

Alphabetical Data Dictionary

Note: For ease of review, this document includes the specific data elements collected for the Children's Asthma Care performance measure set. These data elements are as specified in the Data Dictionary found in the 4.0 version of the Specifications Manual for National Hospital Inpatient Quality Measures. The 4.0 version of the manual applies to discharges effective January 1, 2012.

The data elements denoted to be collected for "all records" are general data elements collected by hospitals and submitted for every patient that falls into any of the selected Initial Patient Populations.

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Data Element Name: *Admission Date*

Collected For: CMS/The Joint Commission: All Records

Definition: The month, day, and year of admission to acute inpatient care.

Suggested Data Collection Question: What is the date the patient was admitted to acute inpatient care?

Format:

Length: 10 – MM-DD-YYYY (includes dashes)

Type: Date

Occurs: 1

Allowable Values:

MM = Month (01-12)

DD = Day (01-31)

YYYY = Year (2001-Current Year)

Notes for Abstraction:

- The intent of this data element is to determine the date that the patient was actually admitted to acute inpatient care. Because this data element is critical in determining the population for all measures, the abstractor should NOT assume that the claim information for the admission date is correct. If the abstractor determines through chart review that the date from billing is incorrect, for purposes of abstraction, she/he should correct and override the downloaded value.
- For patients who are admitted to Observation status and subsequently admitted to acute inpatient care, abstract the date that the determination was made to admit to acute inpatient care and the order was written. Do not abstract the date that the patient was admitted to Observation.
Example:
 - Medical record documentation reflects that the patient was admitted to observation on 04-05-20xx. On 04-06-20xx the physician writes an order to admit to acute inpatient effective 04-05-20xx. The *Admission Date* would be abstracted as 04-06-20xx; the date the determination was made to admit to acute inpatient care and the order was written.
- If there are multiple inpatient orders, use the order that most accurately reflects the date that the patient was admitted. The admission date should not be abstracted from the earliest admission order without regards to substantiating documentation. If documentation suggests that the earliest admission order does not reflect the date the patient was admitted to inpatient care, this date should not be used.

Example:

Preoperative Orders are dated as 04-06-20xx with an order to admit to Inpatient. Postoperative Orders, dated 05-01-20xx, state to admit to acute inpatient. All other documentation supports that the patient presented to the hospital for surgery on 05-01-20xx. The admission date would be abstracted as 05-01-20xx.

Suggested Data Sources:

ONLY ALLOWABLE SOURCES

1. Physician orders
2. Face Sheet
3. UB-04, Field Location: 12

Excluded Data Sources

UB-04, Field Location: 06

Inclusion Guidelines for Abstraction:

None

Exclusion Guidelines for Abstraction:

- Admit to observation
- Arrival date

Data Element Name: *Birthdate*

Collected For: CMS/The Joint Commission: All Records

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

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

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

Format:

Length: 10 – MM-DD-YYYY (includes dashes)

Type: Date

Occurs: 1

Allowable Values:

MM = Month (01-12)

DD = Day (01-31)

YYYY = Year (1880-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, she/he should correct and override the downloaded value. If the abstractor is unable to determine the correct birthdate through chart review, she/he should default to the date of birth on the claim information.

Suggested Data Sources:

- Emergency department record
- Face sheet
- Registration form
- UB-04, Field Location: 10

Inclusion Guidelines for Abstraction:

None

Exclusion Guidelines for Abstraction:

None

Data Element Name: *Clinical Trial*

Collected For: CMS/Joint Commission: All AMI Measures, All HF Measures, PN-3a, PN-3b, PN-4, PN-5c, SCIP-Inf-1, SCIP-Inf-2, SCIP-Inf-3, SCIP-Inf-4, SCIP-Inf-6, SCIP-Inf-9, SCIP-Card-2, SCIP-VTE-1, SCIP-VTE-2; **CMS Only:** PN-6; **The Joint Commission Only:** All CAC, PN-5, PN-6a, PN-6b, All STK Measures, All VTE Measures

Definition: Documentation that during this hospital stay the patient was enrolled in a clinical trial in which patients with the same condition as the measure set were being studied (i.e. AMI, CAC, HF, PN, SCIP, STK, VTE).

Suggested Data Collection Question: During this hospital stay, was the patient enrolled in a clinical trial in which patients with the same condition as the measure set were being studied (i.e. AMI, CAC, HF, PN, SCIP, STK, VTE)?

Format:

Length: 1

Type: Alphanumeric

Occurs: 1

Allowable Values:

- | | |
|---------|--|
| Y (Yes) | There is documentation that during this hospital stay the patient was enrolled in a clinical trial in which patients with the same condition as the measure set were being studied (i.e. AMI, CAC, HF, PN, SCIP, STK, VTE). |
| N (No) | There is no documentation that during this hospital stay the patient was enrolled in a clinical trial in which patients with the same condition as the measure set were being studied (i.e. AMI, CAC, HF, PN, SCIP, STK, VTE), or unable to determine from medical record documentation. |

Notes for Abstraction:

- To select “Yes” to this data element, BOTH of the following must be true:
 1. **There must be a signed consent form for clinical trial.** For the purposes of abstraction, a clinical trial is defined as an **experimental study** in which research subjects are recruited and assigned a treatment/intervention and their outcomes are measured based on the intervention received. Treatments/interventions most often include use of drugs, surgical procedures, and devices. Often a control group is used to compare with the treatment/intervention. Allocation of different interventions to participants is usually randomized.
 2. **There must be documentation on the signed consent form that during this hospital stay the patient was enrolled in a clinical trial in which patients with the same condition as the measure set were**

being studied (i.e. AMI, CAC, HF, PN, SCIP, STK, VTE). Patients may either be newly enrolled in a clinical trial during the hospital stay or enrolled in a clinical trial prior to arrival and continued active participation in that clinical trial during this hospital stay.

- In the following situations, select "No":
 1. **There is a signed patient consent form for an observational study only.** Observational studies are non-experimental and involve no intervention (e.g., registries). Individuals are observed (perhaps with lab draws, interviews, etc.), data is collected, and outcomes are tracked by investigators. Although observational studies may include the assessment of the effects of an intervention, the study participants are not allocated into intervention or control groups.
 2. **It is not clear whether the study described in the signed patient consent form is experimental or observational.**
 3. **It is not clear which study population the clinical trial is enrolling.** Assumptions should not be made if it is not specified.

AMI:

Only capture patients enrolled in clinical trials studying patients with acute myocardial infarction (AMI), ST-elevation myocardial infarction (STEMI), Non ST-elevation MI (NSTEMI), heart attack, or acute coronary syndrome (ACS).

CAC:

Only capture patients enrolled in clinical trials studying children with asthma.

HF:

Only capture patients enrolled in clinical trials studying patients with heart failure (HF).

PN:

Only capture patients enrolled in clinical trials studying patients with pneumonia.

SCIP:

The clinical trial should be relevant to one or more of the SCIP measures.

Some examples may include but are not limited to:

- The clinical trial involved the use of antibiotics.
- The clinical trial involved testing a new beta-blocker.
- The clinical trial involved the use of VTE prophylaxis.

STK:

Only capture patients enrolled in clinical trials studying patients with stroke.

VTE:

Only capture patients enrolled in clinical trials studying patients with VTE (prevention or treatment interventions).

Suggested Data Sources:**ONLY ACCEPTABLE SOURCES**

Signed consent form for clinical trial

Inclusion Guidelines for Abstraction:

None

Exclusion Guidelines for Abstraction:

None

Data Element Name: *Discharge Date*

Collected For: CMS/The Joint Commission: All Records; **Used in Algorithms for: CMS/The Joint Commission:** AMI-1, PN-3a, PN-3b, PN-5c, SCIP-Inf-4, SCIP-VTE-1, SCIP-VTE-2; **CMS Only:** PN-6; **The Joint Commission Only:** PN-5, PN-6a, PN-6b, All SUB Measures, All TOB Measures; **CMS Informational Only:** All SUB Measures, All TOB Measures

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

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

Format:

Length: 10 – MM-DD-YYYY (includes dashes)

Type: Date

Occurs: 1

Allowable Values:

MM = Month (01-12)

DD = Day (01-31)

YYYY = Year (2001 – Current Year)

Notes for Abstraction:

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

Suggested Data Sources:

- Discharge summary
- Face sheet
- Nursing discharge notes
- Physician orders
- Progress notes
- Transfer note
- UB-04, Field Location: 6

Inclusion Guidelines for Abstraction:

None

Exclusion Guidelines for Abstraction:

None

Data Element Name: *Discharge Disposition*

Collected For: CMS/The Joint Commission: AMI-1, AMI-2, AMI-3, AMI-4, AMI-5, AMI-10, All HF Measures, All IMM Measures, PN-3b, PN-4, PN-5c; **The Joint Commission Only:** PN-5, CAC-3, STK-2, STK-3, STK-6, STK-8, STK-10, SUB-3, SUB-4, TOB-3, TOB-4, VTE-3, VTE-4, VTE-5; **CMS Informational Only:** SUB-3, SUB-4, TOB-3, TOB-4

Definition: The final place or setting to which the patient was discharged on the day of discharge.

Suggested Data Collection Question: What was the patient's discharge disposition on the day of discharge?

Format:

Length: 1

Type: Alphanumeric

Occurs: 1

Allowable Values:

- | | |
|---|---|
| 1 | Home |
| 2 | Hospice - Home |
| 3 | Hospice – Health Care Facility |
| 4 | Acute Care Facility |
| 5 | Other Health Care Facility |
| 6 | Expired |
| 7 | Left Against Medical Advice/AMA |
| 8 | Not Documented or Unable to Determine (UTD) |

Notes for Abstraction:

- **Only use documentation from the day of or the day before discharge** when abstracting this data element.

Example:

Documentation in the Discharge Planning notes on 04-01-20xx state that the patient will be discharged back home. On 04-06-20xx the physician orders and nursing discharge notes on the day of discharge reflect that the patient was being transferred to skilled care. The documentation from 04-06-20xx would be used to select value "5".

- Consider discharge disposition documentation in the discharge summary or a post-discharge addendum as day of discharge documentation, regardless of when it was dictated/written.
- If documentation is contradictory, use the latest documentation. If there is documentation that further clarifies the level of care that documentation should be used to determine the correct value to abstract.
Example:
Nursing discharge note documentation reflects that the patient is being discharged to “XYZ” Hospital. The Social Service notes from the day before discharge further clarify that the patient will be transferred to the rehab unit of “XYZ” Hospital, select value “5”.
- If the medical record states only that the patient is being discharged to another hospital and does not reflect the level of care that the patient will be receiving, select value “4”.
- To select value “7” there must be explicit documentation that the patient left against medical advice.
Examples:
 - Progress notes state that patient requests to be discharged but that discharge was medically contraindicated at this time. Nursing notes reflect that patient left against medical advice and AMA papers were signed, select value “7”.
 - Physician order written to discharge to home. Nursing notes reflect that patient left before discharge instructions could be given, select value “1”.

Suggested Data Sources:

- Discharge instruction sheet
- Discharge planning notes
- Discharge summary
- Nursing discharge notes
- Physician orders
- Progress notes
- Social service notes
- Transfer record

Excluded Data Sources:

- Any documentation prior to the day of or day before discharge
- UB-04

Inclusion Guidelines for Abstraction:

For Value 1:

- Assisted Living Facilities
- Court/Law Enforcement – includes detention facilities, jails, and prison
- Home – includes board and care, foster or residential care, group or personal care homes, and homeless shelters
- Home with Home Health Services

- Outpatient Services including outpatient procedures at another hospital, Outpatient Chemical Dependency Programs and Partial Hospitalization

For Value 3:

- Hospice Care - General Inpatient and Respite
- Hospice Care - Residential and Skilled Facilities
- Hospice Care - Other Health Care Facilities (excludes home)

For Value 4:

- Acute Short Term General and Critical Access Hospitals
- Cancer and Children's Hospitals
- Department of Defense and Veteran's Administration Hospitals

For Value 5:

- Extended or Intermediate Care Facility (ECF/ICF)
- Long Term Acute Care Hospital (LTACH)
- Nursing Home or Facility including Veteran's Administration Nursing Facility
- Psychiatric Hospital or Psychiatric Unit of a Hospital
- Rehabilitation Facility including Inpatient Rehabilitation Facility/Hospital or Rehabilitation Unit of a Hospital
- Skilled Nursing Facility (SNF), Sub-Acute Care or Swing Bed
- Transitional Care Unit (TCU)

Exclusion Guidelines for Abstraction:

None

Data Element Name: *Home Management Plan of Care Document Addresses Arrangements for Follow-up Care*

Collected For: The Joint Commission Only: CAC-3

Definition: Documentation exists that the Home Management Plan of Care (HMPC) document, separate and specific to the patient and provided to the patient/caregiver, prior to or upon discharge, includes information that arrangements for referral or follow-up care with a healthcare provider has been made.

Suggested Data Collection Question: Does the HMPC document, separate and specific to the patient and provided to the patient/caregiver, prior to or upon discharge, include information that arrangements for referral or follow-up care with a healthcare provider has been made?

Format:

Length: 1

Type: Alphanumeric

Occurs: 1

Allowable Values:

- 1 The HMPC document includes documentation that an appointment for referral or follow-up care with a healthcare provider has been made.
- 2 The HMPC document includes documentation that the patient/caregiver has been given information (healthcare provider/clinic/office name and phone number) to make arrangements for follow-up care.
- 3 Documentation exists that the patient/caregiver refused an appointment/information for referral or follow-up care with a healthcare provider.
- 4 The HMPC document does not include:
 - Documentation that an appointment for referral or follow-up care with a healthcare provider has been made;
 - Documentation that the patient/caregiver has been given information (healthcare provider/clinic/office name and phone number) to make arrangements for follow-up care;
 - OR
 - Unable to determine from the medical record documentation.

Notes for Abstraction:

- The healthcare provider could be a primary care physician, an asthma specialist, an advance practice registered nurse (e.g., APN), or a physician assistant (PA) in order to select “1 or 2”.
- Documentation of appointment for referral or follow-up care must include **all** of the following in order to select “1” for the data element:
 - Provider/clinic/office name
 - Date of appointment
 - Time of appointment
- Documentation of information for referral or follow-up care must include **all** of the following in order to select “2” for the data element:
 - Provider/clinic/office name
 - Telephone number
 - Time frame for appointment for follow-up care, e.g., 7-10 days
- If the patient’s home is out of state or out of the country and there is documentation that provider contact information is not accessible to the health care organization, AND there is documentation that the patient/caregiver were given a time frame for appointment for follow-up care, select Allowable Value 2.
Example:
Patient lives outside of US, unable to access provider contact information.
Caregiver instructed to make appointment for follow-up care as soon as possible upon return home.
- 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.

Suggested Data Sources:

HMPC document

Inclusion Guidelines for Abstraction:

None

Exclusion Guidelines for Abstraction:

None

Data Element Name: *Home Management Plan of Care Document Addresses Environmental Control and Control of Other Triggers*

Collected For: The Joint Commission Only: CAC-3

Definition: Documentation exists that the Home Management Plan of Care (HMPC) document, separate and specific to the patient and provided to the patient/caregiver, prior to or upon discharge, includes written information on avoidance or mitigation of environmental and other triggers.

Suggested Data Collection Question: Does the HMPC document, separate and specific to the patient and provided to the patient/caregiver, prior to or upon discharge, include written information on avoidance or mitigation of environmental and other triggers?

Format:

Length: 1

Type: Alphanumeric

Occurs: 1

Allowable Values:

Y (Yes) The HMPC document includes written information on avoidance or mitigation of environmental and other triggers.

N (No) The HMPC document does not include written information on avoidance or mitigation of environmental and other triggers or unable to determine from medical record documentation.

Notes for Abstraction:

- Specificity to the patient entails explicit information pertaining to the patient, i.e., the patient's specific controllers and relievers medication information (name, dose, frequency, and method of administration), environmental control and control of other triggers, and methods and timing of rescue actions specific to the patient, in order to select "Yes".
- HMPC must be a separate, stand alone document, in order to select "Yes".
- Triggers are things in the environment or life circumstances that could lead to asthma attacks. Triggers could be allergens or irritants. Environmental triggers could be found indoors or outdoors. Indoor locations could be homes, schools, workplace, churches, concert halls, etc.

Examples of environmental triggers:

- Animal dander (from the skin, hair, or feathers of animals)
- Dust mites (contained in house dust)
- Cockroaches
- Pollen from tree and grass
- Mold (indoor and outdoor)
- Cigarette or tobacco smoke

- Air pollutants (dust, house hold cleaners, hair sprays, other chemicals)
 - Cold air or changes in weather
 - Strong emotional expression (including crying or laughing hard)
 - Stress
- Other triggers may include:
- Medications such as aspirin and beta-blockers
 - Sulfites in food (dried fruit) or beverages (wine)
 - Infections and inflammatory conditions (i.e., flu, cold, rhinitis)
 - Gastroesophageal reflux disease that causes heartburn and can worsen asthma symptoms, especially at night
 - Emotional stress
 - Exercise or strenuous activity
- Documentation must clearly convey that the patient was given a copy of the HMPC to take home.
 - The HMPC does NOT need to be given at the time of discharge. A home management plan of care given at anytime during the hospital stay is acceptable.
 - If there is documentation of Triggers (environment or others), select “Yes”.
 - 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.

Suggested Data Sources:

HMPC document

Inclusion Guidelines for Abstraction:

None

Exclusion Guidelines for Abstraction:

None

Data Element Name: *Home Management Plan of Care Document Addresses Methods and Timing of Rescue Actions*

Collected For: The Joint Commission Only: CAC-3

Definition: Documentation exists that the Home Management Plan of Care (HMPC) document, separate and specific to the patient and provided to the patient/caregiver, prior to or upon discharge, addresses what to do if asthma symptoms worsen after discharge, i.e., when to take action, what specific steps to take, and contact information to be used, when an asthma attack occurs or is about to occur.

Suggested Data Collection Question: Does the HMPC document, separate and specific to the patient and provided to the patient/caregiver, prior to or upon discharge, included written information indicating when to take action, what specific steps to take, and contact information to be used, when an asthma attack occurs or is about to occur?

Format:

Length: 1

Type: Alphanumeric

Occurs: 1

Allowable Values:

- | | |
|---------|---|
| Y (Yes) | The HMPC document includes written information including when to take action, what specific steps to take, and contact information to be used, when an asthma attack occurs or is about to occur. |
| N (No) | The HMPC document does not include written information indicating when to take action, what specific steps to take, and contact information to be used, when an asthma attack occurs or is about to occur or unable to determine from medical record documentation. |

Notes for Abstraction:

- Specificity to the patient entails explicit information pertaining to the patient, i.e., the patient's specific controllers and relievers medication information (name, dose, frequency, and method of administration), environmental control and control of other triggers, and methods and timing of rescue actions specific to the patient, in order to select "Yes".
- HMPC must be a separate, stand alone document, in order to select "Yes".
- Documentation that addresses methods and timing of rescue actions must include **all** of the following, in order to select "Yes":
 1. When to take action, i.e., assessment of severity (e.g., peak flow meter reading, signs and symptoms to watch for).
 2. Steps to take, i.e., initial treatment instructions (e.g., inhaled relievers up to three treatments of 2-4 puffs by MDI at 20-minute intervals or single nebulizer treatment).

3. Contact information and when to contact the physician.
- Documentation must clearly convey that the patient was given a copy of the HMPC document to take home.
 - The HMPC does NOT need to be given at the time of discharge. A home management plan of care document given at anytime during the hospital stay is acceptable.
 - 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.

Suggested Data Sources:

HMPC document

Inclusion Guidelines for Abstraction:

None

Exclusion Guidelines for Abstraction:

None

Data Element Name: *Home Management Plan of Care Document Addresses Use of Controllers*

Collected For: The Joint Commission Only: CAC-3

Definition: Documentation exists that the Home Management Plan of Care (HMPC) document, separate and specific to the patient and provided to the patient/caregiver, prior to or upon discharge, includes information on the appropriate use of controllers. This information includes the medication name, dose, frequency, and method of administration, in order to adequately maintain control of asthma.

Controllers are long term asthma medications that reduce airway inflammation and prevent asthma exacerbations (asthma attacks or asthma episodes).

Suggested Data Collection Question: Does the HMPC document, separate and specific to the patient and provided to the patient/caregiver, prior to or upon discharge, included information on the appropriate use of controllers?

Format:

Length: 1

Type: Alphanumeric

Occurs: 1

Allowable Values:

Y (Yes) The HMPC document includes information on the appropriate use of controllers.

N (No) The HMPC document does not include information on the appropriate use of controllers or unable to determine from the medical record documentation.

Notes for Abstraction:

- Specificity to the patient entails explicit information pertaining to the patient, i.e., the patient's specific controllers and relievers medication information (name, dose, frequency, and method of administration), environmental control and control of other triggers, and methods and timing of rescue actions specific to the patient, in order to select "Yes".
- HMPC must be a separate, stand alone document, in order to select "Yes".
- If controller medications were prescribed, information must have been given on **all** of the following, in order to select "Yes" to this question:
 - medication name
 - dose
 - frequency
 - method of administration
- "Controller Not Specified (NOS)" can be used to answer "Yes" to this question in the following situations:

- For new controllers that are not yet listed in Table 6.1.
- When there is documentation that a controller was prescribed but unable to identify the name. It must be apparent that the medication is a controller.

Example:

On 2-12-08, the medical record contains the documentation, “Controller prescribed *name illegible*, 75mcg (*one inhalation*), BID.” (If “Controller prescribed” had not been documented in this example, the medication could not be abstracted as Home Management Plan of Care Document Addresses Use of Controllers.)

- Documentation must clearly convey that the patient/caregiver was given a copy of the HMPC document to take home.
- The HMPC does NOT need to be given at the time of discharge. A HMPC document given at anytime during the hospital stay is acceptable.
- 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.

Suggested Data Sources: HMPC document

Inclusion Guidelines for Abstraction:

Refer to Appendix C, Table 6.1 for the comprehensive list of Controller Medications.

Exclusion Guidelines for Abstraction:

None

Data Element Name: *Home Management Plan of Care Document Addresses Use of Relievers*

Collected For: The Joint Commission Only: CAC-3

Definition: Documentation exists that the Home Management Plan of Care (HMPC) document, separate and specific to the patient and provided to the patient/caregiver, prior to or upon discharge, includes written information on the appropriate use of relievers. This information includes the medication name, dose, frequency, method of administration, and a stepwise method of adjusting the dose, based on severity of symptoms, in order to quickly relieve the symptoms of asthma exacerbation (asthma attack or asthma episodes).

Relievers are medications that relax the bands of muscle surrounding the airways. They are also known as rescue, quick-relief, or short acting medications of choice to quickly relieve asthma exacerbations brought about by bronchoconstriction and exercise-induced bronchospasm.

Relievers do not reduce inflammation of the airways in a person with asthma and are, therefore, not useful for long term control.

Suggested Data Collection Question: Does the HMPC document, separate and specific to the patient and provided to the patient/caregiver, prior to or upon discharge, included written information on the appropriate use of relievers?

Format:

Length: 1

Type: Alphanumeric

Occurs: 1

Allowable Values:

Y (Yes) The HMPC document includes written information on the appropriate use of relievers.

N (No) The HMPC document does not include written information on the appropriate use of relievers or unable to determine from the medical record documentation.

Notes for Abstraction:

- Specificity to the patient entails explicit information pertaining to the patient, i.e., the patient's specific controllers and relievers medication information (name, dose, frequency, and method of administration), environmental control and control of other triggers, and methods and timing of rescue actions specific to the patient, in order to select "Yes".
- HMPC must be a separate, stand alone document, in order to select "Yes".

- If reliever medications were prescribed, information must have been given on **all** of the following, in order to select “Yes” to this question:
 - medication name
 - dose
 - frequency
 - method of administration
 - stepwise method of adjusting the dose and/or frequency, based on severity of symptoms
- “Reliever Not Specified (NOS)” can be used to answer “Yes” to this question in the following situations:
 - For new relievers that are not yet listed in Table 6.2
 - When there is documentation that a reliever was prescribed but unable to identify the name. It must be apparent that the medication is a reliever.
 Example:
 On 2-12-08, the medical record contains the documentation, “Reliever prescribed *name illegible*, 2.5 ml, PO, BID.” (If “Reliever prescribed” had not been documented in this example, the medication could not be abstracted as Home Management Plan of Care Document Addresses Use of Relievers.)
- Documentation must clearly convey that the patient/ caregiver was given a copy of the HMPC document to take home.
- The HMPC does NOT need to be given at the time of discharge. A HMPC document given at anytime during the hospital stay is acceptable.
- 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.

Suggested Data Sources:

HMPC document

Inclusion Guidelines for Abstraction:

Refer to Appendix C, Table 6.2 for the comprehensive list of Reliever Medications.

Exclusion Guidelines for Abstraction:

None

Data Element Name: *Home Management Plan of Care Document Given to Patient/Caregiver*

Collected For: The Joint Commission Only: CAC-3

Definition: Documentation exists that the Home Management Plan of Care (HMPC) as a separate document, specific to the patient, was given to the patient/caregiver, prior to or upon discharge.

Suggested Data Collection Question: Does documentation exist that the HMPC as a separate document, specific to the patient, was given to the patient/caregiver, prior to or upon discharge?

Format:

Length: 1

Type: Alphanumeric

Occurs: 1

Allowable Values:

- | | |
|-------------|---|
| Y (Yes) | Documentation exists that the HMPC document was given to the patient/caregiver, prior to or upon discharge. |
| N (No) | Documentation does not exist that the HMPC document was given to the patient/caregiver, prior to or upon discharge, or unable to determine from the medical record documentation. |
| R (Refused) | Documentation exists that the HMPC document was refused by the patient/caregiver. |

Notes for Abstraction:

- Specificity to the patient entails explicit information pertaining to the patient, i.e., the patient's specific controllers and relievers medication information (name, dose, frequency, and method of administration), environmental control and control of other triggers, and methods and timing of rescue actions specific to the patient, in order to select "Yes".
- HMPC must be a separate, stand alone document, in order to select "Yes".
- Documentation must clearly convey that the patient/caregiver was given a copy of the HMPC to take home.
- The HMPC does NOT need to be given at the time of discharge. An HMPC given at anytime during the hospital stay is acceptable.
- 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.

Suggested Data Sources:

- HMPC document found in the Medical Record
- Discharge instruction sheet
- Discharge summary
- Nursing notes
- Progress notes
- Teaching sheet

Inclusion Guidelines for Abstraction:

None

Exclusion Guidelines for Abstraction:

None

Data Element Name: *Home Management Plan of Care Document Present*

Collected For: The Joint Commission Only: CAC-3

Definition: The Home Management Plan of Care (HMPC) document, separate and patient-specific should be a written instruction given to the patient/caregiver. The document must be present in the medical record, in the form of an explicit and separate document specific to the patient rather than components or segments of the plan spread across discharge instruction sheets, discharge orders, education sheets, or other instruction sheets.

Suggested Data Collection Question: Is there a separate, patient specific Home Management Plan of Care document present in the medical record?

Format:

Length: 1

Type: Alphanumeric

Occurs: 1

Allowable Values:

Y (Yes) There is a separate, patient specific Home Management Plan of Care document present in the medical record.

N (No) There is no separate, patient specific Home Management Plan of Care document present in the medical record or unable to determine from the medical record documentation.

Notes for Abstraction:

- The Home Management Plan of Care (HMPC) document could be in the form of a Daily Self-Management Plan or an Asthma Action Plan only if it is a separate, patient-specific document.
- This data element seeks to determine the presence and content of a patient specific document separate from the traditional discharge instructions.
- Specificity to the patient entails explicit information pertaining to the patient, i.e., the patient's specific controllers and relievers medication information (name, dose, frequency, and method of administration), environmental control and control of other triggers, and methods and timing of rescue actions specific to the patient, in order to select "Yes".

Suggested Data Sources:

Medical record

Inclusion Guidelines for Abstraction:

None

Exclusion Guidelines for Abstraction:

None

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

Collected For: CMS/The Joint Commission: All Records; **Used in Algorithms for: CMS/The Joint Commission:** All IMM Measures, PN-3a, PN-3b, PN-4, PN-5c; **CMS Only:** PN-6; **The Joint Commission Only:** PN-5, PN-6a, PN-6b, SUB-3, SUB-4, TOB-2, TOB-3, All VTE Measures; **CMS Informational Only:** SUB-3, SUB-4, TOB-2, TOB-3

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

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

Format:

Length: 6 (with or without decimal point)

Type: Alphanumeric

Occurs: 24

Allowable Values:

Any valid ICD-9-CM diagnosis code

Notes for Abstraction:

None

Suggested Data Sources:

- Discharge summary
- Face sheet
- 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 Other Procedure Codes*

Collected For: CMS/The Joint Commission: All Records; **Used in Algorithms for:** CMS/The Joint Commission: AMI-8, AMI-8a, HF-1, HF-2, HF-3, HF-4, IMM-2; **The Joint Commission Only:** SUB-3, SUB-4; **CMS Informational Only:** SUB-3, SUB-4

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

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

Format:

Length: 5 (with or without decimal point)

Type: Alphanumeric

Occurs: 24

Allowable Values:

Any valid ICD-9-CM procedure code

Notes for Abstraction:

None

Suggested Data Sources:

- Discharge summary
- Face sheet
- UB-04, Field Location: 74A-E

Inclusion Guidelines for Abstraction:

For inclusion in the algorithms listed above, refer to Appendix A, for ICD-9-CM Code Tables (AMI, HF, IMM, SUB).

Exclusion Guidelines for Abstraction:

None

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

Collected For: CMS/The Joint Commission: All Records

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

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

Format:

Length: 10 – MM-DD-YYYY (includes dashes) or UTD

Type: Date

Occurs: 24

Allowable Values:

MM = Month (01-12)

DD = Day (01-31)

YYYY = Year (2001 – Current Year)

UTD = Unable to Determine

Notes for Abstraction:

- If the procedure date for the associated procedure 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 date documented is obviously in error (not a valid format/range or outside of the parameters of care [after *Discharge Date*]) **and** no other documentation is found that provides this information, the abstractor should select “UTD”.
Examples:
 - Documentation indicates the *ICD-9-CM Other Procedure Dates* was 02-42-20xx. No other documentation in the medical record provides a valid date. Since the *ICD-9-CM Other Procedure Dates* 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 documentation indicates the *ICD-9-CM Other Procedure Dates* was 03-12-20xx. Other documentation in the medical record supports the date of death as being accurate. Since the *ICD-9-CM Other Procedure Dates* is after the *Discharge Date* (death), it is outside of the parameters 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 and the Joint Commission’s Data Warehouse. Use of “UTD” for *ICD-9-CM Other Procedure Dates* allows the case to be accepted into the warehouse.

Suggested Data Sources:

- Consultation notes
- Diagnostic test reports
- Discharge summary
- Face sheet
- Operative notes
- Procedure notes
- Progress notes
- UB-04, Field Location: 74A-E

Inclusion Guidelines for Abstraction:

None

Exclusion Guidelines for Abstraction:

None

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

Collected For: CMS/The Joint Commission: All Records; **Used in Algorithms for: CMS/The Joint Commission:** ED-1, ED-2, All IMM Measures; **The Joint Commission Only:** STK-2, STK-3, STK-4, STK-5, STK-6, SUB-3, SUB-4, TOB-2, TOB-3, All VTE Measures; **CMS Informational Only:** SUB-3, SUB-4, TOB-2, TOB-3

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

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

Format:

Length: 6 (with or without 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:

- Discharge summary
- Face sheet
- UB-04, Field Location: 67

Inclusion Guidelines for Abstraction:

Refer to Appendix A, for ICD-9-CM Code Tables (AMI, ED, HF, IMM, PN, STK, SUB, TOB, VTE).

Exclusion Guidelines for Abstraction:

Refer to Appendix A, for ICD-9-CM Code Tables (ED, SCIP, IMM).

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

Collected For: CMS/The Joint Commission: All Records; **Used in Algorithm For:** CMS/The Joint Commission: AMI-8, AMI-8a, HF-1, HF-2, HF-3, HF-4, IMM-2, All SCIP Records; **The Joint Commission Only:** VTE-1, VTE-2, SUB-3, SUB-4; **CMS Informational Only:** SUB-3, SUB-4

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

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

Format:

Length: 5 (with or without decimal point)

Type: Alphanumeric

Occurs: 1

Allowable Values:

Any valid ICD-9-CM procedure code

Notes for Abstraction:

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

Suggested Data Sources:

- Discharge summary
- Face sheet
- UB-04, Field Location: 74

Inclusion Guidelines for Abstraction:

For inclusion in the algorithms listed above, refer to Appendix A, for ICD-9-CM Code Tables (AMI, HF, SCIP, VTE, IMM, SUB).

Exclusion Guidelines for Abstraction:

None

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

Collected For: CMS/The Joint Commission: All Records

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

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

Format:

Length: 10 – MM-DD-YYYY (includes dashes) 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 principal procedure date 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 date documented is obviously in error (not a valid date/format or is outside of the parameters of care [after *Discharge Date*]) **and** no other documentation is found that provides this information, the abstractor should select “UTD”.

Examples:

- Documentation indicates the *ICD-9-CM Principal Procedure Date* was 02-42-20xx. No other documentation in the medical record provides a valid date. Since the *ICD-9-CM Principal Procedure 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 documentation indicates the *ICD-9-CM Principal Procedure Date* was 03-12-20xx. Other documentation in the medical record supports the date of death as being accurate. Since the *ICD-9-CM Principal Procedure 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 and the Joint Commission’s Data Warehouse. Use of “UTD” for *ICD-9-CM Principal Procedure Date* allows the case to be accepted into the warehouse.

Suggested Data Sources:

- Consultation notes
- Diagnostic test reports
- Discharge summary
- Face sheet
- Operative notes
- Procedure notes
- Progress notes
- UB-04, Field Location: 74

Inclusion Guidelines for Abstraction:

None

Exclusion Guidelines for Abstraction:

None

Data Element Name: *Payment Source*

Collected For: CMS/The Joint Commission: All Records

Definition: The source of payment for this episode of care.

Suggested Data Collection Question: What is the patient's source of payment for this episode of care?

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 of payers, select "1".
- If the patient has Medicaid only or Medicaid and another insurance type, other than Medicare, select "2". If the patient has Medicaid and Medicare, 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:

- Medicare Fee for Service (includes DRG or PPS)
- Black Lung
- End Stage Renal Disease (ESRD)
- Railroad Retirement Board (RRB)
- Medicare Secondary Payer
- Medicare HMO/Medicare Advantage

Exclusion Guidelines for Abstraction:

None

Data Element Name: *Reason for Not Administering Relievers*

Collected For: The Joint Commission Only: CAC-1

Definition: Reasons for not administering relievers during this hospitalization:

- Allergy to relievers
- Other reasons documented by physician/APN/PA or pharmacist

Relievers are medications that relax the bands of muscle surrounding the airways and are used to quickly alleviate bronchoconstriction and prevent exercise-induced bronchospasm. Relievers are also known as rescue, quick-relief, or short acting medications of choice to quickly relieve asthma exacerbations.

Suggested Data Collection Question: Is there documentation of a reason for not administering relievers during this hospitalization?

Format:

Length: 1

Type: Alphanumeric

Occurs: 1

Allowable Values:

- | | |
|---------|---|
| Y (Yes) | There is documentation of a reason for not administering relievers during this hospitalization. |
| N (No) | There is no documentation of a reason for not administering relievers during this hospitalization or unable to determine from medical record documentation. |

Notes for Abstraction:

- When there is documentation of an “allergy,” “sensitivity,” “intolerance,” “adverse or side effects,” cardiac dysrhythmias, etc., regard this as documentation of a reason for not administering relievers regardless of what type of reaction might be noted. Do not attempt to distinguish between true allergies, sensitivities, intolerances, adverse or side effects, cardiac dysrhythmias, etc. (e.g., “Allergies: Relievers – select “Yes”).
- When conflicting information is documented in a medical record, select “Yes”.
- When determining whether there is a reason documented by a physician/APN/PA or pharmacist for not administering relievers during this hospitalization:
 - Reasons must be explicitly documented or clearly implied (e.g., intolerance to relievers” or “problems with relievers in past”).

Suggested Data Sources:

- Consultation notes
- Discharge summary

- Emergency department record
- History and physical
- Medication administration record (MAR)
- Medication reconciliation form
- Nursing notes
- Physician orders
- Progress notes

Inclusion Guidelines for Abstraction:

- Allergies/sensitivities/intolerance
- Cardiovascular side effects
- Cardiac dysrhythmias or arrhythmias
- Side effects

Refer to Appendix C, Table 6.2 for a comprehensive list of Reliever Medications.

Exclusion Guidelines for Abstraction:

None

Data Element Name: *Reason for Not Administering Systemic Corticosteroids*

Collected For: The Joint Commission Only: CAC-2

Definition: Reasons for not administering systemic corticosteroids during this hospitalization:

- Allergy to systemic corticosteroids
- Oral, IM, or intravenous (systemic) corticosteroids were administered to the patient within 24 hours prior to arrival AND patient was not a candidate to receive an additional dose during this hospitalization
- Other reasons documented by physician/APN/PA or pharmacist

Corticosteroids are a family of potent anti-inflammatory medications produced either naturally by the adrenal cortex or manufactured synthetically, in inhaled, topical, oral, IM, and intravenous forms.

Suggested Data Collection Question: Is there documentation of a reason for not administering systemic corticosteroids during this hospitalization?

Format:

Length: 1

Type: Alphanumeric

Occurs: 1

Allowable Values:

Y (Yes) There is documentation of a reason for not administering systemic corticosteroids during this hospitalization.

N (No) There is no documentation of a reason for not administering systemic corticosteroids during this hospitalization or unable to determine from medical record documentation.

Notes for Abstraction:

- When there is documentation of an “allergy,” “sensitivity,” “intolerance,” “adverse or side effects,” regard this as documentation of a reason for not administering systemic corticosteroids regardless of what type of reaction might be noted. Do not attempt to distinguish between true allergies, sensitivities, intolerances, adverse or side effects, etc. (e.g., “Allergies: Systemic Corticosteroids – select “Yes”).
- When conflicting information is documented in a medical record, select “Yes”.
- When determining whether there is a reason documented by a physician/APN/PA or pharmacist for not administering oral, IM, or intravenous (systemic) corticosteroids during this hospitalization.
 - Reasons must be explicitly documented or clearly implied (e.g., “intolerance to systemic corticosteroids” or “problems with systemic corticosteroids in past”).

Suggested Data Sources:

- Ambulance record
- Consultation notes
- Discharge summary
- Emergency department record
- History and physical
- Medication administration record (MAR)
- Medication reconciliation form
- Nursing notes
- Physician orders
- Progress notes
- Records from physician's office, clinic, or transferring facility (must be a part of this current medical record)

Inclusion Guidelines for Abstraction:

- Allergies/sensitivities/intolerance
- Side effects

Refer to Appendix C, Table 6.3 for a comprehensive list of Systemic Corticosteroids.

Exclusion Guidelines for Abstraction:

None

Data Element Name: *Relievers Administered*

Collected For: The Joint Commission Only: CAC-1

Definition: Documentation that the patient received reliever medication(s) for asthma exacerbation during this hospitalization. Inpatient hospitalization includes the time from arrival to the emergency department (ED) or observation area until discharge from the inpatient setting.

Relievers are medications that relax the bands of muscle surrounding the airways and are used to quickly alleviate bronchoconstriction and prevent exercise-induced bronchospasm.

Suggested Data Collection Question: Did the patient receive a reliever medication(s) during this hospitalization?

Format:

Length: 1

Type: Alphanumeric

Occurs: 1

Allowable Values:

Y (Yes) The patient received a reliever medication(s) during this hospitalization.

N (No) The patient did not receive a reliever medication(s) during this hospitalization or unable to determine from the medical record documentation.

Notes for Abstraction:

- For the purposes of the CAC measures, inpatient hospitalization includes the time of arrival to the emergency department (ED) or observation area until discharge from the inpatient setting.
- For reliever medication(s) administered in the Emergency Department observation area which was given prior to the inpatient admission, select “Yes”.
- “Reliever Not Specified (NOS)” can be used to answer “Yes” to this question in the following situations:
 - For new relievers that are not yet listed in Table 6.2.
 - When there is documentation that a reliever was administered but unable to identify the name. It must be apparent that the medication is a reliever.
Example:
On 2-12-20xx, the ED record contains the documentation, “Reliever started *name illegible*, 2.5 ml, PO, 0200-JM.” In the reliever grid, “Reliever NOS” would be entered for the name, PO for the route, 0200 for the time and 2-12-20xx for the date. (If “Reliever started” had not been

documented in this example, the medication could not be abstracted as *Relievers Administered*.)

Suggested Data Sources:

- Emergency department record
- Medication administration record (MAR)
- Nursing flow sheet
- Nursing notes

Inclusion Guidelines for Abstraction:

Refer to Appendix C, Table 6.2 for a comprehensive list of Reliever Medications.

Exclusion Guidelines for Abstraction:

None

Data Element Name: Sex

Collected For: CMS/The Joint Commission: All Records; **Used in Algorithms For: CMS/The Joint Commission:** SCIP-Card-2

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: *Systemic Corticosteroids Administered*

Collected For: The Joint Commission Only: CAC-2

Definition: Documentation that the patient received oral, IM, or intravenous (systemic) corticosteroids for asthma exacerbation during this inpatient hospitalization. Inpatient hospitalization includes the time from arrival to the emergency department (ED) or observation area until discharge from the inpatient setting.

Systemic corticosteroids (oral, IM, or intravenous corticosteroids) are recommended as short term or rescue medications to relieve bronchoconstriction rapidly, making them useful in gaining quick initial control of asthma and in treatment of moderate to severe asthma exacerbations.

Suggested Data Collection Question: Did the patient receive oral, IM, or intravenous corticosteroids during this hospitalization?

Format:

Length: 1

Type: Alphanumeric

Occurs: 1

Allowable Values:

Y (Yes) The patient received oral, IM, or intravenous corticosteroids during this hospitalization.

N (No) The patient did not receive oral, IM, or intravenous corticosteroids during this hospitalization or unable to determine from the medical record documentation.

Notes for Abstraction:

- For the purpose of the CAC measures, inpatient hospitalization includes the time of arrival to the emergency department (ED) or observation area until discharge from the inpatient setting.
- For systemic corticosteroids (oral, IM, or intravenous) administered in the Emergency Department/observation area which was given prior to the inpatient admission, select “Yes”.
- “Systemic Corticosteroid Not Specified (NOS)” can be used to answer “Yes” to this question in the following situations:
 - For new systemic corticosteroids that are not yet listed in Table 6.3.
 - When there is documentation that a systemic corticosteroid was administered but unable to identify the name. It must be apparent that the medication is a systemic corticosteroid.
Example:
On 2-12-20xx, the ED record contains the documentation, “Systemic corticosteroid started name illegible, 100 mg, IV, 0200-JM.” In the reliever

grid, “Systemic corticosteroid NOS” would be entered for the name, IV for the route, 0200 for the time and 2-12-20xx for the date. (If “Systemic corticosteroid started” had not been documented in this example, the medication could not be abstracted as *Systemic Corticosteroid Administered*.)

Suggested Data Sources:

- Emergency department record
- Medication administration record (MAR)
- Nursing flow sheet
- Nursing notes

Inclusion Guidelines for Abstraction:

Include corticosteroids given:

PO/NG/PEG tube:

- Any kind of feeding tube, e.g., percutaneous endoscopic gastrostomy, percutaneous endoscopic jejunostomy, gastrostomy tube
- By mouth
- Gastric tube
- G-tube
- Jejunostomy
- J-tube
- Nasogastric tube
- PO
- P.O.

Intramuscular:

- IM

Intravenous:

- Bolus
- Infusion
- IV
- I.V.
- IV Piggyback (IVP)

Refer to Appendix C, Table 6.3 for a comprehensive list of oral, IM, or intravenous Systemic Corticosteroids.

Exclusion Guidelines for Abstraction:

- Inhalation
- Nasal sprays