

**HOSPITAL
QUALITY
INITIATIVE**

Abstraction Tips February 2007

Summary of Acute Myocardial Infarction (AMI) and Heart Failure (HF) Changes – 7/1/06+ and 10/1/06+ Discharges

A. AMI and HF Measure Revisions – Effective 7/1/06+ Discharges

AMI

- 1. All measures:** Added exclusion of Comfort Measures Only patients from population.

Change made in response to Q&As and voiced concerns from the community. This change will make the AMI population criteria consistent with the Pneumonia population criteria. Since patients with a discharge status code of Hospice are already excluded from measures AMI-2, AMI-3, AMI-4, AMI-5, AMI-9, and AMI-T2, this change will help capture those patients who are terminal but who are not actually discharged to Hospice for whatever reason(s).

- 2. AMI-7 (Median Time to Fibrinolysis) and AMI-7a (Fibrinolytic Therapy Received within 30 Minutes of Hospital Arrival):**

- a. Terminology changed: From thrombolysis to fibrinolysis and from thrombolytic agent to fibrinolytic therapy.

Change made to maintain consistency with language used in the American College of Cardiology/American Heart Association (ACC/AHA) guidelines and performance measures.

- b. Added exclusion: Patients who did not receive fibrinolytic therapy within 30 minutes and had a reason for delay documented by a physician, nurse practitioner, or physician assistant (e.g., social, religious, initial concern, or refusal).

Change made in response to Q&As and voiced concerns from the community. This change recognizes there are justifiable medical and patient reasons for not administering fibrinolytic therapy within 30 minutes after hospital arrival. It will ultimately help reduce the number of falsely inflated times currently being included in the measures. Additionally, it will maintain consistency with ACC/AHA performance measures.



557 Cranbury Road, Suite 21 ♦ East Brunswick, NJ 08816-5419
Phone: 732-238-5570 ♦ Fax: 732-238-7766 ♦ Website: www.hqsi.org

ORIGINAL MATERIALS DEVELOPED BY THE HOSPITAL INTERVENTIONS QUALITY IMPROVEMENT ORGANIZATION SUPPORT CENTER (HIQIOSC). THIS MATERIAL WAS PREPARED BY HEALTHCARE QUALITY STRATEGIES, INC., (HQSI), THE MEDICARE QUALITY IMPROVEMENT ORGANIZATION FOR NEW JERSEY, UNDER CONTRACT WITH THE CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS), AN AGENCY OF THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES. THE CONTENTS PRESENTED DO NOT NECESSARILY REFLECT CMS POLICY. 8SOW-NJ-INPT-07-09(a)

3. AMI-8 (Median Time to Percutaneous Coronary Intervention [PCI]) and AMI-8a (PCI Received within 90 Minutes of Hospital Arrival):

- a. Added exclusion: PCI described as non-primary by physician, nurse practitioner, or physician assistant.

Change made in response to Q&As and voiced concerns from the community. This change will ultimately filter the more relevant, primary PCI cases into the measures. Additionally, it will maintain consistency with ACC/AHA performance measures.

- b. Added exclusion: Patients who did not receive PCI within 90 minutes and had a reason for delay documented by a physician, nurse practitioner, or physician assistant (e.g., social, religious, initial concern, or refusal).

Change made in response to Q&As and voiced concerns from the community. This change recognizes there are justifiable medical and patient reasons for not doing a PCI within 90 minutes after hospital arrival. It will ultimately help reduce the number of falsely inflated times currently being included in the measures. Additionally, it will maintain consistency with ACC/AHA performance measures.

- c. Terminology change: “Primary” added to measure description (i.e., “Median Time to Primary PCI,” “Primary PCI Received within 90 Minutes of Hospital Arrival”).

Change made in response to addition of exclusions 3a and 3b above. Additionally, it will help maintain consistency with language used in ACC/AHA performance measures.

4. AMI-8a (PCI Received within 90 Minutes of Hospital Arrival): Time frame reduced from 120 minutes to 90 minutes.

This change reflects the new recommendation from the 2004 ACC/AHA STEMI guidelines that read, “delay from patient contact with the health care system (typically, arrival at the emergency department or contact with paramedics) to balloon inflation should be less than 90 min.” Additionally, it will maintain consistency with ACC/AHA performance measures.

5. AMI-T1b (LDL Cholesterol Testing within 24 Hours After Hospital Arrival; Optional Test Measure): Deleted.

There are no plans to convert this measure to a core measure at any point in the future. Additionally, ACC/AHA do not include this measure in their performance measures.

HF

All measures: Added exclusion of Comfort Measures Only patients from population.

Change made in response to Q&As and voiced concerns from the community. This change will make the HF population criteria consistent with the Pneumonia population criteria. Since patients with a discharge status code of Hospice are already excluded from all HF measures, this change will help capture those patients who are terminal but who are not actually discharged to Hospice for whatever reason(s).

B. AMI and HF Data Element Revisions – Effective 7/1/06+ Discharges

Data Element	New	Clarification	CLARIFICATION OR CHANGE
ACEI* Prescribed at Discharge AND ARB† Prescribed at Discharge AND Aspirin Prescribed at Discharge AND Beta Blocker Prescribed at Discharge		√	Abstraction guidelines added to clarify how to handle conflicting documentation amongst different sources in the medical record. *Angiotensin Converting Enzyme Inhibitor †Angiotensin II Receptor Blocker
Adult Smoking Counseling		√	Excluded source added: Any documentation dated/timed after discharge, except discharge summary and operative/procedure/diagnostic test reports (from procedure done during hospital stay).
Adult Smoking History	√		Abstraction guidelines changed to direct abstractor to mark ‘No’ in conflicting documentation cases where there is specific documentation that the patient has not smoked anytime during the year prior to hospital arrival.
Comfort Measures Only	√		New data element for AMI and HF.
Contraindication to Aspirin at Discharge AND Contraindication to Aspirin on Arrival		√	Medication hold during the hospitalization constitutes a “clearly implied” reason for not prescribing the medication – Exception of one-time holds – Abstraction guidelines added which further define one-time hold: a. Use physician orders only. b. Refers to the holding of just one dose of a medication or holding of a medication for a defined time period. c. The physician order of the one-time hold needs to be explicit and able to stand on its own. (Don’t cross reference.)
		√	Abstraction guideline added that clarifies hold/dc references to general medication classes do not suffice (e.g., “hold all anticoagulants”).
		√	Abstraction guideline added that clarifies if there is documentation of a plan to initiate/restart medication (conditional or non-conditional) AND the underlying reason/problem underlying the delay is also noted, this counts as clearly implied reason for not prescribing the medication.
		√	Abstraction guideline that clarifies the use of sandbags should not be considered “medical intervention” was expanded. Abstractors should NOT count reapplication of sandbags later after the procedure dressing changes, use of a femostop, use of D-stat, or application of pressure to the site as “medical intervention”.
		√	Excluded source added: Any documentation dated/timed after discharge, except discharge summary and operative/procedure/diagnostic test reports (from procedure done during hospital stay).

Data Element	New	Clarification	CLARIFICATION OR CHANGE
Contraindication to Beta Blocker at Discharge AND Contraindication to Beta Blocker on Arrival		√	Abstraction guidelines revised to clarify that second or third degree heart block or pacemaker ECG findings can be taken from unsigned ECG reports. MD/NP/PA documentation is not required.
		√	Medication hold during the hospitalization constitutes a “clearly implied” reason for not prescribing the medication – Exception of one-time holds – Abstraction guidelines added that further define one-time hold: a. Use physician orders only. b. Refers to the holding of just one dose of a medication or holding of a medication for a defined time period. c. The physician order of the one-time hold needs to be explicit and able to stand on its own. (Don’t cross reference.)
		√	Abstraction guideline added that clarifies hold/dc references to general medication classes do not suffice (e.g., “Hold all BP meds,” “Dc antihypertensive drugs”).
		√	Abstraction guideline added that clarifies if there is documentation of a plan to initiate/restart medication (conditional or non-conditional) AND the underlying reason/problem underlying the delay is also noted, this counts as clearly implied reason for not prescribing the medication.
		√	Excluded source added: Any documentation dated/timed after discharge, except discharge summary and operative/procedure/diagnostic test reports (from procedure done during hospital stay).
Contraindication to Both ACEI and ARB at Discharge		√	Medication hold during the hospitalization constitutes a “clearly implied” reason for not prescribing the medication – Exception of one-time holds – Abstraction guidelines added which further define one-time hold: a. Use physician orders only. b. Refers to the holding of just one dose of a medication or holding of a medication for a defined time period. c. The physician order of the one-time hold needs to be explicit and able to stand on its own. (Don’t cross reference.)
		√	Abstraction guideline added that clarifies hold/dc references to general medication classes do not suffice (e.g., “Hold all BP meds,” “Dc nephrotoxic drugs”).
		√	Abstraction guideline added that clarifies if there is documentation of a plan to initiate/restart medication (conditional or non-conditional) AND the underlying reason/problem underlying the delay is also noted, this counts as clearly implied reason for not prescribing the medication.
		√	Excluded source added: Any documentation dated/timed after discharge, except discharge summary and operative/procedure/diagnostic test reports (from procedure done during hospital stay).

Data Element	New	Clarification	CLARIFICATION OR CHANGE
Discharge Instructions Address Activity AND	√		Abstraction guidelines revised to treat teaching sheets the same as brochures, booklets, etc. Teaching sheets should no longer be treated like discharge instruction sheets and physician order/ instruction sheets.
Discharge Instructions Address Diet AND Discharge Instructions Address Follow-up AND Discharge Instructions Address Symptoms Worsening AND Discharge Instructions Address Weight Monitoring	√		In cases where a teaching sheet, brochure, booklet, or other instruction material is present in the medical record and there is no explicit documentation that a copy was given to the patient, abstraction guideline added to allow the abstractor to make the inference that a copy was given to the patient/caregiver IF the patient's name or the medical record number appears on the material AND the hospital staff or patient/caregiver has signed the material.
Discharge Instructions Address Medications		√	Abstraction guideline added that clarifies discharge medication information from discharge summaries dictated after discharge should still be used in determining the medications prescribed at discharge, as long as the summary was added during the hospital's normal course of completing a medical record per organization policy, or within 30 days after discharge, whichever is sooner.
		√	Abstraction guidelines revised to clarify that a discharge medication list or discharge instruction sheet signed or completed by the MD/NP/PA and given to the patient should only be presumed complete in cases where a list of discharge medications is not documented elsewhere in the record, and the completeness of the medication list given to the patient cannot be confirmed.
		√	Abstraction guidelines added to clarify how to handle conflicting documentation among different sources in the medical record.
		√	Abstraction guideline added to clarify that medications, which the patient will not be taking at home (and/or the caregiver will not be giving at home), are NOT required in written discharge instructions (e.g., monthly B12 injections, Natrecor infusions, dialysis meds).
	√		Abstraction guidelines revised to treat teaching sheets the same as brochures, booklets, etc. Teaching sheets should no longer be treated like discharge instruction sheets and physician order/ instruction sheets.

Data Element	New	Clarification	CLARIFICATION OR CHANGE
Discharge Instructions Address Medications (cont'd)	√		In cases where a teaching sheet, brochure, booklet, or other instruction material is present in the medical record and there is no explicit documentation that a copy was given to the patient, abstraction guideline added to allow the abstractor to make the inference that a copy was given to the patient/caregiver IF the patient's name or the medical record number appears on the material AND the hospital staff or patient/caregiver has signed the material.
Fibrinolytic Administration AND Fibrinolytic Administration Date AND Fibrinolytic Administration Time	√		Terminology change: From "thrombolytic" to "fibrinolytic."
First PCI Time	√		Time the wire, balloon, or other device (e.g., angiojet or other thrombectomy device, rotablate) reached, passed through, or crossed the lesion was deleted from allowable time list.
	√		Priority order was removed – Abstraction guidelines changed to take the earliest time from the balloon inflation time and lesion treatment time inclusion terms.
		√	Abstraction guideline added that clarifies the earliest time from the allowable times should be used regardless of how many vessels were treated or which ones were successful vs. unsuccessful.
Initial ECG Interpretation	√		MIs where the age is not addressed was deleted as an exclusion.
	√		ST abnormality, ST changes, or ST segment described as consistent with ischemia was deleted as an exclusion.
	√		Intermittent LBBB was deleted as an inclusion.
	√		"Possible" was deleted as excluded qualifier/exclusion. Abstractors essentially directed to disregard "possible" ST elevation/LBBB in abstraction.
	√		ST-elevation clearly described as confined to ONE lead was added as an exclusion.
	√		ST-elevation described as minimal, < .10mV, < 1 mm, non-diagnostic, or non-specific in ALL leads noted to have ST-elevation was added as an exclusion.
	√		If ST-elevation is described as minimal, < .10mV, < 1 mm, non-diagnostic, or non-specific in GENERAL terms, where lead(s) are NOT specified, abstraction guideline added to direct abstractor to infer this description is referring to ALL leads which have ST-elevation.

Data Element	New	Clarification	CLARIFICATION OR CHANGE
LVF Assessment		√	Excluded source added: Any documentation dated/timed after discharge, except discharge summary and operative/procedure/diagnostic test reports (from procedure done during hospital stay).
LVSD		√	Exclusion, “Hypokineses described as diffuse, generalized, or global AND mild” added.
	√		Abstraction guideline change in handling cases where there is conflicting documentation in reference to the same, most recent test (appendix H): If there are one or more numeric ejection fractions (EFs) in combination with one or more narrative descriptions of left ventricular systolic function (LVSF), abstractors directed to take the numeric EF over narrative LVSF description(s).
Non-Primary PCI	√		New data element.
Reason for Delay in Fibrinolytic Therapy	√		New data element.
Reason for Delay in PCI	√		New data element.

C. AMI and HF Measure Revisions – Effective 10/1/06+ Discharges: NONE

D. AMI and HF Data Element Revisions – Effective 10/1/06+ Discharges:

Data Element	New	Clarification	Change
Comfort Measures Only		√	Clarification added regarding excluding comfort measures only (hospice, palliative care, etc.) at discharge – when documentation is in reference to care planned after discharge only.
	√		“Continue supportive care” is no longer a potential inclusion, regardless of context (patient’s age, chronic illness, or terminal/ grave prognosis).
	√		To count comfort measures only, only those terms identified in the list of inclusions are acceptable. No other terminology will be accepted.
	√		The following terms are now inclusions: <ul style="list-style-type: none"> • Comfort care • Comfort measures • End-of-life care • Terminal care
	√		The following terms are no longer inclusions: <ul style="list-style-type: none"> • Comfort measures provided • Maintain treatment for comfort • Physician documentation that care is limited at family’s request or due to patient’s age or chronic illness or patient’s condition is grave or that death is imminent • Supportive care only

Data Element	New	Clarification	Change
Comfort Measures Only (cont'd)	√		<p>The following terms are now exclusions:</p> <ul style="list-style-type: none"> • Do not resuscitate (DNR) • Keep comfortable • No aggressive treatment • No cardiopulmonary resuscitation (NCR) • No CPR (cardiopulmonary resuscitation) • Supportive care
Discharge Instructions Address Activity AND	√		Abstractors should only use the documentation provided in the medical record itself. They should no longer review a teaching sheet, brochure, etc. outside of the medical record to determine what areas of instruction are included.
Discharge Instructions Address Diet AND Discharge Instructions Address Follow-up AND Discharge Instructions Address Medications AND Discharge Instructions Address Symptoms Worsening AND Discharge Instructions Address Weight Monitoring	√		<p>Documentation must clearly convey which instructions (diet, activity, etc.) are included in literature given to the patient/ caregiver, akin to that required for electronically formatted media (e.g., CDs). This documentation can take many forms. Examples:</p> <ul style="list-style-type: none"> • Discharge nursing note that outlines the areas covered in the material, such as “Heart Failure Management brochure given to pt. Addresses diet, activity, and weight monitoring” • Notation on discharge instruction sheet such as “Activity: Given Heart Failure Management brochure” • Copy of brochure/booklet Table of Contents included in medical record (if this illustrates the areas covered) • Copy of brochure/booklet included in medical record (either in full or just the section(s) that address the different areas)