# Alphabetical Data Element List

***NOTE:*** Click on element name in list below to go to specified data element. *To be returned to the list, click data element name on any page.*

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

**Collected For:** OP-6, OP-7

**Definition:** Documentation that the patient received antibiotics during this outpatient encounter. 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 (e.g., quinolones) which has the capacity to inhibit the growth of or destroy bacteria and other microorganisms. Antibiotics are used in the prevention and treatment of infectious diseases.

**Suggested Data Collection Question:** Did the patient receive an antibiotic during this outpatient encounter?

**Format:**

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

**Allowable Values:**

| | |
|---|---|
| Y (Yes) | Antibiotic received during this outpatient encounter. |
| N (No) | No antibiotics received during this outpatient encounter or unable to determine from medical record documentation. |

**Notes for Abstraction:**

- Only consider antibiotics listed in Appendix C, OP Table 6.0. Do not consider any medications other than antibiotics (i.e., antivirals, antifungals, antituberculins, antiprotozoans, etc.).
- Consider antibiotics initiated via an appropriate route (PO, IV, IM or UTD) to answer this data element.
- The method of designation of administration on hand-written or pre-printed forms such as medication administration records (MARs) or electronic medication administration records (eMARs), with pre-printed scheduled times for administration, must be clearly designated as given. The methods may vary. Whatever method is used, it must be clear that the dose was administered.
- Antibiotic initiation information should be abstracted from a single source that demonstrates actual administration of the specific antibiotic. If the antibiotic name and route are not contained in a single source for that specific antibiotic, utilize "UTD" for the missing information.
  - Do not abstract doses from a physician order unless they are clearly designated as given on the physician order form.
  - Do not collect antibiotics documented on the operative report unless the surgeon states that the surgeon actually administered the dose.
- A dose can be abstracted that is given by one person and be documented as being given by another person if that dose is not documented by the person that actually administered

it. Example: OR nurse, S. Smith RN, documents, “Cefazolin 1 gm IV given at 0500 per JDoe RN.” This dose can be abstracted as given if not documented by the person that gave the dose.

- Authentication on one side/page of a multi-side or multi-page form applies to all pages of the form. The sides/pages of the form must be identifiable as being from the same form.
- Do not abstract antibiotics from sources that do not represent actual administration. Examples that **do not** represent actual administration:

  Pre-Op Checklist states:

  X IV Started at 1730
  X Preop Antibiotic Given at 1800
  X Lab on Chart

  Operative Report states:

  IV antibiotics were given prior to procedure.
- Do not abstract antibiotics from narrative charting unless there is no other documentation that reflects that the same antibiotic was given during the specified timeframe. Example: Narrative states “Ancef 1 gram given IV prior to incision.” No other doses of Ancef are documented. The dose in the narrative should be abstracted using UTD for missing data.
- **For urologic and pubovaginal sling procedures only:**
  - If there is documentation that an oral antibiotic was taken prior to arrival for surgical prophylaxis, enter this antibiotic name and route as an antibiotic that was taken during the outpatient encounter.
  - If there is documentation of instructions for “oral antibiotics” to be taken at home OR documentation of instructions or prescriptions given to the patient in regard to oral antibiotics, assume the antibiotics were taken and collect them as given during the outpatient encounter. Note: The instructions or prescriptions are for oral antibiotics to be taken prior to arrival, not those ordered postoperatively.
  - If the oral antibiotic is listed on the medication reconciliation list or the patient’s list of home medications, but there is documentation that the antibiotic is NOT a routine medication, collect this antibiotic as given during the outpatient encounter.

**Suggested Data Sources:**

- Outpatient record

**Inclusion Guidelines for Abstraction:**

**This list is all inclusive**

Include any antibiotics given:

**Intravenous:**
Intravenous

- IV bolus
- IV infusion
- IV
- I.V.

- IVPB
- IV piggyback
- IV push

**PO/NG/PEG tube:**

- Feeding tube (e.g., percutaneous endoscopic gastrostomy, percutaneous endoscopic jejunostomy, gastrostomy tube)
- By mouth
- Oral
- Gastric tube
- G-tube
- Jejunostomy
- J-tube
- Nasogastric tube
- PO
- P.O.

**IM**

- IM
- I.M.
- Intramuscular

Refer to Appendix C, OP Table 6.0, Antimicrobial Medications.

**Exclusion Guidelines for Abstraction:**
**All terms other than those on the Inclusion list**

**Data Element Name:** ***Antibiotic Allergy***

**Collected For:** OP-7

**Definition:** Documentation that the patient has an allergy, sensitivity, or intolerance to penicillin, beta-lactams, or cephalosporins. An allergy can be defined as an acquired, abnormal immune response to a substance (allergen) that does not normally cause a reaction.

**Suggested Data Collection Question:** Did the patient have any allergies, sensitivities or intolerance to beta-lactam/penicillin antibiotic or cephalosporin medications?

**Format:**

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

**Allowable Values:**

| | |
|---|---|
| Y (Yes) | Documentation that the patient has an antibiotic allergy to beta-lactam, penicillin, or cephalosporins (e.g., either history or current finding). |
| N (No) | No documentation that the patient had an allergy to beta-lactam, penicillin, or cephalosporins or unable to determine from medical record documentation. |

**Notes for Abstraction:**

- If the patient was noted to be allergic to “cillins”, “penicillin,” or “all cillins,” select “Yes.”
- If one source in the record documents “Allergies: penicillin” and another source in the record documents “penicillin causes upset stomach,” select “Yes.”
- If a physician/advanced practice nurse/physician assistant (physician/APN/PA) or pharmacist documents a specific reason not to give penicillin, beta-lactams, or cephalosporins, select “Yes.”

**Suggested Data Sources:**

- Outpatient record

**Inclusion Guidelines for Abstraction:**

**Symptoms include:**

- Adverse drug event
- Adverse effect
- Adverse reaction
- Anaphylaxis
- Anaphylactic reaction
- Hives
- Rash

Refer to Appendix C, OP Table 6.1, Antibiotic Allergy.

**Exclusion Guidelines for Abstraction:**
None

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

**Collected For:** OP-6, OP-7

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

**Suggested Data Collection Question:** What is the name of the antibiotic(s)?

**Format:**

**Length:** 244
**Type:** Alphanumeric
**Occurs:** 20

**Allowable Values:**

Name of any antibiotic - see Appendix C, OP Table 6.0

**Notes for Abstraction:**

- For **EACH** Antibiotic Name, enter an Antibiotic Route.
- **Collect only antibiotics initiated via an appropriate route (PO , IV, IM or UTD) to answer this question.**
- Antibiotic initiation information should be abstracted from a single source that demonstrates actual administration of the specific antibiotic. If the antibiotic name and route are not contained in a single source for that specific antibiotic, utilize "UTD" for the missing information.
- Collect the name of the antibiotics initiated (started) during this outpatient encounter.
- **For urologic and pubovaginal sling procedures only:**
    - If there is documentation that an oral antibiotic was taken prior to arrival for surgical prophylaxis, enter this antibiotic name and route as an antibiotic that was taken during the outpatient encounter.
    - If there is documentation of instructions for "oral antibiotics" to be taken at home OR documentation of instructions or prescriptions given to the patient in regard to oral antibiotics, assume the antibiotics were taken and collect them as given during the outpatient encounter. Note: The instructions or prescriptions are for oral antibiotics to be taken prior to arrival, not those ordered postoperatively.
    - If the oral antibiotic is listed on the medication reconciliation list or the patient's list of home medications, but there is documentation that the antibiotic is NOT a routine medication, collect this antibiotic as given during the outpatient encounter.
- Only use "Antibiotic NOS" in the following situations:
    - For new antibiotics that are not yet listed in Appendix C, OP Table 6.0.

- When the Antibiotic Name is missing or if there is documentation that a medication was administered and it cannot be determined what the name of the medication is. It must be apparent that the medication is an antibiotic.

- If an antibiotic name is misspelled or abbreviated in the medical record and it can be determined from supporting documentation which medication was administered, that medication may be abstracted for *Antibiotic Name*.
- A specific antibiotic is defined as having a single generic name and being administered via a single appropriate route (if trade names are used, a crosswalk is provided in Appendix C, OP Table 6.0). If the route of administration of an antibiotic changes during the encounter, record the antibiotic name once for each route by which it was administered.
- The method of designation of administration on hand-written or pre-printed forms such as MARs or eMARs, with pre-printed scheduled times for administration, must be clearly designated as given. The methods may vary. Whatever method is used, it must be clear that the dose was administered.
  - Do not abstract doses from a physician order unless they are clearly designated as given on the physician order form.
  - Do not collect antibiotics documented on the operative report unless the surgeon states that the surgeon actually administered the dose.
- A dose can be abstracted that is given by one person and be documented as being given by another person if that dose is not documented by the person that actually administered it. Example: OR nurse, S. Smith RN, documents, "Cefazolin 1 gm IV given at 0500 per JDoe RN." This dose can be abstracted as given if not documented by the person that gave the dose.
- Authentication on one side/page of a multi-side or multi-page form applies to all pages of the form. The sides/pages of the form must be identifiable as being from the same form.
- Do not abstract antibiotics from sources that do not represent actual administration.

  Examples that **do not** represent actual administration:

  <u>Pre-Op Checklist states:</u>

  X IV Started at 1730
  X Preop Antibiotic Given at 1800
  X Lab on Chart

  <u>Operative Report states:</u>

  IV antibiotics were given prior to procedure.
- Do not abstract antibiotics from narrative charting unless there is no other documentation that reflects that the same antibiotic was given during the specified timeframe. Example: Narrative states "Ancef 1 gram given IV prior to incision." No other doses of Ancef are documented. The dose in the narrative should be abstracted using UTD for missing data.

**Suggested Data Sources:**

- Outpatient record

**Inclusion Guidelines for Abstraction:**
Refer to Appendix C, OP Table 6.0, Antimicrobial Medications.

**Exclusion Inclusion Guidelines for Abstraction:**
None

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

**Collected For:** OP-6, OP-7

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

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

**Format:**

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

**Allowable Values:**

1 PO/NG/PEG tube (Oral)

2 IV (Intravenous)

3 UTD

4 IM (Intramuscular)

**Notes for Abstraction:**

- Collect only antibiotics administered via an appropriate route **(PO , IV, IM or UTD)** to answer this question.
- For EACH Antibiotic Name, enter an Antibiotic Route. If a route is missing for a dose, the dose must be collected using "UTD" for the missing data.
- The method of designation of administration on hand-written or pre-printed forms such as MARs or eMARs, with pre-printed scheduled times for administration, must be clearly designated as given. The methods may vary. Whatever method is used, it must be clear that the dose was administered.
- A specific antibiotic is defined as having a single generic name and being administered via a single appropriate route (if trade names are used, a crosswalk is provided in Appendix C, OP Table 6.0). If the route of administration of an antibiotic changes during the encounter, record the antibiotic name once for each route by which it was administered.
- Antibiotic initiation information should be abstracted from a single source that demonstrates actual administration of the specific antibiotic. If the antibiotic name and route are not contained in a single data source for that specific antibiotic, utilize "UTD" for the missing information.
    - Do not abstract doses from a physician order unless they are clearly designated as given on the physician order form.
    - Do not collect antibiotics documented on the operative report unless the surgeon states that the surgeon actually administered the dose.

- A dose can be abstracted that is given by one person and be documented as being given by another person if that dose is not documented by the person that actually administered it. Example: OR nurse, S. Smith RN, documents, “Cefazolin 1 gm IV given at 0500 per JDoe RN.” This dose can be abstracted as given if not documented by the person that gave the dose.
- Authentication on one side/page of a multi-side or multi-page form applies to all pages of the form. The sides/pages of the form must be identifiable as being from the same form.
- Do not abstract antibiotics from sources that do not represent actual administration.

  Examples that **do not** represent actual administration:

  Pre-Op Checklist states:

  X IV Started at 1730
  X Preop Antibiotic Given at 1800
  X Lab on Chart

  Operative Report states:

  IV antibiotics were given prior to procedure.
- Do not abstract antibiotics from narrative charting unless there is no other documentation that reflects that the same antibiotic was given during the specified timeframe. Example: Narrative states “Ancef 1 gram given IV prior to incision.” No other doses of Ancef are documented. The dose in the narrative should be abstracted using UTD for missing data.

**Suggested Data Sources:**
Outpatient record

**Inclusion Guidelines for Abstraction:**

**This list is all inclusive**

Include any antibiotics given:
**Intravenous:**
- Intravenous
- IV bolus
- IV infusion
- IV
- I.V.
- IVPB
- IV piggyback
- IV push

**PO/NG/PEG tube:**
- Feeding tube (e.g., percutaneous endoscopic gastrostomy, percutaneous endoscopic jejunostomy, gastrostomy tube)
- By mouth
- Oral
- Gastric tube
- G-tube
- Jejunostomy

- J-tube
- Nasogastric tube
- PO
- P.O.

**IM**
- IM
- I.M.
- Intramuscular

Refer to Appendix C, OP Table 6.0, Antimicrobial Medications.

**Exclusion Guidelines for Abstraction:**

**All terms other than those on the Inclusion list**

**Data Element Name:** ***Antibiotic Timing***

**Collected For:** OP-6

**Definition:** Documentation that an antibiotic was initiated (started) within 60 minutes (120 minutes for Vancomycin or Quinolones) prior to surgical incision.

**Suggested Data Collection Question:** Was an antibiotic initiated (started) within 60 minutes (120 minutes for Vancomycin or Quinolones) prior to surgical incision?

**Format:**

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

**Allowable Values:**

| | |
|---|---|
| Y (Yes) | An antibiotic was initiated (started) within 60 minutes (120 minutes for Vancomycin or Quinolones) prior to surgical incision. |
| N (No) | An antibiotic was not initiated (started) within 60 minutes (120 minutes for Vancomycin or Quinolones) prior to surgical incision or unable to be determined from medical record documentation. |

**Notes for Abstraction:**

- This data element applies to the antibiotics administered via the **intravenous** route only. Do NOT consider antibiotics that are given orally for this data element. For a list of acceptable intravenous inclusions, refer to the data element *Antibiotic Route*.
- Antibiotic initiation information should be abstracted from a single source that demonstrates actual administration of the specific antibiotic.
- If the route for the antibiotic(s) given within the 60 minutes (120 minutes for vancomycin and quinolones) prior to incision is unable to be determined, answer “No.”
- If more than one procedure from OP Table 6.0 was performed during the same surgical episode, the incision time will be the incision that occurs first. If no incision time is documented, use the priority list of synonyms.
- If an incision time is not documented in the hospital outpatient record, follow the priority order list of synonyms. If multiple times are found, use the earliest time among the highest priority of synonyms.

  **First priority:** Incision Time

  **Second priority:** Surgery start/begin time or Operation start time or Procedure start time or Start of surgery (SOS) or Case start time

  **Third priority:** Anesthesia begin time or Anesthesia start time or Operating room start time

- If two SURGICAL procedures were performed during the same surgical episode but the first procedure performed is not on OP Table 6.0, the incision time OR surgery start time of the first procedure should be used to determine *Antibiotic Timing* if **IV antibiotics were given prior to the first procedure**. If antibiotics were not given for the first procedure (not on OP Table 6.0), use the incision time or other priority terms for the procedure on OP Table 6.0.
- Some procedures that are done during the same "surgical episode" should not be considered procedures that involve an incision. An example would be a central line placement or electrophysiology study performed before a procedure on OP Table 6.0.
- The use of "hang time" or "infusion time" is acceptable as antibiotic administration time when other documentation cannot be found.
- **Laparoscopy to Open:** If the procedure starts as a laparoscopic procedure and it is converted to an open procedure, the incision time will be the incision that is documented for the open procedure.

  Example:
  The incision time for the laparoscopic procedure is 1300. The procedure is converted to an open procedure. The incision time to the open procedure is 1400. Use the 1400 incision time.

**Suggested Data Sources:**

- Outpatient record

**Inclusion Guidelines for Abstraction:**
Refer to Appendix C, OP Table 6.0, Antimicrobial Medications.
Refer to Appendix C, OP Table 6.11, Quinolones.
Refer to Appendix C, OP Table 6.12, Vancomycin.

**Exclusion Guidelines for Abstraction:**
None

**Data Element Name:** ***Arrival Time***

**Collected For:** All Records (used in algorithm for OP-1, OP-2, OP-3, OP-5, OP-16, OP-18, OP-20, OP-21, OP-23)

**Definition:** The earliest documented time (military time) the patient arrived at the outpatient or emergency department.

**Suggested Data Collection Question:** What was the **earliest** documented time the patient arrived at the outpatient or emergency department?

**Format:**

**Length:** 5 - HH:MM (with or without colon) or UTD
**Type:** Time
**Occurs:** 1

**Allowable Values:**

Enter the earliest documented time of arrival

HH = Hour (00-23)
MM = Minutes (00-59)
UTD = Unable to Determine

Time must be recorded in military time format.

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.

Examples:
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

**Note:**
00:00 = midnight. If the time is documented as 00:00 11-24-20XX, review supporting documentation to determine if the *Outpatient Encounter Date* should remain 11-24-20XX or if it should be converted to 11-25-20XX.

When converting Midnight or 24:00 to 00:00 do not forget to change the *Outpatient Encounter Date*.

Example: Midnight or 24:00 on 11-24-20XX = 00:00 on 11-25-20XX

**Notes for Abstraction:**

- For times that include "seconds," remove the seconds and record the time as is.
  Example: 15:00:35 would be recorded as 15:00

- If the time of the arrival is unable to be determined from medical record documentation, select "UTD".
- The medical record must be abstracted as documented (taken at "face value"). When the time documented is obviously in error (not a valid time) **and** no other documentation is found that provides this information, the abstractor should select "UTD."

  Example:
  Documentation indicates the *Arrival Time* was 3300. No other documentation in the list of ONLY ACCEPTABLE SOURCES provides a valid time. Since the *Arrival Time* is outside of the range in the Allowable Values for "Hour," it is not a valid time and the abstractor should select "UTD."
  **Note:** Transmission of a case with an invalid time as described above will be rejected from the Clinical Warehouse. Use of "UTD" for *Arrival Time* allows the case to be accepted into the warehouse.

- Review the ONLY ACCEPTABLE SOURCES to determine the earliest time the patient arrived at the ED, nursing floor, observation or as a direct admit to the cath lab. Use the earliest time documented unless other documentation suggests the patient was not in the hospital at that time. The intent is to utilize any documentation which reflects processes that occurred in the ED or hospital.
  - In determining if there is documentation which suggests the patient was not in the hospital at a given time, sources outside of the ONLY ACCEPTABLE SOURCES list can be referenced. However, do not use times described as hospital arrival on these sources for *Arrival Time*.

    Examples:

    - ED ECG timed as 1742. ED Greet Time 2125. ED Triage Time 2130. EMS record shows patient was enroute at 2100. Enter 2125 as *Arrival Time*.
    - ED face sheet noted arrival time as 1000. The first vitals are recorded at 1120. There is no documentation to support that the patient was not in the hospital at 1000. Enter 1000 for *Arrival Time*.
    - ED Triage Time 0800. ED rhythm strip 0830. EMS report indicates the patient was receiving EMS care from 0805 through 0825. Enter 0830 for *Arrival Time*.

- The source "Emergency department record" includes any documentation from the time period that the patient was an ED patient e.g., ED face sheet, ED consent/Authorization for treatment forms, ED/Outpatient Registration/sign-in forms, ED vital sign record, triage record, ED physician orders, ECG reports, telemetry rhythm strips, laboratory reports, x-ray reports.
- Do not use preprinted times on a vital sign graphic record.
- The source "Procedure notes" refers to procedures such as cardiac caths, endoscopies, and surgical procedures. Procedure notes do not include ECG and x-ray reports.
- The arrival time may differ from the admission time.
- If the patient is in either an outpatient setting of the hospital other than observation status, (e.g. dialysis, chemotherapy, cardiac cath) or a SNF unit of the hospital, and is

subsequently admitted to acute inpatient, use the time the patient arrived to the ED or on the floor of acute inpatient care as the arrival time.

**Observation Status:**

- If the patient was admitted to observation from an outpatient setting of the hospital, use the time the patient arrived at the ED or on the floor for observation care as the arrival time.
- If the patient was admitted to observation from the ED of the hospital, use the time the patient arrived at the ED as the arrival time.

**Direct Admits:**

- If the patient is a "Direct Admit" to the cath lab, use the earliest time the patient arrived at the cath lab (or cath lab staging/holding area) as the arrival time.
- For "Direct Admits" to acute inpatient or observation, use the earliest time the patient arrived on the nursing floor for observation (as documented in the ONLY ACCEPTABLE SOURCES) as the arrival time.
- If the patient was transferred from your hospital's satellite/free-standing ED or from another hospital within your hospital's system (as an inpatient, ED patient), and there is one medical record for the care provided at both facilities, use the arrival time at the first facility.

**ONLY ACCEPTABLE SOURCES:**

- Emergency Department record
- Nursing admission assessment/admitting note
- Observation record
- Procedure notes
- Vital signs graphic record

**Inclusion Guidelines for Abstraction:**
None

**Exclusion Guidelines for Abstraction:**

- Addressographs/stamps

**Data Element Name:** ***Aspirin Received***

**Collected For:** OP-4

**Definition:** Aspirin received within 24 hours before emergency department arrival or administered prior to transfer. Aspirin reduces the tendency of blood to clot by blocking the action of a type of blood cell involved in clotting. Aspirin improves the chances of surviving a heart attack and reduces the risk of recurrence in patients who have experienced a heart attack.

**Suggested Data Collection Question:** Was aspirin received within 24 hours before emergency department arrival or administered prior to transfer?

**Format:**

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

**Allowable Values:**

| | |
|---|---|
| Y (Yes) | Aspirin was received within 24 hours before emergency department arrival or administered prior to transfer. |
| N (No) | Aspirin was not received within 24 hours before emergency department arrival or administered prior to transfer or unable to determine from medical record documentation. |

**Notes for Abstraction:**

- Aspirin listed as “current” or “home” medication should be inferred as taken within 24 hours prior to arrival, unless documentation suggests otherwise. EXCEPTION: Aspirin documented as a PRN current/home medication does not count unless documentation is clear it was taken within 24 hours prior to arrival.
- When aspirin is noted only as received prior to arrival, without information about the exact time it was received (e.g., "Baby ASA X 4" per the "Treatment Prior to Arrival" section of the Triage Assessment), infer that the patient took aspirin within the 24 hour timeframe, unless documentation suggests otherwise.

**Suggested Data Sources:**

- Ambulance record
- Emergency Department record

**Inclusion Guidelines for Abstraction:**
Refer to Appendix C, OP Table 1.1, Aspirin and Aspirin-Containing Medications.

**Exclusion Guidelines for Abstraction:**
None

**Data Element Name:** ***Birthdate***

**Collected For:** All Records

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

NOTE: Patient Age on *Outpatient Encounter Date* (in years) is calculated by *Outpatient Encounter Date* minus *Birthdate*. The algorithm to calculate age must use the month and day portion of encounter date and birthdate to yield the most accurate age.

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

**Format:**

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

**Allowable Values:**

MM = Month (01-12)
DD = Day (01-31)
YYYY = Year (1880-Current Year)

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

**Suggested Data Sources:**

- Outpatient record
- Emergency Department record

**Inclusion Guidelines for Abstraction:**
None

**Exclusion Guidelines for Abstraction:**
None

**Data Element Name:** ***Case Canceled***

**Collected For:** OP-6, OP-7

**Definition:** Documentation that the case was canceled prior to incision.

**Suggested Data Collection Question:** Was the case canceled prior to incision?

**Format:**

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

**Allowable Values:**

| | |
|---|---|
| Y (Yes) | There is documentation that the case was canceled prior to incision. |
| N (No) | There is no documentation that the case was canceled prior to incision or unable to determine from medical record documentation. |

**Notes for Abstraction:**

- If the case was canceled before an incision was made, answer "yes." If there is documentation of the case being canceled without documentation of puncture or incision, answer "yes."
- If the case was canceled prior to anesthesia start or procedure start and no incision was made, answer "yes."
- If the abstractor is unable to determine from medical record documentation whether the case was canceled prior to incision, select "No."

**Suggested Data Sources:**

- Outpatient record

**Inclusion Guidelines for Abstraction:**
None

**Exclusion Guidelines for Abstraction:**
None

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

**Collected For:** OP-6, OP-7

**Definition:** Documentation the patient was enrolled in a clinical trial during this outpatient encounter, relevant to the measure for this encounter. Clinical trials are organized studies to provide large bodies of clinical data for statistically valid evaluation or treatment. These studies are usually rigorously controlled tests of new drugs, invasive medical devices, or therapies on human subjects.

**Suggested Data Collection Question:** Was the patient enrolled in a clinical trial during this outpatient encounter relevant to the measure?

**Format:**

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

**Allowable Values:**

| | |
|---|---|
| Y (Yes) | There is documentation at the time of this outpatient encounter that the patient was enrolled in a clinical trial relevant to the measure. |
| N (No) | There is no documentation at the time of this outpatient encounter that the patient was enrolled in a clinical trial relevant to the measure, or unable to determine from medical record documentation. |

**Notes for Abstraction:**

- This data element is used to exclude patients that are enrolled in a clinical trial at the time of this outpatient encounter relevant to the measure.
- If the patient was previously enrolled in a hospital outpatient clinical trial and has continued to take the medication for the trial, as documented on the trial protocol, select "Yes" only if documented during this encounter.
- If the patient was newly enrolled in a clinical trial during the encounter, select "Yes."
- If it is not clear which study population that the clinical trial is enrolling, select "No." Assumptions should not be made if it is not specified.
- Consider the patient enrolled in a clinical trial at the time of this encounter if documentation indicates:
    - Only capture patients enrolled in a trial of alternate types and routes of prophylactic antibiotics for surgical patients.

**Suggested Data Sources:**

**Documentation from this Outpatient Encounter only:**

- Outpatient record

**Inclusion Guidelines for Abstraction:**
None

**Exclusion Guidelines for Abstraction:**
None

**Data Element Name:** ***CPT® Code***

**Collected For:** OP-6, OP-7

**Definition:** The Current Procedural Terminology (CPT®) code associated with this outpatient encounter.

**Suggested Data Collection Question:** What was the CPT® code selected for this outpatient encounter?

**Format:**

**Length:** 5
**Type:** Alphanumeric
**Occurs:** 1

**Allowable Values:**

Select the CPT® Code from Appendix A, OP Table 6.0.

**Notes for Abstraction:**

- If more than one procedure from OP Table 6.0 was performed during this encounter, select the procedure performed first chronologically.

**Suggested Data Sources:**

- Outpatient record

**Inclusion Guidelines for Abstraction:**
Refer to Appendix A, OP Table 6.0.

**Exclusion Guidelines for Abstraction:**
None

**Data Element Name:** ***CPT® Code Date***

**Collected For:** OP-6, OP-7

**Definition:** The date the selected Current Procedural Terminology (CPT®) code was performed.

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

**Format:**

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

**Allowable Values:**

MM = Month (1-12)
DD = Day (01-31)
YYYY = Year (2000-Current Year)
UTD = Unable to Determine

**Note:**
Transmission of a case with an invalid date will be rejected from the OPPS Clinical Warehouse. Use of "UTD" for CPT® Code Date allows the case to be accepted into the warehouse.

**Notes for Abstraction:**

- If more than one procedure from OP Table 6.0 was performed during this hospital outpatient encounter, record the date of the procedure that was performed first chronologically.

**Suggested Data Sources:**

- Outpatient record

**Inclusion Guidelines for Abstraction:**
None

**Exclusion Guidelines for Abstraction:**
None

**Data Element Name:** ***Date Last Known Well***

**Collected For:** OP-23

**Definition:** The date prior to hospital arrival at which the patient was last known to be without the signs and symptoms of the current stroke or at his or her baseline state of health.

**Suggested Data Collection Question:** What was the date at which the patient was last known to be well or at his or her baseline state of health?

**Format:**

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

**Allowable Values:**

MM = Month (01-12)
DD = Day (01-31)
YYYY = Year (2001-Current Year)
UTD = Unable to Determine

**Notes for Abstraction:**

- If the date last known well is unable to be determined from medical record documentation, enter "UTD".
- The medical record must be abstracted as documented (taken at "face value"). When the date documented is obviously in error (not a valid date/format) **and** no other documentation is found that provides this information, the abstractor should select "UTD".

  Example:
  Documentation indicates the date last known well was 03-**42**-20xx. No other documentation in the medical record provides a valid date. Since the *Date Last Known Well* is outside of the range listed in the Allowable Values for "Day," it is not a valid date and the abstractor should select "UTD".

  **Note:** Transmission of a case with an invalid date as described above will be rejected from the Data Warehouse. Use of "UTD" for *Date Last Known Well* allows the case to be accepted into the warehouse.
- When an actual date is not documented but there is reference to the date described in the medical record (e.g., today, tonight, this evening, and this morning), assume that the *Date Last Known Well* is the same as the date for that timeframe preceding hospital arrival. The *Date Last Known Well* and the *Arrival Date* may be the same date or a different date.

  Examples:
  - "Wife reports patient normal this evening. Hospital arrival is 0030 on 12-10-20xx." *Date Last Known Well* is 12-09-20xx.
  - "Patient states he felt perfectly fine earlier today. Arrives at hospital 3:59 PM on 12-10-20xx." *Date Last Known Well* is 12-10-20xx.

**Suggested Data Sources:**

- Emergency Department records

- History and Physical
- Progress notes

**Inclusion Guidelines for Abstraction:**
None

**Exclusion Guidelines for Abstraction:**
None

**Data Element Name:** ***Discharge Status***

**Collected For:** OP-1, OP-2, OP-3, OP-4, OP-5, OP-16, OP-18, OP-19, OP-20, OP-21, OP-23

**Definition:** The place or setting to which the patient was discharged from the emergency department.

**Suggested Data Collection Question:** What was the patient's discharge disposition from the emergency department?

**Format:**

**Length:** 2
**Type:** Alphanumeric
**Occurs:** 1

**Allowable Values:**

01 **Discharged to home care or self care (routine discharge)**

Usage Note: Includes discharge to home; home on oxygen if DME only; any other DME only; group home, foster care, independent living and other residential care arrangements; outpatient programs, such as partial hospitalization or outpatient chemical dependency programs.

02 **Discharged/transferred to a short term general hospital for inpatient care (Acute Care Facility)**

03 **Discharged/transferred to skilled nursing facility (SNF) with Medicare certification in anticipation of covered skilled care**

Usage Note: Medicare indicates that the patient is discharged/transferred to a Medicare certified nursing facility. For hospitals with an approved swing bed arrangement, use Code 61-Swing Bed. For reporting other discharges/transfers to nursing facilities, see 04 and 64.

04 **Discharged/transferred to a facility that provides custodial or supportive care**
Usage Note: Includes intermediate care facilities (ICFs) if specifically designated at the state level. Also used to designate patients that are discharged/transferred to a nursing facility with neither Medicare nor Medicaid certification and for discharges/transfers to Assisted Living Facilities.

05 **Discharged/transferred to a designate cancer center or children's hospital**
Usage Note: Transfers to non-designated cancer hospitals should use Code 02. A list of (National Cancer Institute) Designated Cancer Centers can be found at http://cancercenters.cancer.gov/cancer_centers/cancer-centers-names.html

06 **Discharged/transferred to home under care of organized home health service organization in anticipation of covered skilled care**

Usage Note: Report this code when the patient is discharged/transferred to home with a written plan of care (tailored to the patient's medical needs) for home care services.

07 **Left against medical advice or discontinued care**

09 **Admitted as an inpatient to this hospital**

Usage Note: For use only on Medicare outpatient claims. Applies only to those Medicare outpatient services that begin greater than three days prior to an admission.

20 **Expired**

21 **Discharged/transferred to court/law enforcement**
Usage Note: Includes transfers to incarceration facilities such as jail, prison, or other detention facilities.

41 **Expired in a medical facility (e.g., hospital, SNF, ICF or freestanding hospice)**
Usage Note: For use only on Medicare and TRICARE claims for hospice care.

43 **Discharged/transferred to a Federal health care facility**
Usage Note: Discharges and transfers to a government operated health care facility such as a Department of Defense hospital, a Veteran's Administration hospital or a Veteran's Administration nursing facility. To be used whenever the destination at discharge is a federal health care facility, whether the patient resides there or not.

50 **Hospice - home**

51 **Hospice - medical facility (certified) providing hospice level of care**

61 **Discharged/transferred to hospital-based Medicare approved swing bed**
Usage Note: Medicare-used for reporting patients discharged/ transferred to a SNF level of care within the hospital's approved swing bed arrangement.

62 **Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital**

63 **Discharged/transferred to a Medicare certified long term care hospital (LTCH)**
Usage Note: For hospitals that meet the Medicare criteria for LTCH certification.

64 **Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare**

65 **Discharged/transferred to a psychiatric hospital or psychiatric distinct part of a hospital**

66 **Discharged/transferred to a Critical Access Hospital (CAH)**

70 **Discharged/transferred to another type of Health Care Institution not Defined Elsewhere in this Code List (see code 05)**

**Note:**
CMS is aware that there are additional UB-04 allowable values for this data element; however, they are not used for the hospital outpatient measures at this time.

**Notes for Abstraction:**

- The values for *Discharge Status* are taken from the National Uniform Billing Committee (NUBC) manual which is used by the billing/HIM to complete the UB-04.
- Because this data element is critical in determining the population for these measures, the abstractor should NOT assume that the UB-04 value is what is reflected in the medical record. For abstraction purposes, it is important that the medical record reflect the appropriate discharge status. If the abstractor determines through chart review that the claim information discharge status is not what is reflected in the medical record, correct and override the downloaded value.

**Suggested Data Sources:**

- Emergency Department record
- UB-04

**Inclusion Guidelines for Abstraction:**
None

**Exclusion Guidelines for Abstraction:**
None

**Data Element Name:** ***E/M Code***

**Collected For:** OP-1, OP-2, OP-3, OP-4, OP-5, OP-16, OP-18, OP-19, OP-20, OP-21, OP-23

**Definition:** The code used to report evaluation and management services provided in the hospital outpatient department clinic or emergency department.

**Suggested Data Collection Question:** What was the E/M Code documented for this outpatient encounter?

**Format:**

**Length:** 5
**Type:** Alphanumeric
**Occurs:** 1

**Allowable Values:**

Select the E/M code from Appendix A, OP Table 1.0.

**Suggested Data Sources:**

- Outpatient record

**Inclusion Guidelines for Abstraction:**
Refer to Appendix A, OP Table 1.0, E/M Codes.

**Exclusion Guidelines for Abstraction:**
None

**Data Element Name:** ***ECG***

**Collected For:** OP-5

**Definition:** Documentation a 12-lead electrocardiogram (ECG) was performed prior to emergency department arrival or in the ED prior to transfer.

**Suggested Data Collection Question:** Was an ECG performed within 1 hour before emergency department arrival or in the ED prior to transfer?

**Format:**

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

**Allowable Values:**

| | |
|---|---|
| Y (Yes) | There was an ECG performed within 1 hour before emergency department arrival or in the ED prior to transfer. |
| N (No) | There was not an ECG performed within 1 hour before emergency department arrival or in the ED prior to transfer or unable to determine from medical record documentation. |

**Notes for Abstraction:**

- If there is an ECG performed exactly one hour prior to arrival select “Yes.”
- If there are multiple ECGs performed within one hour prior to emergency department arrival and/or in the ED prior to transfer, select “Yes.”

**Suggested Data Sources:**

- Ambulance record
- Emergency Department record

**Inclusion Guidelines for Abstraction:**
ECGs performed in the ambulance (within one hour prior to arrival)

**Exclusion Guidelines for Abstraction:**
None

**Data Element Name:** ***ECG Date***

**Collected For:** OP-5

**Definition:** The month, day, and year at which the earliest 12-lead Electrocardiogram (ECG) was performed.

**Suggested Data Collection Question:** What is the date the earliest 12-lead Electrocardiogram (ECG) was performed?

**Format:**

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

**Allowable Values:**

Enter the documented date of the earliest ECG
MM = Month (01-12)
DD = Day (01-31)
YYYY = Year (2000-Current)
UTD = Unable to Determine

**Notes for Abstraction:**

- The medical record must be abstracted as documented (taken at "face value"). When the date documented is obviously in error (not a valid format/range or outside of the parameters of care [after the *ECG Date*) **and** no other documentation is found that provides this information, the abstractor should select "UTD".

  Examples:

  - Documentation indicates the *ECG Date* was 03-**42**-20xx. No other documentation in the list of ONLY ACCEPTABLE SOURCES provides a valid date. Since the *ECG Date* is outside of the range listed in the Allowable Values for "Day", it is not a valid date and the abstractor should select "UTD".
  - Patient expires on 02-12-20xx and all documentation within the ONLY ACCEPTABLE SOURCES indicates the *ECG Date* was 03-12-20xx. Other documentation in the medical record supports the date of death as being accurate. Since the *ECG Date* is after the date of death, it is outside of the parameter of care and the abstractor should select "UTD".

  **Note:** Transmission of a case with an invalid date as described above will be rejected from the Clinical Warehouse. Use of "UTD" for *ECG Date* allows the case to be accepted into the warehouse.

- **In the event the patient had an ECG performed within 60 minutes prior to arrival at the emergency department, enter the date the patient arrived at this emergency department.**
- If the date of the ECG is unable to be determined from medical record documentation, abstract UTD.

Exceptions: If there are multiple ECGs done and the earlier ECG(s) do not have a date, but subsequent ECG(s) do, the next available ECG Date may be used.

- Only collect ECGs performed within 60 minutes prior to arrival or prior to transfer.
- If there are 2 ECGs performed (one prior to arrival and one after arrival) abstract the ECG performed prior to arrival.
- Abstract the ECG performed closest to arrival.

**Suggested Data Sources:**
- Emergency Department record

**Inclusion Guidelines for Abstraction:**
None

**Exclusion Guidelines for Abstraction:**
None

**Data Element Name:** ***ECG Time***

**Collected For:** OP-5

**Definition:** The time (military time) represented in hours and minutes at which the earliest 12-lead Electrocardiogram (ECG) was performed.

**Suggested Data Collection Question:** What is the time the earliest 12-lead Electrocardiogram (ECG) was performed?

**Format:**

**Length:** 5 - HH-MM (with or without colon) or UTD
**Type:** Time
**Occurs:** 1

**Allowable Values:**

HH = Hour (00-23)
MM = Minutes (00-59)
UTD = Unable to Determine

Time must be recorded in military time format.
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

Examples:

| | |
|---|---|
| Midnight – 00:00 | Noon – 12:00 |
| 5:31 am – 05:31 | 5:31 pm – 17:31 |
| 11:59 am – 11:59 | 11:59 p.m. – 23:59 |

**Note:**
00:00 = midnight. If the time is documented as 00:00 11-24-20xx, review supporting documentation to determine if the *ECG Date* should remain 11-24-20xx or if it should be converted to 11-25-20xx.

When converting Midnight or 24:00 to 00:00 do not forget to change the *ECG Date.*

Example:
Midnight or 24:00 on 11-24-20xx = 00:00 on 11-25-20xx.

**Notes for Abstraction:**

- For times that include “seconds”, remove the seconds and record the time as is.
  Example: 15:00:35 would be recorded as 15:00
- If the ECG Time is unable to be determined from medical record documentation, select “UTD”.
  - The medical record must be abstracted as documented (taken at “face value”). When the time documented is obviously in error (not a valid time) **and** no other documentation is found that provides this information, the abstractor should select “UTD”.

Example:

Documentation indicates the ECG Time was 3300. No other documentation in the medical record provides a valid time. Since the ECG Time is outside of the range listed in the Allowable Values for "Hour," it is not a valid time and the abstractor should select "UTD".

**Note:** Transmission of a case with an invalid time as described above will be rejected from the Data Warehouse. Use of "UTD" for *ECG Time* allows the case to be accepted into the warehouse.

- **In the event the patient had an ECG performed within 60 minutes prior to arrival at the emergency department, enter the time the patient arrived at this emergency department.**
- If the time of the ECG is unable to be determined from medical record documentation, abstract UTD.
  - Exceptions: If there are multiple ECGs done and the earlier ECG(s) do not have a time, but subsequent ECG(s) do, the next available ECG Time may be used.
- Only collect ECGs performed within 60 minutes prior to arrival or prior to transfer.
- If there are 2 ECGs performed (one prior to arrival and one after arrival) abstract the ECG performed prior to arrival.
- Abstract the ECG performed closest to arrival.
- If there are multiple times documented for the same ECG, use the printed ECG strip time.
  - If there are multiple ECG times documented and the earlier time can be verified to be invalid, the subsequent time may be used (e.g., ECG strip time indicates the ECG took place three hours prior to the patient arrival and nurses' notes indicate a time the patient was at the facility, this time may be used).
  - If the only ECG time is the strip time and this is known to be invalid/inaccurate abstract UTD.

**Suggested Data Sources:**

- Emergency Department record

**Inclusion Guidelines for Abstraction:**

None

**Exclusion Guidelines for Abstraction:**

None

**Data Element Name:** ***ED Departure Date***

**Collected For:** OP-3, OP-18

**Definition:** The month, day, and year at which the patient departed from the emergency department.

**Suggested Data Collection Question:** What is the date the patient departed from the emergency department?

**Format:**

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

**Allowable Values:**

Enter the documented date of the ED Departure
MM = Month (01-12)
DD = Day (01-31)
YYYY = Year (2000-Current)
UTD = Unable to Determine

**Notes for Abstraction:**

- The medical record must be abstracted as documented (taken at "face value"). When the date documented is obviously in error (not a valid format/range or outside of the parameters of care **and** no other documentation is found that provides this information, the abstractor should select "UTD".

  Examples:

  - Documentation indicates the *ED Departure Date* was 03-**42**-20xx. No other documentation in the list of ONLY ACCEPTABLE SOURCES provides a valid date. Since the *ED Departure Date* is outside of the range listed in the Allowable Values for "Day", it is not a valid date and the abstractor should select "UTD".
  - Patient expires on 02-12-20xx and all documentation within the ONLY ACCEPTABLE SOURCES indicates the *ED Departure Date* was 03-12-20xx. Other documentation in the medical record supports the date of death as being accurate. Since the *ED Departure Date* is after the *Discharge Date* (death), it is outside of the parameter of care and the abstractor should select "UTD".

  **Note:** Transmission of a case with an invalid date as described above will be rejected from the Clinical Warehouse. Use of "UTD" for *ED Departure Date* allows the case to be accepted into the warehouse.
- If the date the patient departed is unable to be determined from medical record documentation, select "UTD".
- If the date of departure is not documented, but you are able to determine the date from other documentation this is acceptable (e.g., you are able to identify from documentation the patient arrived and was transferred on the same day).

- If there is documentation the patient left against medical advice and it cannot be determined what date the patient left against medical advice, select “UTD”.
- For patients who are placed into observation outside the services of the emergency department, abstract the date of departure from the emergency department.
- For patients who are placed into observation under the services of the emergency department, abstract the date of departure from the observation services (e.g., patient) is seen in the ED and admitted to an observation unit of the ED on 01-01-20xx then is discharged from the observation unit on 01-03-20xx abstract 01-03-20xx as the departure date.
- The inclusion and exclusion lists are not to be considered comprehensive lists of inclusions and exclusions.

**Suggested Data Sources:**
**ONLY ACCEPTABLE SOURCES:**
Emergency Department record

**Inclusion Guidelines for Abstraction:**
- ED Departure Date
- ED Discharge Date
- ED Leave Date

**Exclusion Guidelines for Abstraction:**
- Disposition Date

**Data Element Name:** ***ED Departure Time***

**Collected For:** OP-3, OP-18

**Definition:** The time (military time) represented in hours and minutes at which the patient departed from the emergency department.

**Suggested Data Collection Question:** What is the time the patient departed from the emergency department?

**Format:**

**Length:** 5 – HH:MM (with or without colon) or UTD
**Type:** Time
**Occurs:** 1

**Allowable Values:**

HH = Hour (00-23)
MM = Minutes (00-59)
UTD = Unable to Determine

Time must be recorded in military time format.
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

Examples:

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

**Note:**
00:00 = midnight. If the time is documented as 00:00 11-24-20xx, review supporting documentation to determine if the *ED Departure Date* should remain 11-24-20xx or if it should be converted to 11-25-20xx.

When converting Midnight or 24:00 to 00:00, do not forget to change the *ED Departure Time.*

Example:

Midnight or 24:00 on 11-24-20xx = 00:00 on 11-25-20xx

**Notes for Abstraction:**

- For times that include “seconds”, remove the seconds and record the time as is.
  Example: 15:00:35 would be recorded as 15:00
- The intention is to capture the latest time at which the patient was receiving care in the emergency department, under the care of emergency department services, or awaiting transport to services/care.

- The medical record must be abstracted as documented (taken at "face value"). When the time documented is obviously in error (not a valid format/range) **and** no other documentation is found that provides this information, the abstractor should select "UTD".

  Example:

  Documentation indicates the *ED Departure Time* was 3300. No other documentation in the list of ONLY ACCEPTABLE SOURCES provides a valid time. Since the *ED Departure Time* is outside of the range in the Allowable Values for "Hour," it is not a valid time and the abstractor should select "UTD".

  **Note:** Transmission of a case with an invalid time as described above will be rejected from the Clinical Warehouse. Use of "UTD" for *ED Departure Time* allows the case to be accepted into the warehouse.
- *ED Departure Time* is the time the patient physically left the emergency department (e.g., nurses notes state "18:00 transfer to floor-room 300" and other documentation includes a time that the patient left the ED via stretcher, abstract the later time or nurses notes state "18:00 transport to unit" and other documentation includes a time that the patient actually left the ED to be transferred, abstract the later time).
- If the time the patient departed is unable to be determined from medical record documentation, select, "UTD".
- When more than one acceptable emergency department departure/discharge time is documented abstract the latest time.

  Example:

  Two departure times are found in the nurse's notes: 12:03 via wheelchair and 12:20 via wheelchair. Select the later time of 12:20.
- If patient expired in the ED, use the time of death as the departure time.
- Do not use the time the discharge order was written because it may not represent the actual time of departure.
- For patients who are placed into observation outside the services of the emergency department, abstract the time of departure from the emergency department.
  - If the patient is placed into observation services and remains in the ED or in a unit of the ED abstract the time they depart the ED or ED unit for the floor/surgery etc. Do not abstract the time they are placed into observation services.
- For patients who are placed into observation under the services of the emergency department, abstract the time of departure from the observation services.
  - If a patient is seen in the ED and admitted to an observation unit of the ED, then discharged from the observation unit, abstract the time they depart the observation unit.
  - If the patient is placed into observation services and remains in the ED or in a unit of the ED abstract the time they depart the ED or ED unit for the floor/surgery etc. Do not abstract the time they are placed into observation services.
- The inclusion and exclusion lists are not to be considered comprehensive lists of inclusions and exclusions.

**Suggested Data Sources:**
**ONLY ACCEPTABLE SOURCES:**
Emergency Department record

**Inclusion Guidelines for Abstraction:**

- ED Leave Time
- ED Discharge Time
- ED Departure Time
- ED Check Out Time

**Exclusion Guidelines for Abstraction:**

- Report Called Time
- Disposition Time

**Data Element Name:** ***Fibrinolytic Administration***

**Collected For:** OP-1, OP-2, OP-3

**Definition:** Fibrinolytic 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:** Did the patient receive fibrinolytic therapy at this emergency department?

**Format:**

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

**Allowable Values:**

| | |
|---|---|
| Y (Yes) | Fibrinolytic therapy was initiated at this emergency department. |
| N (No) | There is no documentation fibrinolytic therapy was initiated at this emergency department, or unable to determine from medical record documentation. |

**Notes for Abstraction:**

- In the event the patient was brought to the hospital via ambulance and fibrinolytic therapy was infusing at the time of arrival, select "Yes."
- In the event the patient was brought to the emergency department via ambulance and fibrinolytic therapy was infused during transport **but was completed** at the time of emergency department arrival, select "No."
- If the first dose of reteplase (Retavase) is given in the ambulance and the second dose is given in the emergency department, select "Yes."

**Suggested Data Sources:**

- Emergency Department record

**Inclusion Guidelines for Abstraction:**
Refer to Appendix C, OP Table 1.3, Fibrinolytic Agents.

**Exclusion Guidelines for Abstraction:**
None

**Data Element Name:** ***Fibrinolytic Administration Date***

**Collected For:** OP-1, OP-2

**Definition:** The month, day, and year primary fibrinolytic therapy was administered at this facility. Fibrinolytic 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 primary fibrinolytic therapy was initiated during this hospital stay?

**Format:**

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

**Allowable Values:**

MM = Month (01-12)
DD = Day (01-31)
YYYY = Year (2001 – Current Year)
UTD = Unable to Determine

**Notes for Abstraction:**

- If the date primary fibrinolytic therapy was initiated is unable to be determined from medical record documentation, enter "UTD".
- The medical record must be abstracted as documented (taken at "face value"). When the date documented is obviously in error (not a valid date/format) **and** no other documentation is found that provides this information, the abstractor should select "UTD".

  Example:

  Documentation indicates the *Fibrinolytic Administration Date* was 03-**42**-20xx. No other documentation in the medical record provides a valid date. Since the *Fibrinolytic Administration Date* is outside of the range listed in the Allowable Values for "Day," it is not a valid date and the abstractor should select "UTD".

  **Note:** Transmission of a case with an invalid date as described above will be rejected from the Clinical Warehouse. Use of "UTD" for *Fibrinolytic Administration Date* allows the case to be accepted into the warehouse.
- If there are two or more different fibrinolytic administration dates (either different fibrinolytic episodes or corresponding with the same episode), enter the earliest date.
- In the event the patient was brought to the hospital via ambulance and fibrinolytic therapy was infusing at the time of hospital arrival, enter the date the patient arrived at this hospital.

**Suggested Data Sources:**

- Ambulance record
- Discharge summary
- Emergency department record

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

**Inclusion Guidelines for Abstraction:**
None

**Exclusion Guidelines for Abstraction:**
- Fibrinolytics given during or after a PCI

**Data Element Name:** ***Fibrinolytic Administration Time***

**Collected For:** OP-1, OP-2

**Definition:** The time (military time) that primary fibrinolytic therapy started. Fibrinolytic 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 primary fibrinolytic therapy was initiated during this hospital stay?

**Format:**

**Length:** 5 - HH:MM (with or without colon) or UTD
**Type:** Time
**Occurs:** 1

**Allowable Values:**

HH = Hour (00-23)
MM = Minutes (00-59)
UTD = Unable to Determine

Time must be recorded in military time format.
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

Examples:

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

**Note:**
00:00 = midnight. If the time is documented as 00:00 11-24-20xx, review supporting documentation to determine if the *Fibrinolytic Administration Date* should remain 11-24-20xx or if it should be converted to 11-25-20xx.

When converting Midnight or 24:00 to 00:00 do not forget to change the *Fibrinolytic Administration Date.*

Example:

Midnight or 24:00 on 11-24-20xx = 00:00 on 11-25-20xx

**Notes for Abstraction:**

- For times that include “seconds”, remove the seconds and record the time as is.
  Example: 15:00:35 would be recorded as 15:00
- If the time primary fibrinolytic therapy was initiated is unable to be determined from medical record documentation, enter UTD.

- The medical record must be abstracted as documented (taken at "face value"). When the time documented is obviously in error (not a valid time/format) **and** no other documentation is found that provides this information, the abstractor should select "UTD".

  Example:

  Documentation indicates the *Fibrinolytic Administration Time* was 3300. No other documentation in the medical record provides a valid time. Since the *Fibrinolytic Administration Time* is outside of the range listed in the Allowable Values for "Hour," it is not a valid time and the abstractor should select "UTD".

  **Note:** Transmission of a case with an invalid time as described above will be rejected from the Clinical Warehouse. Use of "UTD" for *Fibrinolytic Administration Time* allows the case to be accepted into the warehouse.

- If there are two or more different fibrinolytic administration times (either different fibrinolytic episodes or corresponding with the same episode), enter the earliest time.
- In the event the patient was brought to the hospital via ambulance and fibrinolytic 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

**Inclusion Guidelines for Abstraction:**
None

**Exclusion Guidelines for Abstraction:**
- Fibrinolytics given during or after a PCI

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

**Collected For:** All Records

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

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

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

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

**Notes for Abstraction:**
None

**Suggested Data Sources:**
- Outpatient record
- Emergency Department record

**Inclusion Guidelines for Abstraction:**
None

**Exclusion Guidelines for Abstraction:**
None

**Data Element Name:** ***Head CT or MRI Scan Interpretation Date***

**Collected For:** OP-23

**Definition:** The month, day, and year at which the earliest Head CT or MRI Scan Interpretation was completed or reported.

**Suggested Data Collection Question:** What is the date the earliest Head CT or MRI Scan Interpretation was completed or reported?

**Format:**

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

**Allowable Values:**

Enter the documented date of the Head CT or MRI Scan Interpretation
MM = Month (01-12)
DD = Day (01-31)
YYYY = Year (2000-Current)
UTD = Unable to Determine

**Notes for Abstraction:**

- The medical record must be abstracted as documented (taken at "face value"). When the date documented is obviously in error (not a valid format/range or outside of the parameters of care **and** no other documentation is found that provides this information, the abstractor should select "UTD".

  Examples:

  - Documentation indicates the *Head CT or MRI Scan Interpretation Date* was 03-**42**-20xx. No other documentation in the list of ONLY ACCEPTABLE SOURCES provides a valid date. Since the *Head CT or MRI Scan Interpretation Date* is outside of the range listed in the Allowable Values for "Day", it is not a valid date and the abstractor should select "UTD".
  - Patient expires on 02-12-20xx and all documentation within the ONLY ACCEPTABLE SOURCES indicates the *Head CT or MRI Scan Interpretation Date* was 03-12-20xx. Other documentation in the medical record supports the date of death as being accurate. Since the *Head CT or MRI Scan Interpretation Date* is after the date of death, it is outside of the parameter of care and the abstractor should select "UTD".

  **Note:** Transmission of a case with an invalid date as described above will be rejected from the Clinical Warehouse. Use of "UTD" for *Head CT or MRI Scan Interpretation Date* allows the case to be accepted into the warehouse.

- If the date of the Head CT or MRI Scan Interpretation is unable to be determined from medical record documentation, abstract UTD.
- Abstract the result of the earliest Head CT or MRI Scan Interpretation (closest to arrival).
- If there are multiple result dates documented for the same Head CT or MRI Scan, use the earliest result date.

**Suggested Data Sources:**
- Emergency Department record

**Inclusion Guidelines for Abstraction:**
None

**Exclusion Guidelines for Abstraction:**
None

**Data Element Name:** ***Head CT or MRI Scan Interpretation Time***

**Collected For:** OP-23

**Definition:** The time (military time) represented in hours and minutes at which the earliest Head CT or MRI Scan Interpretation was completed or reported.

**Suggested Data Collection Question:** What is the time the earliest Head CT or MRI Scan Interpretation was completed or reported?

**Format:**

**Length:** 5 - HH-MM (with or without colon) or UTD
**Type:** Time
**Occurs:** 1

**Allowable Values:**

HH = Hour (00-23)
MM = Minutes (00-59)
UTD = Unable to Determine

Time must be recorded in military time format.
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

Examples:

| | |
|---|---|
| Midnight – 00:00 | Noon – 12:00 |
| 5:31 am – 05:31 | 5:31 pm – 17:31 |
| 11:59 am – 11:59 | 11:59 p.m. – 23:59 |

**Note:**
00:00 = midnight. If the time is documented as 00:00 11-24-20xx, review supporting documentation to determine if the *Head CT or MRI Scan Interpretation Date* should remain 11-24-20xx or if it should be converted to 11-25-20xx.

When converting Midnight or 24:00 to 00:00 do not forget to change the *Head CT or MRI Scan Interpretation Date.*

Example:

Midnight or 24:00 on 11-24-20xx = 00:00 on 11-25-20xx.

**Notes for Abstraction:**

- For times that include “seconds”, remove the seconds and record the time as is.
  Example: 15:00:35 would be recorded as 15:00
- If the Head CT or MRI Scan Interpretation Time is unable to be determined from medical record documentation, select “UTD”.
- The medical record must be abstracted as documented (taken at “face value”). When the time documented is obviously in error (not a valid time) **and** no other documentation is found that provides this information, the abstractor should select “UTD”.

Example:

Documentation indicates the Head CT or MRI Scan Interpretation was 3300. No other documentation in the medical record provides a valid time. Since the Head CT or MRI Scan Interpetation Time is outside of the range listed in the Allowable Values for "Hour," it is not a valid time and the abstractor should select "UTD".

**Note:** Transmission of a case with an invalid time as described above will be rejected from the Clinical Warehouse. Use of "UTD" for *Head CT or MRI Scan Interpretation Time* allows the case to be accepted into the warehouse.

- If the time of the Head CT or MRI Scan Interpretation is unable to be determined from medical record documentation, abstract UTD.
- Abstract the result of the earliest Head CT or MRI Scan Interpretation (closest to arrival).
- If there are multiple result times documented for the same Head CT or MRI Scan, use the earliest result time.

**Suggested Data Sources:**
- Emergency Department record

**Inclusion Guidelines for Abstraction:**
None

**Exclusion Guidelines for Abstraction:**
None

**Data Element Name:** ***Head CT or MRI Scan Order***

**Collected For:** OP-23

**Definition:** Documentation in the medical record that a Computerized Tomography (CT) or Magnetic Resonance Imaging (MRI) scan of the head was ordered during emergency department visit.

**Suggested Data Collection Question:** Was a Head CT or MRI scan ordered by the physician during the emergency department visit?

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

**Allowable Values:**

| | |
|---|---|
| Y (Yes) | There is documentation a Head CT or MRI scan was ordered by the physician/APN/PA during the emergency department visit |
| N (No) | There is no documentation a Head CT or MRI scan was ordered by the physician/APN/PA during the emergency department visit. |

**Notes for Abstraction:**
For purposes of the Head CT or MRI Scan Order use these priority sources:

- Nurses notes
- Physician notes/orders
- Radiology notes

**Suggested Data Sources:**

- Nurses Notes
- Physician Notes/Orders
- Radiology Notes

**Inclusion Guidelines for Abstraction:**
None

**Exclusion Guidelines for Abstraction:**
None

**Data Element Name:** ***Hispanic Ethnicity***

**Collected For:** All Records

**Definition:** Documentation that the patient is of Hispanic ethnicity or Latino.

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

**Format:**
**Length:** 1
**Type:** Character
**Occurs:** 1

**Allowable Values:**

| | |
|---|---|
| Y (Yes) | Patient is of Hispanic ethnicity or Latino. |
| N (No) | Patient is not of Hispanic ethnicity or Latino or unable to determine from medical record documentation. |

**Notes for Abstraction:**
The data element, Race, is required in addition to this data element.

**Suggested Data Sources:**
- Outpatient record
- Emergency Department record

**Inclusion Guidelines for Abstraction:**
A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race. The term "Spanish origin" can be used in addition to "Hispanic or Latino."

Examples:
- Black-Hispanic
- Chicano
- H
- Hispanic
- Latin American
- Latino/Latina
- Mexican-American
- Spanish
- White-Hispanic

**Exclusion Guidelines for Abstraction:**
None

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

**Collected For:** OP-4, OP-5, OP-16

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

**Suggested Data Collection Question:** What were the ICD-9-CM other diagnoses codes selected for this medical record?

**Format:**

**Length:** 6 (with or without decimal)
**Type:** Alphanumeric
**Occurs:** 24

**Allowable Values:**

Any valid ICD-9-CM diagnosis code

**Notes for Abstraction:**

None

**Suggested Data Sources:**

- Outpatient record
- Emergency Department record
- UB-04, Field Locations: 67A-Q
  NOTE: Medicare will only accept codes listed in fields A-H

**Inclusion Guidelines for Abstraction:**

None

**Exclusion Guidelines for Abstraction:**

None

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

**Collected For:** OP-1, OP-2, OP-3, OP-4, OP-5, OP-16, OP-18, OP-21, OP-23

**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 the outpatient encounter.

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

**Format:**

**Length:** 6 (with or without a decimal point)
**Type:** Alphanumeric
**Occurs:** 1

**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:**

- Outpatient record
- Emergency Department record
- UB-04, Field Location: 67

**Inclusion Guidelines for Abstraction:**

Refer to Appendix A, ICD-9-CM Code tables

**Exclusion Guidelines for Abstraction:**

None

**Data Element Name:** ***Infection Prior to Anesthesia***

**Collected For:** OP-6, OP-7

**Definition:** Documentation the patient had an infection during this outpatient encounter, prior to surgery.

**Suggested Data Collection Question:** Did the patient have an infection during this outpatient encounter prior to surgery?

**Format:**

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

**Allowable Values:**

| | |
|---|---|
| Y (Yes) | Physician/advanced practice nurse/physician assistant (physician/APN/PA) documentation that the patient had an infection during this outpatient encounter prior to surgery. |
| N (No) | There is no physician/APN/PA documentation that the patient had an infection during this outpatient encounter prior to surgery, or unable to determine from medical record documentation. |

**Notes for Abstraction:**

- If there is preoperative documentation of an infection or possible/suspected infection, select "Yes."
- Documentation of symptoms (example: fever, elevated white blood cells, etc.) should not be considered an infection unless documented as an infection or possible/suspected infection. Do not assume infection if a wound/surgical site is described as reddened, swollen and hot, as other conditions can also cause these symptoms.
- The physician/APN/PA documentation of preoperative infection must be in place prior to surgery. Do not accept documentation of infection documented after incision time.
- H&Ps timed/dated greater than 24 hours prior to arrival should not be used for this data element unless the physician updates the information contained in the document. The H & P should reflect that an infection or possible/suspected infection is current. If an infection is documented as "chronic," there must be additional documentation that the infection is current or still present preoperatively, during the outpatient encounter. If an infection is only documented as "chronic" without other documentation that the infection is still present preoperatively, answer "No."

**Suggested Data Sources:**
**PHYSICIAN/APN/PA DOCUMENTATION ONLY**

- Outpatient record

**Excluded Data Sources:**
Any documentation of an infection found in the Operative Report or Pathology Reports.

**Inclusion Guidelines for Abstraction:**

- Abscess
- Acute abdomen
- Aspiration pneumonia
- Bloodstream infection
- Bone infection
- Cellulitis
- Endometritis
- Fecal Contamination
- Free air in abdomen
- Gangrene
- H. pylori
- Necrosis
- Necrotic/ischemic/infarcted bowel
- Osteomyelitis
- Other documented infection
- Penetrating abdominal trauma
- Perforation of bowel
- Pneumonia or other lung infection
- Purulence/Pus
- Sepsis
- Surgical site or wound infection
- Urinary tract infection (UTI)

**Exclusion Guidelines for Abstraction:**

- Bacteria in urine/Bacteruria
- “carditis” (such as pericarditis) without mention of an infection
- Colonization or positive screens for MRSA, VRE, or for other bacteria
- Fungal infections
- History of infection, recent infection or recurrent infection not documented as a current or active infection
- Viral infections

**Data Element Name:** ***Initial ECG Interpretation***

**Collected For:** OP-1, OP-2, OP-3

**Definition:** ST-segment elevation or a left bundle branch block (LBBB) based on the documentation of the electrocardiogram (ECG) performed closest to emergency department 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. A bundle branch block (BBB) results from impaired conduction in one of the branches of the conduction system between the atria and the ventricles, 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 emergency department 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 emergency department arrival. |
| N (No) | No ST-elevation or LBBB on the interpretation of the 12-lead ECG performed closest to emergency department arrival, no interpretation or report available for the ECG performed closest to emergency department arrival or unable to determine from medical record documentation. |

**Notes for Abstraction:**

**Methodology:**

1. Identify the ECG performed closest to arrival, either before or after emergency department arrival, but not more than 1 hour prior to arrival. If unable to determine which ECG was performed closest to arrival, select “No.”

2. Start with review of the SIGNED tracing. Evaluate the findings line by line. Determine if the terms or phrases are Inclusions or Exclusions. If you have an Exclusion, select “No”, regardless of other documentation, and there is no need to review further.

3. If there is no signed tracing, or in the absence of an Exclusion on the signed tracing, proceed to other interpretations that you can say clearly refer to the ECG done closest to arrival. Only those terms specifically identified or referred to by the physician/APN/PA as **ECG findings** AND where documentation is clear it is from the ECG performed closest to arrival should be considered in abstraction (e.g., “STEMI” listed only as a physician

diagnosis or impression would not be used). Do not cross reference findings between interpretations unless otherwise specified. If you encounter an Exclusion in any of the other interpretations, select "No", regardless of other documentation, and there is no need to review further.

4. At the end of your review, if you have no Exclusions, and either the signed ECG tracing or interpretations of this ECG tracing include at least one Inclusion, select "Yes." Otherwise, select "No."

- ECG interpretation is defined as:
    - 12-lead tracing with name/initials of the physician/advanced practice nurse/physician assistant (physician/APN/PA) who reviewed the ECG signed, or typed on the report, or
    - Physician/APN/PA documentation of ECG findings in another source (e.g., ED record, H&P).
- Do not measure ST-segment elevation or attempt to determine if there is an LBBB from the tracing itself.
- Consider a tracing 12-lead if it has the appropriate markings (the presence of multiple leads: I, II, III, AVR, AVL, AVF, V1-V6).
- If ECG documentation outside of a tracing is not specified as 12-lead, assume it is 12-lead unless documentation indicates otherwise.
- Disregard any description of an MI or ST-segment that is not on either the Inclusion list or the Exclusion list.
- If documentation is contradictory (e.g., "ST-elevation" and "No ST-elevation"), select "No."
- If at least one interpretation describes an LBBB as old, chronic, or previously seen, or states LBBB and "no changes," "unchanged," "no acute changes," "no new changes," or "no significant changes" when compared to a prior ECG, all LBBB findings should be disregarded.
- Notations which describe ST-elevation as old, chronic, or previously seen, or which state ST-elevation and "no changes," "unchanged," "no acute changes," "no new changes," or "no significant changes" when compared to a prior ECG should be disregarded. Other documentation of ST-elevation not described as such may still count as an inclusion. EXCEPTION: When the ST-elevation on the ECG done closest to arrival is described as previously seen on an ECG done by EMS or physician office prior to arrival, this ST-elevation may count as an Inclusion. Documentation must be explicit **within the ECG interpretation** itself (e.g., "Initial ECG shows ST-elevation 1mm V1-V2. Improved from ECG done in the field."). Abstractors should NOT make inferences based on documentation outside of the interpretation (context, sequence of events, etc.).
- Notations which describe ST-elevation as a range where it cannot be determined if elevation is less than1 mm/.10mV (e.g., "0.5-1 mm ST-elevation"), should be completely disregarded in abstraction. Other documentation of ST-elevation not described as such may still count as an Inclusion.
- If any of the inclusion terms are described using the qualifier "possible," disregard that finding (neither Inclusion nor Exclusion).

- Do not consider “subendocardial” an MI “location” (e.g., “acute subendocardial MI” should be disregarded).

**Suggested Data Sources:**

**PHYSICIAN/APN/PA DOCUMENTATION ONLY**

- ECG reports
- Emergency Department record

**Inclusion Guidelines for Abstraction:**

**ST-segment elevation**

- 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 MI, IF DESCRIBED AS ACUTE/EVOLVING
- ST ↑
- ST, ST abnormality, or ST changes consistent with injury or acute/evolving MI
- ST-elevation (STE)
- ST-elevation myocardial infarction (STEMI)
- ST-segment noted as ≥ .10mV
- ST-segment noted as ≥ 1 mm
- Transmural MI, IF DESCRIBED AS ACUTE/EVOLVING

**Left bundle branch block (LBBB)**

- Intraventricular conduction delay of LBBB type
- Variable LBBB

**Exclusion Guidelines for Abstraction:**

**ST-segment elevation**

- Non Q wave MI (NQWMI)
- Non ST-elevation MI (NSTEMI)
- ST-elevation (ST ↑) clearly described as confined to ONE lead
- All ST-elevation (ST ↑, STE) in one interpretation described in one or more of the following ways:
  - Minimal
  - Less than .10mV
  - Less than 1 mm
  - Non-diagnostic
  - Use of one of the negative modifiers or qualifiers listed under the Exclusion Guidelines for abstraction

- ST-segment noted as greater than or equal to .10mV/1mm AND described using one of the negative modifiers or qualifiers listed under the Exclusion Guidelines for Abstraction
- ST-elevation (ST ↑) with mention of early repolarization, left ventricular hypertrophy (LVH), normal variant, pericarditis, or Printzmetal/Printzmetal's variant
- ST, ST abnormality, or ST changes consistent with injury or acute/evolving MI OR any of the "myocardial infarction" (MI) Inclusion terms described using one of the negative modifiers or qualifiers listed under the Exclusion Guidelines for Abstraction. ST-segment elevation, or any of the other ST-segment elevation inclusion terms, with mention of pacemaker/pacing (unless atrial only or nonfunctioning pacemaker)

**Left bundle branch block (LBBB)**

- Incomplete left bundle branch block (LBBB)
- Left bundle branch block (LBBB), or any of the other left bundle branch block inclusion terms, described using one of the negative modifiers or qualifiers listed under the Exclusion Guidelines for Abstraction.
- Left bundle branch block (LBBB), or any of the other left bundle branch block inclusion terms, with mention of pacemaker/pacing (unless atrial only or nonfunctioning pacemaker)

**Qualifiers and Modifiers**

The following qualifiers and modifiers should be abstracted as ***negative findings***, unless otherwise specified – **Consider this list all-inclusive:**

**Qualifiers**

- And/or (+/-; e.g., "ST abnormalities consistent with ischemia and/or injury"), except when comparing only Inclusions (e.g., "ST segment elevation and/or STEMI")
- Cannot exclude
- Cannot rule out
- Could be
- Could have been
- May be
- May have
- May have had
- May indicate
- Or, except when comparing only Inclusions
- Questionable (?)
- Risk of
- Ruled out (r'd/o, r/o'd)
- Suggestive of
- Suspect
- Suspicious
- Vs., except when comparing only Inclusions

**Modifiers**

- Borderline
- Insignificant
- Scant
- Slight
- Sub-clinical
- Subtle
- Trace
- Trivial

**Data Element Name:** ***Last Known Well***

**Collected For:** OP-23

**Definition:** The date and time prior to hospital arrival at which it was witnessed or reported that the patient was last known to be without the signs and symptoms of the current stroke or at his or her baseline state of health.

**Suggested Data Collection Question:** Is there documentation that the date and time of last known well was witnessed or reported?

**Format:**

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

**Allowable Values:**

| | |
|---|---|
| Y (Yes) | There is documentation that the date and time of last known well was witnessed or reported. |
| N (No) | There is no documentation that the date and time of last known well was witnessed or reported, OR date, time, or both date and time are unknown. |

**Notes for Abstraction:**

- In order to abstract allowable value "Yes", both date and time of last known well must be documented.
- If a date and time of last known well is listed in the medical record, without reference to the circumstances preceding its detection, select "Yes".
- For patients with a documented date and time of witnessed onset of stroke signs and symptoms, select "Yes".

  Examples:

  - "Patient driving to work on 12/05/20xx. Felt left side go numb at approximately 8:15 A.M. Pulled over and called 911 from cell phone."
  - "Wife reports that while eating dinner with patient, right corner of mouth started to droop and speech slurred about 6:00 P.M this evening."
  - "Patient watching TV and complains to family of blurred vision in both eyes at 8:00 PM tonight."
- If there is documentation referencing that the patient was discovered with symptoms already present and the date or time of last known well cannot be determined, select "No".

  Example:

  "Patient OK last night. Went to bed and woke up in AM unable to move right arm and leg."
- If there is documentation that symptoms were not present at the time of hospital arrival and occurred at a later date or time following hospital arrival, select "No".

  Example:

"Motor vehicle accident victim arrives in ED and sent for outpatient surgery. Observation status post-op and subsequently admitted following onset of stroke symptoms."

- If there is documentation that the date or time of last known well is unknown, select "No".
- The patient may self-report the date and time of last known well, OR the date and time may be reported by a family member, caregiver, or another third-party individual.

**Suggested Data Sources:**

- Emergency department records
- History and physical
- Progress notes

**Inclusion Guidelines for Abstraction:**
**Signs and Symptoms of Stroke**

- Sudden numbness or weakness of the face, arm or leg, especially on one side of the body
- Sudden confusion, trouble speaking or understanding
- Sudden trouble seeing in one or both eyes
- Sudden trouble walking, dizziness, loss of balance or coordination
- Sudden severe headache

**Exclusion Guidelines for Abstraction:**
None

**Data Element Name:** ***Last Name***

**Collected For:** All Records

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

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

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

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

**Notes for Abstraction:**
None

**Suggested Data Sources:**
- Outpatient record
- Emergency Department record

**Inclusion Guidelines for Abstraction:**
None

**Exclusion Guidelines for Abstraction:**
None

**Data Element Name:** ***Observation Services***

**Collected For:** OP-18

**Definition:** Observation services are those services furnished by a hospital on the hospital's premises, including use of a bed and periodic monitoring by a hospital's nursing or other staff, which are reasonable and necessary to evaluate an outpatient's condition or determine the need for a possible admission to the hospital as an inpatient.

**Suggested Data Collection Question:** Was there documentation the patient was placed in observation services during the encounter or hospitalization?

**Format:**

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

**Allowable Values:**

| | |
|---|---|
| Y (Yes) | There was documentation the patient was placed into observation services in this facility's emergency department. |
| N (No) | There was no documentation the patient was placed into observation services in this facility's emergency department or unable to determine from medical record documentation. |

**Notes for Abstraction:**

- If there is documentation the patient was placed into observation services and received care in observation provided by the emergency department or an observation unit of the emergency department, select "Yes".
- If there is documentation the patient is being admitted for observation outside the emergency department, select "No".
- If there is no documentation the patient received services in observation either in the emergency department or was to be admitted to another department for observation, select "No".
- The intent is to capture emergency department patients placed into observation services prior to admission to the facility as an inpatient.

**Suggested Data Sources:**
**ONLY ALLOWABLE SOURCES:**
Emergency Department record

**Inclusion Guidelines for Abstraction:**
None

**Exclusion Guidelines for Abstraction:**
None

**Data Element Name:** ***Outpatient Encounter Date***

**Collected For:** All Records

**Definition:** The documented month, day and year the patient arrived in the hospital outpatient setting.

**Suggested Data Collection Question:** What was date the patient arrived in the hospital outpatient setting?

**Format:**

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

**Allowable Values:**

MM = Month (01-12)
DD = Day (01-31)
YYYY = Year (2008-Current Year)

**Notes for Abstraction:**

- The intent of this data element is to determine the date the patient arrived in the hospital outpatient setting.
- UTD is NOT an allowable value.
- Consider the outpatient encounter date as the earliest documented date the patient arrived in the applicable hospital outpatient setting. If the patient had preoperative laboratory or other screening tests performed prior to the date of surgery, use the date the patient arrived for surgery.

**Suggested Data Sources:**

- Outpatient record
- Emergency Department record

**Inclusion Guidelines for Abstraction:**
None

**Exclusion Guidelines for Abstraction:**

- Preoperative tests or screening

**Data Element Name:** ***Pain Medication***

**Collected For:** OP-21

**Definition:** Documentation the patient was administered oral or parenteral pain medication.

**Suggested Data Collection Question:** Was there documentation the patient received oral or parenteral pain medication during this emergency department visit?

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

**Allowable Values:**

| | |
|---|---|
| Y (Yes) | There is documentation the patient received oral (aged 2 to less than 18 years) or parenteral (aged 2 years or greater) pain medication. |
| N (No) | There is no documentation the patient received oral (aged 2 to less than 18 years) or parenteral (aged 2 years or greater) pain medication during this emergency department visit, or there is documentation the patient refused the pain medication during this emergency department visit, or unable to determine from medical record documentation. |

**Notes for Abstraction:**

- For patients aged 2 to less than 18 years, if oral or parenteral pain medication (including local or regional anesthesia/analgesia) is administered, answer "Yes."
- For patients aged 18 years or greater, if parenteral pain medication (including local or regional anesthesia/analgesia) is administered, select "Yes." EXCEPTION: For patients aged 18 years or greater, if **initial** medication administration is oral, select "No."
- There must be documentation in the medical record the medication was administered in the emergency department, not just ordered.
- There must be documentation in the medical record of the medication route either in the physician orders or the medication administration documentation.
- Medication administration documentation must include the signature or initials of the person administering the medication.
- If there is documentation in the medical record the patient received oral or parenteral pain medication administered by a provider (e.g., physician's office or ambulance) prior to arrival, select "No".
- If there is physician/APN/PA documentation of a reason for not administering pain medication, select "No" (e.g., pt unconscious, decreased respiratory rate, patient refusal).

**Suggested Data Sources:**

- Nurses Notes
- Physician Notes

**Inclusion Guidelines for Abstraction:**
See Appendix C, OP Table 9.1 for a list of pain medications

**ANESTHESIA OR ANALGESIA**

- Local anesthesia/analgesia
- Epidural anesthesia/analgesia
- Spinal anesthesia/analgesia
- Regional anesthesia/analgesia
- Nerve block (median, ulnar, radial, posterior tibial, sural, saphenous, deep peroneal, superficial peroneal, femoral, brachial plexus, etc.)
- Regional nerve block
- Peripheral nerve block
- Lidocaine block
- Intravenous anesthesia/analgesia
- Procedural sedation
- General anesthesia
- Interscalene block
- IV regional anesthesia/analgesia
- Saddle block
- Caudal block
- Bier block

**Exclusion Guidelines for Abstraction:**
None

**Data Element Name:** ***Pain Medication Date***

**Collected For:** OP-21

**Definition:** The month, day, and year at which the earliest oral or parenteral pain medication was administered.

**Suggested Data Collection Question:** What is the date the earliest oral or parenteral pain medication was administered?

**Format:**

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

**Allowable Values:**

Enter the documented date of the earliest oral or parenteral pain medication.
MM = Month (01-12)
DD = Day (01-31)
YYYY = Year (2000-Current)
UTD = Unable to Determine

**Notes for Abstraction:**

- The medical record must be abstracted as documented (taken at "face value"). When the date documented is obviously in error (not a valid format/range or outside of the parameters of care) **and** no other documentation is found that provides this information, the abstractor should select "UTD".

  Examples:

  - Documentation indicates the *Pain Medication Date* was 03-**42**-20xx. No other documentation in the list of ONLY ACCEPTABLE SOURCES provides a valid date. Since the *Pain Medication Date* is outside of the range listed in the Allowable Values for "Day", it is not a valid date and the abstractor should select "UTD".
  - Patient expires on 02-12-20xx and all documentation within the ONLY ACCEPTABLE SOURCES indicates the *Pain Medication Date* was 03-12-20xx. Other documentation in the medical record supports the date of death as being accurate. Since the *Pain Medication Date* is after the date of death, it is outside of the parameter of care and the abstractor should select "UTD".

  **Note:** Transmission of a case with an invalid date as described above will be rejected from the QIO Clinical Warehouse. Use of "UTD" for *Pain Medication Date* allows the case to be accepted into the warehouse.

- If the date of oral or parenteral pain medication administration is unable to be determined from medical record documentation, abstract UTD.
- Abstract the result of the earliest oral or parenteral pain medication administered (closest to arrival).

- If there are multiple result dates documented for the exact same medication administration, use the earliest date.
- If there is documentation in the medical record the patient received pain medication prior to arrival, abstract the *Pain Medication Date* as the *Outpatient Encounter Date*.
- For patients aged 2 to less than 18 years, *Pain Medication Date* will be for the initial oral or parenteral pain medication, including local or regional anesthesia.
- For patients aged 18 years or greater, *Pain Medication Date* will be for the initial parenteral pain medication, including local or regional anesthesia.

**Suggested Data Sources:**
- Emergency Department record

**Inclusion Guidelines for Abstraction:**
None

**Exclusion Guidelines for Abstraction:**
None

**Data Element Name:** ***Pain Medication Time***

**Collected For:** OP-21

**Definition:** The time (military time) represented in hours and minutes at which the earliest oral or parenteral pain medication was administered.

**Suggested Data Collection Question:** What is the time the earliest oral or parenteral pain medication was administered?

**Format:**

**Length:** 5 - HH-MM (with or without colon) or UTD
**Type:** Time
**Occurs:** 1

**Allowable Values:**

HH = Hour (00-23)
MM = Minutes (00-59)
UTD = Unable to Determine

Time must be recorded in military time format.
With the exception of midnight and Noon:
- o If the time is in the a.m., conversion is not required
- o If the time is in the p.m., add 12 to the clock time hour

Examples:

| | |
|---|---|
| Midnight – 00:00 | Noon – 12:00 |
| 5:31 am – 05:31 | 5:31 pm – 17:31 |
| 11:59 am – 11:59 | 11:59 p.m. – 23:59 |

**Note:**
00:00 = midnight. If the time is documented as 00:00 11-24-20xx, review supporting documentation to determine if the *Pain Medication Date* should remain 11-24-20xx or if it should be converted to 11-25-20xx.

When converting Midnight or 24:00 to 00:00 do not forget to change the *Pain Medication Date.*

Example:

Midnight or 24:00 on 11-24-20xx = 00:00 on 11-25-20xx.

**Notes for Abstraction:**

- For times that include “seconds”, remove the seconds and record the time as is.
  Example: 15:00:35 would be recorded as 15:00
- If the *Pain Medication Time* is unable to be determined from medical record documentation, select “UTD”.
- The medical record must be abstracted as documented (taken at “face value”). When the time documented is obviously in error (not a valid time) and no other documentation is found that provides this information, the abstractor should select “UTD”.

Example:

Documentation indicates the *Pain Medication Time* was 3300. No other documentation in the medical record provides a valid time. Since the *Pain Medication Time* is outside of the range listed in the Allowable Values for "Hour," it is not a valid time and the abstractor should select "UTD".

**Note:** Transmission of a case with an invalid time as described above will be rejected from the Data Warehouse. Use of "UTD" for *Pain Medication Time* allows the case to be accepted into the warehouse.

- If the time of the oral or parenteral pain medication administration is unable to be determined from medical record documentation, abstract UTD.
- Abstract the result of the earliest oral or parenteral pain medication (closest to arrival).
- If there are multiple result times documented for the exact same oral or parenteral pain medication administration, use the earliest result time.
- If there is documentation in the medical record the patient received pain medication prior to arrival, abstract the *Pain Medication Time* as the *Arrival Time*.
- For patients aged 2 to less than 18 years, *Pain Medication Time* will be for the initial oral or parenteral pain medication, including local or regional anesthesia.
- For patients aged 18 years or greater, *Pain Medication Time* will be for the initial parenteral pain medication, including local or regional anesthesia.

**Suggested Data Sources:**
- Emergency Department record

**Inclusion Guidelines for Abstraction:**
None

**Exclusion Guidelines for Abstraction:**
None

**Data Element Name:** ***Patient HIC #***

**Collected For:** Collected by CMS for patients with a Payment Source of Medicare who have a standard HIC number

**Definition:** The patient's Medicare health insurance claim number.

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

**Format:**

**Length:** 7 - 12
**Type:** Character
**Occurs:** 1

**Allowable Values:**

General Rules

- No embedded dashes or spaces or special characters
- Must have both alpha and numeric characters
- Alpha characters must be upper case
- Length cannot be more than 12 or less than 7 characters
- For alphanumeric values, do not allow all numeric values to be 9's For example do not allow 1 alpha + 999999999, etc.

**If First Character is Numeric**

Suffix rules:

- If the **first character is numeric, (0-9)**, then the first 9 characters must be numeric. For example:

  **HIC # length:** 10 **Rule:** 9 numeric + 1 alpha
  **HIC # length:** 11 **Rule:** 9 numeric + 1 alpha + 1 numeric Or 9 numeric + 2 alpha

**If First Character is Alpha**

Prefix rules:

- If the **first character is alpha**, there must be 1-3 alpha characters followed by 6 or 9 numbers.

  **HIC # length:** 7 **Rule:** 1 alpha + 6 numeric
  **HIC # length:** 8 **Rule:** 2 alpha + 6 numeric
  **HIC # length:** 9 **Rule:** 3 alpha + 6 numeric
  **HIC # length:** 10 **Rule:** 1 alpha + 9 numeric
  **HIC # length:** 11 **Rule:** 2 alpha + 9 numeric
  **HIC # length:** 12 **Rule:** 3 alpha + 9 numeric

**Notes for Abstraction:**
*Patient HIC#* is required for data transmission of all cases that have a standard HIC#.

- Refer to the Hospital Outpatient Department Quality Measure Data Transmission sub-section, within the Transmission section, for further guidance.

**Suggested Data Sources:**

- Emergency Department record
- Face sheet
- UB-04, Field Location: 60A, B or C, which ever line corresponds to the Medicare entry

**Inclusion Guidelines for Abstraction:**
None

**Exclusion Guidelines for Abstraction:**
None

**Data Element Name:** ***Patient Identifier***

**Collected For:** All Records

**Definition:** The number used by the hospital to identify this patient's hospital outpatient encounter. The number provided will be used to identify the patient in communications with the hospital outpatient setting, e.g., Medical Record Number, Account Number, Unique Identifiable Number as determined by the facility, etc.

A patient identifier is required.

**Suggested Data Collection Question:** What was the number used to identify this outpatient encounter?

**Format:**

**Length:** 40
**Type:** Character
**Occurs:** 1

**Allowable Values:**

Up to 40 letters and/or numbers

**Notes for Abstraction:**
None

**Suggested Data Sources:**

- Outpatient record
- Emergency Department record

**Inclusion Guidelines for Abstraction:**
None

**Exclusion Guidelines for Abstraction:**
None

**Data Element Name:** ***Payment Source***

**Collected For:** All Records

**Definition:** The source of payment for this outpatient encounter.

**Suggested Data Collection Question:** What is the patient's source of payment for this outpatient encounter?

**Format:**

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

**Allowable Values:**

**1** Source of payment is Medicare.

**2** Source of payment is Non-Medicare.

**Notes for Abstraction:**

- If Medicare is listed as the primary, secondary, tertiary, or even lower down on the list or payers, select "1."
- If the patient is an Undocumented Alien or Illegal immigrant, select "1." Undocumented Alien: Section 1011 of the Medicare Modernization Act of 2003 allows for reimbursement for services rendered to patients who are: Undocumented or illegal aliens (immigrants), Aliens who have been paroled into a United States port of entry and Mexican citizens permitted to enter the United States on a laser visa.

**Suggested Data Sources:** Face sheet
UB-04, Field Location: 50A, B or C

**Inclusion Guidelines for Abstraction:**

- Medicare includes, but is not limited to:
- Black Lung
- End Stage Renal Disease (ESRD)
- Medicare Fee for Service (includes DRG or PPS)
- Medicare HMO/Medicare Advantage
- Medicare Secondary Payer
- Railroad Retirement Board (RRB)

**Exclusion Guidelines for Abstraction:**
None

**Data Element Name:** ***Physician 1***

**Collected For:** All Records (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

**Inclusion Guidelines for Abstraction:**

None

**Exclusion Guidelines for Abstraction:**

None

**Data Element Name:** ***Physician 2***

**Collected For:** All Records (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

**Inclusion Guidelines for Abstraction:**

None

**Exclusion Guidelines for Abstraction:**

None

**Data Element Name:** ***Postal Code***

**Collected For:** All records

**Definition:** The postal code of the patient's residence. For 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.

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

**Format:**

**Length:** 9
**Type:** Character
**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:**
If the postal code of the patient is unable to be determined from medical record documentation, enter the provider's postal code.

**Suggested Data Sources:**

- Outpatient record
- Emergency Department record
- UB-04, Field Location: 09 (line 2d)

**Inclusion Guidelines for Abstraction:**
None

**Exclusion Guidelines for Abstraction:**
None

**Data Element Name:** ***Probable Cardiac Chest Pain***

**Collected For:** OP-4, OP-5, OP-16

**Definition:** Documentation that a nurse or physician/APN/PA presumed the patient's chest pain to be cardiac in origin.

**Suggested Data Collection Question:** Was the patient's chest pain presumed to be cardiac in origin?

**Format:**

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

**Allowable Values:**

| | |
|---|---|
| Y (Yes) | There was nurse or physician/APN/PA documentation the chest pain was presumed to be cardiac in origin. |
| N (No) | There was no nurse or physician/APN/PA documentation the chest pain was presumed to be cardiac in origin or unable to determine from medical record documentation. |

**Notes for Abstraction:**

- If there is documentation of a differential/working diagnosis of acute myocardial infarction select "Yes."
- Disregard documentation of inclusions/exclusions described with terms indicating the condition is not acute, such as "history of."
- If there is documentation by the nurse or physician of an exclusion term, select "No", unless there is a working/differential diagnosis of AMI continue to select "Yes".

**EXCLUDED DATA SOURCES:**

- Chest X-Ray Reports
- Radiology Reports

**Suggested Data Sources:**

**NURSE or PHYSICIAN/APN/PA DOCUMENTATION ONLY**

- Emergency Department record

**Inclusion Guidelines for Abstraction:**

**Acute Myocardial Infarction and Chest Pain Inclusions**

- Acute coronary syndrome
- Acute myocardial infarction (AMI)
- Angina

- Cardiac
- Cardiac Chest Pain
- Chest Pain
- Heart attack
- Ischemia
- Myocardial Infarction
- Unstable angina

The following qualifiers should be abstracted as ***positive findings*** if listed with any of the above inclusion terms;

- Appears to have
- Cannot exclude
- Cannot rule out
- Consider
- Consistent with (c/w)
- Could be
- Could have been
- Diagnostic of
- Differential diagnosis
- Evidence of
- Indicative of
- Likely
- May have
- May have had
- May indicate
- Most likely
- Possible
- Probable
- Questionable (?)
- Representative of
- Risk of
- Rule(d) out (r/o)
- Suggestive of
- Suspect
- Suspicious
- Versus (vs)
- Working diagnosis
- +

**Exclusion Guidelines for Abstraction:**

- Atypical Chest Pain
- Chest Pain musculoskeletal
- Chest Pain qualified by a non-cardiac cause
- Chest wall pain
- Non Cardiac Chest Pain
- Non-specific Chest Pain
- Traumatic Chest Pain
- Trauma
- MVA (Motor Vehicle Accident)

**Data Element Name:** ***Provider Contact Date***

**Collected For:** OP-20

**Definition:** The month, day, and year for the first direct, personal exchange between an ambulatory patient and a physician or medical personnel acting under the direct supervision of a physician for health care services in the emergency department.

**Suggested Data Collection Question:** What is the date the patient first had direct contact with the physician/APN/PA in the emergency department?

**Format:**

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

**Allowable Values:**

MM = Month (01-12)
DD = Day (01-31)
YYYY = Year (2000-Current)
UTD = Unable to Determine

**Notes for Abstraction:**

- There must be documentation of direct contact between the ambulatory patient and the physician/APN/PA. Advanced Practice Nurse (APN, APRN) titles may vary between state and clinical specialities. Some common titles that represent the advanced practice nurse role are Nurse Practitioner (NP), Certified Registered Nurse Anesthetist (CRNA), Clinical Nurse Specialist (CNS), and Certified Nurse Midwife (CNM).
- The medical record must be abstracted as documented (taken at "face value"). When the date documented is obviously in error (not a valid format/range or outside of the parameters of care) **and** no other documentation is found that provides this information, the abstractor should select "UTD".

  Examples:

  - Documentation indicates the *Provider Contact Date* was 03-**42**-20xx. No other documentation in the list of ONLY ACCEPTABLE SOURCES provides a valid date. Since the *Provider Contact Date* is outside of the range listed in the Allowable Values for "Day", it is not a valid date and the abstractor should select "UTD".
  - Patient expires on 02-12-20xx and all documentation within the ONLY ACCEPTABLE SOURCES indicates the *Provider Contact Date* was 03-12-20xx. Other documentation in the medical record supports the date of death as being accurate. Since the *Provider Contact Date* is after the *Discharge Date* (death), it is outside of the parameter of care and the abstractor should select "UTD".

  **Note:** Transmission of a case with an invalid date as described above will be rejected from the QIO Clinical Warehouse. Use of "UTD" for *Provider Contact Date* allows the case to be accepted into the warehouse.

- If the date the patient first had direct contact with the physician/APN/PA is unable to be determined from medical record documentation, select, “UTD”.
- If the date of provider contact is not documented, but you are able to determine the date from other documentation this is acceptable.
- If there is documentation the patient left against medical advice and it cannot be determined whether the patient had direct contact with the physician/APN/PA, select “UTD”.
- The inclusion and exclusion lists are not to be considered comprehensive lists of inclusions and exclusions.

**Suggested Data Sources:**
**ONLY ACCEPTABLE SOURCES:**
Emergency Department record

**Inclusion Guidelines for Abstraction:**
- Any physician/APN/PA documentation of contact

**Exclusion Guidelines for Abstraction:**
- Admission Date
- Arrival Date
- Presentation Date
- Triage Date

**Data Element Name:** ***Provider Contact Time***

**Collected For:** OP-20

**Definition:** The time (military time) represented in hours and minutes for the first direct, personal exchange between an ambulatory patient and a physician or medical personnel acting under the direct supervision of a physician for health care services in the emergency department.

**Suggested Data Collection Question:** What is the time the patient first had direct contact with the physician/APN/PA in the emergency department?

**Format:**

**Length:** 5 – HH:MM (with or without colon) or UTD
**Type:** Time
**Occurs:** 1

**Allowable Values:**

HH = Hour (00-23)
MM = Minutes (00-59)
UTD = Unable to Determine

Time must be recorded in military time format.
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

Examples:

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

**Note:**
00:00 = midnight. If the time is documented as 00:00 11-24-20xx, review supporting documentation to determine if the *Provider Contact Date* should remain 11-24-20xx or if it should be converted to 11-25-20xx.

When converting Midnight or 24:00 to 00:00, do not forget to change both the *Provider Contact Time* and *Provider Contact Date.*

Example:

Midnight or 24:00 on 11-24-20xx = 00:00 on 11-25-20xx

**Notes for Abstraction:**

- For times that include “seconds”, remove the seconds and record the time as is.

  Example: 15:00:35 would be recorded as 15:00
- There must be documentation of direct contact between the ambulatory patient and the physician/APN/PA. The intention is to capture the earliest time at which the patient had

direct contact with the physician/APN/PA in the emergency department. Advanced Practice Nurse (APN, APRN) titles may vary between state and clinical specialities. Some common titles that represent the advanced practice nurse role are Nurse Practitioner (NP), Certified Registered Nurse Anesthetist (CRNA), Clinical Nurse Specialist (CNS), and Certified Nurse Midwife (CNM).

- The medical record must be abstracted as documented (taken at "face value"). When the time documented is obviously in error (not a valid format/range) **and** no other documentation is found that provides this information, the abstractor should select "UTD".

  Example:

  Documentation indicates the *Provider Contact Time* was 3300. No other documentation in the list of ONLY ACCEPTABLE SOURCES provides a valid time. Since the *Provider Contact Time* is outside of the range in the Allowable Values for "Hour," it is not a valid time and the abstractor should select "UTD".

  **Note:** Transmission of a case with an invalid time as described above will be rejected from the QIO Clinical Warehouse. Use of "UTD" for *Provider Contact Time* allows the case to be accepted into the warehouse.

- If the time the patient first had direct contact with the physician/APN/PA is unable to be determined from medical record documentation, select, "UTD".
- If there is documentation the patient left against medical advice and it cannot be determined whether the patient had direct contact with the physician/APN/PA, select "UTD".
- The inclusion and exclusion lists are not to be considered comprehensive lists of inclusions and exclusions.

**Suggested Data Sources:**
**ONLY ACCEPTABLE SOURCES:**
Emergency Department record

**Inclusion Guidelines for Abstraction:**
- Any physician/APN/PA documentation of contact

**Exclusion Guidelines for Abstraction:**
- Admission Time
- Arrival Time
- Presentation Time
- Triage Time

**Data Element Name:** ***Race***

**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:** Character
**Occurs:** 1

**Allowable Values:**

Select one:

1 **White:** Patient's race is White or the patient has origins in Europe, the Middle East, or North Africa.

2 **Black or African American:** Patient's race is Black or African American.

3 **American Indian or Alaska Native:** Patient's race is American Indian/Alaska Native.

4 **Asian:** Patient's race is Asian.

5 **Native Hawaiian or Pacific Islander:** Patient's race is Native Hawaiian/Pacific Islander.

7 **UTD:** Unable to determine the patient's race or not stated (e.g., not documented, conflicting documentation or patient unwilling to provide).

**Notes for Abstraction:**

- The data element Hispanic Ethnicity is required in addition to this data element.
- If documentation indicates the patient has more than one race (e.g., Black-White, Indian-White), select the first listed race.
- Although the terms "Hispanic" and "Latino" are actually descriptions of the patient's ethnicity, it is not uncommon to find them referenced as race. If the patient's race is documented only as Hispanic/Latino, select "White." If the race is documented as mixed Hispanic/Latino with another race, use whatever race is given (e.g., Black-Hispanic – select "Black"). Other terms for Hispanic/Latino include Chicano, Cuban, H (for Hispanic), Latin American, Latina, Mexican, Mexican-American, Puerto Rican, South or Central American, and Spanish.

**Suggested Data Sources:**

- Outpatient record
- Emergency Department record

**Inclusion Guidelines for Abstraction:**

**Black or African American**
A person having origins in any of the black racial groups of Africa. Terms such as “Haitian” or “Negro” can be used in addition to “Black or African American.”

**American Indian or Alaska Native**
A person having origins in any of the original peoples of North and South America (including Central America) and who maintains tribal affiliation or community attachment (e.g., any recognized tribal entity in North and South America [including Central America], Native American.)

**Asian**
A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

**White**
A person having origins in any of the original peoples of Europe, the Middle East, or North Africa (e.g., Caucasian, Iranian, White).

**Native Hawaiian or Pacific Islander**
A person having origins in any of the other original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

**Exclusion Guidelines for Abstraction:**
None

**Data Element Name:** ***Reason for Delay in Fibrinolytic Therapy***

**Collected For:** OP-1, OP-2

**Definition:** Documentation of a reason for a delay in initiating fibrinolytic therapy after hospital arrival by a physician/advanced practice nurse/physician assistant (physician/APN/PA). **System reasons for delay are NOT acceptable**.

**Suggested Data Collection Question:** Is there a reason documented by a physician/APN/PA for a delay in initiating fibrinolytic therapy after hospital arrival?

**Format:**

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

**Allowable Values:**

| | |
|---|---|
| Y (Yes) | Reason documented by a physician/APN/PA for a delay in initiating fibrinolytic therapy after hospital arrival. |
| N (No) | No reason documented by a physician/APN/PA for a delay in initiating fibrinolytic therapy after hospital arrival, or unable to determine from medical record documentation. |

**Notes for Abstraction:**

- **System reasons for delay are not acceptable, regardless of any linkage to the delay in fibrinolysis/reperfusion.**
  - Equipment-related (e.g., IV pump malfunction)
  - Staff-related (e.g., waiting for fibrinolytic agent from pharmacy)
  - Consultation with other clinician that is not clearly linked to a patient-centered (non-system) reason for delay
- Documentation must be made clear **somewhere** in the medical record that (1) a "hold," "delay," deferral," or "wait" in initiating fibrinolysis/reperfusion actually occurred, AND (2) that the underlying reason for that delay was non-system in nature. Abstractors should NOT make inferences from documentation of a sequence of events alone or otherwise attempt to interpret from documentation. Clinical judgment should not be used in abstraction.

  Examples of acceptable documentation:
  - "Hold on fibrinolytics. Will do CT scan to r/o bleed."
  - "Patient waiting for family and clergy to arrive – wishes to consult with them before fibrinolysis."
  - "Fibrinolysis delayed due to need to control blood pressure before administering fibrinolysis."
  - "Hold fibrinolytics. Need to consult with neurology regarding bleeding risk."
  - "Fibrinolytic therapy initially deferred due to shock."

**EXCEPTIONS:**

- Physician/APN/PA documentation that a cardiopulmonary arrest, balloon pump insertion, or intubation occurred within 30 minutes after hospital arrival OR initial patient/family refusal of fibrinolysis/reperfusion (documented by a physician/APN/PA) are acceptable reasons for delay that do NOT require documentation that a "hold," "delay," "deferral," or "wait" in initiating fibrinolysis actually occurred. In order for cardiopulmonary arrest, balloon pump insertion, or intubation within 30 minutes after hospital arrival to be considered an automatic acceptable reason for delay, physician/APN/PA documentation that it occurred within 30 minutes after hospital arrival must be CLEAR.
    - If unable to determine that a documented reason is system in nature, select "No."
- Reasons for delay in fibrinolytic therapy should be collected regardless of how soon after arrival it was ultimately initiated or how minimal the delay.

**Suggested Data Sources:**

**PHYSICIAN/APN/PA DOCUMENTATION ONLY**

- Code sheet (if signed by physician/APN/PA)
- Consultation Notes
- Discharge Summary
- Emergency Department record
- History and Physical
- Physician Orders
- Progress Notes

**Excluded Data Sources:**

- Any documentation dated/timed after discharge, except discharge summary and operative/procedure/diagnostic test reports from procedure done during hospital stay.

**Inclusion Guidelines for Abstraction:**
**Balloon pump**

- Aortic Balloon Pump
- Intra-aortic balloon (IAB)
- Intra-aortic balloon counterpulsation (IABC)
- Intra-aortic balloon pump (IABP)
- Intra-aortic counterpulsation (IAC)
- Intra-aortic counterpulsation balloon pump (IACBP)

**Cardiopulmonary arrest**

- Cardiac arrest
- Cardiopulmonary resuscitation (CPR)
- Code
- Defibrillation
- Respiratory arrest

- Ventricular fibrillation (V-fib)

**Intubation**

- Endotracheal intubation (ETI)
- Mechanical ventilation
- Nasotracheal intubation (NTI)
- Orotracheal intubation

**Exclusion Guidelines for Abstraction:**
None

**Data Element Name:** ***Reason for No Aspirin on Arrival***

**Collected For:** OP-4

**Definition:** Reasons for not administering aspirin on arrival:

- Aspirin allergy
- Coumadin/warfarin or Pradaxa/dabigatran etexilate as pre-arrival medication
- Other reasons documented by a physician/advanced practice nurse/physician assistant (physician/APN/PA) or pharmacist

Aspirin reduces the tendency of blood to clot by blocking the action of a type of blood cell involved in clotting. Aspirin improves chances of surviving a heart attack and reduces the risk of occurrence in patients who have experienced a heart attack.

**Suggested Data Collection Question:**
Select one of the following documented reasons for not administering aspirin on arrival.

**Format:**

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

**Allowable Values:**

1 **Allergy/Sensitivity to aspirin:** There is documentation of an aspirin allergy/sensitivity.

2 **Documentation of Coumadin/warfarin** or Pradaxa/dabigatran etexilate **prescribed pre-arrival:** Coumadin/warfarin or Pradaxa/dabigatran etexilate is prescribed as a pre-arrival home medication.

3 **Other documented reasons:** There is documentation of a reason for not administering aspirin on arrival.

4 **No documented reason or Unable to determine (UTD):** There is no documentation of a reason for not administering aspirin on arrival or unable to determine from medical record documentation.

**Notes for Abstraction:**

- When conflicting information is documented in a medical record, a positive finding (aspirin allergy) should take precedence over a negative finding (no known allergy).
- Aspirin "allergy" or "sensitivity" documented anytime during the hospital stay counts as an allergy regardless of what type of reaction might be noted (e.g., "Allergies: ASA – Upsets stomach" – select value "1").
- Notation of an aspirin allergy prior to arrival counts as a reason for not administering aspirin, select value "1."
- Documentation of an allergy/sensitivity to one particular type of aspirin is acceptable to take as an allergy to the entire class of aspirin-containing medications (e.g., "Allergic to Empirin").

- Other reasons include any physician/APN/PA or pharmacist documentation of a reason for not administering aspirin. (e.g., ASA not administered because patient has a gastric ulcer).
    - There must be a documented reason. Documentation of “Aspirin not administered” will not be sufficient. Physician/APN/PA or pharmacist crossing out of an aspirin order counts as an "other reason" for not administering aspirin.
- Pre-arrival hold or discontinuation of aspirin or notation such as "No aspirin" counts as a reason for not administering aspirin.
- Pre-arrival "other reason" counts as reason for not administering aspirin (e.g., "Intolerance to aspirin" or "Hx GI bleeding with aspirin").
- In situations where there is documentation that would support more than one of the allowable values, 1-4, select the lowest value. Example: Patient has a documented aspirin allergy and documentation of Coumadin as a pre-arrival medication, select value “1.”
- Consider Coumadin/warfarin or Pradaxa/dabigatran etexilate to be a pre-arrival medication (a reason for not prescribing aspirin on arrival) if there is documentation the patient was on it prior to arrival, regardless of setting. Include cases where there is indication the Coumadin/warfarin or Pradaxa/dabigatran etexilate was on temporary hold or the patient has been non-compliant/self-discontinued their medication (e.g., refusal, side effects, cost).

**Suggested Data Sources:**

- Emergency Department record

**Inclusion Guidelines for Abstraction:**

- Refer to Appendix C, OP Table 1.1, Aspirin and Aspirin-Containing Medications.
- Refer to Appendix C, OP Table 1.2, Warfarin medications.
- Pradaxa/dabigatran etexilate

**Exclusion Guidelines for Abstraction:**

None

**Data Element Name:** ***Reason for Not Administering Fibrinolytic Therapy***

**Collected For:** OP-3

**Definition:** Contraindications/reasons for not administering fibrinolytic therapy include: patient refusal, cardiogenic shock, contraindications or other reasons documented by a physician/APN/PA or pharmacist for not giving fibrinolytics.

**Suggested Data Collection Question:** Select one of the following potential contraindications or reasons for not administering fibrinolytic therapy.

**Format:**

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

**Allowable Values:**

1 **Documented contraindication/reason:** There is a contraindication or other reason documented by a physician/APN/PA or pharmacist for not prescribing fibrinolytic therapy, including patient refusal.

2 **Cardiogenic Shock:** There is physician/APN/PA documentation the patient has a diagnosis of cardiogenic shock.

3 **No documented contraindication/reason or Unable to determine (UTD):** There is no documentation of contraindication/reason for not prescribing fibrinolytic therapy or unable to determine from medical record documentation.

**Notes for Abstraction:**

- When conflicting information is documented in a medical record, a positive finding (fibrinolytic allergy) should take precedence over a negative finding (no known allergy).
- Only use reasons/contraindications listed in the data element.
- In situations where there is documentation that would support more than one of the allowable values, 1-3, select the lowest value. Example: Patient has a documented contraindication from the inclusion list and a diagnosis of cardiogenic shock, select value "1."

**Suggested Data Sources:**

- Emergency Department record

**Inclusion Guidelines for Abstraction:**

**Contraindications**

- Any prior intracranial hemorrhage
- Known structural cerebral vascular lesion (e.g. AVM)
- Known malignant intracranial neoplasm (primary or metastatic)
- Ischemic stroke within 3 months EXCEPT acute ischemic stroke within 3 hours

- Suspected aortic dissection
- Active bleeding or bleeding diathesis (excluding menses)
- Significant closed head trauma or facial trauma within 3 months
- Severe uncontrolled hypertension on presentation (SBP > 180 mm Hg or DBP > 110 mm Hg)
- History of prior ischemic stroke > 3 months, dementia, or known intracranial pathology not covered in contraindications
- Traumatic or prolonged (> 10 minutes) CPR or major surgery (< 3 Weeks)
- Recent (within 2 to 4 weeks) internal bleeding
- Noncompressible vascular punctures
- For streptokinase/anistreplase: prior expose (> 5 days ago) or prior allergic reaction to these agents
- Pregnancy
- Active peptic ulcer
- Current use of anticoagulants prior to arrival: the higher the INR, the higher the risk of bleeding

**Risk**

- Cardiogenic shock

**Exclusion Guidelines for Abstraction:**

- Transfer for Acute Coronary Intervention, PCI

**Data Element Name:** ***Replacement***

**Collected For:** OP-6, OP-7

**Definition:** The procedure performed is a replacement of the gastrostomy tube and not the initial placement.

**Suggested Data Collection Question:** Is this procedure a replacement of a previously placed gastrostomy tube?

**Format:**

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

**Allowable Values:**

| | |
|---|---|
| Y (Yes) | The procedure performed was a replacement of a previously placed gastrostomy tube. |
| N (No) | The procedure performed was not a replacement of a previously placed gastrostomy tube or unable to determine from medical record documentation. |

**Notes for Abstraction:**

- If there is documentation that the case is to REPLACE a PEG tube that has been placed previously, regardless of documentation of incision, answer “yes.”
- If this procedure is NOT to replace a gastrostomy tube, answer “No.”

**Suggested Data Sources:**

- Outpatient record

**Inclusion Guidelines for Abstraction:**
None

**Exclusion Guidelines for Abstraction:**
None

**Data Element Name:** ***Sex***

**Collected For:** All Records

**Definition:** The patient's documented sex on arrival at the hospital.

**Suggested Data Collection Question:** What was the patient's sex on arrival?

**Format:**
**Length:** 1
**Type:** Character
**Occurs:** 1

**Allowable Values:**

M = Male

F = Female

U = Unknown

**Notes for Abstraction:**

- Collect the documented patient's sex at admission or the first documentation after arrival.
- Consider the sex to be unable to be determined and select "Unknown" if:
    - The patient refuses to provide their sex.
    - Documentation is contradictory.
    - Documentation indicates the patient is a Transexual.
    - Documentation indicates the patient is a Hermaphrodite.

**Suggested Data Sources:**

- Consultation notes
- Emergency department record
- Face sheet
- History and physical
- Nursing admission notes
- Progress notes
- UB-04, Field Location: 11

**Inclusion Guidelines for Abstraction:**
None

**Exclusion Guidelines for Abstraction:**
None

**Data Element Name:** ***Time Last Known Well***

**Collected For:** OP-23

**Definition:** The time (military time) prior to hospital arrival at which the patient was last known to be without the signs and symptoms of the current stroke or at his or her baseline state of health.

**Suggested Data Collection Question:** At what time was the patient last known to be well or at his or her prior baseline state of health?

**Format:**

**Length:** 5 - HH-MM (with or without colon) or UTD
**Type:** Time
**Occurs:** 1

**Allowable Values:**

HH = Hour (00-23)
MM = Minutes (00-59)
UTD = Unable to Determine

Time must be recorded in military time format.
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

Examples:

| | |
|---|---|
| Midnight – 00:00 | Noon – 12:00 |
| 5:31 am – 05:31 | 5:31 pm – 17:31 |
| 11:59 am – 11:59 | 11:59 p.m. – 23:59 |

**Note:**
00:00 = midnight. If the time is documented as 00:00 11-24-20xx, review supporting documentation to determine if the *Date Last Known Well* should remain 11-24-20xx or if it should be converted to 11-25-20xx.

When converting Midnight or 24:00 to 00:00 do not forget to change the *Date Last Known Well.*

Example:

Midnight or 24:00 on 11-24-20xx = 00:00 on 11-25-20xx.

**Notes for Abstraction:**

- For times that include “seconds”, remove the seconds and record the time as is.

  Example: 15:00:35 would be recorded as 15:00

- If the time last known well is unable to be determined from medical record documentation, select “UTD”.

- The medical record must be abstracted as documented (taken at "face value"). When the time documented is obviously in error (not a valid time) and no other documentation is found that provides this information, the abstractor should select "UTD".

  Example:

  Documentation indicates the time last known well was 3300. No other documentation in the medical record provides a valid time. Since the time last known well is outside of the range listed in the Allowable Values for "Hour," it is not a valid time and the abstractor should select "UTD".

  **Note:** Transmission of a case with an invalid time as described above will be rejected from the Data Warehouse. Use of "UTD" for *Time Last Known Well* allows the case to be accepted into the warehouse.
- If the time last known well is documented as being a specific number of hours prior to arrival (e.g., felt left side go numb 2 hours ago) rather than a specific time, subtract that number from the time of ED arrival and enter that time as the time last known well.
- If the time last known well is noted to be a range of time prior to ED arrival (e.g., felt left side go numb 2-3 hours ago), assume the maximum time from the range (e.g., 3 hours), and subtract that number of hours from the time of arrival to compute the time last known well.
- If there are multiple times of last known well documented, use the earliest time recorded.

**Suggested Data Sources:**
- Emergency department records
- History and physical
- Progress Notes

**Inclusion Guidelines for Abstraction:**
None

**Exclusion Guidelines for Abstraction:**
None

**Data Element Name:** ***Transfer for Acute Coronary Intervention***

**Collected For:** OP-3

**Definition:** Documentation the patient was transferred from this facility's emergency department to another facility for acute coronary intervention.

**Suggested Data Collection Question:** Was there documentation the patient was transferred from this facility's emergency department to another facility for acute coronary intervention?

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

**Allowable Values:**

1 There was documentation the patient was transferred from this facility's emergency department to another facility specifically for acute coronary intervention.

2 There was documentation the patient was admitted to observation status prior to transfer.

3 There was documentation the patient was transferred from this facility's emergency department to another facility for reasons other than acute coronary intervention, or the specific reason for transfer was unable to be determined from medical record documentation.

**Notes for Abstraction:**

- To select value "1," documentation must include a specifically defined reason for transfer such as "Percutaneous Coronary Intervention," "Angioplasty," or "for cardiac cath."
- To select value "2", there must be documentation of a physician/APN/PA order to admit to observation status.

**Suggested Data Sources:**
Emergency Department record

**Inclusion Guidelines for Abstraction:**

- Acute angiogram
- Acute cardiac intervention
- Acute coronary intervention
- Angioplasty
- Cath lab
- Cardiac catheterization
- Interventional cardiology
- Percutaneous Coronary Intervention

- Primary Percutaneous Coronary Intervention
- Primary PCI
- PCI

**Exclusion Guidelines for Abstraction:**
None

**Data Element Name:** ***Transition Record Received***

**Collected For:** OP-19

**Definition:** Documentation that the transition record containing all of the following elements was received by the patient and/or caregiver(s) at the time of emergency department (ED) discharge. There must be documentation that the transition record contained:

- Major procedures and tests performed during ED visit, AND
- Principal diagnosis at discharge OR chief complaint, AND
- Patient instructions, AND
- Plan for follow-up care (OR statement that none required), including primary physician, other health care professional, or site designated for follow-up care, AND
- List of new medications and changes to continued medications that patient should take after ED discharge, with quantity prescribed and/or dispensed (OR intended duration) and instructions for each

**Suggested Data Collection Question:** Was there documentation that the patient and/or caregiver(s) received a transition record at the time of emergency department (ED) discharge that contained all of the required elements?

**Format:**

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

**Allowable Values:**

| | |
|---|---|
| Y (Yes) | There is documentation that the patient and/or caregiver(s) received a transition record at the time of emergency department (ED) discharge that contained **ALL** of the required elements. |
| N (No) | There is no documentation that the patient and/or caregiver(s) received a transition record at the time of emergency department (ED) discharge that contained **ALL** of the required elements or unable to determine from medical record documentation. |

**Notes for Abstraction:**

- The caregiver is defined as the patient's family or any other person (e.g., home health, VNA provider, prison official or other law enforcement personnel) who will be responsible for care of the patient after discharge.
- A copy of the transition record provided to the patient must be available in the medical record to abstract this data element. Documentation must clearly convey that the patient or caregiver(s) was given a copy of the material. When the material is present in the medical record and there is no documentation which clearly suggests that a copy was given, the inference should be made that it was given IF the patient's name or medical record number appears on the material AND hospital staff or the patient or caregiver(s) has signed the material.

- If any one of the required components listed above is missing from the transition record, select “No.”
- If a printed discharge summary sheet is used and provided to the patient or caregiver(s), all of the components listed above must be included to answer “Yes.” Utilization of a check box on the discharge summary that the patient received the required components is **NOT** adequate to select “Yes.” There must be copies of the documentation provided to the patient or caregiver(s) satisfying each component of the transition record.
- If the patient was discharged into the care of persons other than a caregiver, such as a medical transporter, but the transition record containing the required components was provided, select “Yes.”
- If there is no documentation that the patient received a transition record, select “No.”
- Required components with additional instructions are listed below. The examples provided are not meant to be all-inclusive.
    - The transition record must contain all of the major procedures and tests performed during the emergency department encounter. The major procedures may include fracture management, wound repair, incision and drainage (I & D), foreign body removal, joint reduction, joint aspiration, chest tube placement, emergency endotracheal intubation, central line placement, or lumbar punctures. Tests may include lab tests, scans, or x-rays that were performed. Tests that have results pending should be included, since they were performed during the encounter.
    - The principal clinical diagnosis OR the chief complaint (causing presentation to the emergency department) at discharge must be documented in the transition record.
    - The patient instructions for care after discharge must be documented in the transition record. This may include wound care or instructions about adverse reactions, signs/symptoms of infection, or instructions covering life-threatening emergencies.
    - Instructions for follow-up care must be included in the transition record. This may include a follow-up visit with a primary care physician or other provider, referral to another level of care or site, any post-discharge therapy (oxygen therapy, physical or occupational therapy) that might be needed and durable medical equipment required. If no follow-up care is necessary, a statement to that effect must be provided in the transition record.
    - The post-discharge medication list in the transition record must contain any new medications prescribed as well as changes to current or “home” medications. Instructions for the new medications must be documented. The list of current or “home” medications should contain any over-the-counter (OTC) or herbal medications that are taken. Discontinued medications should be listed along with drug interactions and allergies. The quantity prescribed/dispensed must be documented or the intended duration must be listed. If a discharge or reconciled medication list (medication reconciliation form) is used, all of the above requirements must be fulfilled with that list.

**Suggested Data Sources:**

- Emergency Department record

**Inclusion Guidelines for Abstraction:**
None

**Exclusion Guidelines for Abstraction:**
None

**Data Element Name:** ***Troponin Order***

**Collected For:** OP-16

**Definition:** Documentation in the medical record that a Troponin was ordered during emergency department visit.

**Suggested Data Collection Question:** Was a Troponin ordered by the physician during the emergency department visit?

**Format:**

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

**Allowable Values:**

| | |
|---|---|
| Y (Yes) | There is documentation a Troponin was ordered by the physician/APN/PA during the emergency department visit |
| N (No) | There is no documentation a Troponin was ordered by the physician/APN/PA during the emergency department visit or unable to determine from medical record documentation. |

**Notes for Abstraction:**
For purposes of the Troponin Order use these priority sources:

- Physician notes/orders
- Nurses Notes
- Laboratory Reports

**Suggested Data Sources:**

- Physician Notes/Orders
- Nurses Notes
- Laboratory Reports
- Emergency Department Record

**Inclusion Guidelines for Abstraction:**
None

**Exclusion Guidelines for Abstraction:**
None

**Data Element Name:** ***Troponin Result Date***

**Collected For:** OP-16

**Definition:** The month, day, and year at which the earliest Troponin result was completed or reported.

**Suggested Data Collection Question:** What is the date the earliest Troponin result was completed or reported?

**Format:**

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

**Allowable Values:**

Enter the documented date of the Troponin Result
MM = Month (01-12)
DD = Day (01-31)
YYYY = Year (2000-Current)
UTD = Unable to Determine

**Notes for Abstraction:**

- The medical record must be abstracted as documented (taken at "face value"). When the date documented is obviously in error (not a valid format/range or outside of the parameters of care) **and** no other documentation is found that provides this information, the abstractor should select "UTD".

  Examples:

  - Documentation indicates the *Troponin Result Date* was 03-**42**-20xx. No other documentation in the list of ONLY ACCEPTABLE SOURCES provides a valid date. Since the *Troponin Result Date* is outside of the range listed in the Allowable Values for "Day", it is not a valid date and the abstractor should select "UTD".
  - Patient expires on 02-12-20xx and all documentation within the ONLY ACCEPTABLE SOURCES indicates the *Troponin Result Date* was 03-12-20xx. Other documentation in the medical record supports the date of death as being accurate. Since the *Troponin Result Date* is after the date of death, it is outside of the parameter of care and the abstractor should select "UTD".

  **Note:** Transmission of a case with an invalid date as described above will be rejected from the QIO Clinical Warehouse. Use of "UTD" for *Troponin Result Date* allows the case to be accepted into the warehouse.
- If the date of the Troponin Result is unable to be determined from medical record documentation, abstract UTD.
- Abstract the result of the earliest Troponin (closest to arrival).
- If there are multiple result dates documented for the same Troponin, use the earliest result date.

**Suggested Data Sources:**
- Emergency Department record

**Inclusion Guidelines for Abstraction:**
None

**Exclusion Guidelines for Abstraction:**
None

**Data Element Name:** ***Troponin Result Time***

**Collected For:** OP-16

**Definition:** The time (military time) represented in hours and minutes at which the earliest Troponin result was completed or reported.

**Suggested Data Collection Question:** What is the time the earliest Troponin result was completed or reported?

**Format:**

**Length:** 5 - HH-MM (with or without colon) or UTD
**Type:** Time
**Occurs:** 1

**Allowable Values:**

HH = Hour (00-23)
MM = Minutes (00-59)
UTD = Unable to Determine

Time must be recorded in military time format.
With the exception of midnight and Noon:
- o If the time is in the a.m., conversion is not required
- o If the time is in the p.m., add 12 to the clock time hour

Examples:

| | |
|---|---|
| Midnight – 00:00 | Noon – 12:00 |
| 5:31 am – 05:31 | 5:31 pm – 17:31 |
| 11:59 am – 11:59 | 11:59 p.m. – 23:59 |

**Note:**
00:00 = midnight. If the time is documented as 00:00 11-24-20xx, review supporting documentation to determine if the *Troponin Result Date* should remain 11-24-20xx or if it should be converted to 11-25-20xx.

When converting Midnight or 24:00 to 00:00 do not forget to change the *Troponin Result Date.*

Example:

Midnight or 24:00 on 11-24-20xx = 00:00 on 11-25-20xx.

**Notes for Abstraction:**

- For times that include “seconds”, remove the seconds and record the time as is.

  Example: 15:00:35 would be recorded as 15:00
- If the Troponin result time is unable to be determined from medical record documentation, select “UTD”.
- The medical record must be abstracted as documented (taken at “face value”). When the time documented is obviously in error (not a valid time) and no other documentation is found that provides this information, the abstractor should select “UTD”.

Example:

Documentation indicates the Troponin result was 3300. No other documentation in the medical record provides a valid time. Since the Troponin result time is outside of the range listed in the Allowable Values for “Hour,” it is not a valid time and the abstractor should select “UTD”.

**Note:** Transmission of a case with an invalid time as described above will be rejected from the Data Warehouse. Use of “UTD” for *Troponin Result Time* allows the case to be accepted into the warehouse.

- If the time of the Troponin result is unable to be determined from medical record documentation, abstract UTD.
- Abstract the result of the earliest Troponin (closest to arrival).
- If there are multiple result times documented for the same Troponin, use the earliest result time.

**Suggested Data Sources:**

- Emergency Department record

**Inclusion Guidelines for Abstraction:**

None

**Exclusion Guidelines for Abstraction:**

None

**Data Element Name:** ***Vancomycin***

**Collected For:** OP-7

**Definition:** The documented rationale for using Vancomycin as antimicrobial prophylaxis.

**Suggested Data Collection Question:** What reason was documented for using Vancomycin?

**Format:**

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

**Allowable Values:**

**Select all that apply:**

1 Documentation of beta-lactam (penicillin or cephalosporin) allergy

2 Physician/APN/PA or pharmacist documentation of MRSA colonization or infection

3 Documentation of patient being high-risk due to acute inpatient hospitalization within the last year

4 Documentation of patient being high-risk due to nursing home or extended care facility setting within the last year, prior to admission

5 Physician/APN/PA or pharmacist documentation of increased MRSA rate, either facility-wide or operation-specific

6 Physician/APN/PA or pharmacist documentation of chronic wound care or dialysis

8 Other physician/APN/PA or pharmacist documented reason

9 No documented reason/Unable to Determine

**Notes for Abstraction:**

- For this data element, documentation by an infection control practitioner is acceptable (in addition to physician/APN/PA or pharmacist documentation) if it is specifically designated as “infection control” (ICP) documentation. An infection control practitioner may be a medical technician, nurse, physician/APN/PA, or pharmacist.
- Where applicable to the outpatient setting, in order to select Allowable Values 2, 5, 6 and 8, there must be physician/APN/PA, pharmacist, or infection control practitioner (ICP) documentation of the reason vancomycin was used for prophylaxis.
- Physician/APN/PA, pharmacist or infection control practitioner documentation of the reason for the use of Vancomycin as prophylaxis must have been entered in the medical record preoperatively to select Allowable values 2, 5, 6 and 8. If the documentation was not entered preoperatively, select Value 9-No documented reason/Unable to Determine.
- In order to select allowable value “1” for “Documentation of beta-lactum (penicillin or cephalosporin) allergy,” the answer to the data element Antibiotic Allergy must be “Yes.”

- No value should be selected more than once. A maximum of 7 entries should be recorded. If a value of "9" is selected, no other selection should be recorded.

**Suggested Data Sources:**

**WHERE SPECIFIED IN ALLOWABLE VALUES ABOVE, ONLY PHYSICIAN/APN/PA, PHARMACIST, OR INFECTION CONTROL PRACTITIONER DOCUMENTATION IS ALLOWED.**

- Outpatient record

**Inclusion Guidelines for Abstraction:**

**Hospitalization**

- Acute inpatient
- Federal or VA facility
- Hospice - Acute facility
- Inpatient drug rehabilitation
- Inpatient rehabilitation unit or facility
- Long-term care hospital

**Nursing Home or Extended Care Facility**

- Hospice – Skilled/Respite
- Intermediate care facility (ICF)
- Respite care
- Skilled nursing facility (SNF) or SNF rehabilitation unit
- Sub-acute care
- Sing bed/unit
- Transitional care unit (TCU)

**Exclusion Guidelines for Abstraction:**

- Assisted Living
- Board and Care
- Group home/personal care homes
- Hospice at home
- Psychiatric unit or facility
- Residential care
- Residential or outpatient chemical dependency treatment