FACT SHEET

Summary of Acute Myocardial Infarction (AMI) and Heart Failure (HF) Changes for 1/1/12+ Discharges

AMI-1, AMI-3, and AMI-5:

- Submission to the CMS clinical data warehouse is now optional. This change is based on the August 1, 2011 IPPS Final Rule.

AMI-4 and HF-4:

- Retired- Screening should occur in all patients, not just patients with certain conditions. The global Tobacco Treatment measures developed by The Joint Commission that reside in the Prevention group are CMS Informational Only.

AMI-7, AMI-7a, AMI-8, and AMI-8a:

- Allowable Values for *Transfer from Another Hospital or ASC* have changed to include only those values actually needed to calculate the measures. Algorithms were adjusted accordingly.

  Changed to:
  1. Yes = Patient was received as a transfer from an inpatient, outpatient, or emergency/observation department of an outside hospital or from an ambulatory surgery center.
  2. No = Patient was not received as a transfer from an inpatient, outpatient, or emergency/observation department of an outside hospital or from an ambulatory surgery center, or unable to determine from medical record documentation.

AMI-10:

- LDL-c Less Than 100 Within 24 Hours After Arrival element name was changed to LDL-c Less Than 100 mg/dL. The algorithm and wording of the LDL-c denominator exclusion in the Measure Information Form were adjusted accordingly.

The timeframe for the LDL-c less than 100 exclusion was extended FROM the first 24 hours after hospital arrival TO within the first 24 hours or within 30 days prior to hospital arrival.

Appendix C:

- Table 1.7 ARBs were added.
- Table 1.3 Beta-Blockers were added.

The information below consists of clarifications and changes in abstraction instructions.

Data Element or Table:	*ACEI Prescribed at Discharge* *ARB Prescribed at Discharge* *Aspirin Prescribed at Discharge* *Beta-Blocker Prescribed at Discharge* *Statin Medication Prescribed at Discharge*

Type of Change:	**New** • Abstraction guideline added which disallows credit for a medication prescribed at discharge if that medication is noted only by class (e.g., "ACEI Prescribed at Discharge: Yes" on a core measures form). The medication must be listed by name. [Exception: Aspirin --- "Aspirin" is considered both a medication class and a medication name] **Clarification** • Abstraction guideline added which makes clear that credit cannot be taken if a medication is documented only as a recommended medication for discharge (e.g., "Recommend sending patient home on lovastatin"). Documentation must be clear that the medication was actually prescribed at discharge.
Data Element or Table:	***Arrival Date*** ***Arrival Time***
Type of Change:	**New** • Abstraction guideline added which directs the abstractor to use the earliest time documented in the Only Acceptable Sources unless other documentation suggests the patient was not in the hospital at that time. Sources outside of the Only Acceptable Source list may be used to determine if the patient was not in the hospital at a given time. E.g, ED Triage Time 0800. ED rhythm strip 0830. EMS report indicates patient was receiving EMS care from 0805 through 0825. Enter 0830 for Arrival Time. • Usable ED documentation was expanded from the current limited list (ED vital signs record, ED triage record, etc.) to 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. • Preprinted times on a vital signs graphic record are no longer usable. • The inpatient face sheet is no longer an acceptable source. **Clarification** • Abstraction guideline added to clarify that in cases where a patient was transferred from your hospital's satellite/free-standing ED or from another hospital within your hospital's system (as an inpatient or ED patient), and there is one medical record for the care provided at both facilities, use the arrival time at the first facility. • Multiple rewording and structural Changes made to abstraction guidelines to provide additional clarification.

Data Element or Table:	*Aspirin Received Within 24 Hours Before or After Hospital Arrival*
Type of Change:	**Clarification** • Abstraction guidelines reworded to provide clarification on how to abstract cases when the patient was transferred in from an acute care hospital (e.g., interpreting aspirin noted as a “current medication” in documentation, defining where the 24-hour clock starts).

Data Element or Table:	*Clinical Trial*
Type of Change:	**New** • “Acute coronary syndrome (ACS)” was added to the list of inclusions for AMI trial.

Data Element or Table:	*Discharge Instructions Address Medications*
Type of Change:	**Clarification** • Abstraction guideline added which directs the abstractor to disregard a medication documented **only** as a recommended medication for discharge. E.g., “Recommend sending patient home on Vasotec” – Vasotec is not required in the discharge instructions (but if it is listed on the instructions, this is acceptable). Documentation must be more clear that such a medication was actually prescribed at discharge. • Re guideline “If there is documentation that the patient was discharged on insulin(s) of ANY kind, ANY reference to insulin as a discharge medication in the written discharge instructions can be considered a match …”: Abstraction guideline revised to make clear that contradictory documentation involving a specific insulin medication can still cause a mismatch (e.g., D/C summary notes patient discharged on “Novolog 50 units t.i.d.” and “Novolog 50 units t.i.d.” is discontinued on discharge medication reconciliation form).

Data Element or Table:	*Initial ECG Interpretation*
Type of Change:	**New** • Re guideline “Notations which describe ST-elevation as … previously seen… when compared to a prior ECG should be disregarded”: Revised to allow ST-elevation on the ECG done closest to arrival described as previously seen <u>on an ECG done by EMS or physician office prior to arrival</u> to count as an Inclusion (e.g., "Initial ECG shows ST-elevation 1mm V1-V2. Improved from ECG done in the field."). • Two bullets in Exclusion list collapsed to form the following Exclusion: o <u>ALL ST-elevation in one interpretation</u> is 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 in Appendix H, Table 2.6, Qualifiers and Modifiers Table (except “possible”)
- ST-segment noted as greater than or equal to .10mV/1 mm AND described using one of the negative modifiers or qualifiers listed in Appendix H, Table 2.6, Qualifiers and Modifiers Table (except “possible”)

Foremost, the restructure and rewording will simplify abstraction, but these Changes will also help reduce the number of false inclusions that occur now when certain combinations of ST-elevation documentation co-exist in one interpretation.

Clarification

- Abstraction guideline reworded to make more clear that ST-elevation noted as a range where it cannot be determined if elevation is less than 1 mm/.10mV (e.g., "0.5-1 mm ST-elevation") should be completely disregarded in abstraction.

Data Element or Table: ***LDL-c Less Than 100 mg/dL (formerly LDL-c Less Than 100 Within 24 Hours After Arrival)***

Type of Change: **New**

- As above. The abstractor should now be looking for an LDL-c level < 100 from testing done within the first 24 hours after hospital arrival <u>or within 30 days prior to hospital arrival</u>.
- Abstraction guideline added which allows for collection of LDL < 100 if there are no specific LDL-c values < 100 from testing done within the designated timeframe BUT there is a total cholesterol < 100 from testing done during that timeframe.

Clarification

- Abstraction guidelines reworded to make clear when clock starts: “hospital arrival” = *Arrival Time*.

Data Element or Table: ***LVSD***

Type of Change: **Clarification**

- The following terms were removed from the Exclusion list:
  - Diastolic dysfunction, failure, function, or impairment
  - Ventricular dysfunction not described as left ventricular
  - Ventricular failure not described as left ventricular
  - Ventricular function not described as left ventricular

An abstraction guideline was added which directs the abstractor to simply disregard this terminology. The abstractor should NOT stop review and mark *LVSD* = No in these cases but rather he/she should continue reviewing for more specific LVF/LVSD terminology (see Inclusion list).

Data Element or Table:	*Reason for Delay in Fibrinolytic Therapy* *Reason for Delay in PCI*
Type of Change:	**New** • "Deferral" added to the list of acceptable terminology that indicates a delay occurred ("hold," "delay," "deferral", or "wait") - e.g., "Cath initially deferred due to shock."
Data Element or Table:	***Reason for No Aspirin on Arrival*** ***Reason for No Aspirin at Discharge***
Type of Change:	**New** • Pradaxa/dabigatran now counts as an automatic reason for not prescribing aspirin.
Data Element or Table:	***Transfer From Another Hospital or ASC***
Type of Change:	**Allowable values restructured** • Yes = Patient was received as a transfer from an inpatient, outpatient, or emergency/observation department of an outside hospital or from an ambulatory surgery center. • No = Patient was not received as a transfer from an inpatient, outpatient, or emergency/observation department of an outside hospital or from an ambulatory surgery center, or unable to determine from medical record documentation. **New** • Abstraction guideline added which directs the abstractor to answer "No" in the event there is conflicting documentation and the abstractor is unable to determine whether or not the patient was received as a transfer from an inpatient, outpatient, or emergency/observation department of an outside hospital or from an ambulatory surgery center UNLESS there is supporting documentation for one setting over the other (e.g., One source states patient came from physician office, another source reports patient was transferred from an outside hospital's ED, and transfer records from the outside hospital's ED are included in the record.). • Abstraction guideline added which directs the abstractor to answer "No" if, in cases other than conflicting documentation, the abstractor is unable to determine whether or not the patient was received as a transfer from an inpatient, outpatient, or emergency/observation department of an outside hospital or from an ambulatory surgery center (e.g., "Transferred from Park Meadows" documented - Documentation is not clear whether Park Meadows is a hospital or not). **Clarification** • Abstraction guidelines revised to provide more clarification on how to handle varying transfer scenarios. o "Yes" includes:

- Transfers from hospitals or EDs outside of your hospital regardless of whether that facility is part of your hospital system, shared medical record or not, same provider number, or close proximity.
    - Transfers from LTACs
    - Transfers from rehab/psych units outside your hospital and transfers from rehab/psych hospitals
    - Transfers from the cath lab or same day surgery depts. of outside hospitals (regardless of whether that facility is part of your hospital system, shared medical record or not, same provider number, or close proximity)
  - "No" includes:
    - Transfers from urgent care centers
    - Transfers from clinics
    - Transfers from hospice facilities
    - Transfers from SNF care

For a complete list of Changes, please see the "Release Notes" located in the *Specifications Manual for Hospital Inpatient Department Quality Measures* for encounters 1/1/2012. The manual can be found at:

http://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier4&cid=1228767363466

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