of second or third degree heart block on the ECG AND this same ECG does NOT show pacemaker findings.
  - Disregard pacemaker findings if documentation suggests the patient has a non-functioning pacemaker.
  - Heart block or pacemaker findings do not have to be taken from ECG interpretations: Any notation of second or third degree heart block or pacemaker findings on an ECG report or other source is acceptable with or without physician, nurse practitioner, or physician assistant signature.
- For those potential contraindications which stipulate a 24 hour timeframe: When unable to determine for certain whether a condition occurred either on arrival or within 24 hours after arrival, select “No”.
- When determining whether there is a reason documented by a physician, nurse practitioner, or physician assistant for not prescribing a beta blocker on arrival:
  - Reasons must be explicitly documented (e.g., “COPD – No BBs”) or clearly implied (e.g., “Severe hypotension with beta blockers in past,” “BBs contraindicated”, “Intolerant of beta blockers”, “Problems with beta blockers in past”, “Pt. refusing all medications”, “Terminal care, no further treatment”). If reasons are not mentioned in the context of beta blockers, do not make inferences (e.g., Do not assume that a beta blocker is not being prescribed because of the patient's history of Peripheral Vascular Disease [PVD]).
  - Disregard documentation of a temporary hold, discontinuation, or initiation of a beta blocker which is made conditional (e.g., “Hold Lopressor if pulse drops below 60”, “Stop propranolol if HR < 50”, “Consider beta blocker therapy after BP stabilizes”).

- Suggested Data Sources:**
- Consultation notes
  - Discharge summary
  - ECG/EKG reports
  - Emergency department record
  - History and physical
  - Medication administration record
  - Nursing notes
  - Physician orders
  - Progress notes
  - Vital signs graphic record

**Excluded Location:**

- Chest x-ray reports

**Guidelines for Abstraction:**

Inclusion	Exclusion
<p><b>Heart failure</b></p> <ul style="list-style-type: none"> <li>• biventricular failure</li> <li>• cardiac decompensation</li> <li>• cardiac failure</li> <li>• congestive heart failure (CHF)</li> <li>• edema described as alveolar, diffuse interstitial, diffuse interstitial pulmonary, interstitial, pulmonary, or pulmonary interstitial</li> <li>• edema of the lungs</li> <li>• edema not described as pulmonary in nature, if referenced as chest x-ray finding (e.g., “CXR shows mild edema”)</li> <li>• fluid overload</li> <li>• heart failure described as left, right, or unspecified</li> <li>• perihilar congestion</li> <li>• pulmonary congestion</li> <li>• pump failure</li> <li>• vascular congestion</li> <li>• venous congestion</li> <li>• ventricular failure</li> <li>• volume overload</li> <li>• wet lungs</li> </ul> <p><b>2nd/3rd degree heart blocks (HB):</b>  <b>NOTE: The following inclusive terms may stand alone or be modified by “variable” or “intermittent”</b></p> <ul style="list-style-type: none"> <li>• 2:1 atrioventricular (AV) block</li> </ul>	<p><b>Beta blocker allergy</b></p> <ul style="list-style-type: none"> <li>• beta blocker allergy described using one of the following qualifiers: cannot exclude, cannot rule out, may have, may have had, may indicate, possible, suggestive of, suspect, or suspicious</li> </ul> <p><b>Heart failure</b></p> <ul style="list-style-type: none"> <li>• cardiomyopathy</li> <li>• heart failure, or any of the other heart failure inclusion terms described using one of the following qualifiers: cannot exclude, cannot rule out, may have, may have had, may indicate, possible, suggestive of, suspect, or suspicious</li> </ul> <p><b>2nd/3rd degree heart blocks (HB)</b></p> <ul style="list-style-type: none"> <li>• 2nd/3rd degree heart blocks (HB), or any of the other 2nd/3rd degree heart block inclusion terms described using one of the following qualifiers: cannot exclude, cannot rule out, may have, may have had, may indicate, possible, suggestive of, suspect, or suspicious</li> <li>• atrial flutter</li> <li>• atrioventricular (AV) block</li> <li>• atrioventricular (AV) conduction block</li> <li>• first degree atrioventricular (AV) block</li> <li>• first degree heart block (HB)</li> <li>• intraventricular conduction delay (IVCD)</li> </ul>

**Guidelines for Abstraction Continued:**

<ul style="list-style-type: none"><li>• 2:1 atrioventricular (AV) conduction</li><li>• 2:1 heart block (HB)</li><li>• 3:1 atrioventricular (AV) block</li><li>• 3:1 atrioventricular (AV) conduction</li><li>• 3:1 heart block (HB)</li><li>• atrioventricular (AV) dissociation</li><li>• complete heart block</li><li>• heart block</li><li>• high degree heart block (HB)</li><li>• Mobitz Type 1 or 2</li><li>• second degree atrioventricular (AV) block</li><li>• second degree heart block (HB)</li><li>• third degree atrioventricular (AV) block</li><li>• third degree heart block (HB)</li><li>• Wenckebach</li></ul> <p><b>Pacemaker findings:</b></p> <ul style="list-style-type: none"><li>• atrial pacing</li><li>• AV pacing</li><li>• dual chamber pacing</li><li>• paced rhythm</li><li>• paced spikes</li><li>• ventricular pacing</li></ul> <p><b>Shock:</b></p> <ul style="list-style-type: none"><li>• anaphylactic shock</li><li>• cardiogenic shock</li><li>• cardiovascular collapse</li><li>• hypovolemic shock</li><li>• intravascular collapse</li><li>• septic shock</li><li>• shocky</li></ul> <p>Refer to Appendix C, Table 1.3 for a comprehensive list of Beta Blockers</p>	<p><b>Shock</b></p> <ul style="list-style-type: none"><li>• cardiovascular instability</li><li>• hypotension</li><li>• shock, or any of the other shock inclusion terms described using one of the following qualifiers: cannot exclude, cannot rule out, may have, may have had, may indicate, possible, suggestive of, suspect, or suspicious</li></ul>
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<b>Release Notes:</b> Data Element - Version 1.0
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**Data Element Name:** *Date of Infection*

**Collected For:** SIP-3

**Definition:** The date of the first postoperative infection.

NOTE: Refer also to data element Postoperative Infections for further clarification. Date of Infection should reflect the first time there is documentation that the patient is being treated for an infection following the surgical procedure of interest.

**Suggested Data**

**Collection Question:** What was the date of the first postoperative infection?

**Format:**                      **Length:** 10 – MM-DD-YYYY (includes dashes)  
**Type:**                         Date  
**Occurs:**                        1

**Allowable Values:**        MM =        Month (01-12)  
     DD =        Day (01-31)  
     YYYY =    Year (2000-9999)

**Notes for Abstraction:**    None

- Suggested Data Sources:**
- Consultation note
  - Discharge summary
  - Progress notes

**Guidelines for Abstraction:**

Inclusion	Exclusion
None	None

**Data Element Name:** *Discharge Date*

**Collected For:** All Records (used in algorithm for AMI-1, AMI-6, AMI-T1b [CMS optional test measure], PN-7, PR-2)

**Definition:** The month, day, and year the patient was discharged from acute care, left against medical advice, or expired during this stay.

**Suggested Data**

**Collection Question:** What is the date the patient was discharged from acute care, left against medical advice (AMA), or expired?

**Format:**                   **Length:** 10 – MM-DD-YYYY (includes dashes)  
                                   **Type:** Date  
                                   **Occurs:** 1

**Allowable Values:**   MM =    Month (01-12)  
                                   DD =    Day (01-31)  
                                   YYYY =  Year (2000-9999)

**Notes for Abstraction:** Because this data element is critical in determining the population for many measures, the abstractor should NOT assume that the UB-92 claim information for the discharge date is correct. If the abstractor determines through chart review that the UB-92 date is incorrect, she/he should correct and override the downloaded value. If the abstractor is unable to determine the correct discharge date through chart review, she/he should default to the UB-92 discharge date.

- Suggested Data Sources:**
- Discharge summary
  - Face sheet
  - Nursing discharge notes
  - Physician orders
  - Progress notes
  - Transfer note
  - UB-92, Field Location: 6

**Guidelines for Abstraction:**

Inclusion	Exclusion
None	None

**Data Element Name:** *Discharge Instructions Address Activity*

**Collected For:** HF-1

**Definition:** Written discharge instructions or other documentation of educational material given to patient/caregiver addressing the patient's activity level after discharge.

**Suggested Data**

**Collection Question:** Did the WRITTEN discharge instructions or other documentation of educational material given to the patient/caregiver address the patient's activity level after discharge?

**Format:**                   **Length:** 1  
                                  **Type:** Alphanumeric  
                                  **Occurs:** 1

**Allowable Values:**    Y (Yes) WRITTEN discharge instructions/educational material given to patient/caregiver address the patient's activity level after discharge.  
                                  N (No) WRITTEN discharge instructions/educational material do not address activity or unable to determine from medical record documentation.

**JCAHO NOTE TO PROGRAMMERS:**

In order to identify the specific discharge instructions that are missing, the internal variables (discharge counter and missing flag) must be stored so calculations of rates for each instruction component can be performed.

**Notes for Abstraction:**

- When a discharge instruction sheet, a combination physician order/instruction sheet, or a teaching sheet is present in the medical record, the inference should be made that the patient/caregiver was given a copy.
- When documentation indicates the patient was given a brochure or other instruction material (e.g., "Heart Failure Management booklet given to pt.") and a copy of that literature is not provided in the medical record, that literature should be reviewed to determine what areas of instruction are included.

**Notes for Abstraction continued:**

- Written instructions do NOT need to be given at the time of discharge: Instructions given anytime during the hospital stay are acceptable.
- If the patient refused written discharge instructions or other documentation of educational material which addressed activity, select “Yes”.
- The caregiver is defined as the patient’s family or any other person (e.g., home health/VNA provider) who will be responsible for care of the patient after discharge.

**Suggested Data Sources:**

- Care plans/clinical pathways
- Discharge instruction sheet
- Discharge progress notes
- Discharge summary
- Home health referral form
- Nursing discharge notes
- Physical therapy notes
- Teaching sheet

**Guidelines for Abstraction:**

<b>Inclusion</b>	<b>Exclusion</b>
<p><b>Activity level (examples)</b></p> <ul style="list-style-type: none"> <li>• activity as tolerated</li> <li>• cardiac rehab</li> <li>• exercise instructions</li> <li>• no strenuous activity</li> <li>• physical therapy</li> <li>• regular activity</li> <li>• regular walking</li> <li>• rest</li> <li>• restrict activity</li> </ul>	<p>None</p>

**Data Element Name:** *Discharge Instructions Address Diet*

**Collected For:** HF-1

**Definition:** Written discharge instructions or other documentation of educational material given to patient/caregiver addressing diet/fluid intake instructions after discharge.

**Suggested Data**

**Collection Question:** Did the WRITTEN discharge instructions or other documentation of educational materials given to the patient/caregiver address diet/fluid intake after discharge?

**Format:**                      **Length:** 1  
   **Type:** Alphanumeric  
   **Occurs:** 1

**Allowable Values:**        Y (Yes) WRITTEN discharge instructions/educational material given to patient/caregiver address diet/fluid intake instructions after discharge.  
   N (No) WRITTEN discharge instructions/educational material do not address diet/fluid intake or unable to determine from medical record documentation.

**JCAHO NOTE TO PROGRAMMERS:**

In order to identify the specific discharge instructions that are missing, the internal variables (discharge counter and missing flag) must be stored so calculations of rates for each instruction component can be performed.

**Notes for Abstraction:**

- Diet/fluid intake instructions do not need to be specific to heart failure: ANY diet or fluid intake instructions are acceptable.
- When a discharge instruction sheet, a combination physician order/instruction sheet or a teaching sheet is present in the medical record, the inference should be made that the patient/caregiver was given a copy.
- When documentation indicates the patient was given a brochure or other instruction material (e.g., “Heart Failure Management booklet given to pt.”) and a copy of that literature is not provided in the medical record, that literature should be reviewed to determine what areas of instruction are included.
- Written instructions do NOT need to be given at the time of discharge: Instructions given anytime during the hospital stay are acceptable.
- If the patient refused written discharge instructions or other documentation of educational material which addressed diet/fluid intake, select “Yes”.
- The caregiver is defined as the patient's family or any other person (e.g., home health/VNA provider) who will be responsible for care of the patient after discharge.

**Suggested Data Sources:**

- Care plans/clinical pathways
- Dietary notes
- Discharge instruction sheet
- Discharge progress notes
- Discharge summary
- Home health referral form
- Nursing discharge notes
- Teaching sheet

**Guidelines for Abstraction:**

<b>Inclusion</b>	<b>Exclusion</b>
<b>Diet (examples)</b> <ul style="list-style-type: none"> <li>• continue same diet</li> <li>• diet as instructed</li> <li>• diet as tolerated (DAT)</li> <li>• reg diet</li> <li>• restrict fluids</li> <li>• specific diet (e.g., 2 gm Na<sup>+</sup> diet, 1800 ADA diet) noted</li> <li>• tube feedings</li> </ul>	None

**Data Element Name:** *Discharge Instructions Address Follow-up*

**Collected For:** HF-1

**Definition:** Written discharge instructions or other documentation of educational material given to patient/caregiver addressing follow-up with a physician/nurse practitioner/physician assistant after discharge.

**Suggested Data**

**Collection Question:** Did the WRITTEN discharge instructions or other documentation of educational material given to the patient/caregiver address follow-up with a physician/nurse practitioner/physician assistant after discharge?

**Format:**                   **Length:** 1  
                                  **Type:** Alphanumeric  
                                  **Occurs:** 1

**Allowable Values:**    Y (Yes) WRITTEN discharge instructions/educational material given to patient/given address follow-up with a physician/nurse practitioner/physician assistant after discharge.  
                                  N (No) WRITTEN discharge instructions/educational material given to patient/caregiver do not address follow-up with a physician/nurse practitioner/physician assistant or unable to determine from medical record documentation.

**JCAHO NOTE TO PROGRAMMERS:**

In order to identify the specific discharge instructions that are missing, the internal variables (discharge counter and missing flag) must be stored so calculations of rates for each instruction component can be performed.

**Notes for Abstraction:**

- In the absence of explicit documentation that follow-up involves contact with a physician/nurse practitioner/physician assistant, the abstractor may infer contact with a physician/nurse practitioner/physician assistant, unless documentation suggests otherwise (e.g., BP check, laboratory work only).
- When a discharge instruction sheet, a combination physician order/instruction sheet, or a teaching sheet is present in the medical record, the inference should be made that the patient/caregiver was given a copy.
- When documentation indicates the patient was given a brochure or other instruction material (e.g., “Heart Failure Management booklet given to pt.”) and a copy of that literature is not provided in the medical record, that literature should be reviewed to determine what areas of instruction are included.
- Written instructions do NOT need to be given at the time of discharge: Instructions given anytime during the hospital stay are acceptable.
- If the patient refused written discharge instructions or other documentation of educational material which addressed follow-up, select “Yes”.
- The caregiver is defined as the patient’s family or any other person (e.g., home health/VNA provider) who will be responsible for care of the patient after discharge.

**Suggested Data Sources:**

- Care plans/clinical pathways
- Discharge instruction sheet
- Discharge progress notes
- Discharge summary
- Home health referral form
- Nursing discharge notes
- Teaching sheet

**Guidelines for Abstraction:**

<b>Inclusion</b>	<b>Exclusion</b>
None	<b>Follow-up with a physician/ nurse practitioner/physician assistant</b> <ul style="list-style-type: none"><li>• Follow-up prescribed on PRN or as needed basis</li></ul>

**Data Element Name:** *Discharge Instructions Address Medications*

**Collected For:** HF-1

**Definition:** Written discharge instructions or other documentation of educational material given to patient/caregiver addressing all discharge medications. Instructions must address at least the names of all discharge medications but may also include other usage instructions such as dosages, frequencies, side effects, etc.

**Suggested Data**

**Collection Question:** Did the WRITTEN discharge instructions or other documentation of educational material given to the patient/caregiver address all discharge medications?

**Format:**                   **Length:** 1  
                                  **Type:** Alphanumeric  
                                  **Occurs:** 1

**Allowable Values:**    Y (Yes) WRITTEN discharge instructions/educational material given to patient/caregiver address discharge medications.  
                                  N (No) WRITTEN discharge instructions/educational material do not address all discharge medications or unable to determine from medical record documentation.

**JCAHO NOTE TO PROGRAMMERS:**

In order to identify the specific discharge instructions that are missing, the internal variables (discharge counter and missing flag) must be stored so calculations of rates for each instruction component can be performed.

**Notes for Abstraction:**

- Instructions must address at least the NAMES of all discharge medications. Exception: When general references to laxatives, antacids, vitamins, and herbs are made which, by nature, allow the patient to choose their product of preference, specific names are NOT required (e.g., “laxative of choice”). In addition to names of medications, instructions may include other usage instructions such as dosages, frequencies, side effects, etc. These types of instructions are NOT required.
- Abstraction is a two-step process:
  1. Determine all of the medications being prescribed at discharge, based on available medical record documentation
  2. Check this list against the written discharge instructions given to the patient, to ensure that these instructions addressed at least the names of all of the discharge medications. If a list of discharge medications is not documented elsewhere in the record, and the completeness of the medication list in the written discharge instructions cannot be confirmed, select “No”.
- When a discharge instruction sheet, a combination physician order/instruction sheet, or a teaching sheet is present in the medical record, the inference should be made that the patient/caregiver was given a copy.
- When documentation indicates the patient was given a brochure or other instruction material (e.g., “Heart Failure Management booklet given to pt.”) and a copy of that literature is not provided in the medical record, that literature should be reviewed to determine what areas of instruction are included.
- Written instructions do NOT need to be given at the time of discharge: Instructions given anytime during the hospital stay are acceptable.
- If the patient refused written discharge instructions or other documentation of educational material which addressed discharge medications, select “Yes”.
- The caregiver is defined as the patient’s family or any other person (e.g., home health/VNA provider) who will be responsible for care of the patient after discharge.

**Suggested Data Sources:**

- Care plans/clinical pathways
- Discharge instruction sheet
- Discharge progress notes
- Discharge summary
- Home health referral form
- Nursing discharge notes
- Teaching sheet

**Guidelines for Abstraction:**

<b>Inclusion</b>	<b>Exclusion</b>
None	<b>Medications</b> <ul style="list-style-type: none"><li>• Any general reference to a medication regimen (e.g., “continue home meds”, “Same” or “see MAR” listed in medication section of discharge instruction sheet), without specific documentation of medication names</li></ul>

**Data Element Name:** *Discharge Instructions Address Symptoms Worsening*

**Collected For:** HF-1

**Definition:** Written discharge instructions or other documentation of educational material given to patient/caregiver addressing what to do if heart failure symptoms worsen after discharge.

**Suggested Data Collection Question:** Did the WRITTEN discharge instructions or other documentation of educational material given to the patient/caregiver address what to do if heart failure symptoms worsen after discharge?

**Format:**                      **Length:** 1  
                                      **Type:** Alphanumeric  
                                      **Occurs:** 1

**Allowable Values:**      Y (Yes) WRITTEN discharge instructions/educational material given to patient/caregiver address what to do if heart failure symptoms worsen after discharge.  
                                      N (No) WRITTEN discharge instructions/educational material do not address symptoms worsening or unable to determine from medical record documentation.

**JCAHO NOTE TO PROGRAMMERS:**  
In order to identify the specific discharge instructions that are missing, the internal variables (discharge counter and missing flag) must be stored so calculations of rates for each instruction component can be performed.

**Notes for Abstraction:**

- Include instructions/educational material which address what to do if heart failure symptoms recur or do not improve after discharge.
- If written instructions address what to do if “symptoms” worsen (symptoms not further specified or described - e.g., “Call MD if symptoms get worse”), infer they are referring to heart failure symptoms, unless documentation suggests otherwise.
- When a discharge instruction sheet, a combination physician order/instruction sheet, or a teaching sheet is present in the medical record, the inference should be made that the patient/caregiver was given a copy.
- When documentation indicates the patient was given a brochure or other instruction material (e.g., “Heart Failure Management booklet given to pt.”) and a copy of that literature is not provided in the medical record, that literature should be reviewed to determine what areas of instruction are included.
- Written instructions do NOT need to be given at the time of discharge: Instructions given anytime during the hospital stay are acceptable.
- If the patient refused written discharge instructions or other documentation of educational material which addressed worsening heart failure symptoms, select “Yes”.
- The caregiver is defined as the patient’s family or any other person (e.g., home health/VNA provider) who will be responsible for care of the patient after discharge.

**Suggested Data Sources:**

- Care plans/clinical pathways
- Discharge instruction sheet
- Discharge progress notes
- Discharge summary
- Home health referral form
- Nursing discharge notes
- Teaching sheet

**Guidelines for Abstraction:**

<b>Inclusion</b>	<b>Exclusion</b>
<p><b>Heart failure symptoms</b></p> <ul style="list-style-type: none"> <li>• ankle/foot/leg edema</li> <li>• ankle/foot/leg swelling</li> <li>• breathing difficulty</li> <li>• edema (location not specified)</li> <li>• shortness of breath (SOB) or other breathing difficulty, in any context</li> <li>• swelling (location not specified)</li> <li>• weight gain</li> </ul> <p><b>Worsening symptoms (examples)</b></p> <ul style="list-style-type: none"> <li>• “Call the office if weight gain greater than 2 pounds”</li> <li>• “Come to the emergency room if you experience a problem with breathing”</li> <li>• “Make an appointment if your foot swelling doesn't subside”</li> <li>• “Take additional diuretic if your weight gain continues”</li> <li>• “Call MD if symptoms recur”</li> </ul>	<p><b>Instructions on what to do if heart failure symptoms worsen</b></p> <ul style="list-style-type: none"> <li>• Instructions on heart failure symptoms without mention of what to do if symptoms worsen.</li> </ul>

**Data Element Name:** *Discharge Instructions Address Weight Monitoring*

**Collected For:** HF-1

**Definition:** Written discharge instructions or other documentation of educational material given to patient/caregiver addressing weight monitoring instructions after discharge.

**Suggested Data Collection Question:** Did the WRITTEN discharge instructions or other documentation of educational material given to the patient/caregiver address weight monitoring after discharge?

**Format:**                   **Length:** 1  
                                  **Type:** Alphanumeric  
                                  **Occurs:** 1

**Allowable Values:**    Y (Yes) WRITTEN discharge instructions/educational material given to patient/caregiver address weight monitoring instructions after discharge.  
                                  N (No) WRITTEN discharge instructions/educational material do not address weight monitoring or unable to determine from medical record documentation.

**JCAHO NOTE TO PROGRAMMERS:**  
In order to identify the specific discharge instructions that are missing, the internal variables (discharge counter and missing flag) must be stored so calculations of rates for each instruction component can be performed.

**Notes for Abstraction:**

- When a discharge instruction sheet, a combination physician order/instruction sheet, or a teaching sheet is present in the medical record, the inference should be made that the patient/caregiver was given a copy.
- When documentation indicates the patient was given a brochure or other instruction material (e.g., “Heart Failure Management booklet given to pt.”) and a copy of that literature is not provided in the medical record, that literature should be reviewed to determine what areas of instruction are included.
- Written instructions do NOT need to be given at the time of discharge: Instructions given anytime during the hospital stay are acceptable.
- If the patient refused written discharge instructions or other documentation of educational material which addressed weight monitoring, select “Yes”.
- The caregiver is defined as the patient’s family or any other person (e.g., home health/VNA provider) who will be responsible for care of the patient after discharge.

**Suggested Data Sources:**

- Care plans/clinical pathways
- Discharge instruction sheet
- Discharge progress notes
- Discharge summary
- Home health referral form
- Nursing discharge notes
- Teaching sheet

**Guidelines for Abstraction:**

<b>Inclusion</b>	<b>Exclusion</b>
<b>Weight monitoring (examples)</b> <ul style="list-style-type: none"><li>• call in weights</li><li>• check weight</li><li>• contact physician if sudden weight gain</li><li>• daily weights</li><li>• watch weight</li><li>• weigh patient</li><li>• weigh self</li><li>• weight check</li></ul>	None

<b>Data Element Name:</b>	<i>Discharge Status</i>
<b>Collected For:</b>	All Records (used in algorithm for AMI-2, AMI-3, AMI-4, AMI-5, AMI-9, AMI-T1a and AMI-T2 [CMS optional test measure], All HF Measures, PN-2, PN-4, PN-7, PR-2)
<b>Definition:</b>	The place or setting to which the patient was discharged.
<b>Suggested Data Collection Question:</b>	What was the patient's discharge disposition?
<b>Format:</b>	<b>Length:</b> 2 <b>Type:</b> Alphanumeric <b>Occurs:</b> 1
<b>Allowable Values:</b>	01 Discharged to home care or self care (routine discharge)  02 Discharged/transferred to a short term general hospital for inpatient care  03 Discharged/transferred to skilled nursing facility (SNF) with Medicare certification (Usage Note: Medicare-indicates that the patient is discharged/transferred to a Medicare certified nursing facility. For hospitals with an approved swing bed arrangement, use Code 61-Swing Bed. For reporting other discharges/transfers to nursing facilities see 04 and 64)  04 Discharged/transferred to an intermediate care facility (ICF) (Usage Note: Typically defined at the state level for specifically designated intermediate care facilities. Also used to designate patients that are discharged/transferred to a nursing facility with neither Medicare nor Medicaid certification and for discharges/transfers to state designated Assisted Living Facilities.)  05 Discharged/transferred to a non-Medicare PPS children's hospital or non-Medicare PPS cancer hospital for inpatient care (Usage Note: A Medicare distinct part unit/facility must meet certain Medicare requirements and is exempt from the inpatient Prospective Payment System; children's hospitals and cancer hospitals are two examples. Other distinct part units/facilities types have specific patient status codes: <ul style="list-style-type: none"><li>• Skilled Nursing Facilities (various codes)</li></ul>

- Inpatient rehabilitation facilities (IRF) including rehabilitation distinct part units of a hospital (code 62)
  - Medicare certified long term care hospitals (LTCH) (code 63)
  - Psychiatric hospitals or psychiatric distinct part units of a hospital (code 65)
- 06 Discharged/transferred to home under care of organized home health service organization  
(Usage Note: Report this code when the patient is discharged/transferred to a home with a written plan of care for home care services. Not used for home health services provided by DME supplier or from a Home IV provider for home IV services [see Code 08]).
- 07 Left against medical advice or discontinued care
- 08 Discharged/transferred to home under care of a home IV drug therapy provider
- 20 Expired
- 41 Expired in a medical facility (e.g., hospital, SNF, ICF or freestanding hospice)  
(Usage Note: For use only on Medicare and CHAMPUS [TRICARE] claims for hospice care.)
- 43 Discharged/transferred to a federal health care facility  
(Usage Note: Discharges and transfers to a government operated health care facility such as a Department of Defense hospital, a Veteran's Administration hospital or a Veteran's Administration nursing facility. To be used whenever the destination at discharge is a federal health care facility, whether the patient resides there or not.
- 50 Hospice - home
- 51 Hospice - medical facility
- 61 Discharged/transferred to hospital-based Medicare approved swing bed  
(Usage Note: Medicare-used for reporting patients discharged/transferred to a SNF level of care within the hospital's approved swing bed arrangement.)

- 62 Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital.
- 63 Discharged/transferred to a Medicare certified long term care hospital (LTCH)  
(Usage Note: For hospitals that meet the Medicare criteria for LTCH certification.)
- 64 Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare
- 65 Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital  
(Implementation date pending as of 09-01-2004)

JCAHO NOTE: If state assigned codes are used, it is the measurement systems responsibility to crosswalk the code to one of the allowable values listed above for the purposes of ORYX®.

NOTE: CMS and the Joint Commission are aware that there are additional UB-92 allowable values for this data element, however, they are not used for the national quality measure set at this time.

**Notes for Abstraction:** Because this data element is critical in determining the population for many measures, the abstractor should NOT assume that the UB-92 claim information for the discharge status is correct. If the abstractor determines through chart review that the UB-92 date is incorrect, she/he should correct and override the downloaded value. If the abstractor is unable to determine the correct discharge status through chart review, she/he should default to the UB-92 discharge status.

- Suggested Data Sources:**
- Discharge instruction sheet
  - Discharge summary
  - Face sheet
  - Nursing discharge notes
  - Physician orders
  - Progress notes
  - Social service notes
  - Transfer record
  - UB-92, Field Location: 22

**Guidelines for Abstraction:**

Inclusion	Exclusion
None	None

<b>Data Element Name:</b>	<i>DVT Interventions</i>
<b>Collected For:</b>	All SIP Records – (CMS Optional Data Element)
<b>Definition:</b>	Documentation of deep vein thrombosis (DVT) prophylaxis interventions performed anytime following the surgical procedure of interest. DVT prophylaxis are measures used to prevent deep vein thrombosis.
<b>Suggested Data Collection Question:</b>	Which deep vein thrombosis (DVT) prophylaxis interventions were done at any time following the surgical procedure of interest?
<b>Format:</b>	<b>Length:</b> 1 <b>Type:</b> Alphanumeric <b>Occurs:</b> 1
<b>Allowable Values:</b>	<i>All that apply:</i> <ol style="list-style-type: none"><li>1 Coumadin/warfarin: There is documentation that the patient received Coumadin/warfarin at any time following the first surgical procedure of interest.</li><li>2 Early ambulation: There is documentation that the patient ambulated alone or with assistance at any time within the two days immediately following the first surgical procedure of interest<ul style="list-style-type: none"><li>• Post-op Day 2 is the second full day following the first surgical procedure of interest (e.g., date of surgery = Day 0, first day after surgery date = post-op day 1, second day after surgery date = post-op day 2)</li></ul></li><li>3 Elastic stockings: There is documentation that elastic stockings were applied at any time following the first surgical procedure of interest.<ul style="list-style-type: none"><li>• Include elastic stockings applied prior to surgery, if they were still in place following the surgery.</li></ul></li><li>4 Intermittent pneumatic compression device: There is documentation that an intermittent pneumatic compression device was applied at any time following the first surgical procedure of interest.<ul style="list-style-type: none"><li>• Include intermittent pneumatic compression devices applied prior to surgery, if still in place following the surgery. Assume the devices are still in place if there is no documentation that they were removed.</li></ul></li></ol>

- 5 Inferior Vena Cava (IVC) filter: There is documentation that an IVC filter was inserted at any time following the first surgical procedure of interest.
- 6 Low Dose Unfractionated Heparin (LDUH): There is documentation that the patient received LDUH at any time following the first surgical procedure of interest.
  - Include only heparin given by the subcutaneous (SQ, Subcut, SC, SubQ) route.
- 7 Low Molecular Weight Heparin (LMWH): There is documentation that the patient received LMWH at any time following the first surgical procedure of interest.
- 8 Factor Xa Inhibitors: There is documentation that the patient received a factor Xa inhibitor at any time following the first surgical procedure of interest.
- 9 Anticoagulant NOS: There is documentation of an anticoagulant not otherwise specified in this list of instructions.
- 0 None of the Above: None of the interventions listed above were done at any time following the first surgical procedure of interest.

**Notes for Abstraction:** None

- Suggested Data Sources:**
- Discharge summary
  - ICU flow sheets
  - Medication administration record
  - Nursing notes
  - Physician orders
  - Procedure reports/notes
  - Progress notes

**Guidelines for Abstraction:**

<b>Inclusion</b>	<b>Exclusion</b>
Refer to Appendix H, Table 2.0 DVT Prophylaxis Inclusion Table	None

<b>Data Element Name:</b>	<i>DVT Prophylaxis</i>
<b>Collected For:</b>	All SIP Records – (CMS Optional Data Element)
<b>Definition:</b>	Documentation of any kind of deep vein thrombosis (DVT) prophylaxis ordered or performed during this admission. DVT prophylaxis are measures used to prevent deep vein thrombosis.
<b>Suggested Data Collection Question:</b>	Was any type of deep vein thrombosis (DVT) prophylaxis ordered or done during this admission?
<b>Format:</b>	<b>Length:</b> 1 <b>Type:</b> Alphanumeric <b>Occurs:</b> 1
<b>Allowable Values:</b>	Y (Yes) Any kind of DVT prophylaxis was ordered or done at any time during this admission. N (No) There is no DVT prophylaxis ordered or done at any time during this admission or unable to determine from medical record documentation.
<b>Notes for Abstraction:</b>	None
<b>Suggested Data Sources:</b>	<ul style="list-style-type: none"><li>• Discharge summary</li><li>• ICU flow sheets</li><li>• Medication administration record</li><li>• Nursing notes</li><li>• Physician orders</li><li>• Procedure reports/notes</li><li>• Progress notes</li></ul>

**Guidelines for Abstraction:**

<b>Inclusion</b>	<b>Exclusion</b>
Refer to Appendix H, Table 2.0 DVT Prophylaxis Inclusion Table	<b>LDUH Exclusions</b> <ul style="list-style-type: none"><li>• Ardeparin</li><li>• Dalteparin</li><li>• Danaparoid</li><li>• Enoxaparin</li><li>• Fragmin</li><li>• Heparin lock flushes</li><li>• IV (intravenous) Heparin</li><li>• Innohep</li><li>• Lovenox</li><li>• Normiflo</li><li>• Orgaran</li><li>• Tinzaparin</li></ul>

<b>Data Element Name:</b>	<i>First In-Hospital LDL-Cholesterol Qualitative Description</i>
<b>Collected For:</b>	AMI T2 – (CMS Optional Test Measure)
<b>Definition:</b>	Qualitative description of the results from first LDL-cholesterol (LDL-c) test performed after hospital arrival.
<b>Suggested Data Collection Question:</b>	How did the physician, nurse practitioner, or physician assistant qualitatively describe the results of the first LDL-cholesterol (LDL-c) test performed after hospital arrival?
<b>Format:</b>	<b>Length:</b> 1 <b>Type:</b> Alphanumeric <b>Occurs:</b> 1
<b>Allowable Values:</b>	<ol style="list-style-type: none"><li>1 (Elevated LDL-c) Physician, nurse practitioner, or physician assistant qualitatively described the results of the first LDL-c test performed after hospital arrival in terms consistent with elevated LDL-c.</li><li>2 (No Elevated LDL-c) Physician, nurse practitioner, or physician assistant qualitatively described the results of the first LDL-c test performed after hospital arrival in terms, which are NOT consistent with elevated LDL-c.</li><li>3 (Not Documented) Physician, nurse practitioner, or physician assistant did not qualitatively describe the results of the first LDL-c test performed after hospital arrival in any manner, or unable to determine from medical record documentation.</li></ol>
<b>Notes for Abstraction:</b>	<ul style="list-style-type: none"><li>• If unable to determine which LDL-c test was performed first, select “Elevated LDL-c” if any of the descriptions are consistent with elevated LDL-c.</li><li>• If there are discrepant qualitative descriptions documented for the same specimen (e.g., one description consistent with elevated LDL-c and one not consistent with elevated LDL-c), select “Elevated LDL-c”.</li></ul>

**Suggested Data Sources: PHYSICIAN/NURSE PRACTITIONER/PHYSICIAN ASSISTANT DOCUMENTATION ONLY**

- Consultation notes
- Discharge summary
- Emergency room record
- History and Physical
- Progress notes

**Guidelines for Abstraction:**

<b>Inclusion</b>	<b>Exclusion</b>
<p><b>LDL-cholesterol (LDL-c)</b></p> <ul style="list-style-type: none"> <li>• low den lipoprotein</li> <li>• low density lipoprotein (LDL)</li> </ul> <p><b>Elevated LDL-c</b></p> <ul style="list-style-type: none"> <li>• cholesterol described as elevated, high, or ↑</li> <li>• dyslipidemia</li> <li>• dyslipoproteinemia</li> <li>• hyperbetalipoproteinemia</li> <li>• hypercholesterolemia</li> <li>• hyperlipemia</li> <li>• hyperlipidemia</li> <li>• hyperlipoproteinemia</li> <li>• LDL above goal or target</li> <li>• LDL described as elevated, high, or ↑</li> <li>• LDL-cholesterol (LDL-c) described as elevated, high, or ↑</li> <li>• lipids described as elevated, high, or ↑</li> </ul>	<p><b>LDL-cholesterol (LDL-c)</b></p> <ul style="list-style-type: none"> <li>• VLDL (very low density lipoprotein)</li> </ul> <p><b>Elevated LDL-c</b></p> <ul style="list-style-type: none"> <li>• alpha lipoproteinemia</li> <li>• elevated LDL-c, or any of the other elevated LDL-c inclusion terms, described using one of the following qualifiers: cannot exclude, cannot rule out, may have, may have had, may indicate, possible, suggestive of, suspect, or suspicious</li> </ul>

<b>Data Element Name:</b>	<i>First In-Hospital LDL-Cholesterol Value</i>
<b>Collected For:</b>	AMI-T2 – (CMS Optional Test Measure)
<b>Definition:</b>	Value of first LDL-cholesterol (LDL-c) performed after hospital arrival.
<b>Suggested Data Collection Question:</b>	What is the patient’s LDL-cholesterol (LDL-c), in mg/dL or mg/100 ml, from the first LDL-c test performed after hospital arrival?
<b>Format:</b>	<b>Length:</b> 3 <b>Type:</b> Numeric <b>Occurs:</b> 1
<b>Allowable Values:</b>	Enter the patient’s LDL-c value, in mg/dL or mg/100 ml, from the first LDL-c test performed after hospital arrival.
<b>Notes for Abstraction:</b>	<ul style="list-style-type: none"><li>• If unable to determine which LDL-c test was performed first, enter the highest value.</li><li>• Direct and calculated (indirect) LDL-c values are acceptable. If both direct and calculated LDL-c values are documented for the same specimen date/time, enter the direct LDL-c value.</li><li>• If the indirect LDL-c is reported as “not calculated” because high triglycerides render the LDL-c calculation inaccurate, consider the calculated LDL-c value equal to 0 (zero).</li><li>• If an LDL-c value on the laboratory report conflicts with that from another source of documentation for the same specimen, enter the value from the laboratory report.</li><li>• If a laboratory report documents discrepant LDL-c values for the same specimen, enter the highest value.</li><li>• If sources other than a laboratory report document discrepant LDL-c values for the same specimen, enter the highest value.</li><li>• Disregard LDL-c values reported in units of mmol/L or any other unit of measurement other than mg/dL or mg/100 ml. If the unit of measurement is not documented, assume the unit of measurement is mg/dL.</li><li>• If unable to determine from medical record documentation (e.g., LDL-c testing was done but no values are available), enter “999”.</li></ul>

- Suggested Data Sources:**
- Consultation notes
  - Discharge summary
  - Emergency room record
  - History and physical
  - Laboratory reports
  - Progress notes

**Guidelines for Abstraction:**

<b>Inclusion</b>	<b>Exclusion</b>
<p><b>LDL-cholesterol (LDL-c)</b></p> <ul style="list-style-type: none"> <li>• low den lipoprotein</li> <li>• low density lipoprotein (LDL)</li> </ul>	<p><b>LDL-cholesterol (LDL-c)</b></p> <ul style="list-style-type: none"> <li>• VLDL (very low density lipoprotein)</li> </ul>

**Data Element Name:** *First Name*

**Collected For:** All Records (CMS ONLY)

**Definition:** The patient's first name.

**Suggested Data Collection Question:** What is the patient's first name?

**Format:**                   **Length:** 30  
                                   **Type:** Alphanumeric  
                                   **Occurs:** 1

**Allowable Values:** Enter the patient's first name.

**Notes for Abstraction:** None

**Suggested Data Sources:**

- Emergency room record
- Face sheet
- History and physical

**Guidelines for Abstraction:**

Inclusion	Exclusion
None	None

**Data Element Name:** *First PCI Date*

**Collected For:** AMI-8, AMI-8a

**Definition:** The date associated with the time of the first percutaneous coronary intervention (PCI) done after hospital arrival. PCI is defined as the dilation of a coronary (heart) arterial obstruction by means of a balloon catheter inserted into a narrowed blood vessel and inflated, to flatten plaque against the artery wall. This may be performed with or without a stent, a metal scaffold that is used to assist in establishing and maintaining vessel patency.

**Suggested Data**

**Collection Question:** What is the date associated with the time of the first percutaneous coronary intervention (PCI) done after hospital arrival (i.e., date associated with First PCI Time)?

**Format:** **Length:** 10 - MM-DD-YYYY (includes dashes)  
**Type:** Date  
**Occurs:** 1

**Allowable Values:** MM = Month (01-12)  
 DD = Day (01-31)  
 YYYY = Year (2000-9999)

**Notes for Abstraction:**

- Do NOT include PCIs which were attempted but unsuccessful.
- May pre-populate using PCI ICD-9-CM Principal Procedure Date or ICD-9-CM Other Procedure Date. Abstractor should validate the ICD-9-CM date and correct as appropriate.

**Suggested Data Sources:**

- Diagnostic test reports
- Operative notes
- Procedure notes

**Guidelines for Abstraction:**

Inclusion	Exclusion
None	None

**Data Element Name:** *First PCI Time*

**Collected For:** AMI-8, AMI-8a

**Definition:** The first time the lesion was accessed during the first PCI. PCI is defined as the dilation of a coronary (heart) arterial obstruction by means of a balloon catheter inserted into a narrowed blood vessel and inflated, to flatten plaque against the artery wall. This may be performed with or without a stent, a metal scaffold that is used to assist in establishing and maintaining vessel patency.

**Suggested Data**

**Collection Question:** What was the time of the first percutaneous coronary intervention (PCI) done after hospital arrival?

**Format:** **Length:** 5 - HH:MM (includes colon)  
**Type:** Time  
**Occurs:** 1

**Allowable Values:** HH = Hour (00-23)  
MM = Minutes (00-59)

Military Time – A 24-hour period from midnight to midnight using a 4-digit number of which the first two digits indicate the hour and the last two digits indicate the minute.

Converting clock time to military time:

With the exception of Midnight and Noon:

- If the time is in the a.m., conversion is not required
- If the time is in the p.m., add 12 to the clock time hour

For example:

Midnight - 00:00    Noon - 12:00  
5:31 am - 05:31    5:31 pm - 17:31  
1:59 am - 11:59    11:59 pm - 23:59

**Notes for Abstraction:**

- Do NOT include PCIs which were attempted but unsuccessful.
- Use the following priority order to abstract the time:
  1. Time of the first balloon inflation (Inflate #1, Balloon inflated, # ATM for # minutes/seconds)
  2. Time the wire, balloon or other device (e.g., angiojet or other thrombectomy device, rotablate) reached, passed through, or crossed the lesion
  3. Time of the first treatment of lesion (Cut # time, Excimer time, Time rotablate used, Time angiojet or other thrombectomy device used)
- Use the above priority order regardless of whether the culprit lesion is a native coronary vessel or a graft
- If there is documentation on the procedure sheet of “lesion” accompanied solely by a time (e.g., “08:52 – RCA lesion”), assume this is the time the lesion was crossed (2nd priority)
- When applying the priority order and there are conflicting times (e.g., 2 different balloon inflation times), enter the earliest time.

**Suggested Data Sources:**

- Diagnostic test reports
- Operative notes
- Procedure notes

**Guidelines for Abstraction:**

<b>Inclusion</b>	<b>Exclusion</b>
None	None