APPENDIX B

Specification Manuals
Data Specifications Manual

Emergency Department Transfer
Communication Measure

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Rural Health Research Center

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Stratis Health, based in Bloomington, Minnesota, is a nonprofit organization that leads collaboration and innovation in health care quality and safety, and serves as a trusted expert in facilitating improvement for people and communities.
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### Considerations for Electronic Transfer of Information

#### Measure EDTC-SUB 1

- Measurement Component: Electronic Transfer of Information
- Component Definition: All or None Composite
- Data Elements: Patient Name, Patient Address, Patient Age, Patient Gender, Patient Contact Information, Patient Insurance Information, Pulse, Respiratory Rate, Blood Pressure, Oxygen Saturation, Temperature, Neurological Assessment, Medications Administered in ED, Allergies/Reactions, Home Medications, History and Physical, Reason for Transfer/Plan of Care, Nursing Notes, Sensory Status (formerly Impairments), Catheters/IV, Immobilizations, Respiratory Support, Oral Restrictions, Tests/Procedures Performed, Tests/Procedure Results

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### Selected References

- Title: Electronic Transfer of Information
- Author: John Doe
- Publication: Journal of Healthcare Information Management
- Year: 2023

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### Appendix A: ED Transfer Paper Tool

- Title: ED Transfer Paper Tool
- Purpose: Capture and transfer critical patient information
- Components: Patient Information, Medical History, Allergies, Current Medications, Care Plan, Laboratory Results

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### Appendix B: List of Data Elements

- Title: List of Data Elements
- Purpose: Catalogue of necessary data for electronic transfer
- Data Elements:
  - Patient Name
  - Patient Address
  - Patient Age
  - Patient Gender
  - Patient Contact Information
  - Patient Insurance Information
  - Pulse
  - Respiratory Rate
  - Blood Pressure
  - Oxygen Saturation
  - Temperature
  - Neurological Assessment
  - Medications Administered in ED
  - Allergies/Reactions
  - Home Medications
  - History and Physical
  - Reason for Transfer/Plan of Care
  - Nursing Notes
  - Sensory Status (formerly Impairments)
  - Catheters/IV
  - Immobilizations
  - Respiratory Support
  - Oral Restrictions
  - Tests/Procedures Performed
  - Tests/Procedure Results

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### Appendix C: Emergency Department Transfer Communication Measures: Crosswalk with Meaningful Use Stage Two Requirements

- Title: Emergency Department Transfer Communication Measures: Crosswalk with Meaningful Use Stage Two Requirements
- Purpose: Align ED transfer with Meaningful Use Stage Two regulations
- Measures:
  - EDTC-SUB 1: All or None Composite
  - EDTC-SUB 2: Subset 1
  - EDTC-SUB 3: Subset 2
  - EDTC-SUB 4: Subset 3
  - EDTC-SUB 5: Subset 4
  - EDTC-SUB 6: Subset 5
  - EDTC-SUB 7: Subset 6
  - EDTC- Alternate All or None Composite
Emergency Department Transfer Communication Measure Specifications

ED Transfer Communication Quality Measure Set

<table>
<thead>
<tr>
<th>Measure ID #</th>
<th>Measure Short Name</th>
<th>NQF 1 Measure Number</th>
<th>NQMC 2 Measure Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>EDTC-SUB 1</td>
<td>Administrative communication</td>
<td>0291</td>
<td>7535</td>
</tr>
<tr>
<td>EDTC-SUB 2</td>
<td>Patient information</td>
<td>0291</td>
<td>7536</td>
</tr>
<tr>
<td>EDTC-SUB 3</td>
<td>Vital signs</td>
<td>0291</td>
<td>7537</td>
</tr>
<tr>
<td>EDTC-SUB 4</td>
<td>Medication information</td>
<td>0291</td>
<td>7538</td>
</tr>
<tr>
<td>EDTC-SUB 5</td>
<td>Physician or practitioner generated information</td>
<td>0291</td>
<td>7539</td>
</tr>
<tr>
<td>EDTC-SUB 6</td>
<td>Nurse generated information</td>
<td>0291</td>
<td>7540</td>
</tr>
<tr>
<td>EDTC-SUB 7</td>
<td>Procedures and tests</td>
<td>0291</td>
<td>7541</td>
</tr>
<tr>
<td>EDTC-Alt. All or None</td>
<td>Alternate all or none composite calculation</td>
<td>0291</td>
<td></td>
</tr>
</tbody>
</table>


Background of the Measure

In 2003, an expert panel convened by the University of Minnesota Rural Health Research Center and Stratis Health identified ED care as an important quality assessment measurement category for rural hospitals. While emergency care is important in all hospitals, it is particularly critical in rural hospitals where the size of the hospital and geographic realities make organizing triage, stabilization, and transfer of patients more important. Communication between providers promotes continuity of care and may lead to improved patient outcomes. These measures were piloted by rural hospitals in Hawaii, Iowa, Maine, Minnesota, Missouri, Nebraska, Nevada, New York, Ohio, Oklahoma, Pennsylvania, Utah, Washington, West Virginia, Wisconsin, and Wyoming; projects took place from October 2005 through July 2014. Results of the pilot projects indicated room for improvement in ED care and transfer communication.


Rationale

Communication problems are a major contributing factor to adverse events in hospitals, accounting for 65% of sentinel events tracked by The Joint Commission. In addition, research indicates that deficits exist in the transfer of patient information between hospitals and primary care physicians in the community, and between hospitals and long-term facilities. Transferred patients are excluded from the calculation of most national quality measures, such as those used in Hospital Compare. The Hospital Compare Web site was created to display rates of Process of Care measures using data that are voluntarily submitted by hospitals.

The Joint Commission has adopted National Patient Safety Goal 2, "Improve the Effectiveness of Communication Among Caregivers." This goal required all accredited hospitals to implement a standardized approach to hand-off communications, including nursing and physician handoffs from the emergency department (ED) to inpatient...
Emergency Department Transfer Communication Measure

units, other hospitals, and other types of health care facilities. The process must include a method of communicating up-to-date information regarding the patient’s care, treatment, and services; condition; and any recent or anticipated changes. (Note: The National Patient Safety Goals are reviewed and modified periodically. In 2013 a communication goal focuses on the communication of test results.)


Limited attention has been paid to the development and implementation of quality measures specifically focused on patient transfers between EDs and other health care facilities. Examples are patients transferred between an ED and a skilled nursing facility with their often vulnerable and fragile populations. These measures are important for all health care facilities, but especially so for small rural hospitals that transfer a higher proportion of ED patients.

While many aspects of hospital quality are similar for urban and rural hospitals (e.g., providing heart attack patients with aspirin), the urban/rural contextual differences result in differences in emphasis on quality measurement. Because of its role in linking residents to urban referral centers, important aspects of rural hospital quality include triage-and-transfer decision making about when to provide a particular type of care, transporting patients, and coordinating information flow to specialists beyond the community.

Emergency care is important in all hospitals, but it is particularly important in rural hospitals. Because of their size, rural hospitals are less likely to be able to provide more specialized services, such as cardiac catheterization or trauma surgery. Rural residents often need to travel greater distances than urban residents to get to a hospital initially. In addition, their initial point of contact is less likely to have specialized services and staff found in tertiary care centers, so they are also more likely to be transferred. These size and geographic realities increase the importance of organizing triage, stabilization, and transfer in rural hospitals which, in turn, suggest that measurement of these processes is an important issue for rural hospitals.

The ED Transfer Communication measure aims to provide a means of assessing how well key patient information is communicated from an ED to any healthcare facility. They are applicable to patients with a wide range of medical conditions (e.g., acute myocardial infarction, heart failure, pneumonia, respiratory compromise and trauma) and are relevant for both internal quality improvement purposes and external reporting to consumers and purchasers. The results of the field tests suggest that significant opportunity exists for improvement on these measures.
Emergency Department Transfer Communication Measure

Selected References:


Joint Commission on Accreditation of Healthcare Organizations. Sentinel events statistics. [Internet]. [Accessed 2007 Jul 18].


Emergency Department Transfer Communication Measure

Population and Sampling

ED Transfer Communication (EDTC) Initial Patient Population
The population of the EDTC measure set is defined by identifying those patients admitted to the emergency department who were then transferred/discharged to these facilities:

Inclusions:
3 Hospice – healthcare facility
4a Acute Care Facility- General Inpatient Care
   – including emergency department
4b Acute Care Facility- Critical Access Hospital
   – including emergency department
4c Acute Care Facility- Cancer Hospital or Children’s Hospital –
   including emergency department
4d Acute Care Facility – Department of Defense or Veteran’s Administration – including emergency department
5 Other health care facility:
   • Extended or Intermediate Care Facility (ECF/ICF)
   • Long Term Acute Care Hospital (LTACH)
   • Long Term Care Facility
   • 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)

Note: ED patients that have been put in observation status and then are transferred to another hospital or health care facility should be included.

Exclusions:
1. Home:
   • Assisted Living Facilities
   • Court/Law Enforcement – includes detention facilities, jails, and prison
   • 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
2. Hospice-home
6. Expired
7. AMA (left against medical advice)
8. Not documented/unable to determine

Note: Discharge codes taken from the CMS Hospital Outpatient Quality Reporting Specifications Manual.
Sample Size Requirements
Hospitals need to submit a minimum of 45 cases. Hospitals that choose to sample have the option of sampling quarterly or sampling monthly. A hospital may choose to use a larger sample size than is required. Hospitals whose initial patient population size is less than the minimum number of cases per quarter for the measure set cannot sample.

Regardless of the option used, hospital samples must be monitored to ensure that sampling procedures consistently produce statistically valid and useful data. Sample cases should be randomly selected in such a way that the individual cases in the population have an equal chance of being selected. Due to exclusions, hospitals selecting sample cases MUST submit AT LEAST the minimum required sample size.

The following sample size tables for each option automatically build in the number of cases needed to obtain the required sample sizes. For information concerning how to perform sampling, refer to the Population and Sampling Specifications section in this manual.

Hospitals performing quarterly sampling for ED Transfer Communication must ensure that their initial patient population and sample size meet the following conditions:

<table>
<thead>
<tr>
<th>Population Per Quarter</th>
<th>45-900</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quarterly sample size</td>
<td>45</td>
</tr>
<tr>
<td>Monthly sample size</td>
<td>15</td>
</tr>
<tr>
<td>Population Per Quarter</td>
<td>&lt;45</td>
</tr>
<tr>
<td>Quarterly sample size</td>
<td>Use all cases</td>
</tr>
<tr>
<td>Monthly sample size</td>
<td>Use all cases</td>
</tr>
</tbody>
</table>

Measure Calculation
This measure is calculated using an all or none approach.

The overall EDTC Measure can be calculated as the percent of medical records that met all of the 27 data elements.

Data elements not appropriate for an individual patient are scored as NA (not applicable), are counted in the measure as a positive, or ‘yes’ response, and the patient will meet that element criteria. The patient will either need to meet the criteria for all of the data elements or have an NA.

For quality improvement purposes, facilities are encouraged to review their information at the data element level to identify improvement opportunities in the transfer communication process.

Considerations for Electronic Transfer of Information
For health systems with shared electronic medical records, documentation must indicate that data elements had been entered into the data system and were available to the receiving facility prior to transfer for Administrative Measures or within 60 minutes of discharge for all other measures. If there are not shared records, “sent” means that medical record documentation indicates the information went with the patient or was sent via fax, phone, or internet/Electronic Health Record within 60 minutes of patient discharge.
Emergency Department Transfer Communication Measure

Measure EDTC-SUB 1

Measure Information Form
Measure Set: ED Transfer Communication (EDTC)
Set Measure ID#: EDTC-SUB 1
Performance Measure Name: Administrative communication
Description: Patients who are transferred from an ED to another healthcare facility have physician to
physician communication and healthcare facility to healthcare facility communication prior to discharge.
Rationale: Timely, accurate and direct communication facilitates the handoff to the receiving
facility provides continuity of care and avoids medical errors and redundant tests.
Type of Measure: Process
Improvement Noted As: An increase in the rate

Numerator Statement: Number of patients transferred to another healthcare facility whose medical
record documentation indicated that both communication actions occurred prior to transfer.
- Healthcare facility to healthcare facility communication
- Physician to physician communication

Denominator Statement: All transfers from ED to another healthcare
classification Included Populations: ED Transfers to another healthcare facility
Excluded Populations: None

Rate calculation Sub 1

<table>
<thead>
<tr>
<th>Numerator</th>
<th># of patients who have a yes or NA for both measures: healthcare facility to healthcare facility communication and physician to physician communication</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denominator</td>
<td>All transfers from ED to another healthcare facility</td>
</tr>
</tbody>
</table>

Risk Adjustment: No
Data Collection Approach: Retrospective data sources for required data elements include
administrative data and medical records.
Measure Analysis Suggestions: The data elements for each of the two communication elements provide
the opportunity to assess each component individually.

Sampling: Yes, please refer to the measure set specific sampling requirements. See the Population
and Sampling Specifications Section.
Measure EDTC-SUB 2

Measure Information Form
Measure Set: ED Transfer Communication (EDTC)
Set Measure ID#: EDTC-SUB 2
Performance Measure Name: Patient Information
Description: Patients who are transferred from an ED to another healthcare facility have patient identification information sent to the receiving facility within 60 minutes of discharge
Rationale: Timely, accurate and direct communication facilitates the handoff to the receiving facility provides continuity of care and avoids medical errors and redundant tests.
Type of Measure: Process
Improvement Noted As: An increase in the rate

Numerator Statement:
Number of patients transferred to another healthcare facility whose medical record documentation indicated that all of the elements were communicated to the receiving facility within 60 minutes of departure.
- Name
- Address
- Age
- Gender
- Significant others contact information
- Insurance

Denominator Statement: ED transfers to another healthcare facility

Included Populations: All transfers from ED to another healthcare facility
Excluded Populations: None

Rate calculation Sub 2

<table>
<thead>
<tr>
<th>Numerator</th>
<th># of patients who have a yes or NA for all measures: name, address, age, gender, contact, insurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denominator</td>
<td>All transfers from ED to another healthcare facility</td>
</tr>
</tbody>
</table>

Data Collection Approach: Retrospective data sources for required data elements include administrative data and medical records.
Measure Analysis Suggestions: The data elements for each of the six communication elements provide the opportunity to assess each component individually.

Sampling: Yes, please refer to the measure set specific sampling requirements. See the Population and Sampling Specification Section.
Measure EDTC-SUB 3

Measure Information Form
Measure Set: ED Transfer Communication (EDTC)
Set Measure ID#: EDTC-SUB 3
Performance Measure Name: Vital Signs
Description: Patients who are transferred from an ED to another healthcare facility have communication with the receiving facility within 60 minutes of discharge for patient’s vital signs
Rationale: Timely, accurate and direct communication facilitates the handoff to the receiving facility provides continuity of care and avoids medical errors and redundant tests.
Type of Measure: Process
Improvement Noted As: An increase in the rate

Numerator Statement: Number of patients transferred to another health care facility whose medical record documentation indicated that all of the elements were communicated to the receiving facility within 60 minutes of discharge.
- Pulse
- Respiratory rate
- Blood pressure
- Oxygen saturation
- Temperature
- Glasgow score or other neuro assessment for trauma, cognitively altered or neuro patients only

Denominator Statement: ED transfers to another healthcare facility

Included Populations: All transfers from ED to another healthcare facility
Excluded Populations: None

Rate calculation Sub 3

<table>
<thead>
<tr>
<th>Numerator</th>
<th># of patients who have a yes or NA for all measures: pulse, respiration, blood pressure, oxygen saturation, temperature and neuro assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denominator</td>
<td>All transfers from ED to another health care facility</td>
</tr>
</tbody>
</table>

Risk Adjustment: No
Data Collection Approach: Retrospective data sources for required data elements include administrative data and medical records.
Measure Analysis Suggestions: The data elements for each of the six communication elements provide the opportunity to assess each component individually.

Sampling: Yes, please refer to the measure set specific sampling requirements. See the Population and Sampling Specifications Section.
Emergency Department Transfer Communication Measure

Measure EDTC-SUB 4

Measure Information Form
Measure Set: ED Transfer Communication (EDTC)
Set Measure ID#: EDTC-SUB 4
Performance Measure Name: Medication Information
Description: Patients who are transferred from an ED to another healthcare facility have communication with the receiving facility within 60 minutes of discharge for medication information.
Rationale: Timely, accurate and direct communication facilitates the handoff to the receiving facility providing continuity of care and avoids medical errors and redundant tests.
Type of Measure: Process
Improvement Noted As: An increase in the rate

Numerator Statement: Number of patients transferred from an ED to another healthcare facility whose medical record documentation indicated that all of the elements were communicated to the receiving hospital within 60 minutes of departure.
- Medications administered in ED
- Allergies
- Home medications

Denominator Statement: ED transfers to another healthcare facility

Included Populations: All transfers from ED to another healthcare facility
Excluded Populations: None

Rate calculation Sub 4

<table>
<thead>
<tr>
<th>Numerator</th>
<th># of patients who have a yes or NA for all measures: Medications administered in ED, allergies and home medications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denominator</td>
<td>All transfers from ED to another health care facility</td>
</tr>
</tbody>
</table>

Risk Adjustment: No
Data Collection Approach: Retrospective data sources for required data elements include administrative data and medical records.
Measure Analysis Suggestions: The data elements for each of the three communication elements provide the opportunity to assess each component individually.

Sampling: Yes, please refer to the measure set specific sampling requirements. See the Population and Sampling Specifications Section.
Measure EDTC-SUB 5

Measure Information Form
Measure Set: ED Transfer Communication (EDTC)
Set Measure ID#: EDTC-SUB 5
Performance Measure Name: Physician or Practitioner generated information
Description: Patients who are transferred from an ED to another healthcare facility have communication with the receiving facility within 60 minutes of discharge for history and physical and physician plan of care.
Rationale: Timely, accurate and direct communication facilitates the handoff to the receiving facility provides continuity of care and avoids medical errors and redundant tests.
Type of Measure: Process
Improvement Noted As: An increase in the rate

Numerator Statement: Number of patients transferred to another healthcare facility whose medical record documentation indicated that all of the elements were communicated to the receiving facility within 60 minutes of discharge.
- History and physical/ED provider note
- Reason for transfer and/or plan of care

Denominator Statement: ED transfers to another healthcare facility

Included Populations: All transfers from ED to another healthcare facility
Excluded Populations: None

Rate calculation Sub 5

<table>
<thead>
<tr>
<th>Numerator</th>
<th># of patients who have a yes for all measures: history and physical and reason for transfer and/or plan of care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denominator</td>
<td>All transfers from ED to another health care facility</td>
</tr>
</tbody>
</table>

Risk Adjustment: No
Data Collection Approach: Retrospective data sources for required data elements include administrative data and medical records.
Measure Analysis Suggestions: The data elements for each of the two communication elements provide the opportunity to assess each component individually.

Sampling: Yes, please refer to the measure set specific sampling requirements. See the Population and Sampling Specifications Section.
Emergency Department Transfer Communication Measure

Measure EDTC-SUB 6

Measure Information Form
Measure Set: ED Transfer Communication (EDTC)
Set Measure ID#: EDTC-SUB 6
Performance Measure Name: Nurse Generated Information
Description: Patients who are transferred from an ED to another healthcare facility have communication with the receiving facility within 60 minutes of discharge for key nurse documentation elements
Rationale: Timely, accurate and direct communication facilitates the handoff to the receiving facility provides continuity of care and avoids medical errors and redundant tests.
Type of Measure: Process
Improvement Noted As: An increase in the rate

Numerator Statement: Number of patients transferred to another healthcare facility whose medical record documentation indicated that all of the elements were communicated to the receiving facility within 60 minutes of departure.
- Assessments/interventions/response
- Sensory Status (formerly Impairments)
- Catheters/IV
- Immobilizations
- Respiratory support
- Oral limitations

Denominator Statement: Transfers from an ED to another healthcare facility

Included Populations: All transfers from an ED to another healthcare facility
Excluded Populations: None

Rate calculation Sub 6

<table>
<thead>
<tr>
<th>Numerator</th>
<th># of patients who have a yes or NA for all measures: assessments/interventions/response, sensory status (formerly impairments), catheter, immobilization, respiratory support, oral limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denominator</td>
<td>All transfers from ED to another health care facility</td>
</tr>
</tbody>
</table>

Risk Adjustment: No
Data Collection Approach: Retrospective data sources for required data elements include administrative data and medical records.
Measure Analysis Suggestions: The data elements for each of the six communication elements provide the opportunity to assess each component individually.

Sampling: Yes, please refer to the measure set specific sampling requirements. See the Population and Sampling Specifications Section.
Emergency Department Transfer Communication Measure

Measure EDTC-SUB 7

Measure Information Form
Measure Set: ED Transfer Communication (EDTC)
Set Measure ID#: EDTC-SUB 7
Performance Measure Name: Procedures and Tests
Description: Patients who are transferred from an ED to another healthcare facility have communication with the receiving facility within 60 minutes of discharge of tests done and results sent.
Rationale: Timely, accurate and direct communication facilitates the handoff to the receiving facility provides continuity of care and avoids medical errors and redundant tests.
Type of Measure: Process
Improvement Noted As: An increase in the rate
Numerator Statement: Number of patients transferred to another healthcare facility whose medical record documentation indicated that all of the elements were communicated to the receiving hospital within 60 minutes of discharge.
- Tests and procedures done
- Tests and procedure results sent/ or plan to communicate

Denominator Statement: Transfers from an ED to another healthcare facility Included

Population: All transfers from an ED to another healthcare facility
Excluded Populations: None

Rate calculation Sub 7

<table>
<thead>
<tr>
<th>Numerator</th>
<th># of patients who have a yes or NA for all measures: test and procedures done and test and procedure results sent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denominator</td>
<td>All transfers from ED to another health care facility</td>
</tr>
</tbody>
</table>

Risk Adjustment: No
Data Collection Approach: Retrospective data sources for required data elements include administrative data and medical records.
Measure Analysis Suggestions: The data elements for each of the two communication elements provide the opportunity to assess each component individually.

Sampling: Yes, please refer to the measure set specific sampling requirements. See the Population and Sampling Specifications Section.
Emergency Department Transfer Communication Measure

Measure EDTC- Alternate All or None Composite Calculation

Measure Information Form
Measure Set: ED Transfer Communication (EDTC)
Set Measure ID#: EDTC-All or None
Performance Measure Name: All or None Measure
Description: Patients who are transferred from an ED to another healthcare facility have all necessary communication made available to the receiving facility
Rationale: Timely, accurate, and direct communication facilitates the handoff to the receiving facility provides continuity of care and avoids medical errors and redundant tests.
Type of Measure: Process
Improvement Noted As: An increase in the rate
Numerator Statement: Number of patients transferred to another healthcare facility whose medical record documentation indicated that all of the relevant elements for each of the 7 sub-measures were documented and communicated to the receiving hospital within 60 minutes of discharge.

<table>
<thead>
<tr>
<th>EDTC-SUB 1</th>
<th>Administrative communication</th>
</tr>
</thead>
<tbody>
<tr>
<td>EDTC-SUB 2</td>
<td>Patient information</td>
</tr>
<tr>
<td>EDTC-SUB 3</td>
<td>Vital signs</td>
</tr>
<tr>
<td>EDTC-SUB 4</td>
<td>Medication information</td>
</tr>
<tr>
<td>EDTC-SUB 5</td>
<td>Physician or practitioner generated information</td>
</tr>
<tr>
<td>EDTC-SUB 6</td>
<td>Nurse generated information</td>
</tr>
<tr>
<td>EDTC-SUB 7</td>
<td>Procedures and tests</td>
</tr>
</tbody>
</table>

Denominator Statement: Transfers from an ED to another healthcare facility

Included Population: All transfers from an ED to another healthcare facility
Excluded Populations: None

Calculation:
\[
\frac{\text{# of patients who have a yes or NA for all elements}}{\text{All transfers from ED to another healthcare facility}}
\]

Risk Adjustment: No
Data Collection Approach: Retrospective data sources for required data elements include administrative data and medical records.
Measure Analysis Suggestions: This measure can be used as an overall evaluation of performance on this measure set.

Sampling: Yes, please refer to the measure set specific sampling requirements. See the Population and Sampling Specifications Section.
Emergency Department Transfer Communication

Data Elements
Emergency Department Transfer Communication Measure

Data Element Name:  
*Healthcare Facility to Healthcare Facility Communication* (indicating bed and services available)

Collected For: Emergency Department Records: EDTC-SUB 1

Suggested Data Collection Question: Does the medical record documentation indicate that healthcare facility to healthcare facility communication occurred prior to discharge of the patient from the ED to another healthcare facility?

Allowable Values:
Y (Yes) Select this option if there is documentation of the ED staff communicating with staff of the receiving facility.
N (No) Select this option if there is no documentation of the ED staff communicating with staff of the receiving facility.

Notes for Abstraction:
- Documentation must indicate that healthcare facility to healthcare facility communication occurred prior to transfer.
- Date and time of contact can be used to verify that communication occurred prior to transfer.
- This does not need to be full report. Acceptable communication includes assuring the availability of appropriate bed and services for the patient.

Suggested Data Sources:
- Emergency Department record
- Transfer Summary document
- Nursing note

Inclusion Guidelines for Abstraction: None

Exclusion Guidelines for Abstraction: None
Data Element Name:
Physician to Physician Communication

Collected For: Emergency Department records: EDTC-SUB 1

Suggested Data Collection Question: Does the medical record documentation indicate that physician/advanced practice nurse/physician assistant (physician/APN/PA) to physician/APN/PA communication occurred prior to the transfer of the patient from the ED to another healthcare facility?

Allowable Values:
Y (Yes) Select this option if there is documentation of the ED physician/APN/PA discussion of the patient’s condition with physician/APN/PA staff at the receiving facility.
N (No) Select this option if there is no documentation of the ED physician/APN/PA discussion of the patient’s condition with physician/APN/PA at the receiving facility.
N/A (Not Applicable) Select this option if the transfer is to a non-acute care healthcare facility.

Notes for Abstraction:
- Must include the names of the two communicating providers.
- Documentation must indicate that ED physician/APN/PA to ED physician/APN/PA communication occurred prior to transfer.
- Date and time of contact can be used to verify that communication occurred prior to transfer.
- Documentation of a Practitioner transfer acceptance agreement that specifies advance approval for patients with specific conditions or medical needs would be acceptable.

Suggested Data Sources:
- Emergency Department record
- Transfer Summary document
- EMTALA form

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
None
Emergency Department Transfer Communication Measure

Data Element Name:

*Patient Name*

Collected For: Emergency Department Records: EDTC-SUB 2

Definition: For this question, “sent” refers to medical record documentation that indicates information went with the patient or was communicated via fax or phone or internet/Electronic Health Record connection availability within 60 minutes of the patient’s discharge.

Suggested Data Collection Question: Does the medical record documentation indicate that the patient’s name was sent to the receiving facility?

Allowable Values:
Y (Yes) Select this option if there is documentation that the patient’s name was sent to the receiving facility.
N (No) Select this option if there is no documentation that the patient’s name was sent to the receiving facility.
NA (Not Applicable) Select this option if this information was not available.

Notes for Abstraction:
- If the patient is a John/Jane Doe, and/or is altered neurologically select NA
- If the patient has a potential brain/head injury select NA.
- If the patient refuses to answer the question select NA.

Suggested Data Sources:
- Emergency Department record
- Face sheet
- Transfer Summary document

Inclusion Guidelines for Abstraction: None

Exclusion Guidelines for Abstraction: None
Data Element Name:

**Patient Address**

Definition: For this question, “sent” refers to medical record documentation that indicates information went with the patient or was communicated via fax or phone or internet/Electronic Health Record connection availability within 60 minutes of the patient’s discharge.

Suggested Data Collection Question: Does the medical record documentation indicate that the patient’s address was sent to the receiving facility?

Allowable Values:
Y (Yes) Select this option if there is documentation that the patient’s address was sent to the receiving facility.
N (No) Select this option if there is no documentation that the patient’s address was sent to the receiving facility.
NA (Not Applicable) Select this option if this information was not available

Notes for Abstraction:
- If the patient is a John/Jane Doe, and/or is altered neurologically select NA
- If the patient has a potential brain/head injury select NA
- If the patient refuses to answer the question select NA.

Suggested Data Sources:
- Emergency Department record
- Face sheet
- Transfer Summary document

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
None
Emergency Department Transfer Communication Measure

Data Element Name:

**Patient Age**

Definition: For this question, “sent” refers to medical record documentation that indicates information went with the patient or was communicated via fax or phone or internet/Electronic Health Record connection availability within 60 minutes of the patient’s discharge.

Suggested Data Collection Question: Does the medical record documentation indicate that the patient’s age was sent to the receiving facility?

Allowable Values:

Y (Yes) Select this option if there is documentation that the patient’s age was sent to the receiving facility.

N (No) Select this option if there is no documentation that the patient’s age was sent to the receiving facility.

NA (Not Applicable) Select this option if this information was not available

Notes for Abstraction:

- If the patient is a John/Jane Doe, and/or is altered neurologically select NA.
- If the patient has a potential brain/head injury select NA
- If the patient refuses to answer the question select NA.
- If the patient’s date of birth was sent select yes.

Suggested Data Sources:

- Emergency Department record
- Face sheet
- Transfer Summary document

Inclusion Guidelines for Abstraction:

None

Exclusion Guidelines for Abstraction:

None
Data Element Name:  

*Patient Gender*

Definition: For this question, “sent” refers to medical record documentation that indicates information went with the patient or was communicated via fax or phone or internet/Electronic Health Record connection availability within 60 minutes of the patient’s discharge.

Suggested Data Collection Question: Does the medical record documentation indicate that the patient gender was sent to the receiving facility?

Allowable Values:

Y (Yes) Select this option if there is documentation that gender was sent to the receiving facility.

N (No) Select this option if there is no documentation that gender was sent to the receiving facility.

NA (Not Applicable) Select this option if this information was not available or unable to be determined

Notes for Abstraction:

Suggested Data Sources:

- Emergency Department record
- Face sheet
- Transfer Summary document

Inclusion Guidelines for Abstraction:

None

Exclusion Guidelines for Abstraction:

None
Data Element Name:  

**Patient Contact Information**

Definition: For this question, “sent” refers to medical record documentation that indicates information went with the patient or was communicated via fax or phone or internet/Electronic Health Record connection availability within 60 minutes of the patient’s discharge.

Suggested Data Collection Question: Does the medical record documentation indicate that contact information for a family member/significant other/friend was sent to the receiving facility?

Allowable Values:
- Y (Yes) Select this option if there is documentation that contact information was sent to the receiving facility.
- N (No) Select this option if there is no documentation that contact information was sent to the receiving facility.
- NA (Not Applicable) Select this option if this information was not available.

Notes for Abstraction:
- The patient’s contact can be a family member, significant other or friend.
- Contact information must include both a name and phone number.
- Can have more than one contact but must have at least one.
- If the patient is a John/Jane Doe and/or is altered neurologically select NA.
- If the patient has a potential brain/head injury select NA.
- If the patient refuses to answer the question select NA.

Suggested Data Sources:
- Emergency Department record
- Face sheet
- Transfer Summary document

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
None
Data Element Name:

*Patient Insurance Information*

Definition: For this question, “sent” refers to medical record documentation that indicates information went with the patient or was communicated via fax or phone or internet/Electronic Health Record connection availability within 60 minutes of the patient’s discharge.

Suggested Data Collection Question: Does the medical record documentation indicate that the patient’s insurance information was sent to the receiving facility?

Allowable Values:
Y (Yes) Select this option if there is documentation that insurance information was sent to the receiving facility.
N (No) Select this option if there is no documentation that insurance information was sent to the receiving facility.
NA (Not Applicable) Select this option if this information was not available.

Notes for Abstraction:
- Information must include both the insurance company name and policy number.
- If patient does not have insurance and uninsured status is documented, select yes.
- If the patient is a John/Jane Doe and/or is altered neurologically select NA.
- If the patient has a potential brain/head injury select NA.
- If the patient refuses to answer the question select NA.

Suggested Data Sources:
- Emergency Department record
- Face sheet
- Copy of insurance card
- Transfer Summary document

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
None
Data Element Name: *Pulse*

Definition: For this question, “sent” refers to medical record documentation that indicates information went with the patient or was communicated via fax or phone or internet/Electronic Health Record connection availability within 60 minutes of the patient’s discharge.

Suggested Data Collection Question: Does the medical record documentation indicate that the patient’s pulse was taken and sent to the receiving facility?

Allowable Values:
Y (Yes) Select this option if there is documentation that the patient’s pulse was taken and sent to the receiving facility.
N (No) Select this option if there is no documentation that the patient’s pulse was taken and sent to the receiving facility.

Notes for Abstraction:

Suggested Data Sources:
- Emergency Department record
- Nursing Notes
- Transfer Summary document

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
None
Data Element Name:

*Respiratory Rate*

Definition: For this question, “sent” refers to medical record documentation that indicates information went with the patient or was communicated via fax or phone or internet/Electronic Health Record connection availability within 60 minutes of the patient’s discharge.

Suggested Data Collection Question: Does the medical record documentation indicate that the patient’s respiratory rate was taken and sent to the receiving facility?

Allowable Values:
Y (Yes) Select this option if there is documentation that the patient’s respiratory rate was taken and sent to the receiving facility.
N (No) Select this option if there is no documentation that the patient’s respiratory rate was taken and sent to the receiving facility.

Notes for Abstraction:

Suggested Data Sources:
- Emergency Department record
- Nursing Notes
- Transfer Summary document

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
None
Data Element Name:

**Blood Pressure**

Definition: For this question, “sent” refers to medical record documentation that indicates information went with the patient or was communicated via fax or phone or internet/Electronic Health Record connection availability within 60 minutes of the patient’s discharge.

Suggested Data Collection Question: Does the medical record documentation indicate that the patient’s blood pressure was taken and sent to the receiving facility?

Allowable Values:
Y (Yes) Select this option if there is documentation that the patient’s blood pressure was taken and sent to the receiving facility.
N (No) Select this option if there is no documentation that the patient’s blood pressure was taken and sent to the receiving facility.
NA (Not Applicable) Select this option if the patient is less than or equal to 3 years of age. Select this option if a Blood Pressure is unable to be assessed due to patients’ behavior or mental status.

Notes for Abstraction:

Suggested Data Sources:
- Emergency Department record
- Face sheet
- Transfer Summary document

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
None
Emergency Department Transfer Communication Measure

Data Element Name:

Oxygen Saturation

Definition: For this question, “sent” refers to medical record documentation that indicates information went with the patient or was communicated via fax or phone or internet/Electronic Health Record connection availability within 60 minutes of the patient’s discharge.

Suggested Data Collection Question: Does the medical record documentation indicate that the patient’s oxygen saturation (O2 Sat) was taken and sent to the receiving facility?

Allowable Values:
Y (Yes) Select this option if there is documentation that the patient’s oxygen saturation (O2 Sat) was taken and was sent to the receiving facility.
N (No) Select this option if there is no documentation that the patient’s oxygen saturation (O2 Sat) was taken and sent to the receiving facility.

Notes for Abstraction:

Suggested Data Sources:
- Emergency Department record
- Nursing Notes
- Transfer Summary document

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
None
Emergency Department Transfer Communication Measure

Data Element Name:
Temperature

Definition: For this question, “sent” refers to medical record documentation that indicates information went with the patient or was communicated via fax or phone or internet/Electronic Health Record connection availability within 60 minutes of the patient’s discharge.

Suggested Data Collection Question: Does the medical record documentation indicate that the patient’s temperature was taken and sent to the receiving facility?

Allowable Values:
Y (Yes) Select this option if there is documentation that the patient’s temperature was taken and the temperature was sent to the receiving facility.
N (No) Select this option if there is no documentation that the patient’s temperature was taken and sent to the receiving facility.
NA (Not Applicable) Select this option if the temperature is not required. See notes for abstraction.

Notes for Abstraction:
Temperature is required for patients with physician/APN/PA documentation of suspected infection, hypothermia or heat disorder.

Suggested Data Sources:
- Emergency Department record
- Nursing Notes
- Transfer Summary document

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
None
Emergency Department Transfer Communication Measure

Data Element Name:

**Neurological Assessment**

Definition: For this question, “sent” refers to medical record documentation that indicates information went with the patient or was communicated via fax or phone or internet/Electronic Health Record connection availability within 60 minutes of the patient’s discharge.

Suggested Data Collection Question: Does the medical record documentation indicate that a neurological assessment was done on patients at risk for altered consciousness and sent to the receiving facility?

Allowable Values:
Y (Yes) Select this option if there is documentation that a neuro assessment was done and sent to the receiving facility.
N (No) Select this option if there is no documentation that a neuro assessment for the condition was done and sent to the receiving facility.
NA (Not Applicable) Select this option if a neurologic assessment is not required due to no documentation of altered consciousness, possible brain/head injury, trauma or post seizure, stroke, TIA condition.

Notes for Abstraction: Only required for patients with documentation of:
- Altered consciousness
- Possible brain/head injury
- Post seizure
- Trauma
- Stroke
- TIA

Suggested Data Sources:
- Emergency Department record
- Birth or delivery record
- Transfer Summary document
- Glasgow coma scale
- Neuro flow sheets

Exclusion Guidelines for Abstraction:
None
Data Element Name:  
*Medications Administered in ED*

Definition: For this question, “sent” refers to medical record documentation that indicates information went with the patient or was communicated via fax or phone or internet/Electronic Health Record connection availability within 60 minutes of the patient’s discharge.

Suggested Data Collection Question: Does the medical record documentation indicate that the list of medication(s) administered or that no medications were administered in the ED was sent to the receiving facility?

Allowable Values:
- Y (Yes) Select this option if there is documentation that the list of medications administered were sent to the receiving facility.
- N (No) Select this option if there is no documentation that the list of medications administered were sent to the receiving facility.

Notes for Abstraction:
- If no medications were given during the ED visit, documentation must state that there were no medications given to select yes.
- Medication information documented anywhere in the ED record is acceptable.

Suggested Data Sources:
- Emergency Department record
- Medication Administration Record (MAR) if part of the ED documentation for the current encounter
- Transfer Summary document

Inclusion Guidelines for Abstraction: None

Exclusion Guidelines for Abstraction: None
Data Element Name: **Allergies/Reactions**

Definition: For this question, “sent” refers to medical record documentation that indicates information went with the patient or was communicated via fax or phone or internet/Electronic Health Record connection availability within 60 minutes of the patient’s discharge.

Suggested Data Collection Question: Does the medical record documentation indicate that the patient’s allergy history was sent to the receiving facility?

Allowable Values:
Y (Yes) Select this option if there is documentation the patient’s allergy information was sent to the receiving facility.
N (No) Select this option if there is no documentation the patient’s allergy information was sent to the receiving facility.

Notes for Abstraction:
- See inclusion guidelines for what should be contained in the allergy information.
- If documentation is sent that allergies are unknown, select yes.

Suggested Data Sources:
- Emergency Department record
- Transfer Summary

Inclusion Guidelines for Abstraction:
- Food allergies/reactions
- Medication allergies/reactions
- Other allergies/reactions

Exclusion Guidelines for Abstraction:
None
Data Element Name: *Home Medications*

Definition: For this question, “sent” refers to medical record documentation that indicates information went with the patient or was communicated via fax or phone or internet/Electronic Health Record connection availability within 60 minutes of the patient’s discharge.

Suggested Data Collection Question: Does the medical record documentation indicate that the patient’s medication history was sent to the receiving facility?

Allowable Values:
Y (Yes) Select this option if there is documentation medication history was sent to the receiving facility.
N (No) Select this option if there is no documentation medication history was sent to the receiving facility.

Notes for Abstraction:
- If documentation indicates patient is not on any home medications, select yes.
- If documentation is sent that home medications are unknown, select yes

Suggested Data Sources:
- Emergency Department record
- Transfer Summary

Inclusion Guidelines for Abstraction:
- Complimentary medications
- Over the counter (OTC) medications

Exclusion Guidelines for Abstraction:
None
Emergency Department Transfer Communication Measure

Data Element Name:  

*History and Physical/ED Provider Note*

Definition: For this question, “sent” refers to medical record documentation that indicates information went with the patient or was communicated via fax or phone or internet/Electronic Health Record connection availability within 60 minutes of the patient’s discharge.

Suggested Data Collection Question: Does the medical record documentation indicate that a history and physical/ED Provider Note was done by the physician/advanced practice nurse/physician assistant (physician/APN/PA) and sent to the receiving facility?

Allowable Values:
Y (Yes) Select this option if there is documentation a history and physical/ED Provider Note was done and sent to the receiving facility.
N (No) Select this option if there is no documentation that a history and physical/ED Provider Note was done and sent to the receiving facility.

Notes for Abstraction:
Must minimally include history of the current ED episode, a focused physical exam and relevant chronic conditions. Chronic conditions may be excluded if the patient is neurologically altered.

Suggested Data Sources:
- Emergency Department record
- Transfer Summary

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
None
Emergency Department Transfer Communication Measure

Data Element Name:

Reason for Transfer/Plan of Care

Definition: For this question, “sent” refers to medical record documentation that indicates information went with the patient or was communicated via fax or phone or internet/Electronic Health Record connection availability within 60 minutes of the patient’s discharge.

Suggested Data Collection Question: Does the medical record documentation indicate that a reason for transfer and/or plan of care was done by the physician/advanced practice nurse/physician assistant (physician/APN/PA) and sent to the receiving facility?

Allowable Values:
Y (Yes) Select this option if there is documentation a reason for transfer or plan of care was done and sent to the receiving facility.
N (No) Select this option if there is no documentation that a reason for transfer or plan of care was done and sent to the receiving facility.

Notes for Abstraction:
May include suggestions for care to be received at the receiving facility.

Suggested Data Sources:
- Emergency Department record
- Transfer Summary
- EMTALA form

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
None
Data Element Name:

*Nursing Notes*

Definition: For this question, “sent” refers to medical record documentation that indicates information went with the patient or was communicated via fax or phone or internet/Electronic Health Record connection availability within 60 minutes of the patient’s discharge.

Suggested Data Collection Question: Does the medical record documentation indicate that nursing notes were sent to the receiving facility?

Allowable Values:
Y (Yes) Select this option if there is documentation that nursing notes were sent to the receiving facility.
N (No) Select this option if there is no documentation that nursing notes were sent to the receiving facility.

Notes for Abstraction:
- Examples of nursing notes may include nursing assessment, intervention, response or SOAP notes.

Suggested Data Sources:
- Emergency Department record
- Transfer Summary

Inclusion Guidelines for Abstraction:
None

Exclusion Guidelines for Abstraction:
None
Data Element Name:  
**Sensory Status (formerly Impairments)**  
Definition: For this question, “sent” refers to medical record documentation that indicates information went with the patient or was communicated via fax or phone or internet/Electronic Health Record connection availability within 60 minutes of the patient’s discharge.  

Suggested Data Collection Question: Does the medical record documentation indicate that the patient was assessed for impairments?  

Allowable Values:  
Y (Yes) Select this option if there is documentation that assessment of sensory status was done and information was sent to the receiving facility.  
N (No) Select this option if there is no documentation that assessment of sensory status was done and information was sent to the receiving facility.  

Notes for Abstraction:  
Select Yes if documentation indicates that patient is unresponsive.  
Documentation includes the patient being assessed for mental, speech, hearing, vision, and sensation impairment.  
For example:  
- A History and Physical that includes at least one the following would be acceptable  
  - ENT WNL – indicates assessment of speech and hearing  
  - Oriented - indicates assessment of mental status  
  - Has or denies tingling/numbness – indicates assessment of sensation  
- Nursing Notes that indicate the following would be acceptable:  
  - Wears eyeglasses – indicates assessment of vision  
  - Has hearing aid – indicates assessment of hearing  

Suggested Data Sources:  
- Emergency Department record  
- Transfer Summary  

Inclusion Guidelines for Abstraction:  
None  

Exclusion Guidelines for Abstraction:  
None
Data Element Name:
*Catheters/IV*

Definition: For this question, “sent” refers to medical record documentation that indicates information went with the patient or was communicated via fax or phone or internet/Electronic Health Record connection availability within 60 minutes of the patient’s discharge.

Suggested Data Collection Question: Does the medical record documentation indicate that treatment with IV or any other catheters was provided to the patient and sent to the receiving facility?

Allowable Values:
Y (Yes) Select this option if there is documentation that catheter information was sent to the receiving facility.
N (No) Select this option if there is no documentation that catheter information was sent to the receiving facility.
NA (Not Applicable) Select this option if no catheters were placed.

Notes for Abstraction:
Select NA if no catheters were placed.

Suggested Data Sources:
- Emergency Department record
- Transfer Summary document

Inclusion Guidelines for Abstraction:
- IV (intravenous)
- IT (intrathecal)
- Urinary
- Heparin Lock
- Central line

Exclusion Guidelines for Abstraction:
None
Emergency Department Transfer Communication Measure

Data Element Name: **Immobilizations**

Definition: For this question, “sent” refers to medical record documentation that indicates information went with the patient or was communicated via fax or phone or internet/Electronic Health Record connection availability within 60 minutes of the patient’s discharge.

Suggested Data Collection Question: Does the medical record documentation indicate information was sent regarding any immobilization provided for the patient?

Allowable Values:
- Y (Yes) Select this option if there is documentation that immobilization was done and information was sent to the receiving facility.
- N (No) Select this option if there is documentation that immobilization was done and information was not sent to the receiving facility.
- NA (Not Applicable) Select this option if no immobilization was done

Notes for Abstraction:
Select NA if no immobilization was done.

Suggested Data Sources:
- Emergency Department record
- Transfer Summary document

Inclusion Guidelines for Abstraction:
- Backboard
- Casts
- Neck brace
- Other braces

Exclusion Guidelines for Abstraction:
None
Emergency Department Transfer Communication Measure

Data Element Name:

Respiratory Support

Definition: For this question, “sent” refers to medical record documentation that indicates information went with the patient or was communicated via fax or phone or internet/Electronic Health Record connection availability within 60 minutes of the patient’s discharge.

Suggested Data Collection Question: Does the medical record documentation indicate information was sent regarding any respiratory support provided to the patient?

Allowable Values:
Y (Yes) Select this option if there is documentation that respiratory support was provided and information was sent to the receiving facility.
N (No) Select this option if documentation that respiratory support was provided and information was not sent to the receiving facility.
NA (Not Applicable) Select this option if no respiratory support was provided.

Notes for Abstraction:
If no respiratory support was provided select NA.

Suggested Data Sources:
- Emergency Department record
- Transfer Summary document

Inclusion Guidelines for Abstraction:
- Bronchial drainage
- Intubations
- Oxygen
- Ventilator support

Exclusion Guidelines for Abstraction:
None
Data Element Name: 

**Oral Restrictions**

Definition: For this question, “sent” refers to medical record documentation that indicates information went with the patient or was communicated via fax or phone or internet/Electronic Health Record connection availability within 60 minutes of the patient’s discharge.

Suggested Data Collection Question: Does the medical record documentation indicate information was sent regarding any oral restrictions placed on the patient?

Allowable Values:
- Y (Yes) Select this option if there is documentation that oral restriction were placed and information was sent to the receiving facility.
- N (No) Select this option if there is documentation that oral restrictions were placed and information was not sent to the receiving facility.
- NA (Not Applicable) Select this option if no oral restrictions were placed.

Notes for Abstraction:
Select NA if no oral restrictions were placed.

Suggested Data Sources:
- Emergency Department record
- Transfer Summary document

Inclusion Guidelines for Abstraction:
- NPO
- Clear liquids
- Soft diet
- Low NA diet

Exclusion Guidelines for Abstraction:
None
Emergency Department Transfer Communication Measure

Data Element Name:

*Tests/Procedures Performed*

Definition: For this question, “sent” refers to medical record documentation that indicates information went with the patient or was communicated via fax or phone or internet/Electronic Health Record connection availability within 60 minutes of the patient’s discharge.

Suggested Data Collection Question: Does the medical record documentation indicate information was sent on any tests and procedures done in the ED?

Allowable Values:
- Y (Yes) Select this option if there is documentation that information on all tests and procedures completed in the ED prior to transfer was sent to the receiving facility.
- N (No) Select this option if there is no documentation that information on all tests and procedures completed in the ED prior to transfer was sent to the receiving facility.
- NA (Not Applicable) Select this option if no tests or procedures were done.

Notes for Abstraction:
- If test or procedure results were sent select yes.
- If no tests or procedures were done select NA.

Suggested Data Sources:
- Emergency Department record
- Lab documentation
- Transfer Summary document

Inclusion Guidelines for Abstraction:
- Lab work ordered
- X-rays
- Procedures performed
- EKGs
- Cultures

Exclusion Guidelines for Abstraction:
None
Emergency Department Transfer Communication Measure

Data Element Name:

*Tests/Procedure Results*

Definition: For this question, “sent” refers to medical record documentation that indicates information went with the patient or was communicated via fax or phone or internet/Electronic Health Record connection availability within 60 minutes of the patient’s discharge.

Suggested Data Collection Question: Does the medical record documentation indicate that results were sent from completed tests and procedures done in the ED?

Allowable Values:
Y (Yes) Select this option if there is documentation of results being sent either with the patient or communicated to the receiving facility when available.
N (No) Select this option if there is no documentation of results being sent either with the patient or communicated to the receiving facility when available.
NA (Not Applicable) Select this option if no tests or procedures were done.

Notes for Abstraction:
- If facilities share medical records then tests and procedure results are considered sent – select yes.
- If results are not sent and facilities do not share medical records then documentation must include a plan to communicate results in order to select yes.
- If no plan to communicate results - select no.

Suggested Data Sources:
- Emergency Department record
- Lab documentation
- Transfer Summary document

Inclusion Guidelines for Abstraction:
- Lab results
- X-ray results
- Procedure results
- EKG
- Cultures

Exclusion Guidelines for Abstraction:
None
Appendix B:  
List of Data Elements

Emergency Department Transfer Communication  
Measure Required Data Elements

<table>
<thead>
<tr>
<th>Data Element</th>
<th>Acceptable Values/Format</th>
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<tr>
<td>CMS Certified Number (CCN)</td>
<td>6 digit numeric</td>
</tr>
<tr>
<td>State</td>
<td>Two character postal code (MN)</td>
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<tr>
<td>Patient Discharge Status Code*</td>
<td>Two digit code: 03, 4a, 4b, 4c, 4d, 05</td>
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<td>Date of Patient Encounter</td>
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<td>Healthcare Facility to Healthcare Facility</td>
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<tr>
<td>Communication</td>
<td></td>
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<tr>
<td>Physician to Physician Communication</td>
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<td>Patient Insurance Information</td>
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<td>Pulse</td>
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<td>Respiratory Rate</td>
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<td>Oxygen Saturation</td>
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<td>Temperature</td>
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<td>Neurological Assessment</td>
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<td>Allergies/Reactions</td>
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<td>Home Medication</td>
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<td>History and Physical</td>
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<td>Reason for Transfer Plan of Care</td>
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<td>Nursing Notes</td>
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</tr>
<tr>
<td>Sensory Status (formerly impairments)</td>
<td>Y/N</td>
</tr>
<tr>
<td>Catheters</td>
<td>Y/N/NA</td>
</tr>
<tr>
<td>Immobilizations</td>
<td>Y/N/NA</td>
</tr>
<tr>
<td>Respiratory Support</td>
<td>Y/N/NA</td>
</tr>
<tr>
<td>Oral Restrictions</td>
<td>Y/N/NA</td>
</tr>
<tr>
<td>Tests/Procedures Performed</td>
<td>Y/N/NA</td>
</tr>
<tr>
<td>Tests/Procedure Results</td>
<td>Y/N/NA</td>
</tr>
</tbody>
</table>

*Reference: [www.qualitynet.org](http://www.qualitynet.org) – Outpatient Reporting, Measure Resources, Discharge Code to Discharge Status Crosswalk
Appendix C:  
Emergency Department Transfer Communication Measure:  
Crosswalk with Meaningful Use Stage Two Requirements

Eligible Hospital and Critical Access Hospital Meaningful Use Core Measures  
Measure 12 of 16: Summary of Care  
Date issued: November, 2012  

**Objective:** The eligible hospital or CAH who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care provides a summary care record for each transition of care or referral.

**A summary of care record must include the following elements:**

<table>
<thead>
<tr>
<th>Meaningful Use standard</th>
<th>ED transfer measures SUB</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient name.</td>
<td>2</td>
</tr>
<tr>
<td>Referring or transitioning provider's name and office contact information (EP only).</td>
<td>1</td>
</tr>
<tr>
<td>Procedures.</td>
<td>7</td>
</tr>
<tr>
<td>Encounter diagnosis</td>
<td>5</td>
</tr>
<tr>
<td>Immunizations.</td>
<td>Not included</td>
</tr>
<tr>
<td>Laboratory test results.</td>
<td>7</td>
</tr>
<tr>
<td>Vital signs (height, weight, blood pressure, BMI).</td>
<td>3</td>
</tr>
<tr>
<td>Smoking status.</td>
<td>5, 6</td>
</tr>
<tr>
<td>Functional status, including activities of daily living, cognitive and disability status</td>
<td>3, 6</td>
</tr>
<tr>
<td>Demographic information (preferred language, sex, race, ethnicity, date of birth).</td>
<td>2</td>
</tr>
<tr>
<td>Care plan field, including goals and instructions.</td>
<td>5</td>
</tr>
<tr>
<td>Care team including the primary care provider of record and any additional known care team members beyond the referring or transitioning provider</td>
<td>1</td>
</tr>
<tr>
<td>Discharge instructions</td>
<td>5</td>
</tr>
<tr>
<td>Current problem list (Hospitals may also include historical problems at their discretion) At a minimum a list of current, active and historical diagnoses. We do not limit the eligible hospital to just including diagnoses on the problem list.</td>
<td>5</td>
</tr>
<tr>
<td>Current medication list, and</td>
<td>4</td>
</tr>
<tr>
<td>Current medication allergy list.</td>
<td>4</td>
</tr>
<tr>
<td>Current allergy list: An exaggerated immune response or reaction to substances that are generally not harmful.</td>
<td>4, 5, 6,</td>
</tr>
<tr>
<td>Care Plan: The structure used to define the management actions for the various conditions, problems, or issues. A care plan must include at a minimum the following components: problem (the focus of the care plan), goal (the target outcome) and any instructions that the provider has given to the patient. A goal is a defined target or measure to be achieved in the process of patient care (an expected outcome).</td>
<td>5</td>
</tr>
</tbody>
</table>

Table by Jill M. Klingner, March 2013
Hospital Outpatient Quality Measures
Acute Myocardial Infarction (AMI)

<table>
<thead>
<tr>
<th>Set Measure ID #</th>
<th>Measure Short Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>OP-2*</td>
<td>Fibrinolytic Therapy Received Within 30 Minutes of ED Arrival</td>
</tr>
<tr>
<td>OP-3*</td>
<td>Median Time to Transfer to Another Facility for Acute Coronary Intervention</td>
</tr>
<tr>
<td>OP-5**</td>
<td>Median Time to ECG</td>
</tr>
</tbody>
</table>

*Measures only applicable to AMI Population
†Measures apply to both the AMI Population and Chest Pain Population
**Data for this measure will no longer be reported after 1Q2019 (encounter dates January 1 through March 31, 2019). The last data submission deadline for OP-5 will be August 1, 2019.

OP Acute Myocardial Infarction General Data Element List

<table>
<thead>
<tr>
<th>General Data Element Name</th>
<th>Collected For:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arrival Time</td>
<td>All Records</td>
</tr>
<tr>
<td>Birthdate</td>
<td>All Records</td>
</tr>
<tr>
<td>CMS Certification Number ‡, †</td>
<td>All Records</td>
</tr>
<tr>
<td>First Name</td>
<td>All Records</td>
</tr>
<tr>
<td>Hispanic Ethnicity</td>
<td>All Records</td>
</tr>
<tr>
<td>Last Name</td>
<td>All Records</td>
</tr>
<tr>
<td>National Provider Identifier ‡, †</td>
<td>Optional for All Records</td>
</tr>
<tr>
<td>Outpatient Encounter Date</td>
<td>All Records</td>
</tr>
<tr>
<td>Patient Identifier</td>
<td>All Records</td>
</tr>
<tr>
<td>Payment Source</td>
<td>All Records</td>
</tr>
<tr>
<td>Physician 1</td>
<td>Optional for All Records</td>
</tr>
<tr>
<td>Physician 2</td>
<td>Optional for All Records</td>
</tr>
<tr>
<td>Postal Code</td>
<td>All Records</td>
</tr>
<tr>
<td>Race</td>
<td>All Records</td>
</tr>
<tr>
<td>Sex</td>
<td>All Records</td>
</tr>
</tbody>
</table>

‡Transmission Data Element
†Defined in the Transmission Data Element List within the Hospital Outpatient Measure Data Transmission section of this manual.
OP Acute Myocardial Infarction Specific Data Element List

<table>
<thead>
<tr>
<th>OP AMI Data Element Name</th>
<th>Collected For:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discharge Code</td>
<td>OP-2, OP-3, OP-5</td>
</tr>
<tr>
<td>E/M Code</td>
<td>OP-2, OP-3, OP-5</td>
</tr>
<tr>
<td>ECG</td>
<td>OP-5</td>
</tr>
<tr>
<td>ECG Date</td>
<td>OP-5</td>
</tr>
<tr>
<td>ECG Time</td>
<td>OP-5</td>
</tr>
<tr>
<td>ED Departure Date</td>
<td>OP-3</td>
</tr>
<tr>
<td>ED Departure Time</td>
<td>OP-3</td>
</tr>
<tr>
<td>Fibrinolytic Administration</td>
<td>OP-2, OP-3</td>
</tr>
<tr>
<td>Fibrinolytic Administration Date</td>
<td>OP-2</td>
</tr>
<tr>
<td>Fibrinolytic Administration Time</td>
<td>OP-2</td>
</tr>
<tr>
<td>ICD-10-CM Other Diagnosis Codes</td>
<td>OP-5</td>
</tr>
<tr>
<td>ICD-10-CM Principal Diagnosis Code</td>
<td>OP-2, OP-3, OP-5</td>
</tr>
<tr>
<td>Initial ECG Interpretation</td>
<td>OP-2, OP-3</td>
</tr>
<tr>
<td>Probable Cardiac Chest Pain</td>
<td>OP-5</td>
</tr>
<tr>
<td>Reason for Delay in Fibrinolytic Therapy</td>
<td>OP-2</td>
</tr>
<tr>
<td>Reason for Not Administering Fibrinolytic Therapy</td>
<td>OP-3</td>
</tr>
<tr>
<td>Transfer for Acute Coronary Intervention</td>
<td>OP-3</td>
</tr>
</tbody>
</table>

OP-2, OP-3, and OP-5 Hospital Outpatient Emergency Department AMI Population

Acute Myocardial Infarction

The population of the OP-2 through OP-5 AMI measures is identified using 5 data elements:

- **E/M Code**
- **Discharge Code**
- **Outpatient Encounter Date**
- **Birthdate**
- **ICD-10-CM Principal Diagnosis Code**

Patients seen in a Hospital Emergency Department (*E/M Code* in Appendix A, OP Table 1.0) are included in the OP-2 through OP-5 AMI Hospital Outpatient Population and are eligible to be sampled if they have:

- Discharged/transferred to a short-term general hospital for inpatient care or to a federal healthcare facility (*Discharge Code*), and
- A Patient Age on *Outpatient Encounter Date* (*Outpatient Encounter Date – Birthdate*) ≥ 18 years, and
- An *ICD-10-CM Principal Diagnosis Code* for AMI defined in Appendix A, OP Table 1.1.
AMI Hospital Outpatient Population Algorithm

**OP-2 through OP-5**

**Start**: Start AMI Hospital Outpatient Measure Set Population Logic (cases eligible for OP-2 through OP-5)

**Process all cases that have successfully reached the point in the Data Processing Flow which calls this Initial Patient Population Algorithm. Do not process cases that have been rejected before this point in the Data Processing Flow.**

**EM Code**

On OP Table 1.0 (Appendix A)

**Note**: To determine eligible cases using Discharge Status codes, values = 02 or 43.

**Discharge Code**

= 4a or 4d

Not on OP Table 1.0 (Appendix A)

**Note**: To determine ineligible cases using Discharge Status codes, values = 01, 03, 04, 05, 06, 07, 09, 20, 21, 41, 50, 51, 52, 63, 64, 65, 66, or 70.

**Patient Age on Outpatient Encounter Date (in years)** = \(\frac{\text{Outpatient Encounter Date} - \text{Birthdate}}{365}\)

**Patient Age on Outpatient Encounter Date**

\(\geq 18\) years

**ICD-10-CM Principal Diagnosis Code**

On OP Table 1.1 (Appendix A)

Not on OP Table 1.1 (Appendix A)

**Note**: To calculate age, must use the month and day portion of the outpatient encounter date and birthdate to yield the most accurate age.

\(< 18\) years

**Patient Not In AMI Outpatient Measure Population**

**Patient Not In AMI Hospital Outpatient measure Population for OP-2 through OP-5**

**Patient is eligible to be sampled for AMI Hospital Outpatient Measure Set**

Set OP Population Reject Case Flag = "No"

**Return to Data Processing Flow (Data Transmission section)**

**Patient is Not eligible to be sampled for AMI Hospital Outpatient Measure Set**

Set OP Population Reject Case Flag = "Yes"

**Variable Key**

- Patient Age on Outpatient Encounter Date
- OP Population Reject Case Flag
Algorithm Narrative for OP-2 through OP-5:
AMI Hospital Outpatient Population

1. Start AMI Hospital Outpatient Measure Set Population Logic (cases eligible for OP-2 through OP-5).

2. Start processing all cases that have successfully reached the point in the data processing flow which call this Initial Patient Population Algorithm. Do not process cases that have been rejected before this point in the Data Processing Flow: Clinical in the Data Transmission section.

3. Check E/M Code
   a. If E/M Code is not in Appendix A, OP Table 1.0, patient is not in the Outpatient AMI Population. Patient is not in the AMI Hospital Outpatient Measure Population for OP-2 through OP-5. Patient is not eligible to be sampled for the AMI Hospital Outpatient Measure Set. Set the OP Population Reject Case Flag to Yes. Return to Transmission Data Processing Flow: Clinical in the Data Transmission section.
   b. If E/M Code is in Appendix A, OP Table 1.0, continue processing and proceed to Discharge Code.

   a. If Discharge Code equals 1, 2, 3, 4b, 4c, 5, 6, 7, or 8 (Discharge Status code values would = 01, 03, 04, 05, 06, 07, 09, 20, 21, 41, 50, 51, 61, 62, 63, 64, 65, 66, 70), patient is not in the Outpatient AMI Population. Patient is not in the AMI Hospital Outpatient Measure Population for OP-2 through OP-5. Patient is not eligible to be sampled for the AMI Hospital Outpatient Measure Set. Set the OP Population Reject Case Flag to Yes. Return to Transmission Data Processing Flow: Clinical in the Data Transmission section.
   b. If Discharge Code equals 4a or 4d (Discharge Status code values would = 02 or 43), continue processing and proceed to Patient Age on Outpatient Encounter Date.

5. Calculate Patient Age on Outpatient Encounter Date. Patient age, in years, is equal to the Outpatient Encounter Date minus the Birthdate. Use the month and day portion of the Outpatient Encounter Date and the Birthdate to yield the most accurate age.

6. Check Patient Age.
   a. If patient age is less than 18 years, patient is not in the Outpatient AMI Population. Patient is not in the AMI Hospital Outpatient Measure Population for OP-2 through OP-5. Patient is not eligible to be sampled for the AMI Hospital Outpatient Measure Set. Set the OP Population Reject Case Flag to Yes. Return to Transmission Data Processing Flow: Clinical in the Data Transmission section.
   b. If patient age is greater than or equal to 18 years, continue processing and proceed to ICD-10-CM Principal Diagnosis Code.

7. Check ICD-10-CM Principal Diagnosis Code.
   a. If the ICD-10-CM Principal Diagnosis Code is not in Appendix A, OP Table 1.1, patient is not in the Outpatient AMI Population. Patient is not in the AMI Hospital Outpatient Measure Population for OP-2 through OP-5. Patient is not eligible to be sampled for the AMI Hospital Outpatient Measure Set. Set the OP Population Reject Case Flag to Yes. Return to Transmission Data Processing Flow: Clinical in the Data Transmission section.
   b. If the ICD-10-CM Principal Diagnosis Code is in Appendix A, OP Table 1.1, patient is in the AMI Hospital Outpatient Measure Population for OP-2 through OP-5. Patient is eligible to be sampled for the AMI Hospital Outpatient Measure Set. Set the OP Population Reject Case Flag to No. Return to Transmission Data Processing Flow: Clinical in the Data Transmission section.
Performance Measure Name: Fibrinolytic Therapy Received Within 30 Minutes of ED Arrival

Measure ID #: OP-2

Measure Set: Hospital Outpatient Acute Myocardial Infarction

Outpatient Setting: Emergency Department

Description: Emergency Department acute myocardial infarction (AMI) patients with ST-segment elevation on the ECG closest to arrival time receiving fibrinolytic therapy during the ED stay and having a time from ED arrival to fibrinolysis of 30 minutes or less.

Rationale: The American Heart Association (AHA) estimates that 790,000 people experience a heart attack, or myocardial infarction, in the United States each year (Benjamin, 2017). Timely treatment (through reperfusion) for patients with ST-segment elevation myocardial infarction (STEMI) is a strong predictor of patient outcomes; fibrinolytic therapy is considered a viable option for patients for whom timely access to primary percutaneous coronary intervention (PCI) on site or via transfer is not feasible (Viergutz, 2016). Recent evidence suggests that fibrinolysis is safe even for those STEMI patients who later receive PCI (Armstrong and Welsh, 2017; Costa, 2016; Hernandez, 2016; Peiyuan, 2016; Puymirat, 2017). Clinical practice guidelines recommend that patients with STEMI receive fibrinolytic therapy be given within 30 minutes of hospital arrival in patients with ST-elevation myocardial infarction (O’Gara, 2013; Chew, 2016). For STEMI patients presenting to the ED, initiating treatment within this recommended time frame has been found to significantly improve short-term survival rates and long-term outcomes, including decreased in-hospital mortality and increased years of life saved (Bucholz et al., 2016; Puymirat et al., 2016).

Type of Measure: Process

Improvement Noted As: An increase in the rate

Numerator Statement: Emergency Department AMI patients whose time from ED arrival to fibrinolysis is 30 minutes or less.

Included Populations: Not applicable

Excluded Populations: None

Data Elements:
- Arrival Time
- Fibrinolytic Administration Date
- Fibrinolytic Administration Time
- Outpatient Encounter Date

Denominator Statement: Emergency Department AMI patients with ST-segment elevation on ECG who received fibrinolytic therapy.

Included Populations:
- An E/M Code for emergency department encounter as defined in Appendix A, OP Table 1.0, and
• Patients discharged/transferred to a short-term general hospital for inpatient care, or to a federal healthcare facility, and
• An ICD-10-CM Principal Diagnosis Code for AMI as defined in Appendix A, OP Table 1.1, and
• ST-segment elevation on the ECG performed closest to ED arrival, and
• Fibrinolytic Administration.

Excluded Populations:
• Patients less than 18 years of age
• Patients who did not receive Fibrinolytic Administration within 30 minutes and had a Reason for Delay in Fibrinolytic Therapy

Data Elements:
• Birthdate
• Discharge Code
• E/M Code
• Fibrinolytic Administration
• ICD-10-CM Principal Diagnosis Code
• Initial ECG Interpretation
• Reason for Delay in Fibrinolytic Therapy

Risk Adjustment: No

Data Collection Approach: Retrospective data sources for required data elements include administrative data and medical record documents. Some hospitals may prefer to gather data concurrently by identifying patients in the population of interest. This approach provides opportunities for improvement at the point of care/service. However, complete documentation includes the principal or other ICD-10-CM diagnosis and procedure codes, which require retrospective data entry.

Data Accuracy: Variation may exist in the assignment of ICD-10-CM codes; therefore, coding practices may require evaluation to ensure consistency. There may be additional variation by provider, facility, and documentation protocol for chart-abstracted data elements.

Measure Analysis Suggestions: This measure rate will assist in understanding the number of AMI patients that are receiving fibrinolysis within 30 minutes of emergency department arrival and will identify potential opportunities for improvement to increase the rate of patients receiving fibrinolysis in 30 minutes or less.

Sampling: Yes; for additional information see the Population and Sampling Specifications section.

Data Reported As: Aggregate rate generated from count data reported as a proportion

Selected References:


**OP-2: Fibrinolytic Therapy Received Within 30 Minutes of ED Arrival**

**Numerator:** Emergency Department AMI patients whose time from ED arrival to fibrinolysis is 30 minutes or less.

**Denominator:** Emergency Department AMI patients with ST-segment elevation on ECG who received fibrinolytic therapy.

---

**Variable Key:**
- Time to Fibrinolysis

---

**Diagram Description:**
- **START**
- **Initial ECG Interpretation**
  - Y
  - N
  - OP-2
- **Fibrinolytic Administration**
  - Y
  - N
  - OP-2
- **Fibrinolytic Administration Date**
  - Non-UTD Value
    - Missing
    - UTD
- **Fibrinolytic Administration Time**
  - Non-UTD Value
    - Missing
    - UTD
- **Time to Fibrinolysis**
  - Fibrinolytic Administration Date and Fibrinolytic Administration Time minus Encounter Date and Arrival Time (in minutes)
  - ≥ 0 minutes and ≤ 30 minutes
  - > 30 minutes and ≤ 360 minutes
  - > 360 minutes
  - OP-2
  - Z
  - X
  - Case Will Be Rejected
  - Y
  - N
  - OP-2
  - Z
  - In Measure Population
- **Reason for Delay in Fibrinolytic Therapy**
- **Arrival Time**
  - Non-UTD Value
  - Missing
  - UTD
- **Variable Key:**
  - Time to Fibrinolysis

---

Hospital OQR Specifications Manual
Encounter dates 01-01-19 (1Q19) through 12-31-19 (4Q19) v12.0a

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Algorithm Narrative for OP-2:
Fibrinolytic Therapy Received Within 30 Minutes of ED Arrival

**Numerator:** Emergency Department AMI patients whose time from ED arrival to fibrinolysis is 30 minutes or less.

**Denominator:** Emergency Department AMI patients with ST-segment elevation on ECG who received fibrinolytic therapy.

1. Start. Run all cases that are included in the AMI Hospital Outpatient Population Algorithm and pass the edits defined in the Data Processing Flow through this measure. Proceed to *Initial ECG Interpretation*.

2. Check *Initial ECG interpretation*.
   a. If *Initial ECG interpretation* is missing, the case will proceed to a Measure Category Assignment of X and will be rejected. Return to Transmission Data Processing Flow: Clinical in the Data Transmission section.
   b. If *Initial ECG Interpretation* equals No, the case will proceed to a Measure Category Assignment of B. Return to Transmission Data Processing Flow: Clinical in the Data Transmission section.
   c. If Initial ECG interpretation equals Yes, the case will proceed to *Fibrinolytic Administration*.

3. Check *Fibrinolytic Administration*.
   a. If *Fibrinolytic Administration* is missing, the case will proceed to a Measure Category Assignment of X and will be rejected. Return to Transmission Data Processing Flow: Clinical in the Data Transmission section.
   b. If *Fibrinolytic Administration* equals No, the case will proceed to a Measure Category Assignment of B. Return to Transmission Data Processing Flow: Clinical in the Data Transmission section.
   c. If *Fibrinolytic Administration* equals Yes, the case will proceed to *Fibrinolytic Administration Date*.

4. Check *Fibrinolytic Administration Date*.
   a. If *Fibrinolytic Administration Date* is missing, the case will proceed to a Measure Category Assignment of X and will be rejected. Return to Transmission Data Processing Flow: Clinical in the Data Transmission section.
   b. If *Fibrinolytic Administration Date* equals UTD, the case will proceed to a Measure Category Assignment of D. Return to Transmission Data Processing Flow: Clinical in the Data Transmission section.
   c. If *Fibrinolytic Administration Date* equals Non-UTD Value, the case will proceed to *Fibrinolytic Administration Time*.

5. Check *Fibrinolytic Administration Time*.
   a. If *Fibrinolytic Administration Time* is missing, the case will proceed to a Measure Category Assignment of X and will be rejected. Return to Transmission Data Processing Flow: Clinical in the Data Transmission section.
   b. If *Fibrinolytic Administration Time* equals UTD, the case will proceed to a Measure Category Assignment of D. Return to Transmission Data Processing Flow: Clinical in the Data Transmission section.
   c. If *Fibrinolytic Administration Time* Equals Non-UTD Value, the case will proceed to *Arrival Time*.
6. Check Arrival Time.
   a. If Arrival Time equals UTD, the case will proceed to a Measure Category Assignment of D. Return to Transmission Data Processing Flow: Clinical in the Data Transmission section.
   b. If Arrival Time equals Non-UTD Value, the case will proceed to Time to Fibrinolysis.

7. Calculate the Time to Fibrinolysis. Time in minutes is equal to the Fibrinolytic Administration Date and Fibrinolytic Administration Time (in minutes) minus the Outpatient Encounter Date and Arrival Time (in minutes).

8. Check the Time to Fibrinolysis.
   a. If Time to Fibrinolysis is greater than or equal to 0 minutes and less than or equal to 30 minutes, the case will proceed to a Measure Category Assignment of E. Return to Transmission Data Processing Flow: Clinical in the Data Transmission section.
   b. If Time to Fibrinolysis is less than 0 minutes or greater than 360 minutes, the case will proceed to a Measure Category Assignment of B. Return to Transmission Data Processing Flow: Clinical in the Data Transmission section.
   c. If Time to Fibrinolysis is greater than 30 minutes and less than or equal to 360 minutes, the case will proceed to Reason for Delay in Fibrinolytic Therapy.

9. Check Reason for Delay in Fibrinolytic Therapy.
   a. If Reason for Delay in Fibrinolytic Therapy is missing, the case will proceed to a Measure Category Assignment of X and the case will be rejected. Return to Transmission Data Processing Flow: Clinical in the Data Transmission section.
   b. If Reason for Delay in Fibrinolytic Therapy equals Yes, the case will proceed to a Measure Category Assignment of B. Return to Transmission Data Processing Flow: Clinical in the Data Transmission section.
   c. If Reason for Delay in Fibrinolytic Therapy equals No, the case will proceed to a Measure Category Assignment of D. Return to Transmission Data Processing Flow: Clinical in the Data Transmission section.
NQF-Endorsed Voluntary Consensus Standards for Hospital Care
Measure Information Form

Performance Measure Name: Median Time to Transfer to Another Facility for Acute Coronary Intervention

Measure ID #: OP-3

Measure Set: Hospital Outpatient Acute Myocardial Infarction

Outpatient Setting: Emergency Department

<table>
<thead>
<tr>
<th>Set Measure ID #</th>
<th>Performance Measure Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>OP-3a</td>
<td>Median Time to Transfer to Another Facility for Acute Coronary Intervention - Overall Rate</td>
</tr>
<tr>
<td>OP-3b</td>
<td>Median Time to Transfer to Another Facility for Acute Coronary Intervention - Reporting Measure</td>
</tr>
<tr>
<td>OP-3c</td>
<td>Median Time to Transfer to Another Facility for Acute Coronary Intervention - Quality Improvement Measure</td>
</tr>
</tbody>
</table>

Description: Median time from emergency department arrival to time of transfer to another facility for acute coronary intervention

Rationale: The American Heart Association (AHA) estimates that 790,000 people experience a heart attack, or myocardial infarction, in the United States each year (Benjamin, 2017). Timely transfer for acute coronary intervention (ACI), such as a percutaneous coronary intervention (PCI), is associated with improved patient outcomes (Bucholz, 2016; Martin, 2016). National clinical practice guidelines support initiating PCI (measured through door-to-balloon time) within 120 minutes or less for ST-segment elevation myocardial infarction (STEMI) patients who need to be transferred from a non-PCI capable hospital to one at which PCI can be performed (O’Gara, 2013).

Type of Measure: Process

Improvement Noted As: A decrease in the median value

Continuous Variable Statement: Time (in minutes) from emergency department arrival to transfer to another facility for acute coronary intervention.

Included Populations:
- An E/M Code for emergency department encounter as defined in Appendix A, OP Table 1.0, and
- Patients discharged/transferred to a short-term general hospital for inpatient care or to a federal healthcare facility, and
- An ICD-10-CM Principal Diagnosis Code for AMI as defined in Appendix A, OP Table 1.1, and
- ST-segment elevation on the ECG performed closest to ED arrival, and
- Patients with Transfer for Acute Coronary Intervention

Excluded Populations:
- Patients less than 18 years of age
- Patients receiving Fibrinolytic Administration

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Encounter dates 01-01-19 (1Q19) through 12-31-19 (4Q19) v12.0a

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Data Elements:
- Arrival Time
- Birthdate
- Discharge Code
- ED Departure Date
- ED Departure Time
- E/M Code
- Fibrinolytic Administration
- ICD-10-CM Principal Diagnosis Code
- Initial ECG Interpretation
- Outpatient Encounter Date
- Reason for Not Administering Fibrinolytic Therapy
- Transfer for Acute Coronary Intervention
**Risk Adjustment:** No

**Data Collection Approach:** Retrospective data sources for required data elements include administrative data and medical record documents. Some hospitals may prefer to gather data concurrently by identifying patients in the population of interest. This approach provides opportunities for improvement at the point of care/service. However, complete documentation includes the principal or other ICD-10-CM diagnosis and procedure codes, which require retrospective data entry.

**Data Accuracy:** Variation may exist in the assignment of ICD-10-CM codes; therefore, coding practices may require evaluation to ensure consistency. There may be additional variation by provider, facility, and documentation protocol for chart-abstracted data elements.

**Measure Analysis Suggestions:** None

**Sampling:** Yes; for additional information see the Population and Sampling Specifications section.

**Data Reported As:** Aggregate measure of central tendency

**Selected References:**
**OP-3: Median Time to Transfer to Another Facility for Acute Coronary Intervention**

Continuous Variable Statement: Time (in minutes) from emergency department arrival to transfer to another facility for acute coronary intervention

Start the decision-making process by listing cases included in the AMI Hospital Outpatient Population Algorithm and assess if the criteria defined in the Data Processing Flow through this measure are met.

**Initial ECG Interpretation**
- If the ECG interpretation is missing, continue with the next step.
- If the ECG interpretation is completed, proceed to the next decision point.

**Fibrinolytic Administration**
- If fibrinolytic administration is missing, proceed to the next step.
- If fibrinolytic administration is completed, proceed to the next decision point.

**Transfer for Acute Coronary Intervention**
- If transfer for acute coronary intervention is missing, proceed to the next step.
- If transfer for acute coronary intervention is completed, proceed to the next decision point.

**ED Departure Date**
- If ED departure date is missing, proceed to the next step.
- If ED departure date is completed, proceed to the next decision point.

**ED Departure Time**
- If ED departure time is missing, proceed to the next step.
- If ED departure time is completed, proceed to the next decision point.

**Arrival Time**
- If arrival time is missing, proceed to the next step.
- If arrival time is completed, proceed to the next decision point.

**Measurement Value** = ED Departure Date and ED Departure Time minus Outpatient Encounter Date and Arrival Time (in minutes)

**Out of Measure Population**
- If the measurement value is not within the specified range, the case is excluded from the measure.
- If the measurement value is within the specified range, the case is included in the measure.
Note: Initialize the Measure Category Assignment for OP-3b and OP-3c = 'B'.

Do not change the Measure Category Assignment that was already calculated for the overall rate (OP-3a).

Note: There will be no category assignment E for this measure because it is a continuous variable.
Algorithm Narrative for OP-3:
Median Time to Transfer to Another Facility for Acute Coronary Intervention

Continuous Variable Statement: Time (in minutes) from emergency department arrival to transfer to another facility for acute coronary intervention.

1. Start. Run all cases that are included in the AMI Hospital Outpatient Population Algorithm and pass the edits defined in the Data Processing Flow through this measure. Proceed to Initial ECG Interpretation.

2. Check Initial ECG Interpretation.
   a. If Initial ECG Interpretation is missing, the case will proceed to a Measure Category Assignment of X and will be rejected. Return to Transmission Data Processing Flow: Clinical in the Data Transmission section.
   b. If Initial ECG Interpretation equals No, the case will proceed to a Measure Category Assignment of B. Return to Transmission Data Processing Flow: Clinical in the Data Transmission section.
   c. If Initial ECG Interpretation equals Yes, the case will proceed to Fibrinolytic Administration.

3. Check Fibrinolytic Administration.
   a. If Fibrinolytic Administration is missing, the case will proceed to a Measure Category Assignment of X and will be rejected. Return to Transmission Data Processing Flow: Clinical in the Data Transmission section.
   b. If Fibrinolytic Administration equals Yes, the case will proceed to a Measure Category Assignment of B. Return to Transmission Data Processing Flow: Clinical in the Data Transmission section.
   c. If Fibrinolytic Administration equals No, the case will proceed to Transfer for Acute Coronary Intervention.

4. Check Transfer for Acute Coronary Intervention.
   a. If Transfer for Acute Coronary Intervention is missing, the case will proceed to a Measure Category Assignment of X and will be rejected. Return to Transmission Data Processing Flow: Clinical in the Data Transmission section.
   b. If Transfer for Acute Coronary Intervention equals 2 or 3, the case will proceed to a Measure Category Assignment of B. Return to Transmission Data Processing Flow: Clinical in the Data Transmission section.
   c. If Transfer for Acute Coronary Intervention equals 1, the case will proceed to ED Departure Date.

5. Check ED Departure Date.
   a. If ED Departure Date is missing, the case will proceed to a Measure Category Assignment of X and will be rejected. Return to Transmission Data Processing Flow: Clinical in the Data Transmission section.
   b. If ED Departure Date equals UTD, the case will proceed to a Measure Category Assignment of Y. Return to Transmission Data Processing Flow: Clinical in the Data Transmission section.
   c. If ED Departure Date equals Non-UTD Value, the case will proceed to ED Departure Time.

6. Check ED Departure Time.
   a. If ED Departure Time is missing, the case will proceed to a Measure Category Assignment of X and will be rejected. Return to Transmission Data Processing Flow: Clinical in the Data Transmission section.
   b. If ED Departure Time equals UTD, the case will proceed to a Measure Category Assignment of Y. Return to Transmission Data Processing Flow: Clinical in the Data Transmission section.
c. If $ED\ Departure\ Time$ equals Non-UTD Value, the case will proceed to $Arrival\ Time$.

7. Check $Arrival\ Time$.
   a. If $Arrival\ Time$ equals UTD, the case will proceed to a Measure Category Assignment of Y. Return to Transmission Data Processing Flow: Clinical in the Data Transmission section.
   b. If $Arrival\ Time$ equals Non-UTD Value, the case will proceed to the Measurement Value.

8. Calculate the Measurement Value. Time in minutes is equal to the $ED\ Departure\ Date$ and $ED\ Departure\ Time$ (in minutes) minus the $Outpatient\ Encounter\ Date$ and $Arrival\ Time$ (in minutes).

9. Check the Measurement Value.
   a. If Measurement Value is less than 0 minutes, the case will proceed to a Measure Category Assignment of X and will be rejected. Return to Transmission Data Processing Flow: Clinical in the Data Transmission section.
   b. If Measurement Value is greater than or equal to 0 minutes, the case will proceed to $Reason\ for\ Not\ Administering\ Fibrinolytic\ Therapy$.

10. Check $Reason\ for\ Not\ Administering\ Fibrinolytic\ Therapy$.
    a. If $Reason\ for\ Not\ Administering\ Fibrinolytic\ Therapy$ is missing, the case will proceed to a Measure Category Assignment of X and the case will be rejected. Return to Transmission Data Processing Flow: Clinical in the Data Transmission section.
    b. If $Reason\ for\ Not\ Administering\ Fibrinolytic\ Therapy$ equals 1, 2, or 3, the case will proceed to a Measure Category Assignment of D1, the OP-3a Overall Rate. Initialize the Measure Category Assignment for OP-3b and OP-3c equal to B. Do not change the Measure Category Assignment that was already calculated for the overall rate of OP-3a. Proceed to $Reason\ for\ Not\ Administering\ Fibrinolytic\ Therapy$.

11. Check $Reason\ for\ Not\ Administering\ Fibrinolytic\ Therapy$.
    a. If $Reason\ for\ Not\ Administering\ Fibrinolytic\ Therapy$ equals 1 or 2, the case will proceed to a Measure Category Assignment of D2, the OP-3c Quality Improvement Rate. Return to Transmission Data Processing Flow: Clinical in the Data Transmission section.
    b. If $Reason\ for\ Not\ Administering\ Fibrinolytic\ Therapy$ equals 3, the case will proceed to a Measure Category Assignment of D, the OP-3b Reporting Rate. Return to Transmission Data Processing Flow: Clinical in the Data Transmission section.
Measure Information Form

**Performance Measure Name:** Median Time to ECG

**Measure ID #:** OP-5**

**Data for this measure will no longer be collected after 1Q2019 (encounter dates January 1 through March 31, 2019) for the OQR program. The last data submission deadline for OP-5 will be August 1, 2019.**

**Measure Set:** Hospital Outpatient Acute Myocardial Infarction and Hospital Outpatient Chest Pain

**Outpatient Setting:** Emergency Department

**Description:** Median time from emergency department arrival to ECG (performed in the ED prior to transfer) for acute myocardial infarction (AMI) or Chest Pain patients (with Probable Cardiac Chest Pain)

**Rationale:** The American College of Cardiology Foundation (ACCF) and American Heart Association (AHA) recommend that patients presenting to the ED with chest pain or symptoms suggestive of a heart attack (ST-segment elevation myocardial infarction [STEMI]) undergo a 12-lead electrocardiogram (ECG) within 10 minutes of emergency department arrival (O’Gara, 2013; Nishi, 2016; Handel, 2011). Scientific evidence and clinical practice guidelines support the importance of rapid ECG administration for the timely diagnosis and treatment of patients with acute myocardial infarction (AMI) or chest pain (Ducas, 2016). Timely ECGs, including those performed by emergency medical service (EMS) personnel prior to hospital arrival, assist in identifying STEMI patients, influence the choice of treatment (reperfusion strategy), and are associated with better patient outcomes, including decreased mortality (O’Gara, 2013; Ducas, 2016; Nishi, 2014).

**Type of Measure:** Process

**Improvement Noted As:** A decrease in the median value

**Continuous Variable Statement:** Time (in minutes) from emergency department arrival to ECG (performed in the ED prior to transfer) for AMI or Chest Pain patients (with Probable Cardiac Chest Pain)

**Included Populations:**
- An E/M Code for emergency department encounter as defined in Appendix A, OP Table 1.0 and
- Patients discharged/transferred to a short term general hospital for inpatient care or to a federal healthcare facility, and
- An ICD-10-CM Principal Diagnosis Code for AMI as defined in Appendix A, OP Table 1.1 or an ICD-10-CM Other Diagnosis Codes for Angina, Acute Coronary Syndrome, or Chest Pain as defined in Appendix A, OP Table 1.1a, and
- Patients receiving an ECG

**Excluded Populations:**
- Patients less than 18 years of age

**Data Elements:**
- Arrival Time
- Birthdate
- Discharge Code
- E/M Code
- ECG
- ECG Date
- ECG Time
- ICD-10-CM Other Diagnosis Codes

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• ICD-10-CM Principal Diagnosis Code
• Outpatient Encounter Date
• Probable Cardiac Chest Pain

Risk Adjustment: No

Data Collection Approach: Retrospective data sources for required data elements include administrative data and medical record documents. Some hospitals may prefer to gather data concurrently by identifying patients in the population of interest. This approach provides opportunities for improvement at the point of care/service. However, complete documentation includes the principal or other ICD-10-CM diagnosis and procedure codes, which require retrospective data entry.

Data Accuracy: Variation may exist in the assignment of ICD-10-CM codes; therefore, coding practices may require evaluation to ensure consistency. There may be additional variation by provider, facility, and documentation protocol for chart-abstracted data elements.

Measure Analysis Suggestions: None

Sampling: Yes; for additional information see the Population and Sampling Specifications section. Sampling requirements apply to each distinct Hospital Outpatient measure set (AMI and Chest Pain).

Data Reported As: Aggregate measure of central tendency

Selected References:
**OP-5: Median Time to ECG**

**Continuous Variable Statement:** Time (in minutes) from emergency department arrival to ECG (performed in the ED prior to transfer) for acute myocardial infarction (AMI) or Chest Pain patients (with Probable Cardiac Chest Pain).

Hospital OQR Specifications Manual
Encounter dates 01-01-19 (1Q19) through 12-31-19 (4Q19) v12.0a

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Algorithm Narrative for OP-5:
Median Time to ECG

Continuous Variable Statement: Time (in minutes) from emergency department arrival to ECG (performed in the ED prior to transfer) for acute myocardial infarction (AMI) or Chest Pain patients (with Probable Cardiac Chest Pain).

1. Start. Run all cases that are included in the AMI and Chest Pain Hospital Outpatient Population Algorithms and pass the edits defined in the Data Processing Flow through this measure. Proceed to ICD-10-CM Principal Diagnosis Code.

2. Check ICD-10-CM Principal Diagnosis Code.
   a. If the ICD-10-CM Principal Diagnosis Code is not in Appendix A, OP Table 1.1, the case will proceed to Probable Cardiac Chest Pain.
   b. If the ICD-10-CM Principal Diagnosis Code is in Appendix A, OP Table 1.1, the case will proceed to ECG.

3. Check Probable Cardiac Chest Pain.
   a. If Probable Cardiac Chest Pain is missing, the case will proceed to a Measure Category Assignment of X and will be rejected. Return to Transmission Data Processing Flow: Clinical in the Data Transmission section.
   b. If Probable Cardiac Chest Pain equals No, the case will proceed to a Measure Category Assignment of B. Return to Transmission Data Processing Flow: Clinical in the Data Transmission section.
   c. If Probable Cardiac Chest Pain equals Yes, the case will proceed to ECG.

4. Check ECG.
   a. If ECG is missing, the case will proceed to a Measure Category Assignment of X and will be rejected. Return to Transmission Data Processing Flow: Clinical in the Data Transmission section.
   b. If ECG equals No, the case will proceed to a Measure Category Assignment of B. Return to Transmission Data Processing Flow: Clinical in the Data Transmission section.
   c. If ECG equals Yes, the case will proceed to ECG Date.

5. Check ECG Date.
   a. If ECG Date is missing, the case will proceed to a Measure Category Assignment of X and will be rejected. Return to Transmission Data Processing Flow: Clinical in the Data Transmission section.
   b. If ECG Date equals UTD, the case will proceed to a Measure Category Assignment of Y. Return to Transmission Data Processing Flow: Clinical in the Data Transmission section.
   c. If ECG Date equals Non-UTD Value, the case will proceed to ECG Time.

6. Check ECG Time.
   a. If ECG Time is missing, the case will proceed to a Measure Category Assignment of X and will be rejected. Return to Transmission Data Processing Flow: Clinical in the Data Transmission section.
   b. If ECG Time equals UTD, the case will proceed to a Measure Category Assignment of Y. Return to Transmission Data Processing Flow: Clinical in the Data Transmission section.
   c. If ECG Time equals Non-UTD Value, the case will proceed to Arrival Time.

7. Check Arrival Time.
a. If Arrival Time equals UTD, the case will proceed to a Measure Category Assignment of Y. Return to Transmission Data Processing Flow: Clinical in the Data Transmission section.
b. If Arrival Time equals Non-UTD Value, the case will proceed to Measurement Value.

8. Calculate the Measurement Value. Time in minutes is equal to the ECG Date and ECG Time (in minutes) minus the Outpatient Encounter Date and Arrival Time (in minutes).

   a. If Measurement Value is less than 0 minutes, the case will proceed to a Measure Category Assignment of X and will be rejected. Return to Transmission Data Processing Flow: Clinical in the Data Transmission section.
   b. If Measurement Value is greater than or equal to 0 minutes, the case will proceed to a Measure Category Assignment of D. Return to Transmission Data Processing Flow: Clinical in the Data Transmission section.
Hospital Outpatient Quality Measures
ED-Throughput

<table>
<thead>
<tr>
<th>Set Measure ID #</th>
<th>Measure Short Name</th>
</tr>
</thead>
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<td>OP-18</td>
<td>Median Time from ED Arrival to ED Departure for Discharged ED Patients</td>
</tr>
<tr>
<td>OP-22</td>
<td>Left Without Being Seen*</td>
</tr>
</tbody>
</table>

*Data entry for OP-22 will be achieved through the secure side of QualityNet.org via an online tool available to authorized users. Because the measure uses administrative data and not claims data to determine the measure’s denominator population, OP-22 is not included in the ED-Throughput Population.

OP ED-Throughput General Data Element List

<table>
<thead>
<tr>
<th>General Data Element Name</th>
<th>Collected for:</th>
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<tbody>
<tr>
<td>Arrival Time</td>
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<tr>
<td>Birthdate</td>
<td>All Records</td>
</tr>
<tr>
<td>CMS Certification Number †, ‡</td>
<td>All Records</td>
</tr>
<tr>
<td>First Name</td>
<td>All Records</td>
</tr>
<tr>
<td>Hispanic Ethnicity</td>
<td>All Records</td>
</tr>
<tr>
<td>Last Name</td>
<td>All Records</td>
</tr>
<tr>
<td>National Provider Identifier †, ‡</td>
<td>Optional for All Records</td>
</tr>
<tr>
<td>Outpatient Encounter Date</td>
<td>All Records</td>
</tr>
<tr>
<td>Patient Identifier</td>
<td>All Records</td>
</tr>
<tr>
<td>Payment Source</td>
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<tr>
<td>Physician 1</td>
<td>Optional for All Records</td>
</tr>
<tr>
<td>Physician 2</td>
<td>Optional for All Records</td>
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<tr>
<td>Postal Code</td>
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<tr>
<td>Race</td>
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</tr>
<tr>
<td>Sex</td>
<td>All Records</td>
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</tbody>
</table>

† Transmission Data Element
‡ Defined in the Transmission Data Element List within the Hospital Outpatient Measure Data Transmission section of this manual.

OP ED-Throughput Specific Data Element List

<table>
<thead>
<tr>
<th>OP ED Data Element Name</th>
<th>Collected for:</th>
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</thead>
<tbody>
<tr>
<td>Arrival Time</td>
<td>OP-18</td>
</tr>
<tr>
<td>Discharge Code</td>
<td>OP-18</td>
</tr>
<tr>
<td>E/M Code</td>
<td>OP-18</td>
</tr>
<tr>
<td>ED Departure Date</td>
<td>OP-18</td>
</tr>
<tr>
<td>ED Departure Time</td>
<td>OP-18</td>
</tr>
<tr>
<td>ICD-10-CM Principal Diagnosis Code</td>
<td>OP-18</td>
</tr>
<tr>
<td>Outpatient Encounter Date</td>
<td>OP-18</td>
</tr>
</tbody>
</table>
OP-18 Hospital Outpatient Emergency Department Throughput Population

ED-Throughput
The population of the OP-18 measure is identified using 1 data element:

- E/M Code

Patients seen in a Hospital Emergency Department (E/M Code in Appendix A OP Table 1.0) are included in the OP-18 Hospital Outpatient Population and are eligible to be sampled if they have an E/M Code in Appendix A, OP Table 1.0.
ED Throughput Hospital Outpatient Population Algorithm
OP-18

Start OP-18
Population logic sub-routine

Run all cases that pass the General and Measure Set edits defined in the Data Processing Flow to determine which cases are in the population of the OP-18 measure.

On OP Table 1.0 (Appendix A)

E/M Code
Not on OP Table 1.0 (Appendix A)

Patient is in the OP-18 Outpatient Population
Note: For information concerning sample size requirements for the OP-18 measure, refer to the Population and Sampling Specifications section in this manual.

Patient is eligible to be sampled for the OP-18 measure

Set OP Population Reject Case Flag = "No"

Return to Data Processing Flow (Data Transmission section)

Patient not in the ED Throughput Outpatient Population

Patient is not eligible to be sampled for the OP-18 measure

Set OP Population Reject Case Flag = "Yes"

End
Algorithm Narrative for OP-18:
ED-Throughput Hospital Outpatient Population

Variable Key: OP Population Reject Case Flag

1. Start ED-Throughput Initial Patient Population logic sub-routine. Process all cases that have successfully reached the point in the Transmission Data Processing Flow: Clinical which calls this Initial Patient Population Algorithm. Do not process cases that have been rejected before this point in the Transmission Data Processing Flow.

2. Check E/M Code.
   a. If the E/M Code is not on OP Table 1.0 (Appendix A), the patient is not in the ED Initial Patient Population and is not eligible to be sampled for the ED-Throughput measure set. Set the Initial Patient Population Reject Case Flag to equal Yes. Return to Transmission Data Processing Flow in the Data Transmission section.
   b. If the E/M Code is on OP Table 1.0 (Appendix A), the patient is in the ED Initial Patient Population and is eligible to be sampled for the ED-Throughput measure set. Set Initial Patient Population Reject Case Flag to equal No. Return to Transmission Data Processing Flow in the Data Transmission section.
NQF-Endorsed Voluntary Consensus Standards for Hospital Care
Measure Information Form

Performance Measure Name: Median Time from ED Arrival to ED Departure for Discharged ED Patients

Measure ID #: OP-18

Measure Set: Hospital Outpatient ED-Throughput

Outpatient Setting: Emergency Department

<table>
<thead>
<tr>
<th>Set Measure ID #</th>
<th>Performance Measure Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>OP-18a</td>
<td>Median Time from ED Arrival to ED Departure for Discharged ED Patients – Overall Rate</td>
</tr>
<tr>
<td>OP-18b</td>
<td>Median Time from ED Arrival to ED Departure for Discharged ED Patients – Reporting Measure</td>
</tr>
<tr>
<td>OP-18c</td>
<td>Median Time from ED Arrival to ED Departure for Discharged ED Patients – Psychiatric/Mental Health Patients</td>
</tr>
<tr>
<td>OP-18d</td>
<td>Median Time from ED Arrival to ED Departure for Discharged ED Patients – Transfer Patients</td>
</tr>
</tbody>
</table>

Description: Median time from emergency department arrival to time of departure from the emergency room for patients discharged from the emergency department

Rationale: Empirical evidence demonstrates that emergency department (ED) throughput is an indicator of hospital quality of care, and shows that shorter lengths of stay in the ED lead to improved clinical outcomes. Significant ED overcrowding has numerous downstream effects, including prolonged patient waiting times, increased suffering for those who wait, rushed and unpleasant treatment environments, and potentially poor patient outcomes (Gardner, 2018). Quality improvement efforts aimed at reducing ED overcrowding and length of stay have been associated with an increase in ED patient volume, decrease in number of patients who leave without being seen, reduction in costs, and increase in patient satisfaction (Bucci, 2016; Chang, 2017; Zocchi, 2015).

Recent peer-reviewed studies also demonstrate the need for dedicated emergency mental health services, supplying evidence that the clinical needs for these patients substantively differ from the non-psychiatric population (ACEP, 2017; Lester, 2018).

Type of Measure: Process

Improvement Noted As: A decrease in the median value

Continuous Variable Statement: Time (in minutes) from ED arrival to ED departure for patients discharged from the emergency department
Included Populations:
- Any ED patient from the facility’s emergency department

Excluded Populations:
- Patients who expired in the emergency department

Data Elements:
- Arrival Time
- Discharge Code
- E/M Code
- ED Departure Date
- ED Departure Time
- ICD-10-CM Principal Diagnosis Code
- Outpatient Encounter Date

Risk Adjustment: No

Data Collection Approach: Retrospective data sources for required data elements include administrative data and medical record documents. Some hospitals may prefer to gather data concurrently by identifying patients in the population of interest. This approach provides opportunities for improvement at the point of care/service. However, complete documentation includes the principal or other ICD-10-CM diagnosis and procedure codes, which require retrospective data entry.

Data Accuracy: There may be variation by provider, facility, and documentation protocol for chart-abstracted data elements.

Measure Analysis Suggestions: None

Sampling: Yes; for additional information see the Population and Sampling Specifications section.

Data Reported As: Aggregate measure of central tendency

Selected References:
OP-18: Median Time from ED Arrival to ED Departure for Discharged ED Patients
Continuous Variable Statement: Time (in minutes) from ED arrival to ED departure for patients discharged from the emergency department.

[Diagram of flowchart with decision points and calculations]

Statification Table:

- Measured: Statified By:
  - OP-18a (D1) Overall Measure
  - OP-18b (D) Reporting Measure
  - OP-18c (D2) Psych/Mental Measure
  - OP-18d (D3) Transfer Measure

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An episode of care may receive multiple measure category assignments for this measure.

Note: Initialize the Measure Category Assignment for OP-18b, OP-18c, and OP-18d = 'B'.

Do not change the Measure Category Assignment that was already calculated for the overall rate (OP-18a).
Algorithm Narrative for OP-18:
Median Time from ED Arrival to ED Departure for Discharged ED Patients

**Continuous Variable Statement:** Time (in minutes) from ED arrival to ED departure for patients discharged from the emergency department.

1. Start processing. Run all cases that are included in the ED-Throughput Hospital Outpatient Population Algorithm and pass the edits defined in the Data Processing Flow through this measure. Proceed to ICD-10-CM Principal Diagnosis Code.

2. Check Discharge Code.
   a. If **Discharge Code** is missing, the case will proceed to a Measure Category Assignment of X and will be rejected. Return to Transmission Data Processing Flow: Clinical in the Data Transmission section.
   b. If **Discharge Code** equals 6, 7, or 8, the case will proceed to a Measure Category Assignment of B. Return to Transmission Data Processing Flow: Clinical in the Data Transmission section.
   c. If **Discharge Code** equals 1, 2, 3, 4a, 4b, 4c, 4d, or 5, the case will proceed to **Arrival Time**.

3. Check **Arrival Time**.
   a. If **Arrival Time** equals UTD, the case will proceed to a Measure Category Assignment of Y. Return to Transmission Data Processing Flow: Clinical in the Data Transmission section.
   b. If **Arrival Time** equals Non-UTD Value, the case will proceed to **ED Departure Date**.

4. Check **ED Departure Date**.
   a. If **ED Departure Date** is missing, the case will proceed to a Measure Category Assignment of X and will be rejected. Return to Transmission Data Processing Flow: Clinical in the Data Transmission section.
   b. If **ED Departure Date** equals UTD, the case will proceed to a Measure Category Assignment of Y. Return to Transmission Data Processing Flow: Clinical in the Data Transmission section.
   c. If **ED Departure Date** equals non-UTD, the case will proceed to **ED Departure Time**.

5. Check **ED Departure Time**.
   a. If **ED Departure Time** is missing, the case will proceed to a Measure Category Assignment of X and will be rejected. Return to Transmission Data Processing Flow: Clinical in the Data Transmission section.
   b. If **ED Departure Time** equals UTD, the case will proceed to a Measure Category Assignment of Y. Return to Transmission Data Processing Flow: Clinical in the Data Transmission section.
   c. If **ED Departure Time** equals non-UTD, the case will proceed to Measurement Value.

6. Calculate the Measurement Value. Time in minutes is equal to the **ED Departure Date** and **ED Departure Time** (in minutes) minus the Outpatient Encounter Date and **Arrival Time** (in minutes).

7. Check Measurement Value.
   a. If Measurement Value is less than 0 minutes, the case will proceed to a Measure Category Assignment of X and will be rejected. Return to Transmission Data Processing Flow: Clinical in the Data Transmission section.
   b. If Measurement Value is greater than or equal to 0 minutes, the case will proceed to a Measure Category Assignment of D1.
8. Initialize the Measure Category Assignment for all cases in D1.

9. Proceed to **ICD-10-CM Principal Diagnosis Code**.

10. Check **ICD-10-CM Principal Diagnosis Code**.
    a. If **ICD-10-CM Principal Diagnosis Code** is in Appendix A, OP Table 7.01, the case will proceed to a Measure Category Assignment of D2. Proceed to **Discharge Code**.
    b. If **ICD-10-CM Principal Diagnosis Code** is not in Appendix A, OP Table 7.01, the case will proceed to **Discharge Code**.

11. Check **Discharge Code**.
    a. If **Discharge Code** equals 4a or 4d, the case will proceed to a Measure Category Assignment of D3. Proceed to **ICD-10-CM Principal Diagnosis Code**.
    b. If **Discharge Code** equals 1, 2, 3, 4b, 4c, or 5, the case will proceed to **ICD-10-CM Principal Diagnosis Code**.

12. Check **ICD-10-CM Principal Diagnosis Code**.
    a. If **ICD-10-CM Principal Diagnosis Code** is in Appendix A, OP Table 7.01, the case will proceed to a Measure Category Assignment of B. Return to Transmission Data Processing Flow: Clinical in the Data Transmission section.
    b. If **ICD-10-CM Principal Diagnosis Code** is not in Appendix A, OP Table 7.01, the case will proceed to **Discharge Code**.

13. Check **Discharge Code**.
    a. If **Discharge Code** equals 4a or 4d, the case will proceed to a Measure Category Assignment of B. Return to Transmission Data Processing Flow: Clinical in the Data Transmission section.
    b. If **Discharge Code** equals 1, 2, 3, 4b, 4c, or 5, the case will proceed to a Measure Category Assignment of D. Return to Transmission Data Processing Flow: Clinical in the Data Transmission section.
Measure Information Form

Performance Measure Name: Left Without Being Seen

Measure ID #: OP-22

Measure Set: Hospital Outpatient ED-Throughput

Outpatient Setting: Emergency Department

Description: Percent of patients who leave the Emergency Department (ED) without being evaluated by a physician/advanced practice nurse/physician’s assistant (physician/APN/PA).

Measure ascertains response to the following question(s):
- What was the total number of patients who left without being evaluated by a physician/APN/PA? _________(numerator)
- What was the total number of patients who presented to the ED? _________(denominator)

Annual data submission period: See the timeline posted to QualityNet.org for this measure; select Hospitals-Outpatient and then Data Submission in the drop-down menu. Data entry will be achieved through the secure side of QualityNet.org via an online tool available to authorized users.

Definition for patients who presented to the ED:
- Patients who presented to the ED are those that signed in to be evaluated for emergency services.

Definition for Physician/APN/PA:
- Patients who are seen by a resident or intern are to be considered as seen by a physician.
- An institutionally credentialed provider, acting under the direct supervision of a physician for healthcare services in the emergency department (e.g., an obstetric nurse providing assessment of an obstetric patient) are to be considered as seen by a physician.
- Advanced Practice Nurse (APN, APRN) titles may vary between state and clinical specialties. Some common titles that represent the advanced practice nurse role are:
  - Nurse Practitioner (NP)
  - Certified Registered Nurse Anesthetist (CRNA)
  - Clinical Nurse Specialist (CNS)
  - Certified Nurse Midwife (CNM)
## Appendix A

ICD-10-CM Diagnosis and CPT® Code Tables

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</tr>
<tr>
<td>OP Table 1.1</td>
<td>Acute Myocardial Infarction (AMI) Diagnosis Codes</td>
<td>A – 1</td>
</tr>
<tr>
<td>OP Table 1.1a</td>
<td>Chest Pain, Angina, Acute Coronary Syndrome Codes</td>
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<td>OP Table 7.01</td>
<td>Mental Disorders</td>
<td>A – 4</td>
</tr>
<tr>
<td>OP Table 8.0</td>
<td>Ischemic and Hemorrhagic Stroke</td>
<td>A – 21</td>
</tr>
</tbody>
</table>
## OP Table 1.0: E/M Codes for Emergency Department Encounters

<table>
<thead>
<tr>
<th>Code</th>
<th>Shortened Description</th>
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<tbody>
<tr>
<td>99281</td>
<td>Emergency department visit, new or established patient</td>
</tr>
<tr>
<td>99282</td>
<td>Emergency department visit, new or established patient</td>
</tr>
<tr>
<td>99283</td>
<td>Emergency department visit, new or established patient</td>
</tr>
<tr>
<td>99284</td>
<td>Emergency department visit, new or established patient</td>
</tr>
<tr>
<td>99285</td>
<td>Emergency department visit, new or established patient</td>
</tr>
<tr>
<td>99291</td>
<td>Critical care, evaluation and management</td>
</tr>
</tbody>
</table>

## OP Table 1.1: Acute Myocardial Infarction (AMI) Diagnosis Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Shortened Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>I2101</td>
<td>ST elevation (STEMI) myocardial infarction involving left main coronary artery</td>
</tr>
<tr>
<td>I2102</td>
<td>ST elevation (STEMI) myocardial infarction involving left anterior descending coronary artery</td>
</tr>
<tr>
<td>I2109</td>
<td>ST elevation (STEMI) myocardial infarction involving other coronary artery of anterior wall</td>
</tr>
<tr>
<td>I2111</td>
<td>ST elevation (STEMI) myocardial infarction involving right coronary artery</td>
</tr>
<tr>
<td>I2119</td>
<td>ST elevation (STEMI) myocardial infarction involving other coronary artery of inferior wall</td>
</tr>
<tr>
<td>I2121</td>
<td>ST elevation (STEMI) myocardial infarction involving left circumflex coronary artery</td>
</tr>
<tr>
<td>I2129</td>
<td>ST elevation (STEMI) myocardial infarction involving other sites</td>
</tr>
<tr>
<td>I213</td>
<td>ST elevation (STEMI) myocardial infarction of unspecified site</td>
</tr>
<tr>
<td>I214</td>
<td>Non-ST elevation (NSTEMI) myocardial infarction</td>
</tr>
<tr>
<td>I219</td>
<td>Acute myocardial infarction, unspecified</td>
</tr>
<tr>
<td>I21A1</td>
<td>Myocardial infarction type 2</td>
</tr>
<tr>
<td>I21A9</td>
<td>Other myocardial infarction type</td>
</tr>
<tr>
<td>I220</td>
<td>Subsequent ST elevation (STEMI) myocardial infarction of anterior wall</td>
</tr>
<tr>
<td>I221</td>
<td>Subsequent ST elevation (STEMI) myocardial infarction of inferior wall</td>
</tr>
<tr>
<td>I222</td>
<td>Subsequent non-ST elevation (NSTEMI) myocardial infarction</td>
</tr>
<tr>
<td>I228</td>
<td>Subsequent ST elevation (STEMI) myocardial infarction of other sites</td>
</tr>
<tr>
<td>I229</td>
<td>Subsequent ST elevation (STEMI) myocardial infarction of unspecified site</td>
</tr>
<tr>
<td>I97190</td>
<td>Other postprocedural cardiac functional disturbances following cardiac surgery</td>
</tr>
<tr>
<td>I97191</td>
<td>Other postprocedural cardiac functional disturbances following other surgery</td>
</tr>
<tr>
<td>I97790</td>
<td>Other intraoperative cardiac functional disturbances during cardiac surgery</td>
</tr>
<tr>
<td>I97791</td>
<td>Other intraoperative cardiac functional disturbances during other surgery</td>
</tr>
</tbody>
</table>
### OP Table 1.1a: Chest Pain, Angina, Acute Coronary Syndrome Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Shortened Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>I200</td>
<td>Unstable angina</td>
</tr>
<tr>
<td>I201</td>
<td>Angina pectoris with documented spasm</td>
</tr>
<tr>
<td>I208</td>
<td>Other forms of angina pectoris</td>
</tr>
<tr>
<td>I209</td>
<td>Angina pectoris, unspecified</td>
</tr>
<tr>
<td>I237</td>
<td>Postinfarction angina</td>
</tr>
<tr>
<td>I248</td>
<td>Other forms of acute ischemic heart disease</td>
</tr>
<tr>
<td>I249</td>
<td>Acute ischemic heart disease, unspecified</td>
</tr>
<tr>
<td>I25110</td>
<td>Atherosclerotic heart disease of native coronary artery with unstable angina pectoris</td>
</tr>
<tr>
<td>I25111</td>
<td>Atherosclerotic heart disease of native coronary artery with angina pectoris with documented spasm</td>
</tr>
<tr>
<td>I25118</td>
<td>Atherosclerotic heart disease of native coronary artery with other forms of angina pectoris</td>
</tr>
<tr>
<td>I25119</td>
<td>Atherosclerotic heart disease of native coronary artery with unspecified angina pectoris</td>
</tr>
<tr>
<td>I25700</td>
<td>Atherosclerosis of coronary artery bypass graft(s), unspecified, with unstable angina pectoris</td>
</tr>
<tr>
<td>I25701</td>
<td>Atherosclerosis of coronary artery bypass graft(s), unspecified, with angina pectoris with documented spasm</td>
</tr>
<tr>
<td>I25708</td>
<td>Atherosclerosis of coronary artery bypass graft(s), unspecified, with other forms of angina pectoris</td>
</tr>
<tr>
<td>I25709</td>
<td>Atherosclerosis of coronary artery bypass graft(s), unspecified, with unspecified angina pectoris</td>
</tr>
<tr>
<td>I25710</td>
<td>Atherosclerosis of autologous vein coronary artery bypass graft(s) with unstable angina pectoris</td>
</tr>
<tr>
<td>I25711</td>
<td>Atherosclerosis of autologous vein coronary artery bypass graft(s) with angina pectoris with documented spasm</td>
</tr>
<tr>
<td>I25718</td>
<td>Atherosclerosis of autologous vein coronary artery bypass graft(s) with other forms of angina pectoris</td>
</tr>
<tr>
<td>I25719</td>
<td>Atherosclerosis of autologous vein coronary artery bypass graft(s) with unspecified angina pectoris</td>
</tr>
<tr>
<td>I25720</td>
<td>Atherosclerosis of autologous artery coronary artery bypass graft(s) with unstable angina pectoris</td>
</tr>
<tr>
<td>I25721</td>
<td>Atherosclerosis of autologous artery coronary artery bypass graft(s) with angina pectoris with documented spasm</td>
</tr>
<tr>
<td>I25728</td>
<td>Atherosclerosis of autologous artery coronary artery bypass graft(s) with other forms of angina pectoris</td>
</tr>
<tr>
<td>I25729</td>
<td>Atherosclerosis of autologous artery coronary artery bypass graft(s) with unspecified angina pectoris</td>
</tr>
<tr>
<td>I25730</td>
<td>Atherosclerosis of nonautologous biological coronary artery bypass graft(s) with unstable angina pectoris</td>
</tr>
<tr>
<td>I25731</td>
<td>Atherosclerosis of nonautologous biological coronary artery bypass graft(s) with angina pectoris with documented spasm</td>
</tr>
<tr>
<td>I25738</td>
<td>Atherosclerosis of nonautologous biological coronary artery bypass graft(s) with other forms of angina pectoris</td>
</tr>
<tr>
<td>I25739</td>
<td>Atherosclerosis of nonautologous biological coronary artery bypass graft(s) with unspecified angina pectoris</td>
</tr>
<tr>
<td>I25750</td>
<td>Atherosclerosis of native coronary artery of transplanted heart with unstable angina</td>
</tr>
<tr>
<td>I25751</td>
<td>Atherosclerosis of native coronary artery of transplanted heart with angina pectoris with documented spasm</td>
</tr>
<tr>
<td>I25758</td>
<td>Atherosclerosis of native coronary artery of transplanted heart with other forms of angina pectoris</td>
</tr>
<tr>
<td>I25759</td>
<td>Atherosclerosis of native coronary artery of transplanted heart with unspecified angina pectoris</td>
</tr>
<tr>
<td>I25760</td>
<td>Atherosclerosis of bypass graft of coronary artery of transplanted heart with unstable angina</td>
</tr>
<tr>
<td>I25761</td>
<td>Atherosclerosis of bypass graft of coronary artery of transplanted heart with angina pectoris with documented spasm</td>
</tr>
<tr>
<td>I25768</td>
<td>Atherosclerosis of bypass graft of coronary artery of transplanted heart with other forms of angina pectoris</td>
</tr>
<tr>
<td>I25769</td>
<td>Atherosclerosis of bypass graft of coronary artery of transplanted heart with unspecified angina pectoris</td>
</tr>
<tr>
<td>I25790</td>
<td>Atherosclerosis of other coronary artery bypass graft(s) with unstable angina pectoris</td>
</tr>
<tr>
<td>I25791</td>
<td>Atherosclerosis of other coronary artery bypass graft(s) with angina pectoris</td>
</tr>
<tr>
<td>I25798</td>
<td>Atherosclerosis of other coronary artery bypass graft(s) with other forms of angina pectoris</td>
</tr>
<tr>
<td>I25799</td>
<td>Atherosclerosis of other coronary artery bypass graft(s) with unspecified angina pectoris</td>
</tr>
</tbody>
</table>
## Appendix A

ICD-10-CM Diagnosis and CPT® Code Tables

### OP Table 1.1a: Chest Pain, Angina, Acute Coronary Syndrome Codes (continued)

<table>
<thead>
<tr>
<th>Code</th>
<th>Shortened Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>R070</td>
<td>Pain in throat</td>
</tr>
<tr>
<td>R072</td>
<td>Precordial pain</td>
</tr>
<tr>
<td>R0789</td>
<td>Other chest pain</td>
</tr>
<tr>
<td>R079</td>
<td>Chest pain, unspecified</td>
</tr>
</tbody>
</table>

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EMERGENCY DEPARTMENT (ED)
NATIONAL HOSPITAL INPATIENT QUALITY MEASURES

ED Measure Set Table

<table>
<thead>
<tr>
<th>Set Measure ID #</th>
<th>Measure Short Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>ED-1a</td>
<td>Median Time from ED Arrival to ED Departure for Admitted ED Patients – Overall Rate</td>
</tr>
<tr>
<td>ED-1b</td>
<td>Median Time from ED Arrival to ED Departure for Admitted ED Patients – Reporting Measure</td>
</tr>
<tr>
<td>ED-1c</td>
<td>Median Time from ED Arrival to ED Departure for Admitted ED Patients – Psychiatric/Mental Health Patients</td>
</tr>
<tr>
<td>ED-2a</td>
<td>Admit Decision Time to ED Departure Time for Admitted Patients – Overall Rate</td>
</tr>
<tr>
<td>ED-2b</td>
<td>Admit Decision Time to ED Departure Time for Admitted Patients – Reporting Measure</td>
</tr>
<tr>
<td>ED-2c</td>
<td>Admit Decision Time to ED Departure Time for Admitted Patients – Psychiatric/Mental Health Patients</td>
</tr>
</tbody>
</table>
## ED DATA ELEMENT LIST

### General Data Elements Table

<table>
<thead>
<tr>
<th>Name</th>
<th>Collected For:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admission Date</td>
<td>All Records</td>
</tr>
<tr>
<td>Birthdate</td>
<td>All Records</td>
</tr>
<tr>
<td>Discharge Date</td>
<td>All Records</td>
</tr>
<tr>
<td>First Name</td>
<td>All Records</td>
</tr>
<tr>
<td>Hispanic Ethnicity</td>
<td>All Records</td>
</tr>
<tr>
<td>ICD-10-CM Other Diagnosis Codes</td>
<td>All Records</td>
</tr>
<tr>
<td>ICD-10-PCS Other Procedure Codes</td>
<td>All Records</td>
</tr>
<tr>
<td>ICD-10-PCS Other Procedure Dates</td>
<td>All Records</td>
</tr>
<tr>
<td>ICD-10-CM Principal Diagnosis Code</td>
<td>All Records</td>
</tr>
<tr>
<td>ICD-10-PCS Principal Procedure Code</td>
<td>All Records</td>
</tr>
<tr>
<td>ICD-10-PCS Principal Procedure Date</td>
<td>All Records</td>
</tr>
<tr>
<td>Last Name</td>
<td>All Records</td>
</tr>
<tr>
<td>Patient Identifier</td>
<td>All Records</td>
</tr>
<tr>
<td>Payment Source</td>
<td>All Records</td>
</tr>
<tr>
<td>Physician 1</td>
<td>Optional for All Records</td>
</tr>
<tr>
<td>Physician 2</td>
<td>Optional for All Records</td>
</tr>
<tr>
<td>Postal Code</td>
<td>All Records</td>
</tr>
<tr>
<td>Race</td>
<td>All Records</td>
</tr>
<tr>
<td>Sample</td>
<td>Used in transmission of the Hospital Clinical Data file</td>
</tr>
<tr>
<td>Sex</td>
<td>All Records</td>
</tr>
</tbody>
</table>

### Algorithm Output Data Elements Table

<table>
<thead>
<tr>
<th>Name</th>
<th>Collected For:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measure Category Assignment</td>
<td>Used in the calculation of the Joint Commission’s aggregate data and in the transmission of the Hospital Clinical Data file</td>
</tr>
<tr>
<td>Measurement Value</td>
<td>Used in the calculation of aggregate data and Continuous Variable Measures (All ED Measures)</td>
</tr>
</tbody>
</table>
# ED Data Elements Table

<table>
<thead>
<tr>
<th>Name</th>
<th>Collected For:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arrival Date</td>
<td>ED-1</td>
</tr>
<tr>
<td>Arrival Time</td>
<td>ED-1</td>
</tr>
<tr>
<td>Decision to Admit Date</td>
<td>ED-2</td>
</tr>
<tr>
<td>Decision to Admit Time</td>
<td>ED-2</td>
</tr>
<tr>
<td>ED Departure Date</td>
<td>ED-1, ED-2</td>
</tr>
<tr>
<td>ED Departure Time</td>
<td>ED-1, ED-2</td>
</tr>
<tr>
<td>ED Patient</td>
<td>ED-1, ED-2</td>
</tr>
</tbody>
</table>
Emergency Department (ED) Initial Patient Population


Emergency Department (ED) Sample Size Requirements

Please refer to the Global Initial Patient Population document and Global List, for the sampling requirements for the Emergency Department (ED) Measures.
Measure Information Form

Collected For: The Joint Commission Only

Measure Set: Emergency Department

Set Measure ID #: ED-1

Performance Measure Name: Median Time from ED Arrival to ED Departure for Admitted ED Patients

ED-1 Measure Set Table

<table>
<thead>
<tr>
<th>Set Measure ID #</th>
<th>Performance Measure Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>ED-1a</td>
<td>Median Time from ED Arrival to ED Departure for Admitted ED Patients – Overall Rate</td>
</tr>
<tr>
<td>ED-1b</td>
<td>Median Time from ED Arrival to ED Departure for Admitted ED Patients – Reporting Measure</td>
</tr>
<tr>
<td>ED-1c</td>
<td>Median Time from ED Arrival to ED Departure for Admitted ED Patients – Psychiatric/Mental Health Patients</td>
</tr>
</tbody>
</table>

Description: Median time from emergency department arrival to time of departure from the emergency room for patients admitted to the facility from the emergency department

Rationale: Reducing the time patients remain in the emergency department (ED) can improve access to treatment and increase quality of care. Reducing this time potentially improves access to care specific to the patient condition and increases the capability to provide additional treatment. In recent times, EDs have experienced significant overcrowding. Although once only a problem in large, urban, teaching hospitals, the phenomenon has spread to other suburban and rural healthcare organizations. According to a 2002 national U.S. survey, more than 90% of large hospitals report EDs operating "at" or "over" capacity. Approximately one third of hospitals in the US report increases in ambulance diversion in a given year, whereas up to half report crowded conditions in the ED. In a recent national survey, 40% of hospital leaders viewed ED crowding as a symptom of workforce shortages. ED crowding may result in delays in the administration of medication such as antibiotics for pneumonia and has been associated with perceptions of compromised emergency care. For patients with non-ST-segment-elevation myocardial infarction, long ED stays were associated with decreased use of guideline-recommended therapies and a higher risk of recurrent myocardial infarction. Overcrowding and heavy emergency resource demand have led to a number of problems, including ambulance refusals, prolonged patient waiting times, increased suffering for those who wait, rushed and unpleasant treatment environments, and potentially poor patient outcomes. When EDs are overwhelmed, their ability to respond to community emergencies and disasters may be compromised.
**Type of Measure:** Process

**Improvement Noted As:** A decrease in the median value

**Continuous Variable Statement:** Time (in minutes) from ED arrival to ED departure for patients admitted to the facility from the emergency department.

**Included Populations:**
Any *ED Patient* from the facility’s emergency department

**Excluded Populations:**
Patients who are not an *ED Patient*

**Data Elements:**
- *Arrival Date*
- *Arrival Time*
- *ED Departure Date*
- *ED Departure Time*
- *ED Patient*
- *ICD-10-CM Principal Diagnosis Code*

**Risk Adjustment:** No

**Data Collection Approach:** Retrospective data sources for required data elements include administrative data and medical record documents. Some hospitals may prefer to gather data concurrently by identifying patients in the population of interest. This approach provides opportunity for improvement at the point of care/service. However, complete documentation includes the principal or other ICD-10 diagnosis and procedure codes, which require retrospective data entry.

**Data Accuracy:** None

**Measure Analysis Suggestions:** None

**Sampling:** Yes, please refer to the measure set specific sampling requirements and for additional information see the Population and Sampling Specifications section.

**Data Reported As:** Aggregate measure of central tendency
Selected References:

ED-1: Median Time from ED Arrival to ED Departure for Admitted ED Patients

**Continuous Variable Statement:**
Time (in minutes) from ED arrival to ED departure for patients admitted to the facility from the emergency department.

**Stratification Table:**

<table>
<thead>
<tr>
<th>MeasureID</th>
<th>Stratified By</th>
</tr>
</thead>
<tbody>
<tr>
<td>ED-1a</td>
<td>Overall Measure</td>
</tr>
<tr>
<td>ED-1b</td>
<td>Reporting Measure</td>
</tr>
<tr>
<td>ED-1c</td>
<td>Psych/Mental Measure</td>
</tr>
</tbody>
</table>

**Diagram:**

- **START**
- Run cases that are included in the Global Initial Patient Population and pass the edits defined in the Transmission Data Processing Flow: Clinical through this measure.

- **ED Patient**
  - **Arrival Date**
    - Non-UTD Value
      - **Arrival Time**
        - Non-UTD Value
          - **ED Departure Date**
            - Non-UTD Value
              - **ED Departure Time**
                - Non-UTD Value

- **Measurement Value** = ED Departure Date and ED Departure Time - Arrival Date and Arrival Time (in minutes)

- **Case Will Be Rejected** if any of the following are true:
  - Measurement Value < 0
  - Measurement Value ≥ 0

- **Stop here for CMS. CONTINUE for The Joint Commission**

- **For Overall Measure (ED-1a)**
  - **B-92**

**Notes:**

- **Not In Measure Population**
- **In Measure Population**
- **UTD**
- **Missing**
- **N**
- **Y**
Not on Table 7.01

Overall Rate Category Assignment

ICD-10-CM Principal Diagnosis Code

For Measures (ED-1b, 1c)

Set the Measure Category Assignment for measure ED-1c = ED-1a

Note: Initialize the Measure Category Assignment for measures (ED-1b, 1c)=B.

Note: Copy Measurement value from ED-1a to (ED-1b, ED-1c) if (ED-1b, 1c)=D.

Set the Measure Category Assignment for measure ED-1b = ED-1a

Note: Initialize the Measure Category Assignment for measures (ED-1b, 1c)=B.

Overall Rate Category Assignment

= D or Y or X

Note: X is for The Joint Commission only

For Measure (ED-1c)

Not on Table 7.01

For Measure (ED-1b)

On Table 7.01

B-93
Algorithm Narrative

Emergency Department (ED)-1: Median Time from Emergency Department Arrival to ED Departure for Admitted ED Patients

Continuous Variable Statement: Time, in minutes, from ED arrival to ED departure for patients admitted to the facility from the emergency department.

Stratification Table: The Stratification Table includes the Measure ID and Stratified By.

<table>
<thead>
<tr>
<th>Set Measure ID#</th>
<th>Stratified By</th>
</tr>
</thead>
<tbody>
<tr>
<td>ED-1a</td>
<td>Overall Measure</td>
</tr>
<tr>
<td>ED-1b</td>
<td>Reporting Measure</td>
</tr>
<tr>
<td>ED-1c</td>
<td>Psych/Mental Measure</td>
</tr>
</tbody>
</table>

1. Start processing. Run cases that are included in the Global Initial Patient Population and pass the edits defined in the Transmission Data Processing Flow: Clinical through this measure.

2. Check ED Patient
   a. If ED Patient is missing, the case will proceed to a Measure Category Assignment of X and will be rejected. For CMS, stop processing. For The Joint Commission, assign the Measure Category to X for ED-1a, proceed to step 9.
   b. If ED Patient equals No, the case will proceed to a Measure Category Assignment of B and will not be in the Measure Population. Assign the Measure Category to B for ED-1a, proceed to step 9.
   c. If ED Patient equals “Yes,” continue processing and proceed to check Arrival Date.

3. Check Arrival Date
   a. If the Arrival Date is missing, the case will proceed to a Measure Category Assignment of X and will be rejected. For CMS, stop processing. For The Joint Commission, assign the Measure Category to X for ED-1a, proceed to step 9.
   b. If the Arrival Date equals Unable to Determine, the case will proceed to a Measure Category Assignment of Y and will be in the Measure Population. Assign the Measure Category to Y for ED-1a, proceed to step 9.
   c. If Arrival Date equals a Non-Unable to Determine Value, continue processing and proceed to check Arrival Time.

4. Check Arrival Time
   a. If the Arrival Time is missing, the case will proceed to a Measure Category Assignment of X and will be rejected. For CMS, stop processing. For The Joint Commission, assign the Measure Category to X for ED-1a, proceed to step 9.
b. If the Arrival Time equals Unable to Determine, the case will proceed to a Measure Category Assignment of Y and will be in the Measure Population. Assign the Measure Category to Y for ED-1a, proceed to step 9.

c. If Arrival Time equals a Non-Unable to Determine Value, continue processing and proceed to check ED Departure Date.

5. Check ED Departure Date

a. If the ED Departure Date is missing, the case will proceed to a Measure Category Assignment of X and will be rejected. For CMS, stop processing. For The Joint Commission, assign the Measure Category to X for ED-1a, proceed to step 9.

b. If the ED Departure Date equals Unable to Determine, the case will proceed to a Measure Category Assignment of Y and will be in the Measure Population. Assign the Measure Category to Y for ED-1a, proceed to step 9.

c. If ED Departure Date equals a Non-Unable to Determine Value, continue processing and proceed to check ED Departure Time.

6. Check ED Departure Time

a. If the ED Departure Time is missing, the case will proceed to a Measure Category Assignment of X and will be rejected. For CMS, stop processing. For The Joint Commission, assign the Measure Category to X for ED-1a, proceed to step 9.

b. If the ED Departure Time equals Unable to Determine, the case will proceed to a Measure Category Assignment of Y and will be in the Measure Population. Assign the Measure Category to Y for ED-1a, proceed to step 9.

c. If ED Departure Time equals a Non-Unable to Determine Value, continue processing and proceed to Calculate Measurement Value.

7. Calculate Measurement Value.

Measurement Value, in minutes, is equal to the ED Departure Date and ED Departure Time minus the Arrival Date and Arrival Time. Continue processing and proceed to check Measurement Value.

8. Check Measurement Value

a. If the Measurement Value is greater than or equal to zero minutes, the case will proceed to a Measurement Category Assignment of D and will be in the Measure Population. Assign the Measure Category to D for ED-1a. Proceed to step 9.

b. If the Measurement Value is less than zero minutes, the case will proceed to a Measure Category Assignment of X and will be rejected. For CMS, stop processing. For The Joint Commission, assign the Measure Category to X for ED-1a. Proceed to step 9.
9. Initialize the Measure Category Assignment for measures (ED-1b, 1c) to equal 'B'. Continue processing and proceed to check Overall Rate Category Assignment.

10. Check Overall Rate Category Assignment
   a. If the Overall Rate is “D or Y or X” continue processing and proceed to check ICD-10-CM Principal Diagnosis Code. NOTE: X is for The Joint Commission Only.
   b. If the Overall Rate is equal to B stop processing.

11. Check ICD-10-CM Principal Diagnosis Code
   a. If the ICD-10-CM Principal Diagnosis Code is on Table 7.01, set the Measure Category Assignment for measure ED-1c equal to ED-1a. Stop processing. Note: Copy Measurement value from ED-1a to ED-1c if ED-1c equals D.
   b. If the ICD-10-CM Principal Diagnosis Code is not on Table 7.01, set the Measure Category Assignment for measure ED-1b equal to ED-1a. Stop processing. Note: Copy Measurement value from ED-1a to ED-1b if ED-1b equals D.
Measure Information Form

Measure Set: Emergency Department

Set Measure ID #: ED-2

Performance Measure Name: Admit Decision Time to ED Departure Time for Admitted Patients

<table>
<thead>
<tr>
<th>Set Measure ID#</th>
<th>Performance Measure Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>ED-2a</td>
<td>Admit Decision Time to ED Departure Time for Admitted Patients – Overall Rate</td>
</tr>
<tr>
<td>ED-2b</td>
<td>Admit Decision Time to ED Departure Time for Admitted Patients – Reporting Measure</td>
</tr>
<tr>
<td>ED-2c</td>
<td>Admit Decision Time to ED Departure Time for Admitted Patients – Psychiatric/Mental Health Patients</td>
</tr>
</tbody>
</table>

Description: Median time from admit decision time to time of departure from the emergency department for admitted patients.

Rationale: Reducing the time patients remain in the emergency department (ED) can improve access to treatment and increase quality of care. Reducing this time potentially improves access to care specific to the patient condition and increases the capability to provide additional treatment. In recent times, EDs have experienced significant overcrowding. Although once only a problem in large, urban, teaching hospitals, the phenomenon has spread to other suburban and rural healthcare organizations. According to a 2002 national U.S. survey, more than 90% of large hospitals report EDs operating "at" or "over" capacity. Approximately one third of hospitals in the US report increases in ambulance diversion in a given year, whereas up to half report crowded conditions in the ED. In a recent national survey, 40% of hospital leaders viewed ED crowding as a symptom of workforce shortages. ED crowding may result in delays in the administration of medication such as antibiotics for pneumonia and has been associated with perceptions of compromised emergency care. For patients with non-ST-segment-elevation myocardial infarction, long ED stays were associated with decreased use of guideline-recommended therapies and a higher risk of recurrent myocardial infarction. Overcrowding and heavy emergency resource demand have led to a number of problems, including ambulance refusals, prolonged patient waiting times, increased suffering for those who wait, rushed and unpleasant treatment environments, and potentially poor patient outcomes. When EDs are overwhelmed, their ability to respond to community emergencies and disasters may be compromised.

Type of Measure: Process

Improvement Noted As: A decrease in the median value
**Continuous Variable Statement:** Time (in minutes) from admit decision time to time of departure from the emergency department for admitted patients.

**Included Populations:**
Any *ED Patient* from the facility’s emergency department

**Excluded Populations:**
Patients who are not an *ED Patient*

**Data Elements:**
- *Decision to Admit Date*
- *Decision to Admit Time*
- *ED Departure Date*
- *ED Departure Time*
- *ED Patient*
- *ICD-10-CM Principal Diagnosis Code*

**Risk Adjustment:** No

**Data Collection Approach:** Retrospective data sources for required data elements include administrative data and medical record documents. Some hospitals may prefer to gather data concurrently by identifying patients in the population of interest. This approach provides opportunity for improvement at the point of care/service. However, complete documentation includes the principal or other ICD-10 diagnosis and procedure codes, which require retrospective data entry.

**Data Accuracy:** None

**Measure Analysis Suggestions:** None

**Sampling:** Yes, please refer to the measure set specific sampling requirements and for additional information see the Population and Sampling Specifications section.

**Data Reported As:** Aggregate measure of central tendency

**Selected References:**
• United States General Accounting Office GAO. Hospital Emergency Departments: crowded conditions vary among hospitals and communities. 2003; GAO-03-460.
ED-2: Admit Decision Time to ED Departure Time for Admitted Patients

Continuous Variable Statement: Time (in minutes) from admit decision time to time of departure from the emergency department for admitted patients.

Specifications Manual for National Hospital Inpatient Quality Measures
Discharges 01-01-19 (1Q19) through 06-30-19 (2Q19)
Specifications Manual for National Hospital Inpatient Quality Measures
Discharges 01-01-19 (1Q19) through 06-30-19 (2Q19)

- **ICD-10-CM Principal Diagnosis Code**
  - **ED-2**
  - **H**

For Measures (ED-2b, 2c)

- **Not in Measure Population**

Not: Initialize the Measure Category Assignment for measures (ED-2b, 2c)=‘B’.

- **Overall Rate Category Assignment**

= D or Y or X

Note: X is for The Joint Commission only

- **ICD-10-CM Principal Diagnosis Code**

For Measure (ED-2c)

- **On Table 7.01**
  - **= B**
  - **Set the Measure Category Assignment for measure ED-2c = ED-2a**

For Measure (ED-2b)

- **Not on Table 7.01**

- **Set the Measure Category Assignment for measure ED-2b = ED-2a**

Note: Copy Measurement value from ED-2a to (ED-2b, ED-2c) if (ED-2b, 2c)=‘D’.

STOP
Algorithm Narrative
Emergency Department (ED)-2: Admit Decision Time to Emergency Department Departure Time for Admitted Patients

Continuous Variable Statement: Time, in minutes, from admit decision time to time of departure from the emergency department for admitted patients.

Stratification Table: The Stratification Table includes the Measure ID and Stratified By.

<table>
<thead>
<tr>
<th>Set Measure ID #</th>
<th>Stratified By</th>
</tr>
</thead>
<tbody>
<tr>
<td>ED-2a</td>
<td>Overall Measure</td>
</tr>
<tr>
<td>ED-2b</td>
<td>Reporting Measure</td>
</tr>
<tr>
<td>ED-2c</td>
<td>Psych/Mental Measure</td>
</tr>
</tbody>
</table>

1. Start processing. Run cases that are included in the Global Initial Patient Population and pass the edits defined in the Transmission Data Processing Flow: Clinical through this measure.

2. Check ED Patient
   a. If ED Patient is missing, the case will proceed to a Measure Category Assignment of X and will be rejected. For CMS, stop processing. For The Joint Commission, assign the Measure Category to X for ED-2a, proceed to step 9.
   b. If ED Patient equals No, the case will proceed to a Measure Category Assignment of B and will not be in the Measure Population. Assign the Measure Category to B for ED-2a, proceed to step 9.
   c. If ED Patient equals Yes, continue processing and proceed to check Decision to Admit Date.

3. Check Decision to Admit Date
   a. If the Decision to Admit Date is missing, the case will proceed to a Measure Category Assignment of X and will be rejected. For CMS, stop processing. For The Joint Commission, assign the Measure Category to X for ED-2a, proceed to step 9.
   b. If the Decision to Admit Date equals Unable to Determine, the case will proceed to a Measure Category Assignment of Y and will be in the Measure Population. Assign the Measure Category to Y for ED-2a, proceed to step 9.
   c. If Decision to Admit Date equals a Non-Unable to Determine Value, continue processing and proceed to check Decision to Admit Time.
4. Check Decision to Admit Time
   a. If the Decision to Admit Time is missing, the case will proceed to a Measure Category Assignment of X and will be rejected. For CMS, stop processing. For The Joint Commission, assign the Measure Category to X for ED-2a, proceed to step 9.
   b. If the Decision to Admit Time equals Unable to Determine, the case will proceed to a Measure Category Assignment of Y and will be in the Measure Population. Assign the Measure Category to Y for ED-2a, proceed to step 9.
   c. If Decision to Admit Time equals a Non-Unable to Determine Value, continue processing and proceed to check ED Departure Date.

5. Check ED Departure Date
   a. If the ED Departure Date is missing, the case will proceed to a Measure Category Assignment of X and will be rejected. For CMS, stop processing. For The Joint Commission, assign the Measure Category to X for ED-2a, proceed to step 9.
   b. If the ED Departure Date equals Unable to Determine, the case will proceed to a Measure Category Assignment of Y and will be in the Measure Population. Assign the Measure Category to Y for ED-2a, proceed to step 9.
   c. If ED Departure Date equals a Non-Unable to Determine Value, continue processing and proceed to check ED Departure Date.

6. Check ED Departure Time
   a. If the ED Departure Time is missing, the case will proceed to a Measure Category Assignment of X and will be rejected. For CMS, stop processing. For The Joint Commission, assign the Measure Category to X for ED-2a, proceed to step 9.
   b. If the ED Departure Time equals Unable to Determine, the case will proceed to a Measure Category Assignment of Y and will be in the Measure Population. Assign the Measure Category to Y for ED-2a, proceed to step 9.
   c. If ED Departure Time equals a Non-Unable to Determine Value, continue processing and proceed to Calculate Measurement Value.

7. Calculate Measurement Value. Measurement Value, in minutes, is equal to the ED Departure Date and ED Departure Time minus the Decision to Admit Date and Decision to Admit Time. Continue processing and proceed to check Measurement Value.
Specifications Manual for National Hospital Inpatient Quality Measures  
Discharges 01-01-19 (1Q19) through 06-30-19 (2Q19)  

8. Check Measurement Value  
   a. If the Measurement Value is greater than or equal to zero minutes, the case will proceed to a Measurement Category Assignment of D and will be in the Measure Population. Assign the Measure Category to D for ED-2a. Proceed to step 9.  
   b. If the Measurement Value is less than zero minutes, the case will proceed to a Measure Category Assignment of X and will be rejected. For CMS, stop processing. For The Joint Commission, assign the Measure Category to X for ED-2a. Proceed to step 9.  

9. Initialize the Measure Category Assignment for measures (ED-2b, 2c) to equal 'B'. Continue processing and proceed to check Overall Rate Category Assignment.  

10. Check Overall Rate Category Assignment  
   a. If the Overall Rate is “D or Y or X” continue processing and proceed to check ICD-10-CM Principal Diagnosis Code. NOTE: X is for The Joint Commission Only.  
   b. If the Overall Rate is equal to B stop processing.  

11. Check ICD-10-CM Principal Diagnosis Code  
   a. If the ICD-10-CM Principal Diagnosis Code is on Table 7.01, set the Measure Category Assignment for measure ED-2c equal to ED-2a. Stop processing. Note: Copy measurement value from ED-2a to ED-2c if ED-2c equals D.  
   b. If the ICD-10-CM Principal Diagnosis Code is not on Table 7.01, set the Measure Category Assignment for measure ED-2b equal to ED-2a. Stop processing. Note: Copy measurement value from ED-2a to ED-2b if ED-2b equals D.
Instructions for Completion of the Patient Safety Component-Annual Hospital Survey (CDC 57.103)

<table>
<thead>
<tr>
<th>Data Field</th>
<th>Instructions for Form Completion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facility ID #</td>
<td><em>Required.</em> The NHSN-assigned facility ID will be auto-entered by the computer.</td>
</tr>
<tr>
<td>Survey Year</td>
<td><em>Required.</em> Select the calendar year for which this survey was completed. The survey year should represent the last full calendar year. For example, in 2019, a facility would complete a 2018 survey.</td>
</tr>
<tr>
<td><strong>Facility Characteristics</strong></td>
<td></td>
</tr>
<tr>
<td>Ownership (check one)</td>
<td><em>Required.</em> Select the appropriate ownership of this facility:</td>
</tr>
<tr>
<td></td>
<td>• P - For profit</td>
</tr>
<tr>
<td></td>
<td>• NP - Not for profit, including church</td>
</tr>
<tr>
<td></td>
<td>• GOV - Government</td>
</tr>
<tr>
<td></td>
<td>• MIL - Military</td>
</tr>
<tr>
<td></td>
<td>• VA- Veterans Affairs</td>
</tr>
<tr>
<td></td>
<td>• PHY - Physician owned</td>
</tr>
<tr>
<td>Number of patient days</td>
<td><em>Required.</em> Enter the total number of patient days from inpatient locations in your hospital during the last full calendar year. Newborns should be included in this count.</td>
</tr>
<tr>
<td>Number of admissions</td>
<td><em>Required.</em> Enter the total number of inpatient admissions, including newborns, for your hospital during the last full calendar year.</td>
</tr>
<tr>
<td>Is your hospital a teaching hospital for physicians and/or physicians in training?</td>
<td><em>Required.</em> If a teaching hospital, select ‘Yes’. Otherwise, select 'No'.</td>
</tr>
<tr>
<td>If Yes, what type?</td>
<td><em>Conditionally Required.</em> If a teaching hospital, select the type from the options listed: (Note: There is no minimum requirement for the number of students in training to meet these definitions.)</td>
</tr>
<tr>
<td></td>
<td>• <strong>Major:</strong> Facility has a program for medical students and post-graduate medical training.</td>
</tr>
<tr>
<td></td>
<td>• <strong>Graduate:</strong> Facility has a program for post-graduate medical training (i.e., residency and/or fellowships).</td>
</tr>
<tr>
<td></td>
<td>• <strong>Undergraduate:</strong> Facility has a program for medical students only.</td>
</tr>
</tbody>
</table>
## Facility Characteristics (continued)

<table>
<thead>
<tr>
<th>Number of beds set up and staffed in the following location types (as defined by NHSN)</th>
<th>Required. Record the maximum number of beds set up and staffed for the last full calendar year for the bed types listed below. If any bed type is new or has not been available long enough to have a full calendar year's worth of data from which to obtain the maximum number, indicate the maximum number from the number of months available. For definitions of CDC location types, see CDC Locations and Descriptions chapter.</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. ICU</td>
<td>Enter the number of beds in locations designated as intensive care units (ICUs) in the facility. This includes all adult, pediatric, and neonatal levels II/III and III.</td>
</tr>
<tr>
<td>b. All other inpatient locations</td>
<td>Enter the number of beds set up and staffed in all other inpatient locations used for overnight stay patients in this hospital. This includes all inpatient beds in the facility, and not just those that are subject to NHSN surveillance.</td>
</tr>
</tbody>
</table>

### Facility Microbiology Laboratory Practices.

Completion of this section requires the assistance from the microbiology laboratory. Questions should be answered based on the testing methods that were used for the majority of the last full calendar year.

1. Does your facility have its own laboratory that performs antimicrobial susceptibility testing? If No, where is the facility's antimicrobial susceptibility testing performed? (check one)

   Required. Select 'Yes' if your laboratory performs antimicrobial susceptibility testing; otherwise, select 'No'.

   Conditionally Required. If ‘No’, select the location where your facility's antimicrobial susceptibility testing is performed: Affiliated medical center, Commercial referral laboratory, or Other local/regional, non-affiliated reference laboratory. If multiple laboratories are used indicate the laboratory which performs the majority of the bacterial susceptibility testing. You must complete the remainder of this survey with assistance from your outside laboratory.

2. For the following organisms please indicate which methods are used for (1) primary susceptibility testing and (2) secondary, supplemental, or confirmatory testing (if performed)

   Required. Select from the choices listed the appropriate (1) primary susceptibility testing and (2) secondary, supplemental, or confirmatory testing method (if performed) for each organism.

   Note: Repeat tests using the primary method should not be indicated as secondary methods; instead indicate in the ‘Comments’ column the number of times repeat testing is done using the same primary method.

   If your laboratory does not perform susceptibility testing, please indicate the methods used at the referral laboratory. If ‘Other’ is selected as the method for any pathogen, use the ‘Comments’ column to describe the method used.
### Facility Microbiology Laboratory Practices (continued)

<table>
<thead>
<tr>
<th>Question</th>
<th>Response Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. Has your laboratory implemented the revised cephalosporin and monobactam breakpoints for Enterobacteriaceae recommended by CLSI as of 2010?</td>
<td>Required. Select 'Yes' if your laboratory has implemented the revised cephalosporin and monobactam breakpoints for Enterobacteriaceae recommended by CLSI as of 2010; otherwise, select 'No'.</td>
</tr>
<tr>
<td>4. Has your laboratory implemented the revised carbapenem breakpoints for Enterobacteriaceae recommended by CLSI as of 2010?</td>
<td>Required. Select 'Yes' if your laboratory has implemented the revised carbapenem breakpoints for Enterobacteriaceae recommended by CLSI as of 2010; otherwise, select 'No'.</td>
</tr>
<tr>
<td>5. Does your laboratory perform a special test for carbapenemase production? If Yes, please indicate what is done if carbapenemase production is detected (check one). If Yes, which test is routinely performed to detect carbapenemase (check all that apply).</td>
<td>Required. Select 'Yes' if your laboratory performs a special test for carbapenemase production; otherwise, select 'No'. Conditionally Required. If ‘Yes’, specify what is done if carbapenemase production is detected. Conditionally Required. If ‘Yes’, specify which test is performed to detect carbapenemase.</td>
</tr>
<tr>
<td>6. Does your laboratory perform colistin or polymyxin B susceptibility testing for drug-resistant gram negative bacilli? If Yes, indicate methods (check all that apply).</td>
<td>Required. Select 'Yes' if your laboratory performs colistin or polymyxin B susceptibility testing for drug-resistant gram negative bacilli; otherwise, select 'No'. Conditionally Required. If ‘Yes’, select the method(s) used from the choices provided. If ‘Other’ is selected, please specify.</td>
</tr>
<tr>
<td>7. Which of the following methods are used for yeast identification at your facility’s laboratory or at the outside laboratory serving your facility? (check all that apply)</td>
<td>Required. Select from the choices listed one or more the method(s) used for yeast identification at your facility’s laboratory the outside laboratory serving your facility. If ‘Other’ is selected, please specify.</td>
</tr>
<tr>
<td>8. <em>Candida</em> isolated from which of the following body sites are usually fully identified to the species level? (check all that apply)</td>
<td>Required. Select from the choices listed, one or more body sites from which <em>Candida</em> is routinely identified to the species level without a specific request from a clinician. If ‘Other’ is selected, please specify.</td>
</tr>
</tbody>
</table>
### Facility Microbiology Laboratory Practices (continued)

<table>
<thead>
<tr>
<th>9.</th>
<th>What method is used for antifungal susceptibility testing (AFST) at your facility’s laboratory or the outside laboratory serving your facility? (check all that apply)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Required.</strong> Select from the choices listed, one or more method(s) used for antifungal susceptibility testing at your facility’s laboratory the outside laboratory serving your facility. If ‘Other’ is selected, please specify.</td>
</tr>
</tbody>
</table>

| 10. | AFST is performed on fungal isolates in which of the following situations: |
|     | **Required.** For each of the Candida species listed (Candida albicans, Candida glabrata, and all other Candida species), select the most appropriate response for when antifungals susceptibility testing is performed. Chose “Always” if susceptibility testing is routinely performed without a clinician order on at least the first isolate of that species from the patient, regardless of the source of clinical specimen. Chose “Only when isolated from a sterile site” if susceptibility testing is performed routinely without a clinician order. Chose “only when ordered by a clinician” if susceptibility testing is only performed after a clinician specifically orders antifungal susceptibility testing. On that particular species of Candida when isolated from a sterile site. If ‘Other’ is selected, please specify. |

| 11. | What is the primary testing method for *C. difficile* used most often by your facility’s laboratory or the outside laboratory where your facility’s testing is performed? (check one) |
|     | **Required.** Select from the choices listed the testing methods used to perform *C. difficile* testing by your facility’s laboratory or the outside laboratory where your facility’s testing is done. If ‘Other’ is selected, please specify. **Note:** “Other” should not be used to name specific laboratories, reference laboratories, or the brand names of *C. difficile* tests; most methods can be categorized accurately by selecting from the options provided. Please ask your laboratory or conduct a search for further guidance on selecting the correct option to report. |

| 12. | Please indicate the primary and definitive method used to identify microbes from blood specimens collected in your facility. (SELECT ONE ANSWER) |
|     | **Required.** Select ‘One Answer’ indicating your facility’s primary and definitive method used to identify microbes from blood specimens collected. |

| 13. | Please indicate any additional secondary methods used for microbe identification from blood specimens collected in your facility (e.g., a rapid method that is confirmed with the primary method, a secondary method if the primary method fails to give an identification, or a method that is used in conjunction with the primary method). (SELECT ALL THAT APPLY) |
|     | **Required.** Select ‘All that Apply’ indicating your facility’s secondary methods used for microbe identification from blood specimens collected in your facility. For example, if a rapid method that is confirmed with the primary method, a secondary method if the primary method fails to give an identification, or a method that is used in conjunction with the primary method. |
Infection Control Practices. Completion of this section may require assistance from the Infection Preventionist, Hospital Epidemiologist, other infection control personnel, and/or Quality Improvement Coordinator. Questions should be answered based on the policies and practices that were in place for the majority of the last full calendar year.

<table>
<thead>
<tr>
<th>Question</th>
<th>Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>14. Number of infection preventionists (IPs) in facility</td>
<td>Required. Enter the number of individuals (full-time employees) who work in the infection prevention department of the hospital as infection prevention professionals. Certification in infection control, the CIC credential, is not required to be considered an “IP” on this survey. Enter the number of hours per week engaged in activities designed to find and report healthcare-associated infections (in the hospital) and the appropriate denominators. Total should include time to analyze data and disseminate results. Enter the number of hours per week spent on infection prevention and control activities other than surveillance. These activities include, but are not limited to, education, prevention, meetings, etc.</td>
</tr>
<tr>
<td>a. Total hours per week performing surveillance</td>
<td></td>
</tr>
<tr>
<td>b. Total hours per week for infection control activities other than surveillance</td>
<td></td>
</tr>
<tr>
<td>15. Number or fraction of full-time employees (FTEs) for a designated hospital epidemiologist (or equivalent role) affiliated with your facility</td>
<td>Required. Enter the number or fraction of individuals (full-time employees) who perform the functions of a hospital epidemiologist in the facility. An official title of “hospital epidemiologist” is not required. Hospital epidemiologists traditionally have a doctorate level degree with training in infection control, however such training is not required to be counted on this survey.</td>
</tr>
</tbody>
</table>


<table>
<thead>
<tr>
<th>Question</th>
<th>Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>16. Is it a policy in your facility that patients infected or colonized with MRSA are routinely placed in contact precautions while these patients are in your facility? (check one)</td>
<td>Required. Select ‘No’ if your facility does not routinely place any patient infected or colonized with MRSA in Contact Precautions; otherwise, select the single best choice from the choices listed that most accurately describes the primary indication for placing admitted patients with MRSA on Contact Precautions at your facility. If your facility never admits patients with MRSA, select ‘Not applicable’.</td>
</tr>
<tr>
<td>17. Is it a policy in your facility that patients infected or colonized with VRE are routinely placed in contact precautions while these patients are in your facility?</td>
<td>Required. Select ‘No’ if your facility does not routinely place any patient infected or colonized with VRE in Contact Precautions; otherwise, select the single best choice from the choices listed that most accurately describes the primary indication for placing admitted patients with VRE on Contact Precautions at your facility. If your facility never admits patients with VRE, select ‘Not applicable’.</td>
</tr>
</tbody>
</table>
### Infection Control Practices (continued)

<table>
<thead>
<tr>
<th>Question</th>
<th>Required or Conditionally Required</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>18. Is it a policy in your facility that patients infected or colonized with CRE (regardless of confirmatory testing for carbapenemase production) are routinely placed in contact precautions while these patients are in your facility? (check one)</td>
<td>Required. Select ‘No’ if your facility does not routinely place any patient infected or colonized with CRE in Contact Precautions; otherwise, select the single best choice from the choices listed that most accurately describes the primary indication for placing admitted patients with CRE on Contact Precautions at your facility. If your facility never admits patients with CRE, select ‘Not applicable’.</td>
<td></td>
</tr>
<tr>
<td>19. Is it a policy in your facility that patients infected or colonized with suspected or confirmed ESBL-producing or extended spectrum cephalosporin resistant Enterobacteriaceae are routinely placed in contact precautions while these patients are in your facility? (check one)</td>
<td>Required. Select ‘No’ if your facility does not routinely place any patient infected or colonized with ESBL-producing or extended spectrum cephalosporin-resistant Enterobacteriaceae in Contact Precautions; otherwise, select the single best choice from the choices listed that most accurately describes the primary indication for placing admitted patients with ESBL-producing or extended spectrum cephalosporin-resistant Enterobacteriaceae on Contact Precautions at your facility. If your facility never admits patients with ESBL-producing or extended spectrum cephalosporin-resistant Enterobacteriaceae, select ‘Not applicable’.</td>
<td></td>
</tr>
<tr>
<td>20. Does the facility routinely perform screening testing (culture or non-culture) for CRE?</td>
<td>Required. Select ‘Yes’ if the facility routinely (i.e., it is standard practice to perform the testing when the targeted patient group is present) does screening using either culture or non-culture based methods for CRE; select no if either testing is not routinely performed or not performed at all.</td>
<td>Conditionally Required. If ‘Yes’, select all the situations for which screening testing is done routinely. If ‘Other’ is selected, please specify the situation(s) in which CRE screening is performed. Note: ‘Epidemiologically-linked’ patients refer to contacts of the patient with newly identified CRE. This might include current or prior roommates or patients who shared the same healthcare personnel or patients who are located on the same unit or ward.</td>
</tr>
<tr>
<td>21. Does the facility routinely perform screening testing (culture or non-culture) for MRSA for any patients admitted to non-NICU settings?</td>
<td>Required. Select ‘Yes’ if the facility routinely (i.e., it is standard practice to perform the testing when the targeted patient group is present) does screening using either culture or non-culture based methods for MRSA; select no if either testing is not routinely performed or not performed at all.</td>
<td>Conditionally required. If ‘Yes’, select all the situations for which screening testing is done routinely. If ‘Other’ is selected, please specify the situation(s) in which MRSA screening is performed.</td>
</tr>
</tbody>
</table>
## Infection Control Practices (continued)

<table>
<thead>
<tr>
<th>Question</th>
<th>Requirement</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>22. Does the facility routinely perform screening testing (culture or non-culture) for MRSA for any patients admitted to NICU settings?</td>
<td>Required. Select ‘Yes’ if the facility routinely (i.e., it is standard practice to perform the testing when the targeted patient group is present) does screening using either culture or non-culture based methods for MRSA; select no if either testing is not routinely performed or not performed at all.</td>
<td>Conditionally required. If ‘Yes’, select <strong>all</strong> the situations for which screening testing is done <strong>routinely</strong>. If ‘Other’ is selected, please specify the situation(s) in which MRSA screening is performed.</td>
</tr>
<tr>
<td>If yes, in which situations does the facility routinely perform screening testing for MRSA for NICU settings? (check all that apply)</td>
<td><strong>Required.</strong> Select ‘Yes’ if the facility routinely (i.e., it is standard practice to perform the testing when the targeted patient group is present) does screening using either culture or non-culture based methods for MRSA; select no if either testing is not routinely performed or not performed at all.</td>
<td><strong>Required.</strong> Select ‘Yes’ if the facility routinely (i.e., it is standard practice to perform the testing when the targeted patient group is present) does screening using either culture or non-culture based methods for MRSA; select no if either testing is not routinely performed or not performed at all.</td>
</tr>
<tr>
<td>23. Does the facility routinely use chlorhexidine bathing on any patient to prevent infection or transmission of MDROs at your facility? (Note: this does not include the use of such bathing in pre-operative patients to prevent SSIs)</td>
<td>Required. Select ‘Yes’ if your facility <strong>routinely</strong> uses chlorhexidine bathing on any patient in any ward or unit as an intervention to prevent the transmission of any MDRO. Please do not include the use of this agent in patients undergoing surgery if the purpose is to prevent surgical site infections.</td>
<td>Select ‘No’ if this agent is not used routinely or is not used at all or if it is only used to prevent surgical site infections in pre-operative patients.</td>
</tr>
<tr>
<td>24. Does the facility routinely use a combination of topical chlorhexidine AND intranasal mupirocin (or equivalent agent) on any patients to prevent infection or transmission of MRSA at your facility? (Note: this does not include the use of these agents in pre-operative surgical patients or dialysis patients)</td>
<td>Required. Select ‘Yes’ if the combination of topical chlorhexidine and intranasal mupirocin is used <strong>routinely</strong> (i.e., it is standard practice to use these agents when the targeted patient group is present) on patients in the facility specifically to prevent transmission of MRSA. Please do not include the use of these agents in patients undergoing surgery if the purpose is to prevent surgical site infections. Select ‘No’ if these combined agents are not used routinely or are not used at all or if they are only used to prevent surgical site infections in pre-operative patients.</td>
<td></td>
</tr>
</tbody>
</table>
### Facility Neonatal Patient Care Practices and Neonatal Admission Information

Facilities that provide any level of neonatal care (including well newborn care) will answer the following 6 questions. Facilities that do not provide neonatal care at any level will answer N/A for question 1 and skip questions 2-6.

To ensure data accuracy and quality, it is recommended that this section be completed in collaboration with your facility’s neonatal patient care team. Input should be sought from at least one of the following neonatal patient care team members: NICU Medical Director, Lead Neonatal Physician, Neonatal Nurse Manager, Lead Neonatal Nurse Practitioner.

Questions should be answered based on the policies and practices that were in place for the majority of the last full calendar year.

<table>
<thead>
<tr>
<th>Question</th>
<th>Required</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>25. Was this section completed in collaboration with your facility’s neonatal patient care team (i.e. was input sought from at least one of the following neonatal patient care team members: NICU Medical Director, Lead Neonatal Physician, Neonatal Nurse Manager, Lead Neonatal Nurse Practitioner)?</td>
<td>Select ‘Yes’ if input was sought from one or more of the listed neonatal patient care team members. Select ‘No’ if input was not sought from any of the listed neonatal patient care team members. Select ‘N/A’ if your facility does not provide neonatal patient care at any level, i.e. your facility does not have any of the following NHSN location types:</td>
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<tr>
<td></td>
<td></td>
<td>- Well newborn nursery/mother-baby unit (Level I)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Special care nursery/stepdown neonatal nursery (Level II)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Neonatal critical care unit (Level II/III, Level III, Level IV)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Labor and delivery unit</td>
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<td></td>
<td></td>
<td>- Postpartum unit</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Labor, delivery, recovery, postpartum suite</td>
</tr>
</tbody>
</table>

If N/A was selected in question 25 above, questions 26-30 below do not apply to your facility and should be skipped. If your facility does care for neonates (at any level), please complete questions below.

Questions should be answered based on the policies and practices that were in place for the majority of the last full calendar year.

<table>
<thead>
<tr>
<th>Question</th>
<th>Required</th>
<th>Details</th>
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</thead>
<tbody>
<tr>
<td>26. Excluding Level I units (well newborn nurseries), record the number of neonatal admissions to Special Care Nurseries (Level II) and Intensive Care Units (Level II/III, Level III, Level IV):</td>
<td>Select ‘Yes’ if input was sought from one or more of the listed neonatal patient care team members. Select ‘No’ if input was not sought from any of the listed neonatal patient care team members. Select ‘N/A’ if your facility does not provide neonatal patient care at any level, i.e. your facility does not have any of the following NHSN location types:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Inborn admissions</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Outborn admissions</td>
</tr>
<tr>
<td></td>
<td></td>
<td>a. Inborn admission: admission of an infant delivered in your facility.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>b. Outborn admission: admission of an infant delivered outside of your facility.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Facilities with Level I well newborn nurseries but no neonatal special care nurseries or critical care units will enter 0s for both a and b.</td>
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<tr>
<td></td>
<td>Facility Neonatal Patient Care Practices and Neonatal Admission Information (continued)</td>
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</tr>
<tr>
<td>27.</td>
<td>Excluding Level I units (well newborn nurseries), record the number of neonatal admissions (both inborn and outborn) to Special Care (Level II) and Intensive Care (Level II/III, Level III, Level IV) in each of following birth weight categories: Required. Excluding admissions to Level I units (well newborn nurseries), enter the total number of admissions (both inborn and outborn) to Special Care Nurseries (Level II) or Neonatal Intensive Care Units (Level II/III, Level III, Level IV) for the past full calendar year for each of the five specified birth-weight categories. Summing the number of admissions across the five categories (a-e) should equal the summation of inborn and outborn admissions (a-b) designated in question 2 above. Facilities with Level I well newborn nurseries but no neonatal special care nurseries or critical care units will enter 0s for parts a - e.</td>
<td></td>
</tr>
<tr>
<td>28.</td>
<td>Does your facility provide Level III (or higher) neonatal intensive care as defined by the American Academy of Pediatrics (e.g. capable of providing sustained life support, comprehensive care for infants born &lt;32 weeks gestation and weighing &lt;1500 grams, a full range of respiratory support that may include conventional and/or high-frequency ventilation)? Required. Select ‘Yes’ if your facility has one or more Level III or Level IV NICU; otherwise, select ‘No.’ American Academy of Pediatrics Neonatal Levels of Care: <strong>Level III (NICU):</strong> Level II capabilities plus:   - Provide sustained life support   - Provide comprehensive care for infants born &lt;32 wks gestation and weighing &lt;1500 g and infants born at all gestational ages and birth weights with critical illness   - Provide prompt and readily available access to a full range of pediatric medical subspecialists, pediatric surgical specialists, pediatric anesthesiologists, and pediatric ophthalmologists   - Provide a full range of respiratory support that may include conventional and/or high-frequency ventilation and inhaled nitric oxide   - Perform advanced imaging, with interpretation on an urgent basis, including computed tomography, MRI, and echocardiography <strong>Level IV (Regional NICU):</strong> Level III capabilities plus:   - Located within an institution with the capability to provide surgical repair of complex congenital or acquired conditions   - Maintain a full range of pediatric medical subspecialists, pediatric surgical subspecialists, and pediatric anesthesiologists at the site   - Facilitate transport and provide outreach education <a href="http://pediatrics.aappublications.org/content/pediatrics/130/3/587.full.pdf">http://pediatrics.aappublications.org/content/pediatrics/130/3/587.full.pdf</a></td>
<td></td>
</tr>
</tbody>
</table>
### Facility Neonatal Patient Care Practices and Neonatal Admission Information (continued)

<table>
<thead>
<tr>
<th>Question</th>
<th>Required Note</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>29.</strong> Does your facility accept neonates as transfers for any of the following procedures: Omphalocele repair; ventriculoperitoneal shunt; tracheoesophageal fistula (TEF)/esophageal atresia repair; bowel resection/reanastomosis; meningomyelocele repair; cardiac catheterization.</td>
<td>Select ‘Yes’ if your facility accepts neonates as transfers for at least one of the procedures listed; otherwise, select ‘No.’</td>
</tr>
<tr>
<td><strong>30.</strong> If your facility administers antimicrobials (oral or parenteral) to newborns residing in their mother’s room, to which NHSN location(s) is the baby mapped? (Select all that apply)</td>
<td>Select ‘N/A’ if neonates are never administered antimicrobials while residing in their mother’s room (i.e. your facility requires that newborns be transferred to a higher level of care, such as a special care nursery or NICU, in order for antimicrobials to be administered) Select ‘Level I neonatal unit’ if neonates receiving antimicrobials while residing in their mother’s room are physically mapped in NHSN to a Level I neonatal unit, often called a well newborn nursery/mother-baby unit/family-centered care unit. Select ‘Labor and Delivery Ward, Postpartum Ward, or Labor, Delivery, Recovery, Postpartum Suite’ if neonates receiving antimicrobials while residing in their mother’s room are physically mapped in NHSN to any of the following NHSN location types: - Labor and Delivery Ward - Labor, Delivery, Recovery, Postpartum Suite - Postpartum Ward</td>
</tr>
</tbody>
</table>

### Antibiotic Stewardship Practices

Completion of this by section may require assistance from the pharmacy and/or physicians who focus on Antibiotic Stewardship or Infectious Diseases, where available, and/or members of the Pharmacy and Therapeutic Committee. Antibiotic Stewardship refers to a coordinated, multidisciplinary approach to optimize and measure antibiotic use. For further information, refer to Core Elements of Hospital Antibiotic Stewardship Programs (www.cdc.gov/getsmart/healthcare/implementation/core-elements.html). Questions should be answered based on the policies and practices that were in place for the majority of the last full calendar year.

<table>
<thead>
<tr>
<th>Question</th>
<th>Required Note</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>31.</strong> Our facility has a formal statement of support for antibiotic stewardship (e.g., a written policy or statement approved by the board).</td>
<td>Select ‘Yes’ if there is written evidence of senior-level management support focused on antibiotic use prescribing (e.g., formal letter of support for efforts to improve antibiotic use, written communication to hospital staff that encourages optimal antibiotic prescribing, communication of support that reaches staff beyond those who receive executive-level meeting notes); otherwise, select ‘No’.</td>
</tr>
</tbody>
</table>
### Antibiotic Stewardship Practices (continued)

32. Facility leadership has demonstrated a commitment to antibiotic stewardship efforts by: (Check all that apply.)

- **Required.** Select ‘communicating to staff about stewardship activities, via email, newsletters, events, or other avenues’ if there is evidence of broad-reaching communication from senior-level management to hospital staff about antibiotic stewardship efforts (e.g., written communication to hospital staff that encourages optimal antibiotic prescribing, communication of support that reaches staff beyond those who receive executive-level meeting notes, updates on the facility’s stewardship efforts).

- Select ‘providing opportunities for staff training and development on antibiotic stewardship’ if facility leadership and/or management has provided staff antibiotic stewardship education in-house (e.g., workshops, lectures) or access to antibiotic stewardship trainings (e.g., by approving time and/or providing funds to attend stewardship conferences, webinars) within the past year.

- Select ‘allocating information technology resources to support antibiotic stewardship efforts’ if your facility has prioritized information technology (IT)-related antibiotic stewardship efforts within the most recent budgeted year (e.g., by providing clinical decision support software, IT staff).

- If none of these statements apply to your facility, select ‘None of the above.’

33. Our facility has a committee responsible for antibiotic stewardship.

- **Required.** Select ‘Yes’ if your facility has convened a formalized antibiotic stewardship committee or if your facility has expanded the roles and responsibilities of an existing committee to assess and improve antibiotic use and stewardship; otherwise, select ‘No.’

- **Conditionally Required.** If ‘Yes’ to question 33, specify the qualification or job title of the committee members. If none of the response options provided apply to your facility, select ‘None of the above.’
### Antibiotic Stewardship Practices (continued)

<table>
<thead>
<tr>
<th>Question</th>
<th>Required Description</th>
<th>Conditionally Required Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>34. Our facility has a leader (or co-leaders) responsible for antibiotic stewardship outcomes.</td>
<td><em>Required.</em> Select ‘Yes’ if at least one individual has been identified to lead antibiotic stewardship activities, as evidenced by responsibility for improving antibiotic use in their job description or performance review, authority to coordinate activities of staff from multiple departments (e.g., laboratory, pharmacy, information technology), and/or responsibility to report to senior level management on antibiotic stewardship planning and outcomes; otherwise, select ‘No.’</td>
<td><em>Conditionally Required.</em> If ‘Yes’ to question 34, specify the qualification or job title of the leader(s). If ‘Other’ is selected, please specify the position.</td>
</tr>
<tr>
<td>34a. If Yes, what is the position of this leader? (Check one.)</td>
<td></td>
<td><em>Conditionally Required.</em> If ‘Physician’ or ‘Co-led by both Pharmacist and Physician’ was selected in question 34a, specify qualities of your facility’s <strong>physician</strong> leader from the choices listed.</td>
</tr>
<tr>
<td>34b. If Physician or Co-led is selected, which of the following describes your antibiotic stewardship <strong>physician</strong> leader? (Check all that apply.)</td>
<td>Select ‘Has antibiotic stewardship responsibilities in their contract or job description’ if the <strong>physician</strong> stewardship leader has stewardship responsibilities stated in their contract or job description. This can be evidenced by the physician stewardship leader receiving salary support (any amount) for stewardship activities or being assessed on stewardship involvement during performance review.</td>
<td>Select ‘Is physically on-site in your facility (either part-time or full-time)’ if the <strong>physician</strong> stewardship leader works onsite at the facility, whether full-time or part-time, versus solely engaging in your facility’s stewardship activities remotely.</td>
</tr>
<tr>
<td></td>
<td>Select ‘Completed an ID fellowship’ if the <strong>physician</strong> stewardship leader completed an ID fellowship, i.e., a postdoctoral training program (typically 2–3 years) in infectious diseases.</td>
<td>Select ‘Completed a certificate program or other coursework’ if the <strong>physician</strong> stewardship leader completed a certificate program or other coursework for antibiotic stewardship training that resulted in a certificate or continuing education credit(s).</td>
</tr>
<tr>
<td></td>
<td>If none of these statements apply to your facility’s antibiotic stewardship <strong>physician</strong> leader, select ‘None of the above.’</td>
<td></td>
</tr>
</tbody>
</table>
### Antibiotic Stewardship Practices (continued)

<table>
<thead>
<tr>
<th>Question</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>34c. If Pharmacist or Co-led is selected, which of the following describes your antibiotic stewardship pharmacist leader? (Check all that apply.)</strong></td>
<td></td>
</tr>
<tr>
<td><em>Conditionally Required.</em> If ‘Pharmacist’ or ‘Co-led by both Pharmacist and Physician’ was selected in question 34a, specify from the choices listed qualities of your facility’s pharmacist leader.</td>
<td></td>
</tr>
<tr>
<td>Select ‘Has antibiotic stewardship responsibilities in their contract or job description’ if the pharmacist stewardship leader has stewardship responsibilities stated in their contract or job description. This can be evidenced by the pharmacist stewardship leader receiving salary support (any amount) for stewardship activities or being assessed on stewardship involvement during performance review.</td>
<td></td>
</tr>
<tr>
<td>Select ‘Is physically on-site in your facility (either part-time or full-time)’ if the pharmacist stewardship leader works onsite at the facility, whether full-time or part-time, versus solely engaging in your facility’s stewardship activities remotely.</td>
<td></td>
</tr>
<tr>
<td>Select ‘Completed a PGY2 ID residency and/or ID fellowship’ if the pharmacist stewardship leader completed a PGY2 ID residency and/or ID fellowship, i.e., a postdoctoral training program (typically 2–3 years) in infectious diseases.</td>
<td></td>
</tr>
<tr>
<td>Select ‘Completed a certificate program or other coursework’ if the pharmacist stewardship leader completed a certificate program or other coursework for antibiotic stewardship training that resulted in a certificate or continuing education credit(s).</td>
<td></td>
</tr>
<tr>
<td>If none of these statements apply to your facility’s antibiotic stewardship pharmacist leader, select ‘None of the above’.</td>
<td></td>
</tr>
</tbody>
</table>

| **34d. If Physician or Other is selected, is there at least one pharmacist responsible for improving antibiotic use at your facility?** |
| *Conditionally Required.* If ‘Physician’ or ‘Other’ was selected in question 34a, select ‘Yes’ if your facility has at least one pharmacist who dedicates time distinct from general pharmacy duties to educate staff, and track or monitor antibiotic use to ensure optimal prescribing practices; otherwise, select ‘No’. |
### Antibiotic Stewardship Practices (continued)

<table>
<thead>
<tr>
<th>35. Our facility has a policy or formal procedure for: (Check all that apply.)</th>
<th><strong>Required.</strong> Specify the policies or formal procedures that your facility has in place from the choices listed.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Antibiotic time-out refers to a standardized process or protocol for clinicians on the treating team to reassess the continuing need and choice of antibiotics between 48 and 72 hours after the initial order (to confirm indication, review microbiology results, and review antibiotic choice, dose, and duration).</td>
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<tr>
<td></td>
<td>Prospective audit with feedback refers to the stewardship team (or physicians or pharmacists knowledgeable in antibiotic use and who are overseen by the stewardship team and are not part of the treating team) conducting a prospective review of the appropriateness of antibiotic use and then providing feedback in real-time to the front-line clinicians with recommendations based on the culture results, clinical status of the patient and other important factors.</td>
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<tr>
<td></td>
<td>Prior authorization refers to if your facility has at least one antibiotic agent that requires the stewardship team, or a physician or pharmacist overseen by the stewardship team, to review and approve administration of the drug (on the formulary) due to its spectrum of activity, cost, or associated toxicities before the agent can be dispensed. It is assumed that non-formulary drugs already require prior authorization.</td>
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<tr>
<td></td>
<td>If your facility does not have any of the listed policies or formal procedures, select ‘None of the above.’</td>
</tr>
</tbody>
</table>

| 35a. Our stewardship team monitors adherence to the policy or formal procedure for required documentation of indication for antibiotic orders. | **Conditionally Required.** If ‘required documentation of indication for antibiotic orders’ was selected in question 35, select ‘Yes’ if antibiotic orders have been audited to confirm documentation of indication; otherwise, select ‘No’. |

<table>
<thead>
<tr>
<th>35b. For which categories of antimicrobials? (Check all that apply.)</th>
<th><strong>Conditionally Required.</strong> If ‘prospective audit with feedback’ was selected for question 35, specify for which categories of antimicrobials the stewardship team reviews courses of therapy for specified agents and provides feedback and recommendations to the treating team (i.e., prospective audit and feedback).</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>If none of the listed categories of antimicrobials apply, select ‘None of the above.’</td>
</tr>
<tr>
<td>Antibiotic Stewardship Practices (continued)</td>
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<td>---------------------------------------------</td>
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</tr>
<tr>
<td>35c. For which categories of antimicrobials? (Check all that apply.)</td>
<td>Conditionally Required. If ‘prior authorization’ was selected for question 35, specify for which categories of antimicrobials the stewardship team reviews and approves administration prior to dispensing. If none of the listed categories of antimicrobials apply, select ‘None of the above.’</td>
</tr>
<tr>
<td>36. Providers have access to facility- or region-specific treatment guidelines or recommendations for commonly encountered infections.</td>
<td>Required. Select ‘Yes’ if your facility has, or accesses, and uses facility- or region-specific guidelines or recommendations for antibiotic treatment selection based on national guidelines and local susceptibility reports for ANY common clinical conditions (e.g., community required pneumonia, urinary tract infections, or skin and soft tissue infections); otherwise, select ‘No’. Conditionally Required. If ‘Yes’ to question 36, select ‘Yes’ if charts have been audited to confirm adherence to facility- or region-specific treatment guidelines or recommendations for ANY common clinical conditions (e.g., community required pneumonia, urinary tract infections, or skin and soft tissue infections); otherwise, select ‘No’.</td>
</tr>
<tr>
<td>If Yes: Our stewardship team monitors adherence to facility- or region-specific treatment guidelines or recommendations for commonly encountered infections.</td>
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</tr>
<tr>
<td>37. Our facility targets select diagnoses for active interventions to optimize antibiotic use (e.g., intervening on duration of therapy for patients with community-acquired pneumonia according to clinical response).</td>
<td>Required. Select ‘Yes’ if your facility targets any diagnoses for active interventions specifically to optimize antibiotic use (e.g., intervening on duration of therapy for patients with community-acquired pneumonia according to clinical response); otherwise, select ‘No’.</td>
</tr>
<tr>
<td>38. Our stewardship team monitors: (Check all that apply.)</td>
<td>Required. Select, from the choices listed, the measures that your facility’s stewardship team monitors. Monitoring antibiotic resistance patterns can include antibiograms, either in the facility or at the regional level (e.g., receiving local data from a neighboring hospital). Monitoring <em>Clostridium difficile</em> includes infection rates or events in your facility. If monitoring antibiotic use in a way other than DOT, DDD, or expenditures at least quarterly at the unit-, service-, and/or facility-wide level, select ‘antibiotic use in some other way’ and specify the metric. If your facility does not monitor any of the items listed, select ‘None of the above.’</td>
</tr>
</tbody>
</table>
### Antibiotic Stewardship Practices (continued)

<table>
<thead>
<tr>
<th>Question</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>38a.</td>
<td>If antibiotic use in DOT, DDD, or some other way is selected: Our stewardship team provides individual-, unit-, or service-specific reports on antibiotic use to prescribers, at least annually. <strong>Conditionally Required.</strong> If ‘DOT,’ ‘DDD,’ or ‘Other’ antibiotic use measure is selected for question 38, select ‘Yes’ if individual-, unit-, or service-specific reports are developed and provided to prescribers, at least annually, on their antibiotic use; otherwise, select ‘No.’</td>
</tr>
<tr>
<td>38b.</td>
<td>If Yes is selected: Our stewardship team uses individual-, unit-, or service-specific antibiotic use reports to target feedback to prescribers about how they can improve their antibiotic prescribing, at least annually. <strong>Conditionally Required.</strong> If ‘Yes’ to question 38a, select ‘Yes’ if your facility’s stewardship team provides data-driven, targeted feedback to any prescribers about how they can improve their antibiotic prescribing (e.g., academic detailing, prescriber-specific feedback and recommendations), at least annually; otherwise, select ‘No.’</td>
</tr>
<tr>
<td>39.</td>
<td>Our stewardship team provides the following updates or reports, at least annually: (Check all that apply.) <strong>Required.</strong> Select, from the choices listed, the ways in which your stewardship team reports out your facility’s antibiotic stewardship activities. Select ‘updates to facility leadership on antibiotic use and stewardship efforts’ if your facility’s stewardship team shares updates with facility-level leadership (e.g., executive leadership, or other leadership committees or entities that are responsible for the facility) on antibiotic use and stewardship efforts or outcomes, at least annually. Select ‘outcomes for antibiotic stewardship interventions to staff’ if your facility’s antibiotic stewardship team communicates outcomes of antibiotic stewardship interventions (e.g., antibiotic use or patient outcome measures) with hospital staff, at least annually. If your facility does not provide the updates or reports included in this question, at least annually, select ‘None of the above.’</td>
</tr>
<tr>
<td>40.</td>
<td>Which of the following groups receive education on appropriate antibiotic use at least annually? (Check all that apply.) <strong>Required.</strong> Select, from the choices listed, the groups in your facility that receive education specifically about appropriate antibiotic use (e.g., Grand Rounds, in-service training, and direct instruction) at least annually. ‘Prescribers’ includes both prescribers employed by the facility and licensed independent practitioners. If none of the listed groups at your facility receive education on appropriate antibiotic use at least annually, select ‘None of the above.’</td>
</tr>
</tbody>
</table>
### Optional Antibiotic Stewardship Practices Questions

Responses to the following questions are not required to complete the annual survey. Please provide additional information about your facility’s antibiotic stewardship activities and leadership.

<table>
<thead>
<tr>
<th>Question</th>
<th>Optional/Conditional</th>
</tr>
</thead>
<tbody>
<tr>
<td>41. Antibiotic stewardship activities are integrated into quality improvement and/or patient safety initiatives.</td>
<td>Select ‘Yes’ if your facility’s antibiotic stewardship activities are developed or implemented in conjunction with quality improvement and/or patient safety initiatives in the facility (e.g., the stewardship team works with the quality improvement or patient safety team to implement stewardship interventions, the stewardship team participates in quality improvement meetings regarding sepsis core measures); otherwise, select ‘No.’</td>
</tr>
<tr>
<td>42. Our facility accesses targeted remote stewardship expertise (e.g., tele-stewardship) to obtain facility-specific support for our antibiotic stewardship efforts.</td>
<td>Select ‘Yes’ if, over the past calendar year, your facility ever accessed remote stewardship expertise that was specifically targeted for your facility’s antibiotic stewardship efforts. This does not include generic stewardship resources (e.g., webinars). Otherwise, select ‘No.’</td>
</tr>
<tr>
<td>43. Our facility has a clinical decision support tool embedded in the electronic health record for antibiotic use or stewardship interventions available to prescribers.</td>
<td>Select ‘Yes’ if your facility uses a clinical decision support tool that provides electronically-generated antibiotic use or stewardship interventions (e.g., alerts) that are available to all prescribers; otherwise, select ‘No.’</td>
</tr>
<tr>
<td>44. Our stewardship team works with the microbiology laboratory to inform cascade and/or selective reporting protocols for isolate susceptibilities.</td>
<td>Select ‘Yes’ if your facility uses cascade and/or selective reporting, and stewardship representation participates in the development of cascade and/or selective reporting protocols. Select ‘No’ if your facility uses cascade and/or selective reporting, but protocols are developed without input from stewardship representation. Select ‘Not applicable’ if your facility does not use cascade and/or selective reporting.</td>
</tr>
<tr>
<td>45. Our stewardship team monitors compliance with appropriate surgical prophylaxis.</td>
<td>Select ‘Yes’ if your facility’s stewardship team monitors compliance with appropriate surgical antibiotic prophylaxis guidelines intended to optimize antibiotic selection and duration; otherwise, select ‘No.’</td>
</tr>
<tr>
<td>46. If you selected ‘Yes’ to question 34 (your facility has a leader (or co-leaders) responsible for antibiotic stewardship outcomes): Which committees or leadership entities provide oversight of your facility’s antibiotic stewardship efforts? (Check all that apply.)</td>
<td>Conditional to Q34; optional. If ‘Yes’ to question 34, specify the group(s) that provide(s) oversight of your facility’s antibiotic stewardship efforts and to whom the antibiotic stewardship leader is accountable. If ‘Other’ is selected, please specify the committee or job title. Select ‘None’ if no further oversight is provided to the antibiotic stewardship leader(s).</td>
</tr>
<tr>
<td>Optional Antibiotic Stewardship Practices Questions</td>
<td></td>
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<td>---------------------------------------------------</td>
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<tr>
<td><strong>47.</strong> If you selected ‘Physician’ or ‘Co-led…’ (your facility’s leader (or co-leader) responsible for antibiotic stewardship outcomes is a Physician): On average, what percent time does the <strong>physician</strong> (co) leader dedicate to antibiotic stewardship activities in your facility? (Check one.)</td>
<td></td>
</tr>
<tr>
<td><em>Conditional to Q34; optional.</em> If ‘Physician’ or ‘Co-led by both Pharmacist and Physician’ was selected for question 4a, specify the best estimate for the percentage of time the <strong>physician</strong> stewardship leader dedicates to antibiotic stewardship activities in your facility. This should reflect an estimate of the actual percentage of time dedicated to antibiotic stewardship, on average, in your facility.</td>
<td></td>
</tr>
<tr>
<td><strong>48.</strong> If you selected ‘Pharmacist’ or ‘Co-led…’ (your facility’s leader (or co-leader) responsible for antibiotic stewardship outcomes is a Pharmacist): On average, what percent time does the <strong>pharmacist</strong> (co) leader dedicate to antibiotic stewardship activities in your facility? (Check one.)</td>
<td></td>
</tr>
<tr>
<td><em>Conditional to Q34; optional.</em> If ‘Pharmacist or ‘Co-led by both Pharmacist and Physician’ was selected for question 34 specify the best estimate for the percentage of time the pharmacist stewardship leader dedicates to antibiotic stewardship efforts in your facility. This should reflect an estimate of the actual percentage of time dedicated to antibiotic stewardship activities, on average, in your facility.</td>
<td></td>
</tr>
<tr>
<td><strong>49.</strong> If you selected that the physician (co) leader has antibiotic stewardship responsibilities in their contract or job description: What percent time for antibiotic stewardship activities is specified in the <strong>physician</strong> (co) leader’s contract or job description? (Check one.)</td>
<td></td>
</tr>
<tr>
<td><em>Conditional to Q34; optional.</em> If ‘Has antibiotic stewardship responsibilities in their contract or job description’ was selected for question 34, specify the percent time (or equivalent) stipulated in the <strong>physician</strong> stewardship leader’s contract or job description to be dedicated to antibiotic stewardship activities; if no percent time or equivalent is stipulated, select ‘Not specified.’ This percent time should reflect the stated expectation for stewardship efforts, not necessarily actual time worked. This may be the same, more, or less than the time specified in question 47.</td>
<td></td>
</tr>
<tr>
<td><strong>50.</strong> If you selected that the pharmacist (co) leader has antibiotic stewardship responsibilities in their contract or job description: What percent time for antibiotic stewardship activities is specified in the <strong>pharmacist</strong> (co) leader’s contract or job description? (Check one.)</td>
<td></td>
</tr>
<tr>
<td><em>Conditional to Q34; optional.</em> If ‘Has antibiotic stewardship responsibilities in their contract or job description’ was selected for question 34, specify the percent time (or equivalent) stipulated in the <strong>pharmacist</strong> stewardship leader’s contract or job description to be dedicated to antibiotic stewardship activities; if no percent time or equivalent is stipulated, select “Not specified.” This percent time should reflect the stated expectation for stewardship efforts, not necessarily actual time worked. This may be the same, more, or less than the time specified in question 48.</td>
<td></td>
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</tbody>
</table>
**Water Management Program (prevent legionella)**

(*Optional section. Responses to the following questions are not required to complete the annual survey. Completed with input from facility water management team.)

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| 51. Have you performed an assessment of the water systems in your facility to identify areas of risk for growth and transmission of Legionella and other opportunistic waterborne pathogens? (e.g. pseudomonas, acinetobacter, burkholderia, and nontuberculous mycobacteria) | Optional. Select 'Yes' if your facility has conducted a facility risk assessment to identify where Legionella and other opportunistic waterborne pathogens (for example, Pseudomonas, Acinetobacter, Burkholderia, Stenotrophomonas, nontuberculous mycobacteria, and fungi) could grow and spread in the facility water system (for example, piping infrastructure); Otherwise, select 'No'.

If Yes, when? (Check one) | Conditionally Required. If ‘Yes’, specify the time period in which the most recent assessment was conducted. If ‘Other’ is selected, please specify the time period. |
| 52. Has your hospital established a team specifically for the purpose of developing and implementing a water management program to prevent the growth and transmission of Legionella and other waterborne pathogens? | Optional. Select 'Yes' if your hospital has a water management program to prevent the growth and transmission of Legionella and other opportunistic waterborne pathogens; Otherwise, select 'No'.

If Yes, who is represented on the team? (Check all that apply) | Conditionally Required. If ‘Yes’, specify the roles of the team members represented on the water management program team. If ‘Other’ is selected, please specify the role of the team member. |
| 53. Do you regularly monitor the following parameters in your building’s water system? (Check all that apply) | Optional. Select 'Yes' if your facility regularly monitors the following parameters in your building’s water system; Otherwise, select 'No'.

- Disinfectant (such as residual chlorine)
- Temperature
- Heterotrophic plate counts
- Specific tests for Legionella

If Yes, do you have a plan for corrective actions when disinfectant levels are not within acceptable limits as determined by your water management program? | Conditionally Required. For each parameter, if ‘Yes’, specify if your facility has a plan for corrective actions when the specific parameter is not within acceptable limits as determined by your water management program. |

HEALTHCARE PERSONNEL SAFETY COMPONENT PROTOCOL

Healthcare Personnel Vaccination Module:
Influenza Vaccination Summary

Division of Healthcare Quality Promotion
National Center for Emerging and Zoonotic Infectious Diseases
Atlanta, GA, USA
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| Appendix A | Influenza Vaccination Summary: List of Contracted Healthcare Personnel |
1. Introduction to Healthcare Personnel Safety Component

In recent years, occupational hazards faced by healthcare personnel (HCP) in the United States have received increasing attention. Although recommendations, guidelines, and regulations to minimize HCP exposure to such hazards have been developed, additional information is needed to improve HCP safety. In particular, existing surveillance systems are often inadequate to describe the scope and magnitude of occupational exposures to infectious agents and non-infectious occupational hazards that HCP experience, the outcomes of these exposures and injuries, and the impact of preventive measures. The lack of ongoing surveillance of occupational exposures, injuries, and infections in a national network of healthcare facilities using standardized methodology also compromises the ability of the Centers for Disease Control and Prevention (CDC) and other public health agencies to identify emerging problems, to monitor trends, and to evaluate preventive measures.


Data collected in this surveillance system will assist healthcare facilities, HCP organizations, and public health agencies to monitor and report trends in blood/body fluid exposures, to assess the impact of preventive measures, to characterize antiviral medication use for exposures to influenza, and to monitor influenza vaccination percentages among HCP. In addition, this surveillance component will allow CDC to monitor national trends, to identify newly emerging hazards for HCP, to assess the risk of occupational infection, and to evaluate measures, including engineering controls, work practices, protective equipment, and post-exposure prophylaxis designed to prevent occupationally-acquired infections. Hospitals and other healthcare facilities participating in this system will benefit by receiving technical support and standardized methodologies, including a Web-based application, for conducting surveillance activities on occupational health. The NHSN reporting application will enable participating facilities to analyze their own data and compare these data with a national database.
2. Healthcare Personnel Safety Reporting Plan

The Healthcare Personnel Safety Monthly Reporting Plan (CDC 57.203) is used by NHSN facilities to inform CDC which healthcare personnel safety modules are used during a given month. This allows CDC to select the data that should be included in the aggregate data pool for analysis. Each participating facility is to enter a monthly plan to indicate the modules to be used, if any, and the exposures and/or vaccinations that will be monitored.

A plan must be completed for every month that data are entered into NHSN, although a facility may choose “No NHSN Healthcare Personnel Safety Modules Followed this Month” as an option. When creating a plan for the influenza vaccination summary, all months will be included in the plan regardless of whether data are entered each month. Once the influenza vaccination summary is selected on the reporting plan, it is automatically updated with this information for the entire NHSN-defined influenza season (July 1 to June 30). The Instructions for Completion of the Healthcare Personnel Safety Monthly Reporting Plan Form includes brief instructions for collection and entry of each data element on the form.
3. Healthcare Personnel Vaccination Module: Influenza Vaccination

Summary

Introduction
The Advisory Committee on Immunization Practices (ACIP) recommends that all persons six months of age and older, including HCP and persons in training for healthcare professions, should be vaccinated annually against influenza.[1,2] Persons who are infected with influenza virus, including those who are pre-symptomatic, can transmit the virus to coworkers and patients, including those at higher risk for complications from influenza. Vaccination of working age adults, including HCP, has been associated with reduced risk of influenza illness, and reduced work absenteeism, antibiotic use, and medical visits.[3,4] In addition, HCP vaccination has been found to reduce deaths among nursing home patients [5,6] and elderly hospitalized patients.[6] Although annual vaccination is recommended for all HCP and is a high priority for reducing morbidity associated with influenza in healthcare settings, national survey data have demonstrated that vaccination coverage levels are only approximately 60% [7]. This is well below the Healthy People 2020 goal of 90% for HCP influenza vaccination [8].

Healthcare facilities should provide influenza vaccine to HCP using approaches that have demonstrated effectiveness in increasing vaccination coverage. Healthcare administrators should consider the level of vaccination coverage among HCP to be one measure of a patient safety quality program and consider obtaining signed declinations from personnel who decline influenza vaccination for reasons other than medical contraindications.[9-12] Influenza vaccination rates (including ward-, unit-, and specialty-specific coverage rates) among HCP within facilities should be regularly measured and reported to facility administrators and staff.[12]

Healthcare facilities should offer influenza vaccinations to all HCP, including night, weekend, and temporary staff. Efforts should be made to educate HCP regarding the benefits of vaccination and the potential health consequences of influenza illness for their patients, themselves, and their family members. Studies have demonstrated that organized campaigns can attain higher rates of vaccination among HCP with moderate effort and by using strategies that increase vaccine acceptance.[9,13,14] All HCP should be provided convenient access to influenza vaccine at the work site, free of charge. [9,14,15]

HCP Influenza Vaccination Measure
The HCP Influenza Vaccination Measure is designed to ensure that reported HCP influenza vaccination percentages are consistent over time within a single healthcare facility and comparable across facilities. The use of this measure to monitor influenza vaccination among HCP may also result in increased influenza vaccination uptake among HCP, because improvements in tracking and reporting HCP influenza vaccination status will allow healthcare institutions to better identify and target unvaccinated HCP. Increased influenza vaccination coverage among HCP is expected to result in reduced morbidity and mortality related to influenza virus infection among patients. The HCP Vaccination Module of the HPS Component will allow NHSN users to report HCP influenza vaccination percentages using this HCP Influenza Vaccination Measure.

Settings
All types of healthcare facilities including acute care hospitals, long term acute care hospitals, psychiatric hospitals, rehabilitation hospitals, outpatient dialysis centers, ambulatory surgery centers, and long term care facilities are invited to join NHSN and use the measure.

Requirements
Participating facilities are required to report data according to this protocol, using the NHSN definitions described herein, to ensure data are uniformly reported across participants. Within the HPS Component, monthly reporting plans
must be created or updated to include HCP influenza vaccination summary reporting. Once the “Influenza Vaccination Summary” box is checked on one monthly reporting plan, then the system will auto-check that same box on every monthly reporting plan throughout the entire NHSN-defined influenza season (defined as the 12 months from July 1 – June 30).

CDC/NHSN encourages that HCP influenza vaccination summary counts be updated on a monthly basis and suggests that healthcare facilities update new counts within 30 days of the end of each month (for example, all October data should be added by November 30) so they have the greatest impact on influenza vaccination activities. However, entering a single influenza vaccination summary report at the conclusion of the measure reporting period will meet the minimum data requirements for NHSN participation.

**Reporting Instructions**

**Forms, Description, and Purpose** (See also: *Tables of Instructions for Completion of Healthcare Personnel Influenza Vaccination Summary Form* in Chapter 4)

All facilities using the HCP Vaccination Module for HCP influenza vaccination summary data reporting should complete the following forms: the Healthcare Personnel Safety Monthly Reporting Plan Form and the Healthcare Personnel Influenza Vaccination Summary Form. In addition, dialysis centers that do not provide in-center hemodialysis are also required to complete the Home Dialysis Center Practices Survey.

- **Healthcare Personnel Safety Monthly Reporting Plan Form** (CDC 57.203) – This is used to collect data on which modules and which months (if any) the facility intends to participate in the NHSN HPS Component. Once the influenza vaccination summary is selected on the reporting plan, it is automatically updated with this information for the entire NHSN-defined influenza season (July 1 to June 30).

- **Healthcare Personnel Influenza Vaccination Summary Form** (CDC 57.214) – This is used to collect data on summary influenza vaccination counts among HCP working in a facility. The summary reporting replaces the individual-level influenza vaccination reporting that was previously a part of the HPS Component. HCP influenza vaccination summary reporting in NHSN consists of a single data entry screen per influenza season, so each time a user enters updated data for a particular influenza season, all previously entered data for that season will be overwritten and a new modified date will be auto-filled by the system. When entering summary data, all required fields that are indicated with an asterisk must be completed. Otherwise, the data cannot be saved. Users should enter “0” in a field if no HCP at the facility fall into that category.

- **Home Dialysis Center Practices Survey** (CDC 57.507) – Dialysis centers that do not provide in-center hemodialysis are required to complete the Home Dialysis Center Practices Survey before they can enter the HCP influenza vaccination summary data into NHSN. The Home Dialysis Center Practices Survey captures information about various topics such as surveillance practices, vaccination, and vascular access.

The *Seasonal Survey on Influenza Vaccination Programs for Healthcare Personnel* (CDC 57.215) is encouraged to be completed by facilities, but is not required at this time. The survey collects data on types of personnel groups that are included in a facility’s annual influenza vaccination campaign, methods a facility is using to deliver influenza vaccine to its HCP, strategies a facility uses to promote/enhance HCP influenza vaccination, etc. Only one survey should be completed at the end of the influenza season.
Measure Specifications

Denominator
The denominator for this measure consists of HCP who are physically present in the healthcare facility for at least 1 working day between October 1 and March 31 (for example, the measure reporting period) of the following year. Denominators are to be calculated separately for three required categories of HCP and can also be calculated for a fourth optional category:

a. Employees: This includes all persons who receive a direct paycheck from the reporting facility (for example, on the facility’s payroll), regardless of clinical responsibility or patient contact.

b. Licensed independent practitioners (LIPs): This includes physicians (MD, DO), advanced practice nurses, and physician assistants who are affiliated with the reporting facility, but are not directly employed by it (for example, they do not receive a paycheck from the facility), regardless of clinical responsibility or patient contact. Post-residency fellows are also included in this category if they are not on the facility’s payroll.

c. Adult students/trainees and volunteers: This includes medical, nursing, or other health professional students, interns, medical residents, or volunteers aged 18 or older who are affiliated with the healthcare facility, but are not directly employed by it (for example, they do not receive a paycheck from the facility), regardless of clinical responsibility or patient contact.

d. Other contract personnel (optional): Facilities may also report on individuals who are contract personnel. However, reporting for this category is optional at this time. Contract personnel are defined as persons providing care, treatment, or services at the facility through a contract who do not fall into any of the above-mentioned denominator categories. (See Appendix A for a suggested list of contract personnel. This list may be updated as a revised version becomes available.)

Denominator Notes
1. The denominator includes HCP who have worked at the facility for at least 1 working day between October 1 and March 31 during the reporting period, regardless of clinical responsibility or patient contact. This includes HCP who joined after October 1 or left before March 31, or who were on extended leave during part of the reporting period. Working for any number of hours a day counts as one working day.

2. Both full-time and part-time personnel should be included. HCP should be counted as individuals rather than full-time equivalents. If a healthcare worker (HCW) works in two or more facilities, each facility should include the HCW in their denominator.

3. Licensed practitioners who receive a direct paycheck from the reporting facility, or who are owners of the reporting facility, should be counted as employees.

4. The denominator categories are mutually exclusive. The numerator data are to be reported separately for each of the denominator categories.

Numerator
The numerator for this measure consists of HCP in the denominator population, who during the time from when the vaccine became available (for example, August or September) through March 31 of the following year:

a. received an influenza vaccination administered at the healthcare facility; or
b. reported in writing (paper or electronic) or provided documentation that influenza vaccination was received elsewhere; or

c. were determined to have a medical contraindication/condition of severe allergic reaction to eggs or other component(s) of the vaccine, or history of Guillain-Barré Syndrome (GBS) within 6 weeks after a previous influenza vaccination; or

d. were offered but declined influenza vaccination; or

e. had an unknown vaccination status or did not otherwise meet any of the definitions of the above-mentioned numerator categories.

Numerator Notes
1. Persons who declined vaccination because of conditions other than those specified in category (c) above should be categorized as declined vaccination.*

2. Persons who declined vaccination and did not provide any other information should be categorized as declined vaccination.

3. Persons who did not receive vaccination because of religious or philosophical exemptions should be categorized as declined vaccination.

4. Persons who deferred vaccination all season should be categorized as declined vaccination.

5. The numerator data are mutually exclusive. The sum of the numerator categories should be equal to the denominator for each HCP group.

*Note: For the purposes of this measure, a medical contraindication to vaccination with inactivated influenza vaccine (IIV) is defined as having a severe allergic reaction to eggs or other components of the influenza vaccine or a history of GBS within 6 weeks after a previous influenza vaccination. A healthcare facility may grant medical exemptions to HCP with other conditions besides those defined by the measure and may include these conditions in its list of acceptable medical contraindications to influenza vaccination. However, to ensure that data are comparable across different facilities reporting data using this measure, only those HCP with one of the two conditions stated above should be reported to NHSN as having a medical contraindication to influenza vaccination.

In addition to the two defined medical contraindications to vaccination with IIV mentioned above, the following conditions are accepted medical contraindications to live attenuated influenza vaccine (LAIV): pregnancy; known severe immunodeficiency (for example, hematologic and solid tumors; receiving chemotherapy; congenital immunodeficiency; long-term immunosuppressive therapy; patients with HIV infection who are severely immunocompromised); certain chronic medical conditions include asthma and chronic pulmonary, cardiovascular (except isolated hypertension), renal, hepatic, neurologic/neuromuscular, hematologic, or metabolic disorders. Individuals older than 49 years of age are also not eligible to receive LAIV. HCP who have a medical contraindication to LAIV other than a severe allergic reaction to a vaccine component or history of GBS within 6 weeks after a previous influenza vaccination should be offered IIV by their facility, if available. Medical contraindications for LAIV should not be considered contraindications as those individuals can be given IIV.
**Data Sources**

Data sources for the required data elements include management/personnel data, medical or occupational health records, and vaccination record documents. HCP can self-report in writing (paper or electronic) that the vaccination was received elsewhere or provide documentation of receipt of the influenza vaccine elsewhere. For the purposes of this reporting measure, verbal statements about receiving vaccination elsewhere are not acceptable. However, HCP can provide verbal or written documentation of medical contraindications and verbal or written declination of the influenza vaccine.

**Methodology**

The Influenza Vaccination Summary Module enables a healthcare facility to record information on influenza vaccination for HCP working in the healthcare facility for at least 1 working day between October 1 and March 31. Data are required to be entered for five numerator fields pertaining to vaccination status, and three denominator categories pertaining to HCP groups. A fourth denominator category for other contract personnel is optional at this time; therefore, each facility may decide whether they would like to report these particular data.

This module requires that data be provided to CDC as per reporting requirements. Data covering the entire denominator reporting period (October 1 through March 31) must be entered once into NHSN for each reporting year. The data can be entered on a monthly and/or quarterly basis, but only cumulative data should be entered. Any new data that are entered into NHSN will overwrite and replace the previously entered data. Thus, if a facility would like to keep track of its monthly numbers, it should maintain its own record of this, as it will not be able to review monthly reporting numbers in NHSN.

**Data Analyses**

Influenza vaccination status is calculated separately among each of the three required denominator groups of HCP: employees, LIPs, and adult students/trainees and volunteers. Influenza vaccination status can also be calculated for the fourth optional category of other contract personnel using the modify option within the analysis function. Separate measures are calculated by dividing the number of HCP in one numerator field (for example, number of HCP who received an influenza vaccination at this healthcare facility since influenza vaccine became available this season) by the number of HCP in that denominator group, and multiplying by 100 to produce a vaccination percentage for that specific group. Percentages of vaccination received elsewhere, medical contraindications, declinations, and unknown vaccination status can also be calculated using the second, third, fourth, and fifth numerator fields, respectively. Calculations for employee vaccination percentages are shown below. Vaccination percentages for LIPs, adult students/trainees and volunteers, and other contract personnel are calculated in the same manner.

**Employee Vaccination Percentages**

*Employee Vaccination Percentage (at this healthcare facility)*

\[
\frac{\text{# Employees vaccinated onsite}}{\text{# Employees working in the required time period}} \times 100 = \text{Pct. of Employees Vaccinated Onsite}
\]

*Employee Vaccination Percentage (outside this healthcare facility)*

\[
\frac{\text{# Employees vaccinated elsewhere}}{\text{# Employees working in the required time period}} \times 100 = \text{Pct. of Employees Vaccinated Elsewhere}
\]
Employee Medical Contraindication Percentage

\[
\frac{\text{# Employees reporting contraindication}}{\text{# Employees working in the required time period}} \times 100 = \text{Pct. of Employees Reporting Contraindication}
\]

Employee Declination Percentage

\[
\frac{\text{# Employees declined vaccine}}{\text{# Employees working in the required time period}} \times 100 = \text{Pct. of Employees Reporting Declination}
\]

Employee Unknown Vaccination Percentage

\[
\frac{\text{# Employees with unknown vaccination}}{\text{# Employees working in the required time period}} \times 100 = \text{Pct. Employees with Unknown Status}
\]

HCP Vaccination Percentages

In addition to calculating vaccination percentages for individual denominator groups, percentages can be calculated for all HCP (both employees and non-employees). Percentages can also be calculated for the optional category of contract personnel using the modify option within the analysis function. To determine vaccination for all HCP, the system will add the total number of HCP (employees, LIPs, and adult students/trainees and volunteers) in one numerator field (for example, total number of HCP who received an influenza vaccination at this healthcare facility since influenza vaccine became available this season). The number is divided by the total number of HCP who were working at this healthcare facility for at least 1 working day between October 1 and March 31, and multiplied by 100 to produce a vaccination percentage for that group of HCP. Percentages of vaccination received elsewhere, medical contraindications, declinations, and unknown vaccination status can also be calculated using the second, third, fourth, and fifth numerator fields, respectively. Calculations for total HCP vaccination percentages are shown below. The second calculation in this section shows how a percentage is computed for other contract personnel. Vaccination percentages for other contract personnel are computed in the same manner as the other calculations in this section.

HCP Vaccination Percentage (at this healthcare facility) [excluding OCP]

\[
\frac{\text{# Employees} + \text{# LIPs} + \text{# ASTV vaccinated onsite}}{\text{# Employees} + \text{# LIPs} + \text{# ASTV working in the required time period}} \times 100 = \text{Pct. of HCP Vacc. Onsite (exc. OCP)}
\]

HCP Vaccination Percentage (at this healthcare facility) [including OCP]

\[
\frac{\text{# Employees} + \text{# LIPs} + \text{# ASTV} + \text{# OCP vaccinated onsite}}{\text{# Employees} + \text{# LIPs} + \text{# ASTV} + \text{# OCP working in the required time period}} \times 100 = \text{Pct. of HCP Vacc. Onsite (inc. OCP)}
\]

HCP Vaccination Percentage (outside this healthcare facility) [excluding OCP]

\[
\frac{\text{# Employees} + \text{# LIPs} + \text{# ASTV vaccinated elsewhere}}{\text{# Employees} + \text{# LIPs} + \text{# ASTV working in the required time period}} \times 100 = \text{Pct. of HCP Vacc. Elsewhere (exc. OCP)}
\]

HCP Medical Contraindication Percentage [excluding OCP]

\[
\frac{\text{# Employees} + \text{# LIPs} + \text{# ASTV reporting contraindication}}{\text{# Employees} + \text{# LIPs} + \text{# ASTV working in the required time period}} \times 100 = \text{Pct. of HCP Reporting Contra. (exc. OCP)}
\]

HCP Declination Percentage [excluding OCP]
Vaccination percentages can be calculated for all non-employees (LIPs and adult students/trainees and volunteers). Percentages can also be calculated for the optional category of other contract personnel using the modify option within the analysis function. To determine vaccination for all non-employees, the system will add the total number of HCP (LIPs and adult students/trainees and volunteers) in one numerator field (for example, number of HCP who received an influenza vaccination at this healthcare facility since influenza vaccine became available this season). The number is divided by the total number of HCP who were working at this healthcare facility for at least 1 working day between October 1 and March 31, and multiplied by 100 to produce a vaccination percentage for that group of non-employees. Percentages of vaccination received elsewhere, medical contraindications, declinations, and unknown vaccination status can also be calculated using the second, third, fourth, and fifth numerator fields, respectively. Calculations for non-employee vaccination percentages are shown below. The second calculation in this section shows how a percentage is computed for other contract personnel. Vaccination percentages for other contract personnel are computed in the same manner for the other calculations in this section.

**Non-Employee Vaccination Percentages**

**Non-Employee Vaccination Percentage (at this healthcare facility) [excluding OCP]**

\[
\frac{\# \text{ LIPs} + \# \text{ ASTV vaccinated onsite}}{\# \text{ LIPs} + \# \text{ ASTV working in the required time period}} \times 100 = \text{Pct. of Non-Employees Vacc. Onsite (exc. OCP)}
\]

**Non-Employee Vaccination Percentage (at this healthcare facility) [including OCP]**

\[
\frac{\# \text{ LIPs} + \# \text{ ASTV} + \# \text{ OCP vaccinated onsite}}{\# \text{ LIPs} + \# \text{ ASTV} + \# \text{ OCP working in the required time period}} \times 100 = \text{Pct. of Non-Employees Vacc. Onsite (inc. OCP)}
\]

**Non-Employee Vaccination Percentage (outside this healthcare facility) [excluding OCP]**

\[
\frac{\# \text{ LIPs} + \# \text{ ASTV vaccinated elsewhere}}{\# \text{ LIPs} + \# \text{ ASTV working in the required time period}} \times 100 = \text{Pct. of Non-Employees Vacc. Elsewhere (exc. OCP)}
\]

**Non-Employee Medical Contraindication Percentage [excluding OCP]**

\[
\frac{\# \text{ LIPs} + \# \text{ ASTV reporting contraindication}}{\# \text{ LIPs} + \# \text{ ASTV working in the required time period}} \times 100 = \text{Pct. of Non-Employees Reporting Contra. (exc. OCP)}
\]

**Non-Employee Declination Percentage [excluding OCP]**

\[
\frac{\# \text{ LIPs} + \# \text{ ASTV declined vaccine}}{\# \text{ LIPs} + \# \text{ ASTV working in the required time period}} \times 100 = \text{Pct. of Non-Employees Reporting Declination (exc. OCP)}
\]
Non-Employee Unknown Vaccination Percentage [excluding OCP]

\[
\frac{\text{# LIPs + # ASTV with unknown vaccination}}{\text{# LIPs + # ASTV working in the required time period}} \times 100 = \text{Pct. of Non-Employees with Unknown Status (exc. OCP)}
\]

**Vaccination Compliance**

To determine vaccination compliance, the system will add the total number of HCP who received an influenza vaccination at this healthcare facility to the total number of HCP who provided a written report or documentation of influenza vaccination outside this healthcare facility since influenza vaccine became available this season. The number is divided by the total number of HCP who were working at this healthcare facility for at least 1 working day between October 1 and March 31. This number is then multiplied by 100 to obtain a percentage. Percentages can also be calculated for the optional category of other contract personnel using the modify option within the analysis function. Calculations for employee vaccination compliance, HCP vaccination compliance, and non-employee vaccination compliance percentages are shown below. Vaccination compliance percentages for LIPs, adult students/trainees and volunteers, and other contract personnel are calculated in the same manner.

**Employee Vaccination Compliance Percentage**

\[
\frac{\text{# Employees vaccinated onsite + # Employees vaccinated elsewhere}}{\text{# Employees working in the required time period}} \times 100 = \text{Pct. of Employee Vacc. Compliance}
\]

**HCP Vaccination Compliance Percentage [excluding OCP]**

\[
\frac{\text{(## Emp. + # LIPs + # ASTV vacc. onsite) + (# Emp. + # LIPs + # ASTV vacc. elsewhere)}}{\text{# Emp. + # LIPs + # ASTV working in the required time period}} \times 100 = \text{Pct. of HCP Vacc. Comp. (exc. OCP)}
\]

**HCP Vaccination Compliance Percentage [including OCP]**

\[
\frac{\text{(## Emp. + # LIPs + # ASTV + # OCP vacc. onsite) + (# Emp. + # LIPs + # ASTV + # OCP vacc. elsewhere)}}{\text{# Emp. + # LIPs + # ASTV + # OCP working in the required time period}} \times 100 = \text{Pct. of HCP Vacc. Comp. (inc. OCP)}
\]

**Non-Employee Vaccination Compliance Percentage [excluding OCP]**

\[
\frac{\text{(## LIPs + # ASTV vacc. onsite) + (# LIPs + # ASTV vacc. elsewhere)}}{\text{## LIPs + # ASTV working in the required time period}} \times 100 = \text{Pct. of Non-Employee Vacc. Comp. (exc. OCP)}
\]

**Non-Employee Vaccination Compliance Percentage [including OCP]**

\[
\frac{\text{(## LIPs + # ASTV + # OCP vacc. onsite) + (# LIPs + # ASTV + # OCP vacc. elsewhere)}}{\text{## LIPs + # ASTV + # OCP working in the required time period}} \times 100 = \text{Pct. of Non-Employee Vacc. Comp. (inc. OCP)}
\]

**Vaccination Non-Compliance**

To determine vaccination non-compliance, the system will add the total number of HCP who declined to receive the influenza vaccination to the total number of HCP with unknown vaccination status. The number is divided by the total number of HCP who were working at this healthcare facility for at least 1 working day between October 1 and March 31. This number is then multiplied by 100 to obtain a percentage. Percentages can also be calculated for the optional category of other contract personnel using the modify option within the analysis function. Calculation for employee vaccination non-compliance, HCP vaccination non-compliance, and non-employee vaccination non-compliance percentages are shown below. Vaccination non-compliance percentages for LIPs, adult students/trainees and volunteers, and other contract personnel are calculated in the same manner.
Employee Vaccination Non-Compliance Percentage

\[
\frac{\text{# Employees declined vacc.} + \text{# Employees with unknown status}}{\text{# Employees working in the required time period}} \times 100 = \text{Pct. of Employee Vacc. Non-Compliance}
\]

HCP Vaccination Non-Compliance Percentage [excluding OCP]

\[
\frac{(# \text{Emp.} + \text{# LIPs} + \text{# ASTV declined vacc.}) + (# \text{Emp.} + \text{# LIPs} + \text{# ASTV with unknown status})}{# \text{Emp.} + \text{# LIPs} + \text{# ASTV working in the required time period}} \times 100 = \text{Pct. of HCP Vacc. Non-Comp. (exc. OCP)}
\]

HCP Vaccination Non-Compliance Percentage [including OCP]

\[
\frac{(# \text{Emp.} + \text{# LIPs} + \text{# ASTV} + \text{# OCP dec. vacc.}) + (# \text{Emp.} + \text{# LIPs} + \text{# ASTV} + \text{# OCP with unknown status})}{# \text{Emp.} + \text{# LIPs} + \text{# ASTV} + \text{# OCP working in the required time period}} \times 100 = \text{Pct. of HCP Vacc. Non-Comp. (inc. OCP)}
\]

Non-Employee Vaccination Non-Compliance Percentage [excluding OCP]

\[
\frac{(# \text{LIPs} + \text{# ASTV declined vacc.}) + (# \text{LIPs} + \text{# ASTV with unknown status})}{# \text{LIPs} + \text{# ASTV working in the required time period}} \times 100 = \text{Pct. of Non-Employee Vacc. Non-Comp. (exc. OCP)}
\]

Non-Employee Vaccination Non-Compliance Percentage [including OCP]

\[
\frac{(# \text{LIPs} + \text{# ASTV} + \text{# OCP declined vacc.}) + (# \text{LIPs} + \text{# ASTV} + \text{# OCP with unknown status})}{# \text{LIPs} + \text{# ASTV} + \text{# OCP working in the required time period}} \times 100 = \text{Pct. of Non-Emp. Vacc. Non-Comp. (inc. OCP)}
\]

References


**Healthcare Personnel Safety Monthly Reporting Plan**

<table>
<thead>
<tr>
<th>Facility ID#: ____________________________</th>
<th>*Month/Year: __________ /________</th>
</tr>
</thead>
</table>

- **□** No NHSN Healthcare Personnel Safety Modules followed this month

### Healthcare Personnel Exposure Modules

- **□** Blood/Body Fluid Exposure Only
- **□** Blood/Body Fluid Exposure with Exposure Management
- **□** Influenza Exposure Management

### Healthcare Personnel Vaccination Module

- **□** Influenza Vaccination Summary
- **□** Influenza Vaccination Summary for the Hospital
- **□** Influenza Vaccination Summary for the Inpatient Rehabilitation Facility Unit(s)
- **□** Influenza Vaccination Summary for the Inpatient Psychiatric Facility Unit(s)

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**Assurance of Confidentiality:** The voluntarily provided information obtained in this surveillance system that would permit identification of any individual or institution is collected with a guarantee that it will be held in strict confidence, will be used only for the purposes stated, and will not otherwise be disclosed or released without the consent of the individual, or the institution in accordance with Sections 304, 306 and 308(d) of the Public Health Service Act (42 USC 242b, 242k, and 242m(d)).

Public reporting burden of this collection of information is estimated to average 5 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC, Reports Clearance Officer, 1600 Clifton Rd., MS D-74, Atlanta, GA 30333 ATTN: PRA (0920-0666).

CDC 57.203, v3, r8.4
4. Table 1. Instructions for Completion of the Healthcare Personnel Safety Monthly Reporting Plan Form (CDC 57.203)

This form collects data on which options and which months a facility intends to participate in NHSN Healthcare Personnel Safety (HPS) Component. This form should be completed for every month that the facility will participate in the HPS Component.

<table>
<thead>
<tr>
<th>Data Field</th>
<th>Instructions for Data Collection</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facility ID #</td>
<td>Required. The NHSN-assigned facility ID will be auto-entered by the application.</td>
</tr>
<tr>
<td>Month/Year</td>
<td>Required. Enter the month and year for the surveillance plan being recorded.</td>
</tr>
<tr>
<td>No NHSN Healthcare Personnel Safety Modules Followed this Month</td>
<td>Conditionally required. Check this box if you do not plan to follow any of the NHSN Healthcare Personnel Safety Modules during the month and year selected.</td>
</tr>
</tbody>
</table>

**Healthcare Personnel Exposure Module**

<table>
<thead>
<tr>
<th>Blood/Body Fluid Exposure Only</th>
<th>Conditionally required. Check this box if you plan to follow blood/body fluid exposures only, without following exposure management during the month and year selected.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood/Body Fluid Exposure with Exposure Management</td>
<td>Conditionally required. Check this box if you plan to follow blood/body fluid exposure with exposure management during the month and year selected.</td>
</tr>
<tr>
<td>Influenza Exposure Management</td>
<td>Conditionally required. Check this box if you plan to follow influenza exposure management (for example, antiviral chemoprophylaxis and/or treatment)</td>
</tr>
</tbody>
</table>

**Healthcare Personnel Vaccination Module**

| Influenza Vaccination Summary                                   | Conditionally required. Check this box if you plan to follow the influenza vaccination summary option. Once the influenza vaccination summary is selected on the reporting plan, it is automatically updated with this information for the entire NHSN-defined influenza season (July 1 to June 30). |
# Healthcare Personnel Influenza Vaccination Summary

Record the number of healthcare personnel (HCP) for each category below for the influenza season being tracked.

<table>
<thead>
<tr>
<th>*Facility ID#:</th>
<th>^Location:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>*Vaccination type:</th>
<th><em>Influenza subtype</em>:</th>
<th><em>Influenza Season</em>:</th>
<th>Date Last Modified:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Influenza</td>
<td>□ Seasonal</td>
<td></td>
<td><em><strong>/</strong></em>/____</td>
</tr>
</tbody>
</table>

### Employee HCP

#### *Employees* (staff on facility payroll)

<table>
<thead>
<tr>
<th>Non-Employee HCP</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Licensed independent practitioners: Physicians, advanced practice nurses, &amp; physician assistants</em></td>
</tr>
</tbody>
</table>

1. Number of HCP who worked at this healthcare facility for at least 1 day between October 1 and March 31
2. Number of HCP who received an influenza vaccination at this healthcare facility since influenza vaccine became available this season
3. Number of HCP who provided a written report or documentation of influenza vaccination outside this healthcare facility since influenza vaccine became available this season
4. Number of HCP who have a medical contraindication to the influenza vaccine
5. Number of HCP who declined to receive the influenza vaccine
6. Number of HCP with unknown vaccination status (or criteria not met for questions 2-5 above)

### Custom Fields

<table>
<thead>
<tr>
<th>Label</th>
<th>Label</th>
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<tbody>
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</tr>
</tbody>
</table>

### Comments

*a For the purposes of NHSN, influenza subtype refers to whether seasonal or non-seasonal vaccine is used. Seasonal is the default and only current choice.*

*b For the purposes of NHSN, a flu season is defined as July 1 to June 30.*

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CDC 57.214 v2, R8.2
Healthcare Personnel Influenza Vaccination Summary

Question 1 (Denominator) Notes:

- Include all HCP who have worked at the facility for at least 1 working day during the reporting period, regardless of clinical responsibility or patient contact. This includes HCP who joined after October 1 or left before March 31, or who were on extended leave during part of the reporting period. Working for any number of hours a day counts as one working day.
- Include both full-time and part-time persons. If a HCW works in two or more facilities, each facility should include the HCW in their denominator. Count HCP as individuals rather than full-time equivalents.
- Licensed practitioners who receive a direct paycheck from the reporting facility, or who are owners of the reporting facility, should be counted as employees.
- The HCP categories are mutually exclusive. Each HCP should be counted only once in the denominator (question 1).

Questions 2-6 (Numerator) Notes:

- Questions 2-6 are mutually exclusive. The sum of the HCP in questions 2-6 should equal the number of HCP in question 1 for each HCP category. Questions 2-6 are to be reported separately for each of the three HCP categories.
- Only the following HCP should be counted in question 4: HCP with (1) a severe allergic reaction to eggs or other vaccine component(s) or (2) a history of Guillain-Barré Syndrome within 6 weeks after a previous influenza vaccination.
- The following should be counted in question 5 (declined to receive influenza vaccine):
  - HCP who declined vaccination because of conditions other than those included in question 4.
  - HCP who declined vaccination and did not provide any other information.
  - HCP who did not receive vaccination because of religious or philosophical exemptions.
  - HCP who deferred vaccination for the entire influenza season (for example, from October 1 through March 31).
4. Table 2. Instructions for Completion of Healthcare Personnel Influenza Vaccination Summary Form (CDC 57.214)

This form is used to collect information on summary influenza vaccination counts among healthcare personnel. Data can be entered monthly, but should represent cumulative counts for an entire influenza season. A monthly reporting plan for the influenza season for which data were collected (CDC 57.203) must be completed before a vaccination summary record can be entered in NHSN. A Seasonal Survey on Influenza Vaccination Programs for Healthcare Personnel (CDC 57.215) is also available and is optional but requested to be completed.

<table>
<thead>
<tr>
<th>Data Fields</th>
<th>Instructions for Completion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facility ID #</td>
<td>Required. The NHSN-assigned facility ID will be auto-entered.</td>
</tr>
<tr>
<td>Location</td>
<td>Conditionally Required. Hospitals with CMS IRF units must specify if they are reporting data for their hospital or their CMS IRF unit(s).</td>
</tr>
<tr>
<td>Vaccination Type</td>
<td>Required. Influenza is the default and only current choice.</td>
</tr>
<tr>
<td>Influenza Subtype</td>
<td>Required. Seasonal is the default and only current choice.</td>
</tr>
<tr>
<td>Influenza Season</td>
<td>Required. Select the influenza season years for which data were collected (for example, 2012/2013).</td>
</tr>
<tr>
<td>Date Last Modified</td>
<td>The Date Last Modified will be auto-entered and will indicate the date that these data were last changed by a user.</td>
</tr>
<tr>
<td>Employee HCP (staff on facility payroll)</td>
<td>Required. Defined as all persons that receive a direct paycheck from the healthcare facility (for example, on the facility’s payroll), regardless of clinical responsibility or patient contact.</td>
</tr>
<tr>
<td>Non-Employee HCP: Licensed independent practitioners: Physicians, advanced practice nurses &amp; physician assistants</td>
<td>Required. Defined as physicians (MD, DO); advanced practice nurses; and physician assistants only who are affiliated with the healthcare facility, but are not directly employed by it (for example, they do not receive a paycheck from the facility), regardless of clinical responsibility or patient contact. Post-residency fellows are also included in this category.</td>
</tr>
<tr>
<td>Non-Employee HCP: Adult students/trainees and volunteers</td>
<td>Required. Defined as adult students/trainees and volunteers: medical, nursing, or other health professional students, interns, medical residents, or volunteers aged 18 or older that are affiliated with the healthcare facility, but are not directly employed by it (for example, they do not receive a paycheck from the facility), regardless of clinical responsibility or patient contact.</td>
</tr>
<tr>
<td>Non-Employee HCP: Other contract personnel</td>
<td>Optional. Defined as persons providing care, treatment, or services at the facility through a contract.</td>
</tr>
<tr>
<td>Question 1 (Denominator)</td>
<td>The denominator categories are mutually exclusive. The numerator data are to be reported separately for each of the denominator categories.</td>
</tr>
<tr>
<td>Data Fields</td>
<td>Instructions for Completion</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>1. Number of HCP who worked at this healthcare facility for at least 1 day between October 1 and March 31</td>
<td>Required. Indicate the number of HCP that worked at this healthcare facility for at least 1 working day between October 1 and March 31 of the influenza season. This includes HCP who joined after October 1 or left before March 31, or who were on extended leave during part of the reporting period. Working for any number of hours a day counts as one working day. Both full-time and part-time persons should be included. HCP should be counted as individuals rather than full-time equivalents. If a healthcare worker (HCW) works in two or more facilities, each facility should include the HCW in their denominator. Licensed practitioners that receive a direct paycheck from the reporting facility, or who are owners of the reporting facility, should be counted as employees.</td>
</tr>
</tbody>
</table>

**Questions 2-6 (Numerator)**

<table>
<thead>
<tr>
<th>Questions 2-6 (Numerator)</th>
<th>The numerator data are mutually exclusive. The sum of the numerator categories should be equal to the denominator for each HCP group.</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Number of HCP who received an influenza vaccination at this healthcare facility since influenza vaccine became available this season</td>
<td>Required. Enter the total number of HCP that received an influenza vaccination at this healthcare facility since the influenza vaccine became available this season.</td>
</tr>
<tr>
<td>3. Number of HCP who provided a written report or documentation of influenza vaccination outside this healthcare facility since influenza vaccine became available this season</td>
<td>Required. Enter the total number of HCP that reported in writing (paper or electronic) or provided documentation of influenza vaccination outside this healthcare facility since the influenza vaccine became available this season. For the purposes of this reporting measure, verbal statements are not acceptable.</td>
</tr>
<tr>
<td>4. Number of HCP who have a medical contraindication to the influenza vaccine</td>
<td>Required. Enter the total number of HCP determined to have a medical contraindication to influenza vaccination. Documentation is not required for reporting a medical contraindication. For this measure, for inactivated influenza vaccine (IIV), accepted contraindications include (1) severe allergic reaction (for example, anaphylaxis) after a previous vaccine dose or to a vaccine component, including egg protein, and (2) history of Guillain-Barré Syndrome within 6 weeks after a previous influenza vaccination.</td>
</tr>
</tbody>
</table>


### Data Fields

<table>
<thead>
<tr>
<th>Data Fields</th>
<th>Instructions for Completion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Additional contraindications for live attenuated influenza vaccine (LAIV) include pregnancy; known severe immunodeficiency (for example, hematologic and solid tumors; receiving chemotherapy; congenital immunodeficiency; long-term immunosuppressive therapy; patients with HIV infection who are severely immunocompromised); certain chronic medical conditions include asthma and chronic pulmonary, cardiovascular (except isolated hypertension), renal, hepatic, neurologic/neuromuscular, hematologic, or metabolic disorders. Individuals older than 49 years of age are also not eligible to receive LAIV.</td>
<td></td>
</tr>
</tbody>
</table>

#### 5. Number of HCP who declined to receive the influenza vaccine

*Required.* Enter the total number of HCP that were offered an influenza vaccination but declined to receive this. Documentation is not required for reporting a declination.

The following individuals should be counted in this category:
- HCP that declined vaccination because of conditions other than those included in Question 4.
- HCP that declined vaccination and did not provide any other information.
- HCP that did not receive vaccination because of religious or philosophical exemptions.
- HCP that deferred vaccination for the entire measure reporting period (for example, from October 1 through March 31).

#### 6. Number of HCP with unknown vaccination status (or criteria not met for questions 2-5 above)

*Required.* Enter the total number of HCP with unknown vaccination status (or did not meet the criteria for Questions 2-5 above).

### Custom Fields & Comments

<table>
<thead>
<tr>
<th>Custom Fields &amp; Comments</th>
<th>Instructions for Completion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Custom fields</td>
<td><em>Optional.</em> Can be used to fulfill other reporting requirements not supported by the categories above; for example, reporting vaccination rates by occupational group or by unit/department.</td>
</tr>
<tr>
<td>Comments</td>
<td><em>Optional.</em> Enter any additional information on the Influenza Vaccination Monthly Summary. This information may not be analyzed.</td>
</tr>
</tbody>
</table>
### Seasonal Survey on Influenza Vaccination Programs for Healthcare Personnel

**Facility ID #: ______________________________**

*Date Entered: _________________________  
*For Season: ________ - _________  
(Month/Year)  
(Specify years)

1. Which personnel groups are included in your facility’s annual influenza vaccination campaign? **(check all that apply)**

- [ ] Full-time employees
- [ ] Part-time employees
- Licensed independent practitioners:
  - [ ] Non-employee physicians
  - [ ] Non-employee advanced practice nurses
  - [ ] Non-employee physician assistants
- [ ] Students and trainees (for example, interns, residents)
- [ ] Adult volunteers
- [ ] Other contract personnel
- [ ] Other, specify: ____________________________________

2. Are healthcare personnel at your facility required to pay out-of-pocket costs for influenza vaccination received at your facility?

- [ ] Yes
- [ ] No

If yes, how much do each of the following groups need to pay for influenza vaccination?

- Full-time employees: $ _____
- Part-time employees: $ _____
- Non-employee physicians: $ _____
- Non-employee advanced practice nurses: $ _____
- Non-employee physician assistants: $ _____
- Students and trainees: $ _____
- Adult volunteers: $ _____
- Other contract personnel $ _____
- Other, specify: ____________________________________

3. Which of the following methods is your facility using this influenza season to deliver vaccine to your healthcare personnel? **(check all that apply)**

- [ ] Have mobile vaccination carts
- [ ] Provide vaccination in Occupational/Employee Health
- [ ] Provide vaccination in wards, clinics, cafeterias, or common areas
- [ ] Provide vaccination during nights and weekends
- [ ] Provide vaccination at any meetings or grand rounds
- [ ] Provide visible vaccination of any key personnel/leadership
- [ ] Other, specify: ____________________________________
- [ ] None of the above

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CDC 57.215 Rev. 1, NHSN v7.1
*4. Which of the following strategies does your facility use to promote/enhance healthcare personnel influenza vaccination at your facility? (check all that apply)
   □ Send vaccination reminders by mail, e-mail, and/or pager
   □ Coordinate vaccination with other annual programs (for example, tuberculin skin testing)
   □ Require receipt of vaccination for credentialing (if no contraindications)
   □ Require receipt of vaccination as a condition of employment
   □ Advertise vaccination with a campaign including posters, flyers, buttons, and/or fact sheets
   □ Provide education on the benefits and risks of vaccination
   □ Track unit-based vaccination rates for some or all units/departments
   □ Plan to provide feedback on vaccination rates to facility administration
   □ Provide incentives for vaccination
   □ Track vaccination on a regular basis for targeting purposes
   □ Other, specify: ____________________________________
   □ No formal promotional activities are planned

*5. What is your facility’s influenza vaccination policy for healthcare personnel? (check one)
   □ Influenza vaccination is required; unvaccinated personnel are terminated from employment
   □ Influenza vaccination is required with consequences other than termination for unvaccinated personnel
   □ Influenza vaccination is recommended but not required
   □ My facility does not have a specific influenza vaccination policy for personnel
   □ Other, specify: __________________

*6. Which personnel groups are covered by your facility’s influenza vaccination policy? (check all that apply)
   □ Full-time employees
   □ Part-time employees
   Licensed independent practitioners:
      □ Non-employee physicians
      □ Non-employee advanced practice nurses
      □ Non-employee physician assistants
   □ Students and trainees (for example, interns, residents)
   □ Adult volunteers
   □ Other contract personnel
   □ Other, specify: __________________

*7. Does your facility require healthcare personnel who receive off-site influenza vaccination to provide documentation of their vaccination status?
   □ Yes
   □ No
   If yes, what type of documentation is acceptable? (check all that apply)
      □ Receipt or other proof of purchase from pharmacy or other vaccinator
      □ Insurance claim for receipt of influenza vaccination
      □ Note from person or organization that administered the vaccination
      □ Handwritten statement or e-mail from healthcare worker
      □ Signature of healthcare worker on standard facility form attesting to vaccination
      □ Other, specify: ____________________
**8. What does your facility require from healthcare personnel who refuse influenza vaccination? (check one)**

- Standardized paper or electronic declination form completed by healthcare worker
- Reading a statement about the risks of non-vaccination (no signature required)
- Verbal declination of vaccination by healthcare worker
- Facility does not track vaccine declinations
- Other, specify: ________________________________

**9. Does your facility require healthcare personnel who refuse influenza vaccination to wear a mask or other personal protective equipment (PPE)?**

- Yes
- No
4. Table 3. Instructions for Completion of Seasonal Survey on Influenza Vaccination Programs for Healthcare Personnel (CDC 57.215)

This survey is used to collect information on the influenza vaccination programs at each healthcare facility. Facilities are encouraged to complete this survey, but it is not required at this time. Only one survey should be completed per facility per year, at the end of each influenza season.

<table>
<thead>
<tr>
<th>Data Fields</th>
<th>Instructions for Completion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facility ID #</td>
<td>Required. The NHSN-assigned facility ID will be auto-entered.</td>
</tr>
<tr>
<td>Date Entered</td>
<td>Required. The month and year of the seasonal survey will be auto-entered.</td>
</tr>
<tr>
<td>For Season</td>
<td>Required. Enter the years of the vaccination season for which the survey was completed. This is entered in the format: yyyy – yyyy. Vaccination season is July 1 of the current year to June 30 of the following year.</td>
</tr>
<tr>
<td>1. Which personnel groups are included in your facility’s annual influenza vaccination campaign?</td>
<td>Required. Select the personnel group(s) you included in your campaign or program.</td>
</tr>
<tr>
<td></td>
<td>Employee healthcare personnel (staff on facility payroll): Defined as all persons that receive a direct paycheck from the healthcare facility (for example, on the facility’s payroll), regardless of clinical responsibility or patient contact. (This is a required denominator category for reporting healthcare personnel influenza vaccination summary data.)</td>
</tr>
<tr>
<td></td>
<td>Non-employee healthcare personnel: Licensed independent practitioners: Defined as physicians (MD, DO); advanced practice nurses; and physician assistants only who are affiliated with the healthcare facility, but are not directly employed by it (for example, they do not receive a paycheck from the facility), regardless of clinical responsibility or patient contact. Post-residency fellows are also included in this category. (This is a required denominator category for reporting healthcare personnel influenza vaccination summary data.)</td>
</tr>
<tr>
<td></td>
<td>Non-employee healthcare personnel: Adult students/trainees and volunteers: Defined as medical, nursing, or other health professional students, interns, medical residents, or volunteers aged 18 or older that are affiliated with the healthcare facility, but are not directly employed by it (for example, they do not receive a paycheck from the facility), regardless of clinical responsibility or patient contact. (This is a required denominator category for reporting healthcare personnel influenza vaccination summary data.)</td>
</tr>
</tbody>
</table>
### Data Fields

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<thead>
<tr>
<th>Data Fields</th>
<th>Instructions for Completion</th>
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</thead>
<tbody>
<tr>
<td>Non-employee healthcare personnel: Other contract personnel: Defined as persons providing care, treatment, or services at the facility through a contract and who do not meet the definition of any other required denominator category. (This is an optional denominator category for reporting healthcare personnel influenza vaccination summary data.)</td>
<td></td>
</tr>
<tr>
<td>2. Are healthcare personnel at your facility required to pay out-of-pocket costs for influenza vaccination received at your facility?</td>
<td><em>Required.</em> Select Yes or No. If yes, indicate the exact amount of out-of-pocket costs that the personnel groups were required to pay for influenza vaccination at your facility.</td>
</tr>
<tr>
<td>3. Which of the following methods is your facility using this influenza season to deliver vaccine to your healthcare personnel?</td>
<td><em>Required.</em> Select all methods that your facility used this influenza season to deliver influenza vaccine to your healthcare personnel.</td>
</tr>
<tr>
<td>4. Which of the following strategies does your facility use to promote/enhance healthcare personnel influenza vaccination at your facility?</td>
<td><em>Required.</em> Select all strategies that your facility used to promote/enhance healthcare personnel influenza vaccination at your facility.</td>
</tr>
<tr>
<td>5. What is your facility’s influenza vaccination policy for healthcare personnel?</td>
<td><em>Required.</em> Select the one option that best describes the influenza vaccination policy for healthcare personnel at your facility.</td>
</tr>
<tr>
<td>6. Which personnel groups are covered by your facility’s influenza vaccination policy?</td>
<td><em>Required.</em> Select all personnel groups who are covered by your facility’s influenza vaccination policy.</td>
</tr>
<tr>
<td>Full-time employees: Defined as all persons that receive a direct paycheck from the healthcare facility (for example, on the facility’s payroll), regardless of clinical responsibility or patient contact. These individuals work at the facility on a full-time basis.</td>
<td></td>
</tr>
<tr>
<td>Part-time employees: Defined as all persons that receive a direct paycheck from the healthcare facility (for example, on the facility’s payroll), regardless of clinical responsibility or patient contact. These individuals work at the facility on a part-time basis.</td>
<td></td>
</tr>
<tr>
<td>Data Fields</td>
<td>Instructions for Completion</td>
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</tr>
<tr>
<td>Licensed independent practitioners: Non-employee physicians: Defined as physicians (MD, DO) who are affiliated with the healthcare facility, but are not directly employed by it (for example, they do not receive a paycheck from the facility), regardless of clinical responsibility or patient contact. Post-residency fellows are also included in this category.</td>
<td></td>
</tr>
<tr>
<td>Licensed independent practitioners: Non-employee advanced practice nurses: Defined as advanced practice nurses who are affiliated with the healthcare facility, but are not directly employed by it (for example, they do not receive a paycheck from the facility), regardless of clinical responsibility or patient contact. Advanced practice nurses include nurse practitioners, nurse midwives, clinical nurse specialists, and nurse anesthetists.</td>
<td></td>
</tr>
<tr>
<td>Licensed independent practitioners: Non-employee physician assistants: Defined as physician assistants who are affiliated with the healthcare facility, but are not directly employed by it (for example, they do not receive a paycheck from the facility), regardless of clinical responsibility or patient contact.</td>
<td></td>
</tr>
<tr>
<td>Students and trainees: Defined as medical, nursing, or other health professional students, interns, medical residents, aged 18 or older that are affiliated with the healthcare facility, but are not directly employed by it (for example, they do not receive a paycheck from the facility), regardless of clinical responsibility or patient contact.</td>
<td></td>
</tr>
<tr>
<td>Adult volunteers: Defined as volunteers aged 18 or older that are affiliated with the healthcare facility, but are not directly employed by it (for example, they do not receive a paycheck from the facility), regardless of clinical responsibility or patient contact.</td>
<td></td>
</tr>
<tr>
<td>Other contract personnel: Defined as persons providing care, treatment, or services at the facility through a contract and who do not meet the definition of any other required denominator category.</td>
<td></td>
</tr>
</tbody>
</table>

7. Does your facility require healthcare personnel who receive off-site influenza vaccination

*Required.* Select Yes or No. If yes, select all types of documentation for off-site influenza vaccination that your facility accepted. (Please note that for the Healthcare Personnel Vaccination Module, healthcare personnel who received vaccination outside this healthcare facility are required to provide a written report or documentation of influenza vaccination.)
<table>
<thead>
<tr>
<th>Data Fields</th>
<th>Instructions for Completion</th>
</tr>
</thead>
<tbody>
<tr>
<td>to provide documentation of their vaccination status?</td>
<td></td>
</tr>
<tr>
<td>8. What does your facility require from healthcare personnel who refuse influenza vaccination?</td>
<td>Required. Select the one option that best describes what your facility requires from healthcare personnel who refused influenza vaccination.</td>
</tr>
<tr>
<td>9. Does your facility require healthcare personnel who refuse influenza vaccination to wear a mask or other personal protective equipment (PPE)?</td>
<td>Required. Select Yes or No. Select yes if your facility requires healthcare personnel to wear a mask or other PPE if they refuse influenza vaccination. Select no if your healthcare facility does not have this requirement.</td>
</tr>
</tbody>
</table>
# 5. Key Terms

<table>
<thead>
<tr>
<th>Key term</th>
<th>Definition for purposes of the HCP Influenza Vaccination Summary Module</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Adult students/trainees and volunteers</strong></td>
<td>Medical, nursing, or other health professional students, interns, medical residents, or volunteers aged 18 or older that are affiliated with the healthcare facility, but are not directly employed by it (for example, they do not receive a paycheck from the facility), regardless of clinical responsibility or patient contact.</td>
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<tr>
<td><strong>Contract personnel</strong></td>
<td>Persons providing care, treatment, or services at the facility through a contract, regardless of clinical responsibility or patient contact, who do not meet the definition of employees, licensed independent practitioners, or adult students/trainees and volunteers.</td>
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<tr>
<td><strong>Employees</strong></td>
<td>Persons who receive a direct paycheck from the healthcare facility (for example, on the facility’s payroll), regardless of clinical responsibility or patient contact.</td>
</tr>
<tr>
<td><strong>Healthcare personnel (HCP)</strong></td>
<td>The entire population of healthcare workers working in healthcare settings. HCP might include (but are not limited to) physicians, nurses, nursing assistants, therapists, technicians, emergency medical service personnel, dental personnel, pharmacists, laboratory personnel, autopsy personnel, students/trainees, and volunteers, contractual staff not employed by the healthcare facility (for example, clerical, dietary, housekeeping, maintenance, and volunteers), regardless of clinical responsibility or patient contact.</td>
</tr>
<tr>
<td><strong>HCP Influenza Vaccination Measure reporting period</strong></td>
<td>The reporting period for the HCP Influenza Vaccination Measure is October 1 through March 31. This reporting period refers to the denominator only.</td>
</tr>
<tr>
<td><strong>Healthcare worker (HCW)</strong></td>
<td>A person who works in the healthcare facility, whether paid or unpaid, regardless of clinical responsibility or patient contact. Healthcare worker is the singular form of healthcare personnel.</td>
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<tr>
<td><strong>Influenza season</strong></td>
<td>For the purposes of NHSN, an influenza season is defined as July 1 to June 30 (of the following year).</td>
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<tr>
<td><strong>Licensed independent practitioners (LIPs)</strong></td>
<td>Physicians (MD, DO), advance practice nurses, and physician assistants who are affiliated with the healthcare facility, but are not directly employed by it (for example, they do not receive a paycheck from the facility), regardless of clinical responsibility or patient contact. Post-residency fellows are also included in this category if they are not on a facility’s payroll.</td>
</tr>
<tr>
<td>Key term</td>
<td>Definition for purposes of the HCP Influenza Vaccination Summary Module</td>
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<tr>
<td>Seasonal influenza vaccine</td>
<td>A vaccine for seasonal influenza virus strains that is offered on an annual basis.</td>
</tr>
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</table>
Appendix A

Influenza Vaccination Summary: List of Contracted Healthcare Personnel (HCP)
The list below includes contracted HCP who provide direct patient care and non-direct care. It is noted that HCP listed below can transmit influenza to patients, families, and other staff members. Agency and traveling nurses represent a substantial portion of contracted workers who provide direct patient care in organizations across the country.

Contracted HCP can include the following direct care providers:
- Chaplains
- Dieticians
- Dialysis technicians
- EKG technicians
- EMG technicians
- Home health aides
- Laboratory: Phlebotomists
- Nurses (through agency and travel employers)
- Nursing aides
- Occupational therapists
- Patient care technicians
- Pharmacists
- Pharmacy/medication technicians
- Physical therapists
- Psychologists
- Psych techs/Mental health workers
- Radiology – X-ray technicians
- Recreational therapists/Music therapists
- Respiratory therapists
- Speech therapists
- Social workers/Case managers
- Surgical technicians
- Ultrasound technicians

Contracted HCP can include the following non-direct providers:
- Admitting staff/clerical support/registrars
- Biomedical engineers
- Central supply staff
- Construction workers
- Dietary/food service
- IT staff
• Laboratory: technicians
• Landscapers
• Laundry staff
• Pharmacists
• Pharmacy/medication technicians
• Housekeeping (Please note many housekeeping staff are in patient rooms interacting with patients and visitors.)
• Maintenance staff/engineers
• Patient transporters
• Security staff
• Utilization review nurses