

<b>Data Element</b>	<b>Hospital Abstraction</b>	<b>CDAC Abstraction</b>	<b>CDAC Educational Comments</b>
ACEI Prescribed at Discharge	Yes	No	<i>Found documentation on the DCS that lisinopril was held because of his creatinine. Per guidelines, if an ACEI is not listed as a discharge medication, and there is only documentation of a hold or plan to delay initiation/restarting of an ACEI, select No.</i>
Adult smoking Hx	Yes	No	<i>Found Soc Hx: tobacco on the ED Record, quit smoking about 40 years ago on the H &amp; P, and Smoking History-Yes on page 3 of the Admission Assessment Report. Per guidelines, if there is NO definitive documentation of current smoking or smoking within one year prior to arrival in any of the ONLY ACCEPTABLE SOURCES, select No. Disregard documentation of smoking history or history of tobacco use if current smoking status is not defined.</i>
Adult smoking Hx	Yes	No	<i>ALL acceptable sources indicated patient was not a current cigarette smoker anytime during the year prior to hospital arrival. The H and P is dictated greater than 30 days after discharge; therefore, cannot use. The Admission assessment states no history of smoking in the last 12 months.</i>
Adult smoking Hx	Yes	No	<i>Unable to locate ADSMKHIST on any of the only acceptable sources. Per guidelines, the ONLY ACCEPTABLE SOURCES to obtain history of smoking are the H&amp;P, NAA, Respiratory Notes, and ER Records.</i>
Anesthesia End Time	1640	1710	<i>Found anesthesia end time of 17:10 on the anesthesia record. Per guidelines the anesthesia record is the priority source for the anesthesia end time.</i>
Anesthesia End Time	1052	1108	<i>Hosp anes end time of 1052 found on the anes record as operation end and on the surgical case record as procedure end. This variable is looking for when the anesthesia ended and not when the procedure ended. Found time of 1108 on the surgical case record as anes end, which is one of the qualified terms.</i>
Anesthesia Start Time	0809	0804	<i>Time of 0809 was not found on priority source; anes record as anes start time. Found earliest time of 0804 documented on priority source; anes record as anes start time. As per guidelines the anes record is the priority data source for this element if a valid anes start time is found on the anes record.</i>
Anesthesia Type	General	Both neuraxial and general	<i>Found on the OP report spinal anesthesia. Per guidelines, if a general anesthesia is used and an epidural catheter is placed preoperatively or up to 24 hrs after Anesthesia End Time for anesthesia or other reasons such as for postoperative pain control, select Value 3.</i>

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Antibiotic Dose (route)	IV	UTD	<i>Found dose of Ancef given IV on the anesthesia record on 09/28 however due to poor record copy the time of administration is cut off therefore the time is to be abstracted as UTD.</i>
Antibiotic Dose (route)	IV	UTD	<i>Ancef 12/3 at 0800 without a route was found given documented on anes record as 1st UTD dose route was given. Per guidelines, if the antibiotic name and route are not contained in a single source for that specific antibiotic, abstract UTD for the missing information.</i>
Antibiotic Dose (time)	0730 and 0804	UTD	<i>Found documentation on the anesthesia record that Ancef was given IV however the time of 07:30 and 08:04 are documented as the end time. This is not acceptable as the administered time and is to be abstracted with UTD for the time.</i>
Antibiotic Dose (time)	0234	0327	<i>Found IV Rocephin given at 0327 on the 12/12 MAR (page 1). The time of 0234 found on page 2 of the ED Record under the orders section represents that order time, not the time of administration. Per guidelines, abstract the first administration date, time, and route associated with each ABX name administered within 24 hours after arrival.</i>
Antibiotic Received	During hospital only	Before and during hospital	<i>Found on the H&amp;P(pg (4/135)that the pt takes Bactrim 3 times a wk for Prophylaxis. On page 123 of 135, Bactrim DS is listed as a home med ordered for Mo-We-Fr. Since the patient came in later on Friday and there is no documentation stating that the patient did not take his dose of Bactrim for that day, we will infer that it was taken PTA per guidelines. Pt also received abx during this hospital stay. Select value 2.</i>
Antibiotic Received	During hospital only	Before and during hospital	<i>Found Bactrim DS and Cipro on the home med list. Found "still on Cipro" on the BMG Admit note dated 9/29/10 0730. Per guidelines, antibiotics listed as current or home meds should be inferred as taken within 24 hrs prior to arrival or the day prior to arrival, unless there is documentation they were NOT taken w/in the last 24 hrs.</i>
Arrival Time	1822	1806	<i>Found ER assessment performed on 11/5/2010 at 18:06 on page 10/135. Per guidelines, the intent is to utilize any documentation which reflects processes that occurred in the ED or hospital. Enter 18:06.</i>
Arrival Time	1350	1553	<i>Unable to locate arrival time of 1350. It appears the ED Records were not sent with the record submitted to the CDAC. Found the earliest acceptable arrival time of 1553 on the BC lab reports, when they were drawn in the ED.</i>

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Arrival Time	2255	2305	<i>Pt is an ER admit. Found time of 22:55 used by provider on the Summary-Visit document, which is not an acceptable source for ER admits. Found earliest arrival time of 23:05 on the EKG done in the ER, which is an acceptable source for ER admits.</i>
Aspirin Within 24 Hours Before/After Hospital Arrival	No	Yes	<i>Found Aspirin given 9/26 at 23:10 per the American Medical Response Pre-Hospital Patient Care Report. Pt arrived to the ER 9/26 at 23:32. This is within the 24 hr prior to hospital arrival time, therefore select YES.</i>
Beta-blocker Current	Yes	No	<i>Unable to locate documentation that the patient was on a daily beta-blocker therapy prior to arrival.</i>
Blood Culture Collected	After admission order	In ED, before admission order	<i>Found admit time of 2300 on the ED Physician Form under disposition "admitted" (physician signed it 2300). This is the earliest time that reflects the decision to admit from the ER attending on the ER record. Initial blood cultures were collected @ 1955.</i>
Catheter Removed	Documentation removed POD 0-2	No documentation removed POD 0-2	<i>Found no documentation in the submitted record that the catheter was removed on POD0 through POD 2.</i>
Chest X-ray	Normal	Abnormal	<i>Found "chest x-ray read by ER physician shows ... an infiltrate in the right lower lobe." on the ER H&amp;P. Infiltrate is an inclusion for this data element. Per guidelines, if an inclusion term is not found after reviewing the recommended suggested sources, continue to review the medical record for physician documentation of inclusion terms until the remainder of the chart has been reviewed.</i>
Chest X-ray	Normal	Abnormal	<i>Found documentation on the 9/29 Cardiology Consultation Report that the pt's CXR showed a density in the right middle lobe. A density is an inclusion term for an abnormal CXR finding; select value 1.</i>
Clinical Trial	Yes	No	<i>Unable to find documentation that the patient was enrolled in a clinical trial in the submitted medical record. Per guidelines, the only acceptable source is a signed consent form for clinical trial AND there must be documentation on the signed consent that during the stay patient was enrolled in a clinical trial in which patients with the same condition as the measure set were being studied.</i>
Comfort Measures Only	No	Day 2 or After	<i>Found the inclusion term 'comfort care' documented on the Discharge Summary which is day 2 or after. Per guidelines, if any of the inclusions are documented, select 1,2, or 3 accordingly, unless otherwise specified.</i>

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Comfort Measures Only	No	Day 2 or after	<i>Found "pending hospice evaluation to be ordered by Dr..." on the DC Summary dated 11/29/10. Per guidelines, if any of the inclusions are documented by a physician, select 1, 2, or 3 accordingly unless otherwise specified. Hospice is an inclusion for CMO.</i>
Comfort Measures Only	No	Day 0 or 1	<i>Found the CMO inclusion term "hospice" on the physician signed H&amp;P under Assessment and Plan, dictated on the day after arrival. This is a CMO inclusion for Day 1; answer 1, Day 0-1.</i>
Compromised	Yes	No/UTD	<i>Unable to verify. Found no documentation the patient had a compromising condition.</i>
Compromised	No	Yes	<i>Found documentation on the 11/4 Physician's progress note that the pt is receiving Chemotherapy for Pancreatic cancer. Per guidelines, chemotherapy is considered a compromising condition.</i>
Diagnostic Uncertainty	Yes	No	<i>Unable to verify. Found no indication that the ED physician documented a reason for delay in a diagnosis of pneumonia on arrival.</i>
Discharge Instructions Address Medications	No	Yes	<i>Found all medications prescribed at D/C on the Discharge Instructions that was given to the patient. The D/C meds listed on the DCS was dated past the 30 day time frame and therefore cannot be utilized. Per guidelines, select YES if written D/C instructions given to the patient address all D/C meds.</i>
Discharge Instructions Address Medications	Yes	No	<i>Found Zetia, Diovan, and Protonix listed as D/C meds on the DCS. These meds, however, were not listed on the DCI, therefore creating a mismatch. Per guidelines, ALL DC meds must be listed by NAME on written DC instructions given to the patient. Select NO.</i>
Discharge Instructions Address Medications	Yes	No	<i>Numerous D/C meds are listed on the Med Reconciliation form and the DCS which are not addressed on the DCI given to the patient. The only drug listed on the DCI is Coreg, which matches. Per guidelines, ALL DC meds must be listed by NAME on written DC instructions given to the patient. Select NO to DSINSTADMD.</i>
Discharge Instructions Address Medications	Yes	No	<i>The Discharge Medication Reconciliation has Coreg listed as a discharge medication; however, it is DC'd on the Physician's orders 11/5. This is conflicting information. Per guidelines if after careful examination of circumstances, context, timing, etc, documentation raises enough questions about what meds are being prescribed at DC, the case should be deemed UTD and select No.</i>

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Discharge Instructions Address Symptoms Worsening	Yes	No	<i>Unable to find WRITTEN discharge instructions given to the patient/caregiver addressing what to do if heart failure symptoms worsen after discharge. Found "how many pounds could the patient's weight increase, in any 3 day period, before they should notify their caregiver? (no answer)" on the Exitcare Patient Information. Per guidelines, pre-printed instruction with all fields left blank is an exclusion unless next to a checked checkbox.</i>
Infection Prior to Anesthesia	No	Yes	<i>Found infection during this hospitalization prior to the principal procedure on the Emergency Documentation, dictated 10/12 at 0617, page 3 of 22, as possible pneumonia. Surgery was done 10/22.</i>
Infection Prior to Anesthesia	No	Yes	<i>Found infection during this hospitalization prior to the principal procedure on the consult, dictated 10/29 at 08:57 pm, under assessment # 8 as "versus underlying occult infection". Surgery was done 10/31 0848-1108.</i>
Infection Prior to Anesthesia	Yes	No	<i>Found no acceptable documentation in the record that the patient had an infection PTA. Documentation of UTI was noted on the H&amp;P dated prior to arrival on 10/22 however found no documentation stating that this is a current diagnosis. The sheet stating that there have been no changes to the H&amp;P was noted in the record however there is nothing checked or marked off to indicate that there were no changes.</i>
Initial Blood Culture Collection Time	0012	0010	<i>Found provider's time of 00:12 on ED nursing record, however, found earlier collected time of 00:10 on page 6 of 13 of lab reports. Per guidelines, if multiple times of collection are documented, abstract the earliest time.</i>
Initial Blood Culture Collection Time	1620	1553	<i>Unable to locate a BC time of 1620, as it appears the ED Records were not sent to the CDAC. However, found an earlier BC Collection time of 1553 on the 12/6 lab reports. Per guidelines, if multiple times of collection are documented, abstract the earliest time.</i>

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Initial Blood Culture Collection Time	0059	0108	<i>Found a Physician Order time of 0059 for a BC on page 5 of the ED Record. Per guidelines, do not use physician orders as they do not demonstrate actual collection of the blood culture. Found a BC Collection time of 0108 on page 6 of the lab reports.</i>
Initial Blood Culture Collection Time	2257	2256	<i>Found a BC collection time of 2257 on the lab reports, but also found an earlier BC time of 2256 on page 12 of 14 on the ED record. Per guidelines, if multiple times of collection are documented, abstract the earliest time.</i>
Initial EKG Interpretation	Yes	No	<i>Per ER Record, only one EKG was done. Submitted EKG tracings have date/time at top of form cut off. Found on ER Physician Report, under EKG, "LBBB-old". Per guidelines, If at least one Physician interpretation describes a LBBB on the initial EKG as old, all LBBB are disregarded. Select NO.</i>
Influenza Vaccination Status	Not received	Received prior to admission, current season	<i>Found on the Patient Profile form, pg 431, under Immunizations/Surgical History, the Influenza Vaccine "not required" because it was given previously on the date listed as "9/30/10". This is an inclusion for received prior to admission during the current flu season; answer 2.</i>
Influenza Vaccination Status	Received prior to admission, current season	Not received	<i>Found documentation on page 16 of the electronic nursing record that the pt's last flu vaccine was in 2005, which is not during the current season. No other documentation was found about the pt's vaccine status; select value 5.</i>
Laparoscope	Yes	No	<i>Found the principal procedure was not entirely performed by laparoscope documented on Operative Report 10/28 page 1; "we proceeded to mobilize the sigmoid colon into the operative field." Per this documentation the sigmoid colon was brought out of the abdomen to work on, making this no to laparoscope.</i>
Laparoscope	No	Yes	<i>Found on the OP report procedure was performed entirely by laparoscope or other fiber optic scope. Found no additional incisions, hand insertions or an extension of the laparoscopic insertion site, therefore, abstract "yes" for procedure done entirely by laparoscope.</i>
LVSD	Yes	No	<i>Found documentation of a Cardiac Cath, Echocardiogram and Stress test done during this stay on the reports. Per guidelines, if one or more in-hospital tests are performed, use report from most recent test done closest to discharge. The stress test was done 9/30, closest to discharge. This had an ejection fraction of 43%. Per guidelines, an EF must be less than 40% to be LVSD; therefore, answer is no.</i>

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LVSD	No	Yes	<i>Found documentation of one LVEF assessment done during this stay on the Echo report 11/2. This had an ejection fraction of 25%. Per guidelines, an EF less than 40% is LVSD.</i>
Reasons for Continuing Urinary Catheter	Yes	No	<i>Unable to locate physician/advanced practice nurse/physician assistant (physician/APN/PA) documentation of reasons for not removing the urinary catheter postoperatively. Found no documentation of reasons for not removing the urinary catheter postoperatively in the record.</i>
Reason for Continuing Urinary Catheterization	In ICU and receiving diuretics	No reason documented	<i>Unable to locate documentation that the patient was in the intensive care unit (ICU) AND receiving diuretics. Found no physician/APN/PA documentation of reasons for not removing the urinary catheter postoperatively in the record.</i>
Reason for no ASA on arrival or at discharge	Yes	No	<i>Unable to find a reason for not administering aspirin on arrival in the submitted medical record. Found heme + stool on the ED Record, however, the physician did not document that this was the reason aspirin was not given.</i>
Reason for Not Administering VTE Prophylaxis	No	Yes	<i>Found physician/APN/PA or pharmacist documentation of a reason for not administering pharmacological VTE prophylaxis on consult, dictated 10/28 at 2020, under impression and plan # 2, acute blood loss anemia. Contra to VTE timeframe is from arrival to 24hrs after anes end time. Anes end time was 1659 on 10/28.</i>
Surgical Incision Time	0804	0800	<i>Hosp surgery start time of 0804 found on the anes record as surgery start, however, found an earlier time of 0800 as a symbol on the anes record grid as operation start. Both times are of second priority. Per guidelines, follow the priority order within the Inclusion List for this data element. If multiple times are found, use earliest time among the highest priority.</i>
Temperature	Active warming performed intraoperatively	[Not found]	<i>Unable to locate active warming. Found warm blankets and warm fluids, however, these are not positive findings for active warming. Per guidelines, active warming is limited to forced-air warming, conductive warming, warm water garments and resistive warming.</i>
Temperature	Active warming AND At least one body temp greater than or equal to...	No documentation of allowable values 1 or 2	<i>Found no documentation of active warming that was performed intraoperatively and/or at least one body temperature greater than or equal to 96.8 degrees Fahrenheit/35 degrees Celsius within the 30 minutes immediately prior to or the 15 minutes immediately after Anesthesia End Time 9/28 at 1342, documented in submitted record.</i>

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Temperature		Active warming performed intraop	<i>Found on page 5 of the surgical case record, bair hugger was used. Bair hugger is an inclusion for an active warming device.</i>
Urinary catheter	Had prior	Placed perioperatively	<i>Unable to locate doc that the patient had an indwelling urethral or suprapubic catheter or was being intermittently catheterized prior to the periop timeframe. Found doc that an indwelling urethral catheter was placed periop and was still in place at the time of d/c from the PACU. Found on the OR record, page 3, the foley was placed in the OR and still place after the surgery. The periop timeframe is defined as from hosp arrival through d/c from the PACU/recovery area. Surgery was done 10/22.</i>
Urinary catheter	Had prior	Placed perioperatively	<i>Found documentation on the ED record that the foley cath was placed while the patient was in the ER on 12/09. The periop timeframe for this element is hosp arrival through DC from the Recovery/PACU therefore this is to be abstracted as value 1.</i>
VTE Prophylaxis Timely	Low molecular weight heparin, yes	Low molecular weight heparin, no	<i>Unable to locate LMWH done timely in the record. Found no MARs in the submitted record. VTE timely timeframe of 24 hours prior to anesthesia start time to 24 hours after anesthesia end time. Anes times were 1240-1350 on 11/21.</i>