

CORE MEASURES

Beginning with October 1, Discharges

Coronary Artery Disease/Chest Pain/Acute MI

1. Aspirin within 24 hours before or after of arrival to hospital (IP/OP) and prescribed at discharge (IP).
2. Beta Blocker at discharge (IP).
3. ACEI or ARB for LVSD (IP).
4. Smoking Cessation Counseling (IP).
5. Mortality Rate (IP).
6. Time to reperfusion therapy (IP/OP).
7. Fibrinolytic within 30 minutes (IP/OP).
8. Statin prescribed at discharge (IP).
9. LDL-Cholesterol Assessment (IP).
10. Lipid lowering therapy at discharge (IP).
11. Time to transfer to another facility for acute coronary intervention (OP).
12. Time to EKG.

Congestive Heart Failure

1. Discharge instructions.
2. Evaluation of LVS function.
3. ACEI or ARB for LVSD.
4. Adult smoking cessation counseling.

Pneumonia

1. Pneumococcal vaccination.
2. Blood cultures performed w/in 24 hours prior to or 24 hours after hospital arrival for patient who were transferred or admitted to the ICU w/in 24 hours of arrival.
3. Blood cultures performed in the ED prior to initial antibiotic received in hospital.
4. Adult smoking cessation counseling.
5. Time to antibiotic.
6. Antibiotic received w/in 6 hours of hospital arrival.
7. Initial antibiotic selection for CAP in immunocompetent patient
 - a. ICU patient – dual therapy
 - b. Non-ICU patient – mono therapy
8. Influenza vaccination.

SCIP

1. Prophylactic antibiotic received w/in one hour prior to incision (IP/OP).
2. Prophylactic antibiotic selection for surgical patients (IP/OP).
3. Prophylactic antibiotic discontinued w/in 24 hours after surgery (IP).
4. Appropriate hair removal.
5. Urinary catheter removed on POD 1 or POD 2 with day of surgery being zero.
6. Perioperative temperature management.
7. Patients on beta-blocker therapy prior to arrival receive a beta-blocker during the perioperative period.
8. Recommended VTE prophylaxis ordered.
9. Appropriate VTE received w/in 24 hours prior to surgery to 24 hours after surgery.

Stroke

1. VTE prophylaxis.
2. Discharged on antithrombotic therapy.
3. Anticoagulation therapy for atrial fibrillation/flutter.
4. Thrombolytic therapy.
5. Antithrombotic therapy by end of hospital day 2.
6. Discharged on statin medication.
7. Stroke education.
8. Assessed for rehabilitation.

Venous Thromboembolism (VTE) Prevention

1. VTE prophylaxis.
2. ICU VTE prophylaxis.
3. VTE patient with anticoagulation overlap therapy.
4. VTE patients receiving unfractionated heparin with dosages/platelet count monitoring by protocol.
5. VTE discharge instructions.
6. Incidence of potentially-preventable VTE.

DOCUMENTATION GUIDELINES

Reasons for Delay in Fibrinolytic Therapy

1. Must be documented by a physician/APN/PA.
2. Documentation must be made clear that: (1) a “hold,” “delay,” or “wait” in initiating fibrinolysis actually occurred, AND (2) that the underlying reason for that delay was non-system in nature.
3. The linkage between a non-system reason and the timing /delay of fibrinolysis must be clearly documented in the medical record.

EXAMPLES OF ACCEPTABLE REASONS	EXAMPLES OF UNACCEPTABLE REASONS
<ul style="list-style-type: none">• “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.”• 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 are acceptable reasons that do NOT require documentation that a “hold” “delay” or “wait” in initiating fibrinolysis actually occurred.	<p data-bbox="982 646 1235 680" style="text-align: center;"><u>System Reasons:</u></p> <ul style="list-style-type: none">• Equipment-related.• Staff-related.• Consultation with other clinician that is not clearly linked to a patient-centered (non-system) reason for delay.• Prolonged ED wait time. <p data-bbox="945 1016 1273 1050" style="text-align: center;"><u>Non-System Reasons:</u></p> <ul style="list-style-type: none">• Patient is discussing fibrinolysis with family. (Effect on the timing/delay of fibrinolysis not documented.)• “ST-elevation on initial ECG resolved. Chest pain now recurring. Begin lytics.” (Linkage to timing/delay requires clinical judgment.)• “Fibrinolysis contraindicated – too high risk.”• “Lytic therapy not indicated.”

Reasons for Not Administering Fibrinolytic Therapy

1. There is a contraindication or other reason documented by a physician/APN/PA or pharmacist for not prescribing fibrinolytic therapy, including patient refusal.
2. There is physician/APN/PA documentation the patient has a diagnosis of cardiogenic shock.
3. Only use reasons/contraindications listed in the data element.

<ul style="list-style-type: none"> • Any prior intracranial hemorrhage • Ischemic stroke w/in 3 months EXCEPT acute ischemic stroke w/in 3 hours • History of chronic, severe, poorly controlled hypertension. • For streptokinase/anistreplase: prior exposure (≥ 5 days ago) or prior allergic reaction to these agents 	<ul style="list-style-type: none"> • Known structural cerebral vascular lesion • Suspected aortic dissection • Significant closed head trauma or facial trauma within 3 months • Traumatic or prolonged (≥ 10 minutes) CPR or major surgery (<3 weeks) • Pregnancy • Active Peptic Ulcer • Cardiogenic Shock Diagnosis 	<ul style="list-style-type: none"> • Known malignant intracranial neoplasm • Active bleeding or bleeding diathesis (excluding menses) • Recent (w/in 2-4 weeks) internal bleeding • Noncompressible vascular punctures • Current use of anticoagulants prior to arrival: the higher the INR, the higher the risk of bleeding.
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Reasons for Holding Medications

Aspirin, Lipid-Lowering Therapy, Beta Blocker, ACE/ARB, Anti-Coagulant, Antithrombotic

1. Documented allergy in the medical record.
2. A crossed-out order on a pre-printed order sheet.
3. Reason must be explicitly documented or implied by the physician and specifically state the medication's name.
 - a. Acceptable
 - i. "Chronic hepatitis no aspirin"
 - ii. "GI bleeding with ASA in the past"
 - iii. "Beta blocker contraindicated in patient due to 2nd AV block."
 - iv. "Consult with cardiologist regarding ACE/ARB due to hypotension."
 - b. Unacceptable
 - i. "History of rectal bleeding."
 - ii. "Hold all BP medications."
 - iii. "Consult with cardiologist regarding ACE/ARB."
 - iv. "Will begin ACE if potassium is normal."
 - c. Exceptions
 - i. "Comfort care only"
 - ii. "Patient refusing **all** medication at this time."

Reasons for Not Administering VTE Prophylaxis

1. Physician /APN/PA or pharmacist documentation of a reason for not administering either mechanical or pharmacological VTE prophylaxis on day of or day after hospital admission.
2. Contraindication to pharmacological VTE prophylaxis does not explain why mechanical VTE not ordered.
 - a. "Pt. in MVA with head injury and bilateral fractures to tibias."
 - b. "Active GI bleed and patient is bilateral BKA."
3. Documented patient removal or refusal.
4. For stroke if graduated compression stockings are the only form of VTE prophylaxis administered, a reason for not administering another form of prophylaxis must be documented in the medical record.
5. Assessed as LOW risk for VTE.
6. Explicit documentation that the patient does not need VTE prophylaxis.
7. Surgery patients must have exclusion documentation within 24 hours of surgery time.
8. ICU patients must be assessed on admission or transfer into the ICU.

Reason for No LDL- Cholesterol Testing

1. Reason must be explicitly documented by physician.
 - a. "Patient refusing labs."
 - b. "Limited life expectancy."
 - c. "On Lipitor, testing not needed at this time."

Reason for Not Initiating IV Thrombolytic

1. Reason must be explicitly documented by physician with three exceptions:
 - a. Patient/family refusal.
 - b. NIHSS score of zero.
 - c. Given prior to arrival by EMS or transferring facility.
2. Reason must be mentioned in the context of IV thrombolytics.

Reason for Continuing Urinary Catheterization

1. Documentation by physician must be found on POD 1 or POD 2.
2. Documentation that the patient is in ICU AND receiving diuretics.
3. The physician documents reason for leaving catheter in.
 - a. "Continue catheter. Patient is on total bed rest."
4. Documented patient refusal of catheter removal.
5. Documented high risk for falls.

Reasons to Extend Antibiotics

1. Physician documentation must be within 2 days post procedure with day of surgery being zero. Documentation must be in context with Antibiotic ordered and reason to continue.
 - a. "Continue EES for the purpose of increasing gastric motility."
 - b. "Continue Antibiotic to treat hepatic encephalopathy."
 - c. "Antibiotic for prophylaxis of Pneumocystis pneumonia" for the patient with AIDS.
 - d. Documentation of malignancy to lower extremity, involving the same extremity as the principal procedure that was an original arthroplasty or a joint revision surgery.
 - e. Principal procedure was a joint revision surgery.
 - f. Documentation of *current* infection or suspected infection, such as:
 - i. Abscess
 - ii. Aspiration pneumonia; pneumonia or other lung infection
 - iii. Cellulitis
 - iv. Endometritis
 - v. Fecal contamination
 - vi. Gangrene
 - vii. Necrosis
 - viii. Bowel perforation
 - ix. Purulence/pus
 - x. Surgical site or wound infection
 - xi. Urinary tract infection