

Data Element Name: *Health Care Organization Identifier*

Collected For: Used in data transmission. Please see the most current version of the ORYX[®] Technical Guide for details. (JCAHO ONLY)

Definition: A unique identification number, for the building, or set of adjacent buildings, where a health care organization performs business and from which the patient is discharged or received a substantial amount of services.

Suggestion Data

Collection Question: What is the Joint Commission unique identification number for the provider?

Format: **Length:** See ORYX Technical Implementation Guide
Type: See ORYX Technical Implementation Guide
Occurs: See ORYX Technical Implementation Guide

Allowable Values: See ORYX Technical Implementation Guide

Notes for Abstraction: None

Suggested Data Sources: Does not apply, Joint Commission assigned.

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *Hispanic Ethnicity*

Collected For: All Records

Definition: Documentation that the patient is of Hispanic ethnicity.

Suggested Data Collection Question: Is the patient of Hispanic ethnicity?

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

Allowable Values: Y (Yes) Patient is of Hispanic ethnicity.
 N (No/UTD) Patient is not of Hispanic ethnicity or unable to
 determine from medical record documentation.

Notes for Abstraction: None

Suggested Data Sources: • Emergency department record
 • Face sheet
 • History and physical
 • Nursing admission assessment
 • Progress notes

Guidelines for Abstraction:

Inclusion	Exclusion
<ul style="list-style-type: none"> • Black-Hispanic • Central American • Chicano • Cuban • H • Hispanic • Latin American • Latino/Latina • Mexican • Mexican-American • Puerto Rican • South American • Spanish • White-Hispanic 	None

Data Element Name: *ICD Population Size*

Collected For: Used in data transmission. Please see the most current version of the ORYX[®] Technical Implementation Guide for details. (JCAHO ONLY)

Definition: Indicates the number of case-level records identified for a health care organization, for a specific core measure, prior to the application of data integrity filters, measure exclusions, and/or sampling methodology for the specified time period.

The data element is based on the health care organization's initial identification of case-level records for a measure or measure set. The initial pull should be based upon one or more required general data elements (e.g., specified ICD-9-CM diagnosis or procedure codes). Examples:

- AMI Number of case-level records with ICD-9-CM Principal Diagnosis Code in Appendix A on Table 1.1 for the individual measure during the specified time period.
- HF Number of case-level records with an ICD-9-CM Principal Diagnosis Code in Appendix A on Table 2.1 for the individual measure during the specified time period.
- PN Number of case-level records with an ICD-9-CM Principal Diagnosis Code in Appendix A on Table 3.1 or an ICD-9-CM Principal Diagnosis Code in Appendix A on Table 3.2 or Table 3.3 and an ICD-9-CM Other Diagnosis Code in Appendix A on Table 3.1
- PR-1 &
PR-3 Number of case-level records with a valid ICD-9-CM Principal Diagnosis Code and an ICD-9-CM Principal or Other Diagnosis Codes in Appendix A on Tables 4.01 or 4.02 or 4.03 or 4.04 for the individual measure during the specific time period.
- PR-2 Number of case-level neonate records aged 0-28 days (age calculated Discharge Date minus Birthdate and/or Admission Date minus Birthdate.)
- SIP Number of case-level records with an ICD-9-CM Principal Procedure Code and/or Other Procedure Code in Appendix A on Tables 5.01 to 5.08.

Note to clarify calculating the ICD Population calculation for SIP:

Overall rate measures (SIP-1a, SIP-2a, SIP-3a): Number of case level records with an ICD-9-CM Principal Procedure Code and/or Other Procedure Code on Tables 5.01 to 5.08 in Appendix A.

For strata measures (SIP-1b through SIP-1h, SIP-2b through SIP-2h, SIP-3b through SIP-3h): Number of case level records with an ICD-9-CM Principal Procedure Code and/or Other Procedure Code on Tables 5.01 to 5.08 in Appendix A. Following are the strata measures linked to the individual Procedure Code tables

SIP -1b, 2b, 3b- Table 5.01	Coronary Artery Bypass Graft (CABG)
SIP-1c, 2c, 3c – Table 5.02	Other Cardiac Surgery
SIP-1d, 2d, 3d – Table 5.04	Hip Arthroplasty
SIP-1e, 2e, 3e – Table 5.05	Knee Arthroplasty
SIP-1f, 2f, 3f – Table 5.03	Colon Surgery
SIP-1g, 2g, 3g – Table 5.06, 5.07	Abdominal Hysterectomy, Vaginal Hysterectomy
SIP-1h, 2h, 3h – Table 5.08	Vascular Surgery

Episodes of Care with multiple procedures of interest are counted once in the ICD Population Size for the overall measure. However, if a case has multiple procedure codes of interest such as a CABG Procedure code and a Cardiac Procedure Code then the episode of care should be included in the ICD Population for both stratified measures (e.g., SIP-1b and SIP-1c). Due to potential to count a single episode of care in multiple strata, ICD population size of the overall rate measure may not equal the sum of the ICD population counts of the individual strata measures.

NOTE: If the data that are being transmitted to the measurement system have been sampled, then the field will represent the population from which the sample was originally drawn, NOT the sample size.

Suggestion Data

Collection Question: Not Applicable

Format: **Length:** See ORYX Technical Implementation Guide
Type: See ORYX Technical Implementation Guide
Occurs: See ORYX Technical Implementation Guide

Allowable Values: See ORYX Technical Implementation Guide

Notes for Abstraction: None

Suggested Data Sources: Not Applicable

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Release Notes: Data Element - Version 1.0

Data Element Name: *ICD-9-CM Other Diagnosis Codes*

Collected For: All Records (used in algorithm for AMI-9, All PN Measures, All PR Measures)

Definition: The International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) codes associated with the diagnosis for this hospitalization.

Suggested Data

Collection Question: What were the ICD-9-CM other diagnosis codes selected for this medical record?

Format: **Length:** 6 (implied decimal point)
 Type: Alphanumeric
 Occurs: 15

NOTE: Refer to Appendix F for an explanation on formatting for ICD-9-CM codes

Allowable Values: Any valid ICD-9-CM diagnosis code

Notes for Abstraction: None

Suggested Data Sources:

- Discharge summary
- Face sheet
- UB-92 (Other Diagnosis Codes), Field Location: 68-75

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *ICD-9-CM Other Procedure Codes*

Collected For: All Records (used in algorithm for AMI-8, AMI-8a, PR-1, PR-3, SIP-1, SIP-2, SIP-3)

Definition: The International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) codes identifying all significant procedures other than the principal procedure.

Suggested Data

Collection Question: What were the ICD-9-CM code(s) selected as other procedure(s) for this record?

Format: **Length:** 5 (implied decimal point)
 Type: Alphanumeric
 Occurs: 5

NOTE: Refer to Appendix F for an explanation on formatting for ICD-9-CM codes

Allowable Values: Any valid ICD-9-CM procedure code

Notes for Abstraction: None

- Suggested Data Sources:**
- Discharge summary
 - Face sheet
 - UB-92, Field Location: 81

Guidelines for Abstraction:

Inclusion	Exclusion
For inclusion in the algorithms listed above refer to Appendix A, for ICD-9-CM Code Tables (AMI, PR, SIP)	None

Release Notes: Data Element - Version 1.0

Data Element Name: *ICD-9-CM Other Procedure Dates*

Collected For: All Records

Definition: The month, day, and year when the associated procedure(s) was(were) performed.

Suggested Data Collection Question: What were the date(s) the other procedure(s) were performed?

Format: **Length:** 10 – MM-DD-YYYY (includes dashes)
 Type: Date
 Occurs: 5

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

Notes for Abstraction: None

- Suggested Data Sources:**
- Consultation notes
 - Diagnosis test reports
 - Discharge summary
 - Face sheet
 - Operative notes
 - Procedure notes
 - Progress notes
 - UB-92, Field Location: 81

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *ICD-9-CM Principal Diagnosis Code*

Collected For: All Records

Definition: The International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) code associated with the diagnosis established after study to be chiefly responsible for occasioning the admission of the patient for this hospitalization.

Suggested Data

Collection Question: What was the ICD-9-CM code selected as the principal diagnosis for this record?

Format: **Length:** 6 (implied decimal point)
 Type: Alphanumeric
 Occurs: 1

NOTE: Refer to Appendix F for an explanation on formatting for ICD-9-CM codes.

Allowable Values: Any valid ICD-9-CM diagnosis code

Notes for Abstraction: The principal diagnosis is defined in the Uniform Hospital Discharge Data Set (UHDDS) as “that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care”.

- Suggested Data Sources:**
- Discharge summary
 - Face sheet
 - UB-92, Field Location: 67

Guidelines for Abstraction:

Inclusion	Exclusion
Refer to Appendix A, for ICD-9-CM Code Tables (AMI, HF, PN)	Refer to Appendix A, for ICD-9-CM Code Tables (SIP)

Data Element Name: *ICD-9-CM Principal Procedure Code*

Collected For: All Records (used in algorithm for AMI-8, AMI-8a, PR-1, PR-3, SIP-1, SIP-2, SIP-3)

Definition: The International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) code that identifies the principal procedure performed during this hospitalization. The principal procedure is the procedure performed for definitive treatment rather than diagnostic or exploratory purposes, or which is necessary to take care of a complication.

Suggested Data

Collection Question: What was the ICD-9-CM code selected as the **principal** procedure for this record?

Format:

Length: 5 (implied decimal point)
Type: Alphanumeric
Occurs: 1

NOTE: Refer to Appendix F for an explanation on formatting for ICD-9-CM codes

Allowable Values: Any valid ICD-9-CM procedure code

Notes for Abstraction: The principal procedure as described by the Uniform Hospital Discharge Data Set (UHDDS) is one performed for definitive treatment rather than diagnostic or exploratory purposes, or which is necessary to take care of a complication.

- Suggested Data Sources:**
- Discharge summary
 - Face sheet
 - UB-92, Field Location: 80

Guidelines for Abstraction:

Inclusion	Exclusion
For inclusion in the algorithms listed above refer to Appendix A, for ICD-9-CM Code Tables (AMI, PR, SIP)	None

Release Notes: Data Element - Version 1.0

Data Element Name: *ICD-9-CM Principal Procedure Date*

Collected For: All Records

Definition: The month, day, and year when the principal procedure was performed.

Suggested Data Collection Question: What was the date the principal procedure was performed?

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 notes
 - Diagnostic test reports
 - Discharge summary
 - Face sheet
 - Operative notes
 - Procedure notes
 - Progress notes
 - UB-92, Field Location: 80

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name:	<i>ICU Transfer or Admission Within First 24 Hours</i>
Collected For:	PN-6, PN-6a, PN-6b
Definition:	The patient was admitted or transferred to the intensive care unit (ICU) within the first 24 hours following arrival at this hospital. Direct admits, admissions via the emergency department, or transfers from lower levels of in-patient care are included.
Suggested Data Collection Question:	Was the patient admitted or transferred to the intensive care unit (ICU) within the first 24 hours following arrival at the hospital?
Format:	Length: 1 Type: Alphanumeric Occurs: 1
Allowable Values:	Y (Yes) The patient was admitted or transferred to the ICU within the first 24 hours after arrival. Any time spent in the ICU within the first 24 hours is included. N (No) The patient was not admitted or transferred to an ICU within the first 24 hours of the hospital arrival.
Notes for Abstraction:	None
Suggested Data Sources:	<ul style="list-style-type: none">• Emergency room record• History and physical• Nursing admission assessment• Nursing notes• Physician orders• Progress notes

Guidelines for Abstraction:

Inclusion	Exclusion
<ul style="list-style-type: none">• coronary care unit (CCU, CICU)• intensive care unit (ICU)• medical intensive care unit (MICU, MCU)• respiratory intensive care unit (RICU, RCU)• surgical intensive care unit (SCU, SICU)	<ul style="list-style-type: none">• do not include ED, OR, or procedure units as inpatient units• do not include inpatient units with telemetry monitoring that are not intensive care units

Data Element Name:	<i>In-Hospital LDL-Cholesterol Test</i>
Collected For:	AMI-T1a, AMI-T1b, AMI-T2 – (CMS Optional Test Measures)
Definition:	LDL-cholesterol (LDL-c) test performed during this hospital stay.
Suggested Data Collection Question:	Was an LDL-cholesterol (LDL-c) test performed during this hospital stay?
Format:	Length: 1 Type: Alphanumeric Occurs: 1
Allowable Values:	Y (Yes) LDL-c test was performed during this hospital stay. N (No) LDL-c test was not performed during this hospital stay or unable to determine from medical record documentation.
Notes for Abstraction:	<ul style="list-style-type: none">• In the absence of explicit documentation that an LDL-c test was or was not performed during this hospital stay, it should be inferred that a test was done if:<ul style="list-style-type: none">○ There is documentation of an LDL-c value from a test performed during this hospital stay, or○ There is physician, nurse practitioner, or physician assistant documentation which qualitatively describes the results of an LDL-c test performed during this hospital stay (e.g., “lipids elevated”), or○ There is documentation that lipid testing was performed during this hospital stay.• Do not include an LDL-c value, LDL-c qualitative description, or lipid testing if it cannot be determined that the testing was actually done during this hospital stay. The following examples should not be included:

**Notes for Abstraction
continued:**

- “Impression: Elevated cholesterol” noted in consultation report done on day of admission
- “Hypercholesterolemia” noted as discharge diagnosis in discharge summary, with no evidence that any lipid testing was done during the hospital stay
- Cardiac cath physician writes “Labs within normal range except for cholesterol”, with no evidence that any lipid testing was done during the hospital stay
- Do not include lipid testing or qualitative descriptions of lipid test results if it can be determined that LDL-c measurement was not part of the lipid testing. The following examples should not be included:
 - “Lipid profile done on day 2” per discharge summary, but the laboratory report lists only cholesterol and triglyceride values
 - Physician notes “Labs: elevated cholesterol”, but the laboratory report lists only a total cholesterol value

Suggested Data Sources:

- Consultation notes
- Discharge summary
- Emergency room record
- History and physical
- Laboratory report
- Progress notes

Guidelines for Abstraction:

Inclusion	Exclusion
<p>LDL-cholesterol (LDL-c)</p> <ul style="list-style-type: none"> • low den lipoprotein • low density lipoprotein (LDL) <p>Qualitative description of LDL-c test results</p> <ul style="list-style-type: none"> • cholesterol level qualitatively described (e.g., low, normal, elevated, ↑) • dyslipidemia (presence or absence) • dyslipoproteinemia (presence or absence) • hyperbetalipoproteinemia (presence or absence) • hypercholesterolemia (presence or absence) • hyperlipemia (presence or absence) • hyperlipidemia (presence or absence) • hyperlipoproteinemia (presence or absence) • LDL level qualitatively described (e.g., low, normal, elevated, above goal, below target, ↑) • LDL-cholesterol (LDL-c) level qualitatively described (e.g., low, normal, elevated, ↑) • lipid levels qualitatively described (e.g., low, normal, elevated, ↑) <p>Lipid testing</p> <ul style="list-style-type: none"> • cholesterol analysis • cholesterol check (✓) • cholesterol panel • cholesterol profile • cholesterol testing • fasting lipids • LDL: HDL • LDL: HDL ratio • lipid analysis • lipid check (✓) • lipid panel • lipid profile • lipids • lipoprotein analysis 	<p>LDL-cholesterol</p> <ul style="list-style-type: none"> • VLDL (very low density lipoprotein) <p>Qualitative description of LDL-c test results</p> <ul style="list-style-type: none"> • alpha lipoproteinemia (presence or absence)

Data Element Name: *In-Hospital LDL-Cholesterol Test Within 24 Hours After Hospital Arrival*

Collected For: AMI-T1b – (CMS Optional Test Measure)

Definition: LDL-cholesterol (LDL-c) test drawn within 24 hours after hospital arrival.

Suggested Data Collection Question: Was the first LDL-cholesterol (LDL-c) test drawn within 24 hours after hospital arrival?

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

Allowable Values: Y (Yes) LDL-c test drawn within 24 hours after hospital arrival.
 N (No) LDL-c test was not drawn within 24 hours after hospital arrival or unable to determine from medical record documentation.

Notes for Abstraction:

- If unable to determine which LDL-c level was drawn first, use the earliest documented date/time.
- If unable to determine for certain whether any LDL-c test was performed within 24 hours after hospital arrival (e.g., the lab slip is dated the day after arrival, however the time is illegible), select “No”.
- The dates/times on which LDL-c levels were drawn may be labeled or described as “collected”, “drawn”, “obtained”, “sample”, or “specimen” dates/times, or they may be documented only as dates/times without further specification. Do NOT include dates/times specified as “Log in”, “Order”, “Receipt”, “Received”, “Report”, or “Start”.

Suggested Data Sources: **ONLY ACCEPTABLE SOURCE**

- Laboratory reports

Guidelines for Abstraction:

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

Data Element Name:	<i>Infection Prior to Anesthesia</i>
Collected For:	All SIP Measures
Definition:	Documentation the patient was being treated for an infection prior to the first surgical procedure of interest performed during this hospital stay.
Suggested Data Collection Question:	Was the patient being treated for an infection prior to the first surgical procedure of interest performed during this hospital stay?
Format:	Length: 1 Type: Alphanumeric Occurs: 1
Allowable Values:	Y (Yes) Physician documentation that the patient was undergoing treatment for an infection prior to the first surgical procedure of interest performed during this hospital stay. N (No) There is no physician documentation that the patient was undergoing treatment for an infection prior to the first surgical procedure of interest performed during this hospital stay.
Notes for Abstraction:	None
Suggested Data Sources:	PHYSICIAN/NURSE PRACTITIONER/PHYSICIAN ASSISTANT DOCUMENTATION ONLY <ul style="list-style-type: none">• History and physical• Operative report• Progress notes

Guidelines for Abstraction:

Inclusion	Exclusion
<ul style="list-style-type: none">• Abscess• Bloodstream infection• Bone infection• Cellulitis• H.pylori, if being treated with antibiotics• Osteomyelitis• Other documented infection• Pneumonia or other lung infection• Surgical site or wound infection• Urinary tract infection (UTI)	<ul style="list-style-type: none">• Candidiasis

Data Element Name: *Influenza Vaccination Status*

Collected For: PN-7

Definition: Documentation of the patient's vaccination status during this flu season. If found to be a candidate for the vaccine, documentation that the influenza vaccine was given during this hospitalization. A vaccine is a suspension of an attenuated (weakened) or killed microorganism, such as bacteria or virus, administered for the prevention, amelioration, or treatment of infectious diseases.

Suggested Data Collection Question: What is the patient's influenza vaccination status?

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

- Allowable Values:**
- 1 Influenza vaccine was given during this hospitalization: The patient received influenza vaccine during this hospitalization.
 - 2 Influenza vaccine was received prior to admission during the current flu season*, not during this hospitalization: The patient received the influenza vaccine during the current flu season*, prior to hospitalization.
 - 3 Documentation of patient's refusal of influenza vaccine: Documentation the patient refused influenza vaccine.
 - 4 Allergy/sensitivity to influenza vaccine: There was documentation of an allergy/sensitivity to influenza vaccine OR is medically contraindicated because of bone marrow transplant within the past 12 months.
 - 5 None of the above/Not documented/UTD: None of the answers above are appropriate, there was no documentation of an influenza vaccination status or unable to determine.

Notes for Abstraction: JCAHO NOTE: If the ICD-9-CM Other Diagnosis Code V04.81 or V06.6 exists then default the allowable value to 1.

*The current flu season begins when this season’s flu vaccine is made available to the public, i.e., if the vaccine is available in September, the flu season is September-February. However, for the purposes of this project, the hospitals are only responsible for discharges October-February.

- Suggested Data Sources:**
- Consultation notes
 - Discharge summary
 - Emergency department record
 - History and physical
 - Immunization assessment forms
 - Medication administration record
 - Nursing admission assessment
 - Nursing notes
 - Physician orders
 - Physician progress notes
 - Social service notes
 - Transfer forms
 - Vaccine order sheet

Guidelines for Abstraction:

Inclusion	Exclusion
<p>All patients discharged during October, November, December, January, or February</p> <ul style="list-style-type: none"> • Flu immune • Flu shield • flu shot • Flu vaccine • Fluax • Fluogen • Fluvirin • Fluzone • Influenza virus vaccine • trivalent influenza vaccine 	<ul style="list-style-type: none"> • All discharges from March – September • Patients allergic to eggs or other specific allergy/sensitivity to the vaccine. The allergy/sensitivity should be accompanied by the exact complication. Must be a specific allergy/sensitivity not just physician preference

Data Element Name: *Initial Blood Culture Collection Date*

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

Definition: The month, day, and year the initial blood culture was collected after hospital arrival. 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: What is the date of the initial blood culture collected after hospital arrival?

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

Guidelines for Abstraction:

Inclusion	Exclusion
<ul style="list-style-type: none"> • BC • blood cultures 	<ul style="list-style-type: none"> • Cultures collected prior to arrival

Data Element Name: *Initial Blood Culture Collection Time*

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

Definition: The time (military time) that the initial blood culture was collected or drawn after hospital arrival. 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: What is the time of the initial blood culture collected 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
11: 59 am = 11: 59 11: 59 pm = 23:59

Notes for Abstraction: Do not take times from the lab reports if they are unqualified times, or are marked as anything other than time collected, drawn, or obtained. “Received times”, “log in times”, or “start times”, are not to be abstracted.

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

Guidelines for Abstraction:

Inclusion	Exclusion
<ul style="list-style-type: none">• BC• blood cultures	<ul style="list-style-type: none">• Cultures collected prior to arrival

Data Element Name: *Initial ECG Interpretation*

Collected For: AMI-7, AMI-7a, AMI-8, AMI-8a

Definition: ST segment elevation or a left bundle branch block (LBBB) based on the documentation of the electrocardiogram (ECG) performed closest to hospital arrival. The normal ECG is composed of a P wave (atrial depolarization), Q, R, and S waves (QRS complex, ventricular depolarization), and a T wave (ventricular repolarization). The ST segment, the segment between the QRS complex and the T wave, may be elevated when myocardial injury (AMI) occurs. Between the atria and the ventricles, the conduction system divides electrical impulses into right and left bundle branches. A bundle branch block (BBB) results from impaired conduction in one branch, which in turn results in abnormal ventricular depolarization. In LBBB, left ventricular depolarization is delayed, resulting in a characteristic widening of the QRS complex on the ECG. LBBB may be an electrocardiographic manifestation of an AMI.

Suggested Data

Collection Question: Is there documentation of ST segment elevation or left bundle branch block (LBBB) on the electrocardiogram (ECG) performed closest to hospital arrival?

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

Allowable Values: Y (Yes) ST segment elevation or a LBBB on the interpretation of the 12-lead ECG performed closest to hospital arrival.
 N (No) No ST elevation or LBBB on the interpretation of the 12-lead ECG performed closest to hospital arrival, no interpretation or report available for the ECG performed closest to hospital arrival or unable to determine from medical record documentation.

Notes for Abstraction:

- Use the 12-lead ECG performed closest to the time of hospital arrival, whether prior to or after hospital arrival (e.g., 12-lead ECG done in the ambulance 10 minutes before hospital arrival and a second one done in the ED 30 minutes after arrival – use the ECG done in the ambulance). If there is no interpretation available from the 12-lead ECG performed closest to the time of hospital, select “No”. Do not use an interpretation from another ECG performed that may be available.
- Do NOT use ECGs done more than 1 hour prior to hospital arrival.
- This information must be taken from the interpretation. An ECG interpretation is defined as:
 - A 12-lead ECG report in which the name or initials of the physician/nurse practitioner/physician assistant who reviewed the ECG is signed, stamped, or typed on the report, or
 - Physician/nurse practitioner/physician assistant notation of ECG findings in another source (e.g., progress notes).
- Interpretations must be taken directly from documentation of ECG findings. Do not measure ST segments or attempt to identify a LBBB on the ECG tracing.
- If the ECG report is not specifically labeled “12-lead”, infer that it was 12-lead if lead markings (i.e., I, II, III, aVR, aVL, aVF, V1, V2, V3, V4, V5, V6) are noted on the report.
- If the physician/nurse practitioner/physician assistant references ECG findings but does not specify the ECG was 12-lead, infer that it was 12-lead, unless documentation indicates otherwise.
- If unable to determine which 12-lead ECG was done closest to arrival (e.g., one ECG does not have a time, and it cannot be determined whether it is closer to hospital arrival than another ECG which does have a time), or if the time between the pre-arrival and post-arrival ECG is the same (e.g., both were done 15 minutes from hospital arrival time), select “Yes” if any of these ECGs have ST segment elevation or LBBB documented on the interpretation.
- If the location of an MI is documented and it is described as acute/evolving, or an acute/evolving MI is described as “transmural” or “Q wave”, the presumption is being made that it is an ST elevation MI.
- Do not consider “subendocardial” an MI “location” (e.g., “acute subendocardial MI” should be excluded).
- Consider “infarct” synonymous with myocardial infarction (e.g., “acute inferior infarct”) should be included.

**Notes for Abstraction
continued:**

- MIs MUST be described as **acute or evolving** (in addition to documentation of location or description of MI as “transmural” or “Q wave”). Do NOT include MIs specified as old or previously seen, where the age is documented as undetermined (e.g., “inferior MI age undetermined”, “Extensive anterior infarct, age indeterminant”, “anterolateral MI on or before 09-01-2004”), or where age is not addressed in any manner (e.g., “Q wave MI”). “New” should not be considered synonymous with “acute”. “Evolving” should be considered synonymous with “acute”.
- When both an inclusion and exclusion are documented in reference to the same ECG, or documentation is otherwise conflicting, select “No”. Consider documentation as conflicting if there is documentation of both an included term and excluded term (per inclusion/exclusion lists or Notes for Abstraction) or documentation of an included term with additional documentation which clearly contradicts the inclusion term. Examples:
 - Signed ECG report lists “LBBB” and “non Q wave MI”
 - The ER physician reports “ST elevation” on the initial ECG, while the attending cardiologist interprets this same ECG as “No ST elevation”
 - Signed ECG report notes ST segment = .05mV, which the physician labels “ST elevation”
- If there is documentation of an included term and documentation of a finding which is not addressed in the inclusion/exclusion lists or Notes for Abstraction, this should NOT be considered conflicting documentation. In the following examples, “Yes” should be selected:
 - Signed ECG report notes “probable lateral injury”, while the physician’s progress note states “ST elevation present”
 - Findings of “posterior AMI” and “ST depression” are noted on the signed ECG report
- LBBBs described as old should be included. An old LBBB pattern obscures the ability of the ECG to develop recognizable ST elevation, impairing diagnosis of acute MI. Under this uncertainty, these cases should be treated with reperfusion.
- The term “ST abnormality” should not be considered synonymous with “ST elevation”.

- Suggested Data Sources:**
- Ambulance record
 - Consultation notes
 - ECG/EKG reports
 - Emergency department record
 - History and physical
 - Progress notes

Guidelines for Abstraction:

Inclusion	Exclusion
<p>ST segment elevation</p> <ul style="list-style-type: none"> • myocardial infarction (MI), with any mention of location or combinations of locations (e.g., anterior, apical, basal, inferior, lateral, posterior, or combination), IF DESCRIBED AS ACUTE/EVOLVING (e.g., “posterior AMI”) • Q wave AMI • Q wave MI, IF DESCRIBED AS ACUTE/EVOLVING • ST ↑ • ST abnormality consistent with injury, infarct, or acute/evolving MI • ST changes consistent with injury, infarct, or acute/evolving MI • ST consistent with injury, infarct, or acute/evolving MI • ST elevation • ST elevation myocardial infarction (STEMI) • ST segment noted as $\geq .10\text{mV}$ • transmural AMI • transmural MI, IF DESCRIBED AS ACUTE/EVOLVING <p>Left bundle branch block (LBBB)</p> <ul style="list-style-type: none"> • intermittent LBBB • intraventricular conduction delay of LBBB type • LBBB described as old • variable LBBB 	<p>ST segment elevation</p> <ul style="list-style-type: none"> • myocardial infarctions (MIs) specified as old or noted as previously seen • MIs where the age is documented as undetermined or is not addressed • non Q wave MI (NQWMI) • non ST elevation MI (NSTEMI) • ST abnormality, ST changes, or ST segment described as consistent with ischemia • ST elevation due to early repolarization • ST elevation due to left ventricular hypertrophy (LVH) • ST elevation due to normal variant • ST elevation with mention of pericarditis • ST elevation with mention of Printzmetal/Printzmetal's variant • ST segment elevation, or any of the other ST segment elevation 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 <p>Left bundle branch block (LBBB)</p> <ul style="list-style-type: none"> • incomplete left bundle branch block (LBBB) • intraventricular conduction delay (IVCD) • left bundle branch block (LBBB), or any of the other left bundle branch 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

Data Element Name: *Last Name*

Collected For: All Records (CMS ONLY)

Definition: The patient's last name.

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

Format: **Length:** 60
 Type: Alphanumeric
 Occurs: 1

Allowable Values: Enter the patient's last 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: *Lipid Lowering Agent Prescribed at Discharge*

Collected For: AMI-T2 – (CMS Optional Test Measure)

Definition: Documentation that a lipid lowering agent was prescribed at hospital discharge.

NOTE: Refer to Appendix C, Table 1.6 for a list of lipid lowering agents.

Suggested Data

Collection Question: Was a lipid lowering agent prescribed at discharge?

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

Allowable Values: Y (Yes) Lipid lowering agent prescribed at discharge.
 N (No) Lipid lowering agent 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 1.6 for a comprehensive list of Lipid Lowering Agents	None

Data Element Name: *LVF Assessment*

Collected For: HF-2

Definition: Documentation that left ventricular function (LVF) was assessed either prior to arrival, during hospitalization, or is planned for after discharge or reason documented by physician, nurse practitioner, or physician assistant for not assessing LVF prior to arrival, during hospitalization, or planned for after discharge. LVF assessment is a measure of left ventricular contractility, and may be described either quantitatively (e.g., “left ventricular ejection fraction = 30%”) or qualitatively (e.g., “moderate left ventricular systolic dysfunction”).

**Suggested Data
Collection Question:**

Is there documentation of at least one of the following:

- Left ventricular function (LVF) assessment at anytime prior to arrival or during this hospitalization
- A plan for LVF assessment after discharge
- A reason documented by a physician, nurse practitioner, or physician assistant for not assessing LVF

Format:
Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes) Documentation in the medical record that the LVF was assessed prior to arrival, during the hospital stay, or is planned for after discharge.

N (No) No documentation that LVF was assessed either prior to arrival or during this hospital stay nor a plan to assess LVF after discharge, AND there is no reason documented by a physician, nurse practitioner, or physician assistant for not assessing LVF, or unable to determine from medical record documentation.

R (R) Reason documented by physician, nurse practitioner, or physician assistant for not assessing LVF prior to arrival, during hospital stay, or planned after discharge.

Notes for Abstraction:

- There is no time limitation on pre-arrival LVF assessments: LVF assessments done anytime prior to hospital arrival are acceptable.
- In the absence of explicit documentation that an LVF assessment was done, it should be inferred that an assessment was done if:
 - An echocardiogram, appropriate nuclear medicine test, or a cardiac catheterization with a left ventriculogram was done during this hospital stay, or
 - There is documentation one of the above diagnostic tests was performed anytime prior to arrival (e.g., “Echo done last March”), or
 - There is documentation of LVF, either as an ejection fraction or a narrative qualitative description (e.g., “Pt. admitted with severe LV dysfunction”).
- In determining whether there is a reason documented by physician, nurse practitioner, or physician assistant for not assessing LVF, reasons must be explicitly documented (e.g., “ESRD, life expectancy < 1 month, will not measure EF.”) or clearly implied (e.g., “Patient refusing echo”, “Pt. returning to Wisconsin immediately after discharge, will talk to PCP about need for echo”, “Terminal care, will not do any further evaluation”). If reasons are not mentioned in the context of LVF assessments, do not make inferences (e.g., Do not assume that the physician is not assessing LVF because the patient is already on ACEI therapy or is of advanced age).
- In determining whether there is a plan to assess LVF after discharge, the plan must be documented as definitive (e.g., “Will measure EF after discharge”). Documentation which indicates only that an LVF assessment after discharge will be considered (e.g., “May do echo in 1 month”) is not sufficient.

Suggested Data Sources:

- Consultation notes
- Diagnostic test reports
- Discharge instruction sheet
- Discharge planning notes
- Discharge summary
- Emergency department record
- History and physical
- Operative notes
- Physician orders
- Procedure notes
- Progress notes

Guidelines for Abstraction:

Inclusion	Exclusion
Refer to Appendix H, Table 1.2 LVF Assessment Inclusion Table	Left ventricular function (LVF) <ul style="list-style-type: none">• left ventricular compliance• left ventricular dilatation• left ventricular dilation• left ventricular function, or any of the other terms in the LVF Assessment 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• left ventricular hypertrophy (LVH)

Data Element Name: LVSD

Collected For: AMI-3, HF-3

Definition: Left ventricular systolic dysfunction (LVSD) documented in medical record. LVSD is defined as a left ventricular ejection fraction less than 40% or a narrative description consistent with moderate or severe systolic dysfunction. LVSD is an impairment of left ventricular contractile performance. An ejection fraction (EF) is an index of left ventricular function (LVF) and reflects the proportion of blood ejected during each ventricular contraction compared with the total ventricular filling volume.

Suggested Data Collection Question: Is the left ventricular function (LVF) documented as an ejection fraction (EF) less than 40% or a narrative description consistent with moderate or severe systolic dysfunction?

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

Allowable Values: Y (Yes) LVF is documented as an EF less than 40% or a narrative description consistent with moderate or severe systolic dysfunction.
N (No) LVF is not documented as an EF less than 40% or a narrative description not consistent with moderate or severe systolic dysfunction, or unable to determine from medical record documentation (e.g., LVF assessment was never done, “Echo done last March” [without mention of LVF results]).

Notes for Abstraction: Refer to Appendix H, Table 1.5 LVSD Notes Table.

Suggested Data Sources:

- Consultation notes
- Diagnostic test reports
- Discharge summary
- Emergency department record
- History and physical
- Nursing notes
- Operative notes
- Procedure notes
- Progress notes

Guidelines for Abstraction:

Inclusion	Exclusion
<p>Refer to Appendix H, Table 1.3 Moderate/Severe Systolic Dysfunction Inclusion Table</p>	<p>Moderate or severe systolic dysfunction</p> <ul style="list-style-type: none"> • left ventricular dysfunction (LVD) described as mild-moderate • left ventricular systolic dysfunction (LVSD) described as mild-moderate • moderate or severe systolic dysfunction, or any of the other terms in the Moderate/Severe Systolic Dysfunction 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 • systolic dysfunction described as mild-moderate

Data Element Name: *Measure Category Assignment*

Collected For: Used for measure calculation. (JCAHO ONLY)

NOTE:All hospital measures use this data element in the measure verification process.

Definition: Calculated measures results for each episode of care (EOC) that is processed through a measure algorithm.

Used to summarize the outcome for an EOC that is processed through a specific measure algorithm.

**Suggested Data
Collection Question:**

Not Applicable

Format:

Length: 1

Type: Alphanumeric

Occurs: One Measure Category Assignment per EOC is expected for every measure that a health care organization is participating in.

Allowable Values:

- A **Category A - Missing or Invalid Measure Data**
For rate-based and continuous variable measures:
EOC record does not include enough accurate and valid information to determine whether or not it is a member of the measure's population.
- B **Category B - Not in Measure Population**
For rate-based and continuous variable measures:
EOC record is not a member of a measure's population.
- C **Category C - Missing or Invalid Numerator Data**
For rate-based measures:
EOC record is a member of the measure's population, but there is not enough accurate and valid information to determine the existence of an occurrence of the measures.

D Category D - In Measure Population

For rate-based measures:

EOC record is a member of the measure's population and there has not been an occurrence of the measure.

For continuous variable measures:

EOC record is a member of the measure's population and has sufficient accurate and valid data to compute the measurement.

NOTE: For continuous variable measures, EOC records that have a Measure Category Assignment of "D" are expected to have an associated Measurement Value.

E Category E - In Numerator Population

For rate-based measures:

EOC record is a member of the measure's population and there has been an occurrence of the measure.

For continuous variable measures:

Does not apply.

NOTE: For risk adjusted measures there are two additional category assignments. See Risk Adjustment Category Assignment data element.

Notes for Abstraction: None

Suggested Data Sources: Not Applicable

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *Measurement Value*

Collected For: Used in data transmission for continuous variable measures (AMI-7, AMI-8, PN-5) (JCAHO ONLY)

NOTE: Also used during the measure verification process

Definition: This data element is used to store the calculated results of the measurements that are outputs from continuous variable measure algorithms.

NOTE: Used in conjunction with Measure Category Assignment when its allowable value = “D” (In Measure Population).

Suggested Data

Collection Question: Not Applicable

Format:

Length: 6

Type: Numeric

Occurs: One Measurement Value is expected per EOC for every continuous variable measure.

Allowable Values: Any valid number

NOTE: Zero (0) is not an allowable value for measure AMI-7 or AMI-8. Negative numbers are not valid for measures AMI-7, AMI-8, or PN-5.

Notes for Abstraction: None

Suggested Data Sources: Not Applicable

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *Number of Cases with Missing or Invalid Numerator Data*

Collected For: Used in data transmission. Please see the most current version of the ORYX[®] Technical Implementation Guide for details (JCAHO ONLY)

Definition: The total number of cases that belong, or might belong, to a measure's numerator population, but contain missing or invalid data which prevent an assignment to the numerator population. The data element represents a COUNT of all records with a Measure Category Assignment of "C" for the individual measure during the specified time period.

Suggested Data Collection Question: Not Applicable

Format:
Length: See ORYX Technical Implementation Guide
Type: See ORYX Technical Implementation Guide
Occurs: See ORYX Technical Implementation Guide

Allowable Values: See ORYX Technical Implementation Guide

Notes for Abstraction: None

Suggested Data Sources: Not Applicable

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *Number of Cases with Missing or Invalid Population Data*

Collected For: Used in data transmission. Please see the most current version of the ORYX[®] Technical Implementation Guide for details (JCAHO ONLY)

Definition: The total number of cases that contain missing or invalid data which prevent an assignment to the measure's population (Denominator population for rate-based measures; Number of Cases for continuous variable measures). The data element represents a COUNT of all records with a Measure Category Assignment of "A" for the individual measure during the specified time period.

Suggested Data Collection Question: Not Applicable

Format:
Length: See ORYX Technical Implementation Guide
Type: See ORYX Technical Implementation Guide
Occurs: See ORYX Technical Implementation Guide

Allowable Values: See ORYX Technical Implementation Guide

Notes for Abstraction: None

Suggested Data Sources: Not Applicable

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *Number of Cases with Missing or Invalid Risk Adjustment Data*

Collected For: Used in data transmission. Please see the most current version of the ORYX[®] Technical Implementation Guide for details (JCAHO ONLY)

Definition: The total number of cases that belong to a measure's population, but contain missing or invalid risk adjustment data, preventing the appropriate risk adjustment of the case. The data element represents a COUNT of all records with a Risk Adjustment Category Assignment of "F" for the individual measure during the specified time period.

Suggested Data Collection Question: Not Applicable

Format:
Length: See ORYX Technical Implementation Guide
Type: See ORYX Technical Implementation Guide
Occurs: See ORYX Technical Implementation Guide

Allowable Values: See ORYX Technical Implementation Guide

Notes for Abstraction: None

Suggested Data Sources: Not Applicable

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name:	<i>Oral Antibiotics</i>
Collected For:	All SIP Measures
Definition:	Documentation that the only antibiotic combinations administered prior to hospital arrival or more than 24 hours prior to incision were either oral Neomycin Sulfate + Erythromycin Base or oral Neomycin Sulfate + Metronidazole.
Suggested Data Collection Question:	Were the only antibiotic combinations administered prior to hospital arrival or more than 24 hours prior to incision either oral Neomycin Sulfate + Erythromycin Base or oral Neomycin Sulfate + Metronidazole?
Format:	Length: 1 Type: Alphanumeric Occurs: 1
Allowable Values:	Y (Yes) The only antibiotics administered prior to hospital arrival or more than 24 hours prior to incision were either oral Neomycin Sulfate + Erythromycin Base or oral Neomycin Sulfate + Metronidazole. N (No) Oral Neomycin Sulfate + Erythromycin Base or oral Neomycin Sulfate + Metronidazole were not the only antibiotics administered prior to hospital arrival, or more than 24 hours prior to incision, or unable to determine from medical record documentation.
Notes for Abstraction:	None
Suggested Data Sources:	<ul style="list-style-type: none">• Consultation notes• Emergency department records• History and physical• Medication administration record• Nursing admission assessment• Nursing notes

Guidelines for Abstraction:

Inclusion	Exclusion
<ul style="list-style-type: none"> • Erythromycin Base • Metronidazole • Neomycin Sulfate <p>Refer to Appendix C, Table 3.3 and Table 3.4 for a comprehensive list of Colon-Oral Antibiotics</p>	None

Data Element Name: *Other Patient Case Identifier*

Collected For: All Records

Definition: Captures an additional case identifier when Patient HIC # and Social Security number are not available. This data element and Case Identifier are mandatory if 9s are entered for both the Patient HIC # and Patient Social Security number.

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

Suggested Data

Collection Question: What is the other patient case identifier?

Format: **Length:** 20
 Type: Alphanumeric
 Occurs: 1

Allowable Values: Up to 20 letters and/or numbers.

Notes for Abstraction: None

Suggested Data Sources: None

Guidelines for Abstraction:

Inclusion	Exclusion
Refer to Appendix I, Patient ID	None

Data Element Name: *Other Surgeries*

Collected For: SIP-3

Definition: Another procedure of interest performed during this hospital stay.

Suggested Data

Collection Question: Was any other procedure of interest performed during this hospital stay?

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

Allowable Values: Y (Yes) Documentation that another procedure of interest was performed during this hospital stay.
 N (No) There is no documentation that any other procedure of interest was performed during this hospital stay.

Notes for Abstraction: None

- Suggested Data Sources:**
- Admitting physician orders
 - Admitting progress notes
 - Consultation notes
 - Discharge summary
 - Emergency department record
 - History and physical
 - Nursing notes
 - Operative notes/reports
 - Physician admission notes
 - Physician progress notes
 - Transfer forms

Guidelines for Abstraction:

Inclusion	Exclusion
Refer to Appendix H, Table 1.9 Surgery Performed During Stay (SIP)	Refer to Appendix H, Table 1.9 Surgery Performed During Stay (SIP)

Data Element Name: *Oxygen*

Collected For: All SIP Records – (CMS Optional Data Element)

Definition: Documentation the patient received supplemental oxygen for at least 2 hours postoperatively.

Suggested Data

Collection Question: Did the patient receive supplemental oxygen for at least 2 hours postoperatively?

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

Allowable Values: Y (Yes) The patient received supplemental oxygen for at least 2 hours postoperatively.
 N (No) The patient did not receive supplemental oxygen for at least 2 hours postoperatively.

Notes for Abstraction: None

- Suggested Data Sources:**
- Consultation notes
 - ICU notes
 - Nursing graphic flow sheet
 - Nursing graphic sheets
 - Nursing notes
 - PACU/recovery room record
 - Progress notes
 - Respiratory therapy notes/flow sheets

Guidelines for Abstraction:

Inclusion	Exclusion
<ul style="list-style-type: none"> • face mask/face tent • nasal cannula/nasal catheter (nc) • O₂ • oxygen • rebreather mask • ventilator 	None

Data Element Name: *Patient HIC#*

Collected For: All Records

Definition: The patient's Medicare health insurance claim number.
A patient identifier is required for data submitted to the QIO data warehouse.

Suggested Data Collection Question: What is the patient's Medicare/HIC number?

Format: **Length:** 9 - 12
 Type: Alphanumeric
 Occurs: 1

Allowable Values: Refer to Appendix I for valid format for patient HIC #.

Notes for Abstraction: The abstractor should NOT assume that the UB-92 claim information for the Patient (Medicare) HIC # is correct. If the abstractor determines through chart review that the UB-92 Patient (Medicare) HIC # is incorrect, she/he should correct and override the downloaded value.

- Suggested Data Sources:**
- Emergency department record
 - Face sheet
 - UB-92, Field Location: 60

Guidelines for Abstraction:

Inclusion	Exclusion
Refer to Appendix I, Patient ID	None

Data Element Name: *Patient Social Security Number*

Collected For: All Records

Definition: Social Security number assigned to the patient.
A patient identifier is required for data submitted to the QIO data warehouse.

Suggested Data Collection Question: What is the patient's Social Security number?

Format: **Length:** 9 (no dashes)
 Type: Alphanumeric
 Occurs: 1

Allowable Values: Refer to Appendix I for valid format for patient Social Security number.

Notes for Abstraction:

- The abstractor should NOT assume that the UB-92 claim information for the Patient (Medicare) HIC # or Railroad Retiree # is correct. If the abstractor determines through chart review that the UB-92 Patient (Medicare) HIC # is incorrect, she/he should correct and override the downloaded value.

Suggested Data Sources:

- Emergency department record
- Face sheet
- UB-92, Field Location: 60

Guidelines for Abstraction:

Inclusion	Exclusion
Refer to Appendix I, Patient ID	None

Data Element Name: *Payment Source*

Collected For: All Records

Definition: Source of payment for the services provided to the patient.

Suggested Data

Collection Question: What is the source of payment for the patient's services?

Format:

Length: 1

Type: Alphanumeric

Occurs: 3

Allowable Values:

Record ALL payment sources:

- 1 Medicare (Title 18): Medicare is listed as a payment source. This would include Medicare Fee for Service (included DRG or PPS), Medicare HMO/Medicare + Choice, Black Lung, ESRD, and Railroad Retirement Board (RRB) and Medicare coverage as a secondary payer.
- 2 Medicaid (Title 19): Medicaid is listed as a payment source
- 3 Other: There is a payment other than Medicare or Medicaid (e.g., Veterans Administration [VA], CHAMPUS [TRICARE], Workers' Compensation or private insurance).
- 4 No Insurance/Not documented/Unable to Determine: Patient has no insurance coverage, the payment source is not documented, unable to determine the payment source, or the payment source does not coincide with one of the above options.

Notes for Abstraction: None

- Suggested Data Sources:**
- Face sheet
 - UB-92, Field Location: 50

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *Performance Measure Identifier*

Collected For: Used in data transmission. Please see the National Quality Measure Data Transmission section in this manual or the most current version of the ORYX[®] Technical Implementation Guide for details. (JCAHO ONLY)

Definition: A unique numeric identification number that the Joint Commission assigns to measures. This number may be used to identify Health Care Organization (HCO)-Level performance measure data. Measures may frequently be referred to by the alphanumeric set measure ID# that starts each measure short name (i.e., AMI-7, HF-3, PN-4, etc.). This code is only used for reference purposes and should NOT be used during data transmission.

JCAHO NOTE: A complete list of performance measure identifiers used to transmit data to the Joint Commission is found in the National Hospital Quality Measure Data Transmission section in this manual.

Suggested Data

Collection Question: Not Applicable

Format: **Length:** 10
 Type: Numeric
 Occurs: 1

Allowable Values: 1-999999

Notes for Abstraction: None

Suggested Data Sources: Does not apply, Joint Commission assigned.

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *Performance Measurement System (PMS) Identifier*

Collected For: Used in data transmission and verification. Please see the most current version of the ORYX[®] Technical Implementation Guide for details. (JCAHO ONLY)

Definition: A unique identification number that the Joint Commission assigns to contracted and candidate performance measurement systems.

Suggested Data Collection Question: Not Applicable

Format: **Length:** 7
 Type: Alphanumeric
 Occurs: 1

Allowable Values: Assigned by the Joint Commission
 0001-01 to 9999-99 (including dashes)

Notes for Abstraction: None

Suggested Data Sources: Please refer to the most current version of the ORYX Technical Implementation Guide for additional details.

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *Physician 1*

Collected For: All Records (CMS Optional Element)

Definition: The first physician identifier

Suggested Data Collection Question: What is the first physician identifier?

Format: **Length:** 50
 Type: Alphanumeric
 Occurs: 1

Allowable Values: Enter the first physician identifier, as directed. Up to 50 letters/and or numbers can be entered.

Notes for Abstraction: This data element may be used to capture physician information that might be helpful in internal analysis. This information is for internal analysis only and will not be shared with any external parties in any data output.

Suggested Data Sources: None

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *Physician 2*

Collected For: All Records (CMS Optional Element)

Definition: A second physician identifier

Suggested Data Collection Question: What is the second physician identifier?

Format:

Length: 50

Type: Alphanumeric

Occurs: 1

Allowable Values: Enter the second physician identifier, as directed. Up to 50 letters and/or numbers can be entered.

Notes for Abstraction: This data element may be used to capture physician information that might be helpful in internal analysis. This information is for internal analysis only and will not be shared with any external parties in any data output.

Suggested Data Sources: None

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name:	<i>Plan for LDL-Cholesterol Test</i>
Collected For:	AMI-T1a – (CMS Optional Test Measure)
Definition:	Documentation of a plan to do LDL-cholesterol (LDL-c) testing after discharge.
Suggested Data Collection Question:	Is there a plan to do LDL-cholesterol (LDL-c) testing after discharge?
Format:	Length: 1 Type: Alphanumeric Occurs: 1
Allowable Values:	Y (Yes) Documentation of a plan to do LDL-c testing after discharge. N (No) No documentation of a plan to do LDL-c testing after discharge or unable to determine from medical record documentation.
Notes for Abstraction:	<ul style="list-style-type: none">• There must be documentation of a definitive plan to do LDL-c testing after discharge (e.g., “Will do cholesterol testing after discharge”). Documentation which indicates only that LDL-c testing after discharge will be considered (e.g., “May do cholesterol testing at next office visit”) is not sufficient.• In the absence of explicit documentation of a plan to do LDL-c testing after discharge, it should be inferred that LDL-c testing is planned if there is documentation of a plan to do lipid testing after discharge.
Suggested Data Sources:	<ul style="list-style-type: none">• Consultation notes• Discharge instruction sheet• Discharge planning notes• Discharge summary• Physician orders• Progress notes

Guidelines for Abstraction:

Inclusion	Exclusion
<p>LDL-cholesterol (LDL-c)</p> <ul style="list-style-type: none"> • low den lipoprotein • low density lipoprotein (LDL) <p>Lipid testing</p> <ul style="list-style-type: none"> • cholesterol analysis • cholesterol check (✓) • cholesterol panel • cholesterol profile • cholesterol testing • fasting lipids • LDL: HDL • LDL: HDL ratio • lipid analysis • lipid check (✓) • lipid panel • lipid profile • lipids • lipoprotein analysis 	<p>LDL-cholesterol (LDL-c)</p> <ul style="list-style-type: none"> • VLDL (very low density lipoprotein)

Data Element Name: *Pneumococcal Vaccination Status*

Collected For: PN-2

Definition: Documentation of the patient's pneumococcal vaccination status. If found to be a candidate for the vaccine, documentation that the pneumococcal vaccine was given during this hospitalization. A vaccine is a suspension of an attenuated (weakened) or killed microorganism, such as bacteria or virus, administered for the prevention, amelioration, or treatment of infectious diseases.

Suggested Data

Collection Question: What is the patient's pneumococcal vaccine status?

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

- Allowable Values:**
- 1 Pneumococcal vaccine was given during this hospitalization: The patient received pneumococcal vaccine during the current hospitalization, even if it was also, given anytime in the past.
 - 2 Pneumococcal vaccine was received in the past, not during this hospitalization: The patient received pneumococcal vaccine anytime in the past.
 - 3 Documentation of patient's refusal of pneumococcal vaccine: There is documentation of the patient refusing pneumococcal vaccine.
 - 4 Allergy/sensitivity to pneumococcal vaccine: There is documentation of an allergy/sensitivity to pneumococcal vaccine OR is medically contraindicated because of a bone marrow transplant within the past 12 months.
 - 5 None of the above/Not documented/UTD: None of the answers above are appropriate, there was no documentation of pneumococcal vaccination status or unable to determine.

Notes for Abstraction: JCAHO NOTE: If the ICD-9-CM Other Diagnosis Code V03.82 or V06.6 exists then default the allowable value to 1.

- Suggested Data Sources:**
- Consultation notes
 - Discharge summary
 - Emergency department record
 - History and physical
 - Immunization assessment forms
 - Medication sheets
 - Nursing admission assessment
 - Nursing notes
 - Physician orders
 - Progress notes
 - Social service notes
 - Transfer forms
 - Vaccine order sheet

Guidelines for Abstraction:

Inclusion	Exclusion
<ul style="list-style-type: none"> • pneumococcal vaccine • pneumonia shot • pneumonia vaccine • Pneumovax • Pneumovax 23 • Pnu-immune 23 • polyvalent pneumonia vaccine 	<p>Patients with specific documented allergy/sensitivity (should be accompanied by the exact complication) to vaccine including hypersensitivity to any component in the vaccine, including thimerosal. Also, sizeable local reaction at injection site (> 10.2 cm), or the occurrence of any type of an immediate or delayed hypersensitivity reaction or the occurrence of neurological signs and symptoms following administration. May not be based solely on physician's preference</p>

Data Element Name:	<i>Pneumonia Working Diagnosis on Admission</i>
Collected For:	All PN Measures
Definition:	Physician documentation of the diagnosis of pneumonia written before or at admission. Pneumonia need not be the primary or only diagnosis, but mentioned as a working diagnosis at the time of admission. The phrase “doubt pneumonia” is not considered a working diagnosis.
Suggested Data Collection Question:	Was pneumonia a working diagnosis on admission?
Format:	Length: 1 Type: Alphanumeric Occurs: 1
Allowable Values:	Y (Yes) There is physician/nurse practitioner/physician assistant documentation that pneumonia was a working diagnosis at the time of admission. N (No) There is no physician/nurse practitioner/physician assistant documentation that pneumonia was a working diagnosis at the time of admission.
Notes for Abstraction:	<ul style="list-style-type: none">• Do not include information from consultation notes, history and physical, or physician progress notes written later than admission, even if dated the day of, or the day after admission, unless the patient was a direct admit.• Working diagnosis of pneumonia cannot be taken from the discharge summary, coding or billing documents or face sheet.• If the only documentation of pneumonia is an admission order for “chest x-ray to R/O pneumonia”, this is not sufficient documentation to be considered a working diagnosis of pneumonia on admission.

Notes for Abstraction continued:

- Only use consultation notes if they are documented as completed in the emergency department
- If the consultation note is written after the patient has been transferred from the emergency department, this may not be used as a data source. If unable to determine if the note was written in the emergency department or after admission, do not use this as a source.
- Include “infiltrate” only when documented as an admission impression or diagnosis
- Do not include “infiltrate” if the only mention is in the body of the ED note or body of the H&P without inclusion in the final impression listing working diagnosis on admission.

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

- Admitting physician orders
- Admitting notes
- Consultation notes
- Emergency department record
- Emergency room consultation
- History and physical
- Physician admission note

Guidelines for Abstraction:

Inclusion	Exclusion
<ul style="list-style-type: none"> • initial impression • need to evaluate for • pneumonitis • pneumonia of any type • possible • probable • questionable • rule/out pneumonia • suspected 	<ul style="list-style-type: none"> • aspiration without mention of pneumonia • doubt pneumonia • pneumonia that is diagnosed during the stay but not an admission working diagnosis • respiratory problems without mention of pneumonia

Data Element Name: *Postal Code*

Collected For: All Records

Definition: The postal code of the patient's residence. For the United States zip codes the hyphen is implied. If the patient is determined to not have a permanent residence, then the patient is considered homeless.

Suggestion Data

Collection Question: What is the postal code of the patient's residence?

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

Allowable Values: Any valid five or nine digit postal code or "HOMELESS" if the patient is determined not to have a permanent residence. If the patient is not a resident of the United States, use "NON-US".

Notes for Abstraction: None

- Suggested Data Sources:**
- Face sheet
 - UB-92, Field Location: 13

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name:	<i>Postoperative Infections</i>
Collected For:	SIP-3
Definition:	Any infections treated following any surgery of interest performed during this hospitalization.
Suggested Data Collection Question:	Were any infections treated following any surgery of interest performed during this hospitalization?
Format:	Length: 1 Type: Alphanumeric Occurs: 1
Allowable Values:	Y (Yes) There is physician documentation that the patient was treated for an infection following any surgical procedure of interest during this hospitalization. N (No) There is no physician documentation that the patient was treated for an infection following any surgical procedure of interest or unable to determine from medical record documentation.
Notes for Abstraction:	None
Suggested Data Sources:	PHYSICIAN/NURSE PRACTITIONER/PHYSICIAN ASSISTANT DOCUMENTATION ONLY <ul style="list-style-type: none">• Consultation notes• Discharge summary• Progress notes

Guidelines for Abstraction:

Inclusion	Exclusion
<ul style="list-style-type: none">• Abscess• Bloodstream infection• Bone infection• Cellulitis• H.pylori, if being treated with antibiotic• Osteomyelitis• Other documented infection• Pneumonia or other lung infection• Surgical site or wound infection• Urinary tract infection (UTI)	<ul style="list-style-type: none">• Candidiasis

Data Element Name:	<i>Pre-Arrival LDL-Cholesterol Qualitative Description</i>
Collected For:	AMI-T1a, AMI-T2 – (CMS Optional Test Measures)
Definition:	Qualitative description of the results from the patient’s LDL-cholesterol (LDL-c) test done in the past year.
Suggested Data Collection Question:	How did the physician, nurse practitioner, or physician assistant qualitatively describe the patient’s LDL-cholesterol (LDL-c) from the test performed within one year prior to arrival?
Format:	Length: 1 Type: Alphanumeric Occurs: 1
Allowable Values:	<ol style="list-style-type: none">1 (Elevated LDL-c) Physician, nurse practitioner, or physician assistant qualitatively described the patient’s LDL-c from the test performed within one year prior to arrival in terms consistent with elevated LDL-c (e.g., “Labs done last month showed elevated lipids”).2 (No Elevated LDL-c) Physician, nurse practitioner, or physician assistant qualitatively described the patient’s LDL-c from the test performed within one year prior to arrival in terms which are NOT consistent with elevated LDL-c (e.g., “Lipid levels normal in April”).3 (Not Documented) Physician, nurse practitioner, or physician assistant did not qualitatively describe the patient’s LDL-c from the test performed within one year prior to arrival in any manner, or unable to determine from medical record documentation.

Notes for Abstraction:

- When more than one qualitative description of the patient’s LDL-c from the past year is documented, use the description of the LDL-c from the test performed closest to the time of hospital arrival. If unable to determine which qualitative description refers to the LDL-c closest to the time of hospital arrival, select “Elevated LDL-c” if any of the descriptions are consistent with elevated LDL-c.
- If there are discrepant qualitative descriptions documented for the same pre-arrival specimen (e.g., one description consistent with elevated LDL-c and one not consistent with elevated LDL-c), select “Elevated LDL-c”.

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:

Inclusion	Exclusion
<p>LDL-cholesterol (LDL-c)</p> <ul style="list-style-type: none"> • low den lipoprotein • low density lipoprotein (LDL) • value described as “bad cholesterol” <p>Elevated LDL-c</p> <ul style="list-style-type: none"> • cholesterol described as elevated, high, or ↑ • dyslipidemia • dyslipoproteinemia • hyperbetalipoproteinemia • hypercholesterolemia • hyperlipemia • hyperlipidemia • hyperlipoproteinemia • LDL above goal or target • LDL described as elevated, high, or ↑ • LDL-cholesterol (LDL-c) described as elevated, high, or ↑ • lipids described as elevated, high, or ↑ 	<p>LDL-cholesterol (LDL-c)</p> <ul style="list-style-type: none"> • VLDL (very low density lipoprotein) <p>Elevated LDL-c</p> <ul style="list-style-type: none"> • alpha lipoproteinemia • 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

Data Element Name:	<i>Pre-Arrival LDL-Cholesterol Test</i>
Collected For:	AMI-T1a, AMI-T2 – (CMS Optional Test Measures)
Definition:	LDL-cholesterol (LDL-c) test was performed within one year prior to hospital arrival.
Suggested Data Collection Question:	Was an LDL-cholesterol (LDL-c) test performed within one year prior to hospital arrival?
Format:	Length: 1 Type: Alphanumeric Occurs: 1
Allowable Values:	Y (Yes) LDL-c test was performed within one year prior to hospital arrival. N (No) LDL-c test was not performed within one year prior to hospital arrival or unable to determine from medical record documentation.
Notes for Abstraction:	<ul style="list-style-type: none"> • If there is documentation that LDL-c/lipid testing was done prior to arrival but the exact timeframe is not specified or determinable, select “No”. EXCEPTION: If documentation describes the LDL-c/lipid testing as having been done in the “recent” past, it should be inferred that it was done within one year prior to arrival. • In the absence of explicit documentation that an LDL-c test was or was not performed within one year prior to hospital arrival, it should be inferred that a test was done within one year if: <ul style="list-style-type: none"> ○ There is documentation of an LDL-c value from a test performed within one year prior to hospital arrival (e.g., “LDL-c 135 in November”), or ○ There is physician, nurse practitioner, or physician assistant documentation which qualitatively describes the patient’s LDL-c from a test performed within one year prior to hospital arrival (e.g., “Labs last month showed elevated lipids”, “CABG in June. Cholesterol levels now good on Lipitor”), or ○ There is documentation that lipid testing was performed within one year prior to hospital arrival (e.g., “Cholesterol

**Notes for Abstraction
continued:**

testing done in April”).

- Documentation must suggest that the qualitative description of LDL-c is **from a test** done within one year prior to arrival: Do not make assumptions. In the following examples, “No” should be selected:
 - “Lipids have been good - patient on Zocor” per H&P
 - Nurse practitioner notes “Risk factor - dyslipidemia” in progress note
 - “Pt. denies hypercholesterolemia” per physician progress note
 - ER physician notes “No hx hyperlipidemia”
- Do not include pre-arrival lipid testing or qualitative descriptions of pre-arrival lipid test results if it can be determined that LDL-c measurement was not part of the lipid testing. In the following examples, “No” should be selected:
 - Lipid profile done during hospitalization 6 months ago, per H&P, but the laboratory report from the hospitalization included in the chart lists only cholesterol and triglyceride values.
 - Physician notes “Labs from office visit on 04-03-2004 showed elevated cholesterol”, but the 04-03-2004 laboratory report from the outpatient records included in the chart lists only a total cholesterol value.

Suggested Data Sources:

- Consultation notes
- Discharge summary
- Emergency room record
- History and physical
- Pre-arrival laboratory reports
- Progress notes

Guidelines for Abstraction:

Inclusion	Exclusion
<p>LDL-cholesterol (LDL-c)</p> <ul style="list-style-type: none"> • low den lipoprotein • low density lipoprotein (LDL) • value described as “bad cholesterol” <p>Qualitative description of LDL-c</p> <ul style="list-style-type: none"> • cholesterol level qualitatively described (e.g., low, normal, elevated, ↑) • dyslipidemia (presence or absence) • dyslipoproteinemia (presence or absence) • hyperbetalipoproteinemia (presence or absence) • hypercholesterolemia)presence or absence) • hyperlipemia (presence or absence) • hyperlipidemia (presence or absence) • hyperlipoproteinemia (presence or absence) • LDL level qualitatively described (e.g., low, normal, elevated, above goal, below target, ↑) • LDL-cholesterol (LDL-c) level qualitatively described (e.g., low, normal, elevated, ↑) • lipid levels qualitatively described (e.g., low, normal, elevated, ↑) <p>Lipid testing</p> <ul style="list-style-type: none"> • cholesterol analysis • cholesterol check (√) • cholesterol panel • cholesterol profile • cholesterol testing • fasting lipids • LDL: HDL • LDL: HDL ratio • lipid analysis • lipid check (√) • lipid panel • lipid profile • lipids • lipoprotein analysis 	<p>LDL-cholesterol</p> <ul style="list-style-type: none"> • VLDL (very low density lipoprotein) <p>Qualitative description of LDL-c</p> <ul style="list-style-type: none"> • alpha lipoproteinemia (presence or absence)

Data Element Name:	<i>Pre-Arrival LDL-Cholesterol Value</i>
Collected For:	AMI-T1a, AMI-T2 – (CMS Optional Test Measure)
Definition:	LDL-c cholesterol (LDL-c) value from test done in the past year.
Suggested Data Collection Question:	What is the patient’s LDL-cholesterol (LDL-c), in mg/dL or mg/100 ml, from the LDL-c test performed within one year prior to hospital arrival?
Format:	Length: 3 Type: Numeric Occurs: 1
Allowable Values:	Enter the patient’s LDL-c value, in mg/dL or mg/100 ml, from the LDL-c test performed within one year prior to hospital arrival.
Notes for Abstraction:	<ul style="list-style-type: none">• When more than one LDL-c value from the past year is documented, enter the LDL-c from the test performed closest to the time of hospital arrival. If unable to determine which value was drawn closest to hospital arrival time, enter the highest value.• 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.• 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).• If an LDL-c value on the pre-arrival laboratory report conflicts that with from another source of documentation for the same specimen, enter the value from the laboratory report• If a pre-arrival laboratory report documents discrepant LDL-c values for the same specimen, enter the highest value.• If sources other than a laboratory report document discrepant LDL-c values for the same specimen, enter the highest value.• 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.

- Notes for Abstraction Continued**
- If an LDL-c value from the LDL-c test performed within one year prior to hospital arrival is not documented or if unable to determine from medical record documentation (e.g., LDL-c testing was done within the past year but no values are available), enter “999”.

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

Guidelines for Abstraction:

Inclusion	Exclusion
<p>LDL-cholesterol (LDL-c)</p> <ul style="list-style-type: none"> • low den lipoprotein • low density lipoprotein (LDL) • value described as “bad cholesterol” 	<p>LDL-cholesterol (LDL-c)</p> <ul style="list-style-type: none"> • LDL (very low density lipoprotein)

Data Element Name: *Preop Location*

Collected For: All SIP Records – (CMS Optional Data Element)

Definition: Documentation of the operating room (OR)/preoperative

Suggested Data Collection Question: From where did the patient arrive in the OR/preoperative area?

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

- Allowable Values:**
- 1 **Another hospital unit:** The patient arrived in the OR holding or preoperative area from any patient unit, regardless of the level of care.
 - 2 **Direct Admit:** The patient arrived in the preoperative area or holding room from their usual place of residence or as a transfer from another hospital.
 - 3 **UTD:** There is insufficient information, or if documentation is illegible, or unable to determine from medical record documentation.

Notes for Abstraction: None

- Suggested Data Sources:**
- Emergency room record
 - ICU flow sheet
 - Nursing notes
 - Procedure reports/notes

Guidelines for Abstraction:

Inclusion	Exclusion
<ul style="list-style-type: none"> • all intensive care units • medical/surgical floor • telemetry units • transfers from another ED 	None

Data Element Name: *Prophylactic Antibiotic*

Collected For: SIP-2, SIP-3

Definition: The antibiotic dose administered as a prophylaxis during the admission. 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.

NOTE: Each antibiotic name should be accompanied by Date of Antibiotic, Prophylactic Antibiotic, Route of Antibiotic, Time of Antibiotic.

Suggested Data

Collection Question: Was this antibiotic dose administered as a prophylaxis?

Format: **Length:** 1
Type: Alphanumeric
Occurs: 75

Allowable Values: Y (Yes) Documentation this antibiotic dose was administered as a prophylaxis.
N (No) Documentation this antibiotic dose was not administered as a prophylaxis.

Notes for Abstraction: Prophylactic antibiotics are antibiotics that are administered in the preop (any time prior to surgery), intraop (any time between incision time and close time), or postop (24 hours after surgery end time) to prevent the incidence of operative wound infections.

Suggested Data Sources:

- Anesthesia record
- Emergency department record
- ICU flowsheet
- IV flowsheet
- Medication administration record
- Nursing notes
- Operating room record
- Recovery room record

Guidelines for Abstraction:

Inclusion	Exclusion
Refer to Appendix C, Table 2.1 for a comprehensive list of Antimicrobial Medications	Refer to Appendix C, Table 2.1 for a comprehensive list of Antimicrobial Medications

Data Element Name: *Provider ID*

Collected For: All Records

Definition: Hospital's six digit acute care Medicare provider identifier.

Suggested Data

Collection Question: What is the hospital's six digit acute care Medicare provider ID?

Format:

Length: 6
Type: Alphanumeric
Occurs: 1

Allowable Values: Any valid six digit Medicare provider ID.

The first two digits are the numeric state code. The third digit of zero represents an acute facility. The third digit of "1" and fourth digit of "3" represents a Critical Access Hospital (CAH).

Notes for Abstraction: In the XML file layout:
 The provider-id attribute of the case element is the provider number where the episode of care took place.
 The provider-id attribute of the created-by element is the provider id (provider#, vendor#, QIO#) who created the case.
 The provider-id attribute of the abstractor element is the provider id of who abstracted the case (provider, vendor, QIO).

Suggested Data Sources: UB-92, Field Location: 51

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *Pseudomonas Risk*

Collected For: PN-6, PN-6a

Definition: For the purpose of measurement for PN-6 and PN-6a, risk of pseudomonas is defined as any ICU patient who has documentation of one of the following by the physician/nurse practitioner/physician assistant:

- Bronchiectasis documented as a possible consideration at the time of admission, or identified as a secondary ICD-9-CM code (494.x). Bronchiectasis is defined as chronic dilatation of a bronchus or bronchi, with a secondary infection that usually involves the lower portion of the lung. Dilatation may be in an isolated segment or spread throughout the bronchi.
- Malnutrition documented as a possible consideration at the time of admission
- Serum albumin level less than 3.0 documented within the first 24 hours after hospital arrival.

Suggested Data Collection Question:

Does the patient have risk of pseudomonas?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

- Y (Yes) The ICU patient has risk of pseudomonas as indicated by documentation of one or more of the above conditions.
- N (No) The ICU patient has no risk of pseudomonas as indicated by none of the above conditions being documented in the medical record.

Notes for Abstraction:

- Accept only physician/nurse practitioner/physician assistant documentation when determining if bronchiectasis or malnutrition are considered on admission.
- Do not include information from consultation notes or physician progress notes written later than admission, even if dated the day of, or the day after admission.
- Working diagnosis of malnutrition cannot be taken from the discharge summary, coding or billing documents, or face sheet.
- Only use consultation notes if they are documented as completed in the emergency department.

- Suggested Data Sources:**
- Admitting physician orders
 - Admitting progress notes
 - Consultation notes
 - Diabetic flow sheet
 - Emergency room record
 - Graphic sheet
 - History and physical
 - ICU/nursing flow sheets
 - Laboratory reports
 - Physician admission note
 - Progress notes

Guidelines for Abstraction:

Inclusion	Exclusion
<p>Bronchiectasis: Physician/Nurse Practitioner/Physician Assistant documentation only</p> <ul style="list-style-type: none"> • Initial impression • Need to evaluate for • Possible • Probable • Questionable • Rule/out bronchiectasis <p>Malnutrition: Physician/Nurse Practitioner/Physician Assistant documentation only</p> <ul style="list-style-type: none"> • Cachexia/cachectic • Emaciated • Failure to thrive • Initial impression • Need to evaluate for • Possible • Probable • Questionable • Rule/out malnutrition • Starvation • Suspected <p>Albumin</p> <ul style="list-style-type: none"> • Alb • Albumin 	<p>Bronchiectasis</p> <ul style="list-style-type: none"> • Doubt bronchiectasis • Respiratory problems without mention of bronchiectasis <p>Malnutrition</p> <ul style="list-style-type: none"> • Doubt malnutrition • Malnutrition that is diagnosed during the stay but not as an admission working diagnosis <p>Albumin</p> <ul style="list-style-type: none"> • None

Data Element Name: *Pulse Oximetry Done*

Collected For: PN-1

Definition: Documentation that a pulse oximetry was done within 24 hours of hospital arrival. Pulse oximetry is a non-invasive test to measure the percentage of oxygen saturation of hemoglobin in the patient's arterial circulation. A pulse oximeter may be clipped to a patient's finger to obtain an oxygen saturation. If performed within 24 hours of arrival may be used for this measure. If no pulse oximetry 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 a pulse oximetry was done within 24 hours before or after hospital arrival?

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

Allowable Values: Y (Yes) Pulse oximetry was done within 24 hours before or after hospital arrival.
 N (No) No pulse oximetry was done within 24 hours before or after hospital arrival or unable to determine from medical record documentation.

Notes for Abstraction: None

Suggested Data Sources:

- Consultation notes
- Emergency department record
- Emergency medical services (EMS records)
- Graphic flow sheet
- History and physical
- Laboratory reports
- Nursing notes
- Respiratory therapy notes

Guidelines for Abstraction:

Inclusion	Exclusion
<ul style="list-style-type: none">• O2 sat• pulse oximetry• pulse ox• SaO2• SPO2	Do not accept tests performed after the first 24-hour period

Data Element Name:	<i>Race</i>
Collected For:	All Records
Definition:	Documentation of the patient's race.
Suggested Data Collection Question:	What is the patient's race?
Format:	Length: 1 Type: Alphanumeric Occurs: 1
Allowable Values:	<ol style="list-style-type: none">1 Caucasian: Patient's race is Caucasian/White or the Patient has origins in Europe, the Middle East, or North Africa.2 African American: Patient's race is African American.3 American Indian/Alaska Native: Patient's race is American Indian/Alaska Native.4 Asian: Patient's race is Asian/Far East/Indian.5 Native Hawaiian/Pacific Islander): Patient's race is Native Hawaiian/Pacific Islander.6 Other: Race does not coincide with one of the listed categories (e.g., mixed race: Hispanic).7 UTD: Unable to determine the patient's race (e.g., not documented, conflicting documentation).
Notes for Abstraction:	None
Suggested Data Sources:	<ul style="list-style-type: none">• Emergency department record• Face sheet• History and physical• Nursing admission assessment• Progress notes

Guidelines for Abstraction:

Inclusion	Exclusion
<p>African American B, Black, Haitian, Negro</p> <p>American Indian/Alaska Native any recognized tribal entity in North and South America (including Central America), Native American</p> <p>Asian Asian-American, Cambodian, Chinese, Far East, Filipino, Japanese, Korean, Malaysian, Pakistani, South East Asian, Thailand, Vietnamese</p> <p>Caucasian Iranian, Middle Easterner, W, Whi, White</p> <p>Native Hawaiian/Pacific Islander Guam, Hawaiian, other Pacific Islands, Samoan</p>	<p>None</p>

Data Element Name:	<i>Reason for No LDL-Cholesterol Testing</i>
Collected For:	AMI-T1a – (CMS Optional Test Measure)
Definition:	Documentation of a reason for not doing LDL-cholesterol (LDL-c) testing.
Suggested Data Collection Question:	Is there a reason documented by a physician, nurse practitioner, or physician assistant for not doing LDL-cholesterol (LDL-c) testing?
Format:	Length: 1 Type: Alphanumeric Occurs: 1
Allowable Values:	Y (Yes) Reason documented by a physician, nurse practitioner, or physician assistant for not doing LDL-c testing. N (No) No reason documented by a physician, nurse practitioner, or physician assistant for not doing LDL-c testing, or unable to determine from medical record documentation.
Notes for Abstraction:	<ul style="list-style-type: none">• In determining whether there is a reason documented by physician, nurse practitioner, or physician assistant for not doing LDL-c testing:<ul style="list-style-type: none">○ Reasons must be explicitly documented (e.g., “ESRD, life expectancy < 1 month - Will not do LDL: HDL”) or clearly implied (e.g., “Patient refusing labs”, “Pt. returning to Wisconsin immediately after discharge. Will talk to PCP about need for LDL-c test”. “Terminal care, will not do any further evaluation”). If reasons are not mentioned in the context of LDL-c testing, do not make inferences (e.g., do not assume that the physician is not doing LDL-c testing because the patient is of advanced age).○ When a physician/nurse practitioner/physician assistant documents a reason for not doing lipid testing (e.g., “On Lipitor, Chol. testing not needed at this time”), this should be construed as a reason for not doing LDL-c testing.

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

- Consultation notes
- Discharge summary
- Emergency department record
- History and physical
- Progress notes

Guidelines for Abstraction:

Inclusion	Exclusion
<p>LDL-cholesterol (LDL-c)</p> <ul style="list-style-type: none"> • low den lipoprotein • low density lipoprotein (LDL) <p>Lipid testing</p> <ul style="list-style-type: none"> • cholesterol analysis • cholesterol check (✓) • cholesterol panel • cholesterol profile • cholesterol testing • fasting lipids • LDL: HDL • LDL: HDL ratio • lipid analysis • lipid check (✓) • lipid panel • lipid profile • lipids • lipoprotein analysis 	<p>LDL-cholesterol (LDL-c)</p> <ul style="list-style-type: none"> • VLDL (very low density lipoprotein)

Data Element Name:	<i>Reason for No Lipid Lowering Therapy</i>
Collected For:	AMI-T2 – (CMS Optional Test Measure)
Definition:	Documentation of a reason for not prescribing a lipid lowering agent at discharge.
Suggested Data Collection Question:	Is there a reason documented by a physician, nurse practitioner, or physician assistant for not prescribing a lipid lowering agent at discharge?
Format:	Length: 1 Type: Alphanumeric Occurs: 1
Allowable Values:	Y (Yes) Reason documented by a physician, nurse practitioner, or physician assistant for not prescribing a lipid lowering agent at discharge. N (No) No reason documented by a physician, nurse practitioner, or physician assistant for not prescribing a lipid lowering agent at discharge or unable to determine from medical record documentation.
Notes for Abstraction:	<ul style="list-style-type: none">• In determining whether there is a reason documented by physician, nurse practitioner, or physician assistant for not prescribing a lipid lowering agent at discharge:<ul style="list-style-type: none">○ Reasons must be explicitly documented (e.g., “Active PUD - Lipid lowering therapy contraindicated”) or clearly implied (e.g., “Hx hypersensitivity to statins in past”, “Lipid lowering agents contraindicated”, “Intolerant of lipid lowering agents”, “Problems with lipid lowering agents in past”, “c/o severe diarrhea, will dc Lipitor”, “Pt. refusing all medications”, “Terminal care, no further treatment”).○ If reasons are not mentioned in the context of lipid lowering agents, do not make inferences (e.g., do not assume that a lipid lowering agent is not being prescribed because of the patient’s history of alcoholism or severe liver disease).○ Reasons do NOT need to be documented at the time of discharge or otherwise associated specifically with

Notes for Abstraction continued:

discharge prescription: Documentation of contraindications anytime during the hospital stay are acceptable (e.g., lipid lowering agent held mid-hospitalization “due to abnormal liver enzymes” - select “Yes”, even if documentation indicates that the liver enzyme levels normalized by the time of discharge.)

- Disregard documentation of a temporary hold, discontinuation, or initiation of a lipid lowering agent which is made conditional (e.g., “Hold Zocor if severe diarrhea persists”, “Consider statin therapy after course of Macrolide”).
- Documentation of an allergy/sensitivity to one particular lipid lowering agent is acceptable (e.g., “Allergic to Lipitor”). Allergy documentation does NOT need to refer to the entire class of lipid lowering agents.
- Lipid lowering agents may also be referred to as bile acid sequestrants, fibric acid derivatives, HMG CoA reductase inhibitors (statins), and nicotinic acid (e.g., “Problems with statins in past”).

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

- Consultation notes
- Discharge summary
- Physician orders
- Progress notes

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *Risk Adjustment Category Assignment*

Collected For: Used for risk adjusted measures (AMI-9, All PR measures)
(JCAHO ONLY)

NOTE: Also used during the Joint Commission measure verification process.

Definition: Calculated measure results that summarize the existence/non-existence of missing risk adjusted data elements for each episode of care (EOC) that is processed through a risk-adjusted measure algorithm.

Suggested Data Collection Question: Not Applicable

Format:

Length: 1

Type: Alphanumeric

Occurs: One Risk Adjustment Category Assignment per EOC is expected for every risk-adjusted measure that a health care organization is participating in.

Allowable Values:

F **Category F:** For missing or invalid risk factor data elements: EOC record has one or more risk factor data elements that are missing or invalid.

G **Category G:** All Risk Factor Data Elements Exist For risk-adjusted measures only: EOC record has all required risk factor data elements.

Notes for Abstraction: None

Suggested Data Sources: Not Applicable

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *Sample*

Collected For: All Records

NOTE: Refer to the Sampling Methods section in this manual.

Definition: Indicates if the data being transmitted for a health care organization have been sampled, or represent an entire population for the specified time period.

Suggested Data Collection Question: Does this case represent part of a sample?

Format:
Length: 1
Type: Alpha
Occurs: 1

JCAHO NOTE: See ORYX[®] Technical Implementation Guide

Allowable Values:
 Y (Yes) The data represents part of a sample.
 N (No) The data is not part of a sample; this indicates the hospital is performing 100 percent of the discharges eligible for this topic.

JCAHO NOTE: See ORYX Technical Implementation Guide

Notes for Abstraction: None

Suggested Data Sources: Not Applicable

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *Sex*

Collected For: All Records (used in algorithm for AMI-9, PR-2)

Definition: The patient's sex.

Suggested Data Collection Question: What is the patient's sex?

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

Allowable Values: M = Male
 F = Female
 U = Unknown

Notes for Abstraction: None

Suggested Data Sources:

- Consultation notes
- Emergency department record
- Face sheet
- History and physical
- Nursing admission notes
- Progress notes
- UB-92, Field Location: 15

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *Surgery End Date*

Collected For: SIP-3

Definition: The date the procedure of interest ended.

Suggested Data

Collection Question: On what date did the procedure of interest end?

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:**
- Anesthesia record
 - Operative report
 - Operating room notes
 - Preop checklist

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *Surgery End Time*

Collected For: SIP-3

Definition: The surgical end time of the procedure of interest. The time the incision was closed is considered the surgical end time.

Suggested Data

Collection Question: What was the surgical end time of the procedure of interest?

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
11: 59 am = 11: 59 11: 59 pm = 23:59

Notes for Abstraction: Use the priority order for sources, and use the earliest time among all inclusions for the highest priority sources.

Suggested Data Sources: PRIORITY ORDER FOR THESE SOURCES

- Anesthesia record
- Circulation record
- Nursing notes
- Operative report
- Progress notes

NOTE: Select the highest priority source; if more than one time is available within the same data source, select the earliest time of the following inclusions.

Guidelines for Abstraction:

Inclusion	Exclusion
<ul style="list-style-type: none"> • Anesthesia stop/end time • Arrival in the PACU/recovery room • Care transfer • Chest/abdomen closed • Closure time • Discharge to PACU/recovery room • Dressing stop time • Dressing time • End time • Last stitch in • Operation closed • Operating room end, finish, or stop time • Operating room exit • Procedure end/stop • Room out time • Stop time • To PACU/recovery room • Time incision closed • Time out • Time patient taken from surgery 	None

Data Element Name: *Surgery Performed During Stay*

Collected For: All SIP Measures

Definition: Any surgical procedure of interest performed during this hospital stay.

Suggested Data

Collection Question: Was any surgical procedure of interest performed during this hospital stay?

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

Allowable Values: Y (Yes) Documentation that at least one of the surgical procedures of interest was performed during this hospital stay.
 N (No) There is no documentation that at least one surgical procedure of interest was performed during this hospital stay.

Notes for Abstraction: None

- Suggested Data Sources:**
- Admitting physician orders
 - Admitting progress notes
 - Consultation notes
 - Discharge summary
 - Emergency department record
 - History and physical
 - Nursing notes
 - Physician admission notes
 - Procedure reports/notes
 - Progress notes
 - Transfer forms/notes

Guidelines for Abstraction:

Inclusion	Exclusion
Refer to Appendix H, Table 1.9 Surgery Performed During Stay (SIP)	None

Data Element Name: *Surgery Start Date*

Collected For: All SIP Measures

Definition: The date the procedure of interest started.

Suggested Data

Collection Question: On what date did the procedure of interest start?

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:**
- Anesthesia record
 - Operative report
 - Operating room notes
 - Preop checklist

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *Surgical Incision Time*

Collected For: All SIP Measures

Definition: The time the initial incision was made for the procedure of interest.

Suggested Data Collection Question: At what time was the initial incision made for the procedure of interest?

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
11: 59 am - 11: 59	11: 59 pm - 23:59

Notes for Abstraction:

- Follow priority order. If multiple times are found, select the latest time among the inclusions for the highest priority.

NOTE: Priority order applies to items in inclusion table, not to source document.

Examples:

Example 1 Anesthesia record: “chest time” = 13: 25
Anesthesia record: “procedure start” = 13: 20
Circulation record: “OR start” = 13: 10
Circulation record: “sternotomy time” = 13: 18
Enter 13: 25

**Notes for Abstraction
continued:**

Example 2 Anesthesia record: “operation start” = 08: 20
 Anesthesia record: “anesthesia induction” = 08: 25
 Circulation record: “OR start” = 08: 10
 Circulation record: “surgery start” = 08: 18
 Enter 08: 20

- Instructions for reading times on grids:
 - Measure from the mid-point of the symbol, number, letter.
 - If the time falls between two lines on the grid, take the later time (5-minute increment).

Suggested Data Sources:

- Anesthesia record
- Circulation record
- Nursing notes
- Operative report
- Progress notes

Guidelines for Abstraction:

Inclusion	Exclusion
<p>Follow the priority order below If multiple times are found use later time among the highest priority</p> <p>First priority: Incision time</p> <ul style="list-style-type: none"> • BRB (breastbone) • chest time • leg time • skin time • sternotomy time • symbol used on grid and indicated in legend to be incision time • thoracotomy time <p>Second priority: Surgery Start/Begin Time</p> <ul style="list-style-type: none"> • begin time • case start time • operation opened • operation start time • operating room start time • procedure start time • surgery start time • tourniquet time • tourniquet up, inflated, begin 	<p>None</p>

Guidelines for Abstraction continued:

<p>Third priority: Anesthesia time</p> <ul style="list-style-type: none">• anesthesia begin time• anesthesia induction time• anesthesia opened• anesthesia start time• anesthesia time• induction complete time	
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Data Element Name: *Temperature*

Collected For: All SIP Records – (CMS Optional Data Element)

Definition: Patient’s temperature can be taken via any of the following methods: orally, rectally, axillary or by ear. The value is recorded in either Fahrenheit or Celsius.

Suggested Data

Collection Question: What was the patient’s core temperature obtained upon arrival to the recovery room?

Format: **Length:** 1-5 digit
 Type: Alphanumeric
 Occurs: 1

Allowable Values: If a core temperature was obtained, enter the temperature of the patient in either Fahrenheit or Celsius (if recorded both ways, enter Fahrenheit value).

Notes for Abstraction: If no temperature value is found, enter “999.9”.

- Suggested Data Sources:**
- ICU notes
 - PACU/recovery room record

Guidelines for Abstraction:

Inclusion	Exclusion
<ul style="list-style-type: none"> • axillary temperature • core temp • esophageal temperature • oral/po/by mouth • R • rectal temp • rectally • T/R • tympanic (tymp) temperature 	<ul style="list-style-type: none"> • Skin surface temperatures

Data Element Name: *Temperature Obtained*

Collected For: All SIP Records – (CMS Optional Data Element)

Definition: Documentation of the core temperature while in the recovery room. The core temperature can be taken via any of the following methods: orally, rectally, axillary or by ear. The value is recorded in either Fahrenheit or Celsius.

Suggested Data

Collection Question: Was the patient’s core temperature obtained upon arrival to the recovery room?

Format: **Length:** 1-5 digit
 Type: Alphanumeric
 Occurs: 1

Allowable Values: Y (Yes) The patient’s core temperature was obtained upon arrival to the recovery room.
 N (No) No core temperature was obtained or unable to determine from medical record documentation.

Notes for Abstraction: If there are multiple temperatures taken in the recovery room, record the temperature that occurs first chronologically.

Suggested Data Sources: • ICU notes
 • PACU/recovery room record

Guidelines for Abstraction:

Inclusion	Exclusion
<ul style="list-style-type: none"> • axillary temperature • core temp • esophageal temperature • oral/po/by mouth • R • rectal temp • rectally • T/R • tympanic (tymp) temperature 	<ul style="list-style-type: none"> • Skin surface temperatures

Data Element Name: *Testcase Batch Number*

Collected For: Used in verification (JCAHO ONLY)

Definition: A number, assigned by the Joint Commission, that is used to identify the file that is sent to a performance measurement system for verification of a measure set. Each record or testcase, in the file assigned the same Testcase Batch Number.

Suggested Data

Collection Question: Not Applicable

Format: **Length:** 10
 Type: Numeric
 Occurs: One for every test case included in the verification file.

Allowable Values: Any valid (non-negative) number from 1-999999999

JCAHO NOTE: Refer to the National Hospital Quality Measure Verification Process section in this manual.

Notes for Abstraction: None

Suggested Data Sources: Not Applicable

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name:	<i>Thrombolytic Administration</i>
Collected For:	AMI-7, AMI-7a, AMI-8, AMI-8a
Definition:	<p>The patient received thrombolytic therapy during this hospital stay. Thrombolytic therapy is the administration of a pharmacological agent intended to cause lysis of a thrombus (destruction or dissolution of a blood clot).</p> <p>NOTE: Refer to Appendix C, Table 1.5 for a listing of thrombolytic agents.</p>
Suggested Data Collection Question:	Was thrombolytic therapy received during this hospital stay?
Format:	Length: 1 Type: Alphanumeric Occurs: 1
Allowable Values:	Y (Yes) Thrombolytic therapy administered during hospital stay. N (No) No thrombolytic therapy administered during hospital stay, or unable to determine from medical record documentation.
Notes for Abstraction:	<ul style="list-style-type: none">• In the event the patient was brought to the hospital via ambulance and thrombolytic therapy was infusing at the time of arrival, select “Yes”.• In the event the patient was brought to the hospital via ambulance and thrombolytic therapy was infused during transport but was completed at the time of hospital arrival, select “No”.
Suggested Data Sources:	<ul style="list-style-type: none">• Discharge summary• Emergency department record• ICU/nursing flow sheets• IV flow sheets• Medication administration record• Nursing notes

Guidelines for Abstraction:

Inclusion	Exclusion
Refer to Appendix C, Table 1.5 for a comprehensive list of Thrombolytic Agents	<ul style="list-style-type: none"><li data-bbox="802 275 1218 306">• intracoronary thrombolytics

Data Element Name: *Thrombolytic Administration Date*

Collected For: AMI-7, AMI-7a

Definition: The month, day, and year thrombolytic therapy was administered at this facility. Thrombolytic therapy is the administration of a pharmacological agent intended to cause lysis of a thrombus (destruction or dissolution of a blood clot).

Suggested Data

Collection Question: What was the date thrombolytic therapy was initiated during this hospital stay?

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:**
- If there were 2 different thrombolytic administration episodes, enter the earliest date a thrombolytic was administered during this hospital stay.
 - In the event the patient was brought to the hospital via ambulance and thrombolytic therapy was infusing at the time of hospital arrival, enter the date the patient arrived at this hospital.
 - If a medication sheet does not document a date for the earliest thrombolytic dose, but the date can be determined based on nursing notes or other documentation, abstract the date.

- Suggested Data Sources:**
- Ambulance record
 - Discharge summary
 - Emergency department record
 - ICU/nursing flow sheets
 - IV flow sheets
 - Medication administration record
 - Nursing notes
 - Transfer sheet

Guidelines for Abstraction:

Inclusion	Exclusion
None	<ul style="list-style-type: none"> • intracoronary thrombolytics

Data Element Name: *Thrombolytic Administration Time*

Collected For: AMI-7, AMI-7a

Definition: The time (military time) that thrombolytic therapy started. Thrombolytic therapy is the administration of a pharmacological agent intended to cause lysis of a thrombus (destruction or dissolution of a blood clot).

Suggested Data

Collection Question: What was the time thrombolytic therapy was initiated during this hospital stay?

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
11: 59 am = 11: 59	11: 59 pm = 23:59

Notes for Abstraction:

- If there were 2 different thrombolytic administration episodes, enter the time the earliest thrombolytic was initiated during this hospital stay.
- In the event the patient was brought to the hospital via ambulance and thrombolytic therapy was infusing at the time of hospital arrival, enter the time the patient arrived at this hospital.

Suggested Data Sources:

- Ambulance record
- Emergency department record
- ICU/nursing flow sheets
- IV flow sheets
- Medication administration record
- Nursing notes
- Transfer sheet

Guidelines for Abstraction:

Inclusion	Exclusion
None	<ul style="list-style-type: none">• intracoronary thrombolytics

Data Element Name: *Transfer From Another ED*

Collected For: AMI-1, AMI-6, AMI-7, AMI-7a, AMI-8, AMI-8a, AMI-T1b (CMS optional test measure), All PN measures

Definition: Documentation that patient was received as a transfer from another hospital emergency department.

Suggested Data Collection Question: Was the patient received as a transfer from an emergency department of **another** hospital?

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

Allowable Values: Y (Yes) Patient received as a transfer from another hospital emergency department.
 N (No) Patient not received as a transfer from another hospital emergency department or unable to determine from medical record documentation.

Notes for Abstraction: The emergency department of another hospital includes both emergency room AND observation bed/unit stays at that hospital.

- Suggested Data Sources:**
- Emergency department record
 - Face sheet
 - History and physical
 - Nursing admission assessment
 - Progress notes
 - Transfer sheet

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name:	<i>Type of Infection</i>
Collected For:	All SIP Records – (CMS Optional Data Element)
Definition:	Documentation of type of infection treated anytime following the first surgical procedure of interest.
Suggested Data Collection Question:	What type of infection was the patient treated for at anytime following the first surgical procedure of interest?
Format:	Length: 1 Type: Alphanumeric Occurs: 1
Allowable Values:	All that apply: <ol style="list-style-type: none">1 Abscess: There is physician documentation the patient was treated for an abscess at any time following the first surgical procedure of interest.2 Bloodstream infection: There is physician documentation the patient was treated for a bloodstream infection at any time following the first surgical procedure of interest.3 Bone infection/osteomyelitis: There is physician documentation the patient was treated for a bone infection or osteomyelitis at any time following the first surgical procedure of interest.4 Cellulitis: There is physician documentation the patient was treated for cellulitis at any time following the first surgical procedure of interest.5 Pneumonia or other lung infection: There is physician documentation the patient was treated for pneumonia or other lung infection at any time following the first surgical procedure of interest.6 Surgical site or wound infection: There is physician documentation the patient was treated for a surgical site or wound infection at any time following the first surgical procedure of interest.

- 7 **Urinary tract infection (UTI):** There is physician documentation the patient was treated for urinary tract infection at any time following the first surgical procedure of interest.
- 8 **Other:** There is physician documentation the patient was treated for an infection other than those listed above at any time following the first surgical procedure of interest.
Example: The physician states he will start antibiotics for an upper respiratory infection.
- 9 **Unable to determine (UTD):** There is insufficient information or documentation is illegible.

Notes for Abstraction: None

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

- Consultation notes
- Discharge summary
- Progress notes

Guidelines for Abstraction:

Inclusion	Exclusion
<p>These words listed below may be present in the medical record.</p> <p>For pneumonia and other lung infection:</p> <ul style="list-style-type: none"> • bronchitis • infection of a specific lobe or lobes of the lung • pneumonitis <p>For blood stream infection:</p> <ul style="list-style-type: none"> • sepsis <p>For urinary tract infection:</p> <ul style="list-style-type: none"> • urosepsis 	<ul style="list-style-type: none"> • infiltrates

Data Element Name:	<i>Type of Surgery</i>
Collected For:	All SIP Measures
Definition:	First procedure (of interest) performed during the admission.
Suggested Data Collection Question:	Which procedure of interest was performed first during this admission?
Format:	Length: 1 Type: Alphanumeric Occurs: 1
Allowable Values:	<ol style="list-style-type: none">1 CABG: The procedure performed was a CABG.2 Cardiac Surgery: The procedure performed was a cardiac surgery other than CABG.3 Hip Arthroplasty: The procedure performed was a hip arthroplasty.4 Knee Arthroplasty: The procedure performed was a knee arthroplasty.5 Colon Surgery: The procedure performed was a colon surgery.6 Hysterectomy: The procedure performed was a hysterectomy.7 Vascular Surgery: The procedure performed was a vascular surgery.
Notes for Abstraction:	If a combined procedure is performed during the same operative time frame (for example: coronary artery bypass graft with mitral valve replacement), the surgery listed as the principal procedure is the surgical procedure of interest.

- Suggested Data Sources:**
- Consultation notes
 - Discharge summary
 - Emergency department record
 - Nursing notes
 - Operative report
 - Physician progress notes
 - Procedure reports/notes

Guidelines for Abstraction:

Inclusion	Exclusion
Refer to Appendix H, Table 1.9 Surgery Performed During Stay (SIP)	Refer to Appendix H, Table 1.9 Surgery Performed During Stay (SIP)

- Data Element Name:** *Wound Class*
- Collected For:** All SIP Records – (CMS Optional Data Element)
- Definition:** Documentation of the surgical wound classification.
- Suggested Data Collection Question:** What was the surgical wound classification?
- Format:** **Length:** 1
 Type: Alphanumeric
 Occurs: 1
- Allowable Values:**
- 1 Class I/Clean: The wound class is documented as Class I/Clean.
 - 2 Class II/Clean-Contaminated: The wound class is documented as Class II/Clean-Contaminated.
 - 3 Class III/Contaminated: The wound class is documented as Class III/Contaminated.
 - 4 Class IV/Dirty-Infected: The wound class is documented as Class IV/Dirty-Infected.
 - 5 UTD: The wound class is not documented, or a different wound class than those listed above is documented, or the documentation is illegible.
- Notes for Abstraction:** None
- Suggested Data Sources:**
- Anesthesia record
 - Intraoperative nursing notes
 - Operative report
 - OR circulation notes
 - Perioperative nursing notes
 - Physician progress notes

Guidelines for Abstraction:

Inclusion	Exclusion
<ul style="list-style-type: none"> • If conflicting information is found in the record, defer to “worst” classification • The only acceptable term is wound classification 	None