Hospital Based Inpatient Psychiatric Services 2015 Specifications Manual Updates

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HBIPS Measures

- HBIPS-1 Admission Screening for Violence Risk, Substance Use, Psychological Trauma History and Patient Strengths completed
- HBIPS-2 Hours of physical restraint use
- HBIPS-3 Hours of seclusion use
- HBIPS-4 Patients discharged on multiple antipsychotic medications
HBIPS Measures

- HBIPS-5 Patients discharged on multiple antipsychotic medications with appropriate justification
- HBIPS-6 Post discharge continuing care plan created
- HBIPS-7 Post discharge continuing care plan transmitted to next level of care provider upon discharge
HBIPS-1 Admission Screening
Substance Use

Previous bullet in “Notes” clarified in 2 new ones:

• Intent is to screen for substance use within the 12 months prior to admission - must include the last 12 months at a minimum and should clarify if the past history of substance use was within the past 12 months or prior to the 12 month time frame

• Documentation of “no history” cannot be used, unless it is associated with a time frame

Examples:

➤ No history of substance use within the past 12 months

➤ History of substance use 2 years ago
Violence Risk to Self/Others

Previous bullet in “Notes” clarified in 2 new ones:

• Intent is to screen for being a violence risk to self/others within the 6 months prior to admission - must include the last 6 months at a minimum and should clarify if the past history of violence risk was within the past 6 months or prior to the 6 months

• Documentation of “no history” cannot be used, unless it is associated with a time frame

Examples:

➤ No history of violence risk to self/others within the past 6 months

➤ History of violence risk to self/others over a year ago
HBIPS-2 Hours of physical restraint use
HBIPS-3 Hours of seclusion use
Event Date

New Paragraph;

• When an event begins and ends on different dates this is considered 2 separate events and both dates must be documented in order to determine the total amount of time for each date. If one event date is missing, the event will be rejected. Example;

    Patient placed in physical restraints on 6/1 at 2345. Restraints are discontinued on 6/2 at 0030.

    The first event must have documentation of a start date of 6/1 and timed from 2345 to 2359. The second event begins at 2400 on 6/2 and ends at 0030.
HBIPS-4 Patients discharged on multiple antipsychotic medications
Two new bullets;

- All antipsychotic meds should be counted regardless of indication or reason for prescribing.
- Acceptable to use pharmacy reports or clinical information systems if available and directly derived from the medical record with a process in place to confirm their accuracy. These may be used in lieu of the list of suggested data sources.

Antipsychotic Med Table is now in Appendix C Table 10.0 - Changed from Appendix B to align with the Inpatient Manual.
Pt Referral to Next Level Provider

Allowable Values now have bullets instead of lists.

Change to Allowable Value 2:

2. The record contains one of the following:
   - the pt or guardian refused the next LOC provider upon D/C from inpatient psychiatric setting
   - the pt or guardian refused to authorize release of information
   - **the patient was readmitted to the same facility within 5 days after discharge**
Pt Referral to Next Level Provider

Change to Allowable Value 3:

3. The record contains one of the following:
   - the patient eloped and was discharged
   - patient failed to return from leave and discharged
   - patient has not yet been discharged from hospital
   - patient was discharged from hospital to another LOC outside the hospital system from a setting other than Psych Care
   - ** the patient’s residence is not in the USA, and they are returning to another country after discharge
New under Notes;

- A referral to attend support groups, i.e., Alcoholics Anonymous (AA), Narcotics Anonymous (NA), etc. after discharge is **not** a referral to a next level of care provider. A referral to support groups is a next level of care recommendation.
HBIPS-5 Patients discharged on multiple antipsychotic medications with appropriate justification

**There are no changes to this measure**
HBIPS-6 Post discharge continuing care plan created
HBIPS-7 Post discharge continuing care plan transmitted to next level of care provider upon discharge
Continuing CP - Discharge Meds

New to Notes;

- If more than one list of medications is included in the care plan documents and the lists do not match, select Allowable Value “3” which would capture UTD. Since there is a conflict between two separate documents, a receiving practitioner would not be able to determine which list is accurate.
Tobacco Treatment (TOB)
CMS Manual Version 4.4a
# Tobacco Treatment (TOB)

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TOB-1 Tobacco Use Screening
TOB-1 Tobacco Use Screening

Core Measure Data Elements:

• Admission Date
• Birthdate
• Comfort Measures Only
• Discharge Date
TOB-1 Tobacco Use Screening

Excluded Populations:

- Patients less than 18
- Patients who are cognitively impaired
- Patient with LOS ≤3 days or >120 days
- Patients with *Comfort Measures Only* documented
Tobacco Use Status

Allowable Values:

1 Patient has smoked cigarettes daily on average in a volume of five or more cigarettes (=>1/4 pack) per day and/or cigars daily and/or pipes daily during the past 30 days

2 Patient has smoked cigarettes daily on average in a volume of four or less cigarettes (< 1/4 pack) per day and/or used smokeless tobacco and/or smoked cigarettes but not daily and/or cigars but not daily and/or pipes but not daily during the past 30 days

3 Patient has not used any forms of tobacco in the past 30 days
Tobacco Use Status

Allowable Values (cont.):

4 Patient refused the tobacco use screen

5 Patient was not screened for tobacco use during this hospitalization or unable to determine the patient’s tobacco use status from medical record

6 Patient was not screened for tobacco use during the first three days of admission because of cognitive impairment
Tobacco Use Status

- If you have definitive documentation that patient either currently uses tobacco products or is an ex-user that quit less than 30 days prior to admission, select the appropriate allowable value for the type of product used, regardless of whether or not there is conflicting documentation.

- For the History and Physical (H&P) (suggested) source, use only the H&P report for the current admission. The H&P may be a dictated report, a handwritten report on an H&P form, or a separate entry labeled as the H&P in the progress notes.
Tobacco Use Status

- Classify a form as a nursing admission assessment if the content is typical of a nursing admission assessment (med/surg/social history, current meds, allergies, physical assessment) AND the form is completed/reviewed by a nurse or labeled as a “nursing form.”

- Disregard tobacco use history if the current tobacco use status or timeframe that the patient quit is not defined (e.g., “20 pk/yr smoking history,” “History of tobacco abuse”).

- Do not include documentation of smoking history referenced as a “risk factor” (“risk factor: tobacco,” “risk factor: smoking,” “risk factor: smoker”), where current tobacco use status is not determined.
Tobacco Use Status

• When there is conflicting information with regard to volume - one document indicates patient is a light smoker and another indicates patient is a volume greater than light smoking; select the allowable value “1” indicating the heaviest use.

• If the record indicates the patient smokes cigarettes and the volume is not documented, assume smoking at the heaviest level and select value “1”.

• The tobacco use status screening timeframe must have occurred within the first three days of admission - The day after admission is defined as the first day.
Cognition refers to mental activities associated with thinking, learning, and memory. Cognitive impairment is related to documentation that the patient cannot be screened for tobacco use due to the impairment (comatose, obtunded, confused, memory loss) during the entire first three days.

Cognitive impairment must be documented at all times during the first three days in order to select value “6.” If there is documentation that a patient is cognitively impaired, and there is no additional documentation that the patient’s mental status was normal at any other time during the first three days, i.e., alert and oriented, the abstractor can select value “6.”
Tobacco Use Status

If there is documentation that the patient has temporary cognitive impairment due to acute substance use (overdose or acute intoxication) value “6” (not screened) cannot be selected.

Examples of cognitive impairment include:
- Altered Level of Consciousness (LOC)
- Altered Mental Status
- Cognitive impairment
- Cognitively impaired
- Confused
- Memory loss
- Mentally retarded
- Obtunded
Tobacco Use Status

Inclusion Guidelines:
• Chewing (spit) tobacco
• Dry snuff
• Moist snuff
• Plug tobacco
• Redman
• Smokeless tobacco
• Snus
• Twist

Exclusion Guidelines:
• E-cigarettes
• Hookah pipe
• Illegal drug use only (marijuana)
TOB-2, 2a Tobacco Use Treatment Provided or Offered
TOB-2 Numerator Populations

**TOB-2:** Patients who received or refused practical counseling to quit AND received or refused FDA-approved cessation medications during the first three days after admission.

**TOB-2a:** Patients who received practical counseling to quit AND received FDA-approved cessation medications during the first three days after admission.
TOB- Tobacco Use Treatment

Also Excluded for this measure:

• Patients who are not current tobacco users
• Patients who refused or were not screened for tobacco use during the hospital stay

Exclusions for FDA approved medications only:

• Smokeless tobacco users
• Pregnant smokers
• Light smokers
• Patients with reasons for not administering FDA-approved cessation medication
Tobacco Use Treatment FDA-Approved Cessation Medication

Allowable Values:

1 Patient received one of the FDA-approved tobacco cessation meds during the first 3 days after admission

2 Patient refused the FDA-approved tobacco cessation meds during the first 3 days after admission

3 FDA-approved tobacco cessation meds were not offered to the patient during the first 3 days after admission or unable to determine (UTD)
FDA Approved Medications

- If nicotine replacement therapy (NRT) is ordered PRN and the patient does not receive any doses during the hospital stay, select value “2” (the patient refused the FDA-approved tobacco cessation medications during the hospital stay).
- The timeframe for receiving FDA-approved tobacco cessation medications must have occurred within the first three days of admission. The day after admission is defined as the first day.
FDA Approved Medications

Inclusion Guidelines:
Refer to Appendix C, Table 9.1 for the list of FDA-approved tobacco cessation medications

Exclusion Guidelines:
• Light smokers (4 or less cigarettes per day)
• Pregnant smokers
• Smokeless tobacco user (chewing [spit] tobacco)
Tobacco Use Treatment Practical Counseling

Allowable Values:
1 Patient received all components of practical counseling during the first 3 days after admission

2 Patient refused/declined practical counseling during the first 3 days after admission

3 Practical counseling was not offered to the patient during the first 3 days after admission or unable to determine (UTD) if tobacco use treatment was provided
Tobacco Use Treatment Practical Counseling

Definition:
The components of practical counseling require interaction with the patient to address the following;

✓ Recognizing danger situations
✓ Developing coping skills
✓ Providing basic information about quitting
Practical Counseling

• A referral to the Quitline may be considered a component of practical counseling (providing basic information about quitting), however, handing the patient a phone number to call the quit line will not meet the intent of practical counseling - there must be interaction between the patient and the caregiver.

• “Danger situations” covered in practical counseling might include:
  ✓ alcohol use during the first month after quitting
  ✓ being around smoke and/or other smokers
  ✓ times/situations when the patient routinely smoked (in the car, on break at work, with coffee, after a meal, upon waking up, social events, etc.)
Practical Counseling

- If there is no documentation that practical counseling was given to the patient, select “3.”
- Select value “3” if the documentation provided is not explicit enough to determine if the counseling provided contained all components or if the counseling meets the intent of the measure.
- The timeframe for receiving practical counseling must have occurred within the first three days of admission - the day after admission is defined as the first day.
Practical Counseling

Inclusion Guidelines:
Referral to Quitline

Exclusion Guidelines:
Severe cognitive impairment
Reason for No Tobacco Cessation Med During Stay/Discharge

Allowable Values:

Y (Yes) There is documentation of a reason for not prescribing an FDA-approved cessation medication during the first three days of admission/at discharge.

N (No) There is no documentation of a reason for not prescribing an FDA-approved cessation medication during the first three days of admission/at discharge or unable to determine (UTD).
No Cessation Med During Stay/Discharge

- The timeframe for documenting a reason must have occurred within the first three days of admission - the day after admission is defined as the first day
- Reasons for not prescribing must be documented by a physician/APN/PA or pharmacist
- An allergy or adverse reaction to one of the FDA-approved cessation medications would not be a reason for not prescribing another of the cessation medications
No Cessation Med During Stay/Discharge

• In determining whether there is a reason documented for not prescribing tobacco cessation medications, the reason must be explicitly documented.

• When conflicting information is documented, select the appropriate value for the indicated reasons present for not prescribing the tobacco cessation medications.
No Cessation Med During Stay/Discharge

Inclusion Guidelines:
• Allergy or sensitivity
• Refer to Appendix C, Table 9.1 for a list of FDA-approved tobacco cessation medications

Exclusion Guidelines:
Medication allergy using a negative modifier or qualifier (questionable, risk of, suspect, etc.)
TOB-3, 3a Tobacco Use Treatment Provided or Offered at Discharge
TOB-3 Numerator Populations

TOB-3: Number of patients who were referred to or refused evidence-based outpatient counseling AND received or refused a prescription for FDA-approved cessation medication at discharge

TOB-3a: Number of patients who were referred to evidence-based outpatient counseling AND received a prescription for FDA-approved cessation medication at discharge
TOB-3 Tobacco Use Treatment

Also Excluded for this measure:

• Patients who expired
• Patients who left AMA
• Patients discharged to another hospital
• Patients discharged to another health care facility
• Patients discharged to home for hospice care
• Patients who do not reside in the U.S.
Prescription for Tobacco Cessation Medication

Allowable Values:

1 A prescription for an FDA-approved tobacco cessation medication was given to the patient at discharge.

2 A prescription for an FDA-approved tobacco cessation medication was offered at discharge and the patient refused.

3 The patient’s residence is not in the USA.

4 A prescription for an FDA-approved tobacco cessation medication was not offered at discharge or unable to determine (UTD).
Prescription for Cessation Med

- It is not uncommon to see conflicting documentation among different sources - for example, the discharge summary may list Chantix and this is not included in any of the other discharge medication sources (e.g., discharge orders). All discharge medication documentation available in the chart should be reviewed and taken into account.

- In cases where there is tobacco cessation medication in one source that is not mentioned on other sources, it should be interpreted as a discharge medication. Select value “1” unless documentation elsewhere suggests that it was not prescribed at discharge.
Prescription for Cessation Med

• If documentation is contradictory (physician noted “d/c Chantix” or “hold Chantix” in the discharge orders, but Chantix is listed in the discharge summary’s discharge medication list), or after careful review, documentation raises enough questions, the case should be deemed unable to determine, select value “4”.

• If the physician wishes the patient to continue on over the counter nicotine replacement therapy (NRT) or medication that will be provided by the outpatient counseling such as the quit line - if the medication is listed on the discharge medication list this would be sufficient to select value “1”.

• If the patient does not have a residence in the USA, value “3” must be selected.
Prescription for Cessation Med

Inclusion Guidelines:
Refer to Appendix C, Table 9.1 for a comprehensive list of FDA-approved tobacco cessation medications

Exclusion Guidelines:
None
Referral for Outpatient Tobacco Cessation Counseling

Allowable Values:

1. Referral to outpatient tobacco cessation counseling treatment was made by the healthcare provider or health care organization at any time prior to discharge.

2. Referral information was given to the patient at discharge but the appointment was not made by the provider or health care organization prior to discharge.

3. Patient refused the referral for outpatient tobacco cessation counseling treatment and the referral was not made.

4. Patient’s residence is not in the USA.

5. Referral for outpatient tobacco cessation counseling treatment was not offered at discharge or (UTD).
Referral for OP Counseling

• If a referral is made to a Quitline, defined as a telephone counseling in which at least some of the contact is initiated by the Quitline counselor to deliver tobacco interventions, select “1”
• If the patient is provided with contact information for e-health or internet smoking cessation programs which tailor program content to the user’s needs (collect information from the tobacco user and use algorithms to tailor feedback or recommendations, permitting the user to select from various features including extensive information on quitting, tobacco dependence, and related topics) select “2”
Referral for OP Counseling

- If patient is provided with self-help materials that are not tailored to the patient’s needs and do not provide a structured program, select value “5”
- Select value “5” if it cannot be determined if the referral for outpatient counseling was made or if it is unclear if the absence of the referral was due to patient refusal or it not being offered
- If the patient does not have a residence in the USA, value “4” must be selected
Referral for OP Counseling

Inclusion Guidelines:
• Group counseling
• E-health
• Individual counseling
• Internet structured programs
• Quitline

Exclusion Guidelines:
Self-help interventions (brochures, videotapes, audiotapes)
TOB-4 Tobacco Use: Assessing Status After Discharge
Assessing Status After Discharge

Also Excluded for this measure:

• Patients who do not have a phone or cannot provide contact information
• Patients discharged to a detention facility, jail or prison
• Patients re-admitted within the follow-up time frame
• Patients without a Principal or Other Dx code for Pregnancy who refused Counseling AND Rx for Cessation Medication
• Patients with a Dx code for pregnancy who refused a Referral for Outpatient Counseling
Follow-up Contact Date

- If multiple contacts are made with the discharged patient post discharge, select the date of the latest contact where information is received relative to treatment and quit status.
- If contact is made through e-mail or letter, select the date of receipt of the patient’s alcohol, tobacco, or drug use post discharge status, not the date the e-mail or letter was sent.
- If follow-up contact is not made, select “UTD,” do not leave the date field blank.
- Follow up date must be documented in the inpatient record regardless of whom performs the follow up.
Follow-up Contact

Allowable Values:
1. Follow-up contact was made within the specified time frame post discharge.
2. Follow-up contact was made but not within the specified time frame post discharge.
3. Follow-up contact was not made within the specified time frame post discharge because the patient’s residence is not in the USA, the patient was incarcerated, contact number was no longer valid, the patient had no phone, the patient was re-admitted to the hospital within 30 days post discharge, at least 3 unsuccessful attempts to contact the patient were made, or the patient refused permission for a third party to contact them on behalf of the hospital.
4. Follow-up contact was not made within the specified time frame post discharge or UTD.
Follow-up Contact

- The specified time frame for post discharge contact should be between 15 and 30 days post-discharge.
- If a follow-up contact was made, but outside the 30 day time frame, select value “2”.
- If follow-up contact was made with a family member or other person who answered questions on behalf of the patient, select “1”.
- If follow-up contact was made with a family member or other person who reports the patient expired within 30 days following discharge, select allowable “3”.
Follow-up Contact

- If information was obtained in person at a clinic visit that occurred within the time frame, select “1”
- If follow-up contact is being made for a patient who screened positive for alcohol use or who was found to be alcohol or drug dependent, the contact must be made for the purpose of gaining information about their alcohol or drug use status post discharge
- If follow-up contact is made by letter or e-mail and no response is received within the time frame, select “4”
- If trying to contact the patient and at least 3 attempts were unsuccessful, select value “3” - If less than 3 unsuccessful attempts were made select “2”
Follow-up Contact

- If trying to contact the patient by mail/e-mail/phone and a return is received indicating the contact information is no longer valid, select “3”

- If patient is readmitted following the initial hospitalization, select “3” if the hospitalization continued into the specified time frame for follow-up

- An example of a third party contacting the patient on behalf of the hospital includes, but is not limited to a Tobacco Quitline

- The follow up contact information must be documented in the inpatient record regardless of whom performs the follow up
Tobacco Use Status Post Discharge - Counseling

Allowable Values:

1 Patient is attending outpatient tobacco cessation counseling post discharge
2 Patient is not attending outpatient tobacco cessation counseling post discharge
3 Patient refused to provide information relative to post discharge counseling attendance
4 Not documented or UTD
Post Discharge Counseling

- If the first counseling session has not occurred at the time of the follow-up contact and the patient plans to attend the scheduled appointment, select value “1”
- If follow-up contact is made with the patient but no tobacco use status information is collected, select value “4” UTD
- The counseling, medication and use status information must relate to the follow up contact date selected by the abstractor
Tobacco Use Status Post Discharge - Medication

Allowable Values:
1 Patient is taking the recommended tobacco cessation medication post discharge
2 Patient is not taking the recommended tobacco cessation medication post discharge
3 Patient refused to provide information relative to medication use post discharge
4 Not documented or UTD
Post Discharge Medication

- If the patient is not taking tobacco cessation medication because a prescription for the medication was not given to the patient prior to discharge, select “2”
- If patient is taking an over the counter cessation product not requiring a prescription, select “1”
- If an over the counter cessation medication was listed on the discharge medication list and the patient is not taking the medication, select “2”
- The counseling, medication and use status information must relate to the follow up contact date selected by the abstractor
Tobacco Use Status Post Discharge - Quit Status

Allowable Values:

1 Patient has quit using tobacco products post discharge
2 Patient has not quit using tobacco products post discharge
3 Patient refused to provide information relative to use status at the follow up contact
4 Not documented or UTD
Post Discharge Quit Status

- If the patient has reduced the amount of tobacco products used but has not quit using, select “2”
- If patient has not used any tobacco products in the past 7 days prior to the time of contact, select “1”
- If the patient has initiated a quit attempt but has been tobacco free for less than 7 days prior to the contact, select “2”
- The counseling, medication and use status information must relate to the follow up contact date selected by the abstractor
Immunization (IMM-2)
CMS Manual 4.4a
IMM-2 Influenza Immunization

Numerator Statement: Inpatient discharges who were screened for influenza vaccine status and were vaccinated prior to discharge if indicated

Denominator Statement: Acute care hospitalized inpatients age 6 months and older discharged during October, November, December, January, February or March
Excluded Populations:

- Less than 6 months of age
- Expire prior to discharge
- Patients with organ transplant during current hospitalization (Table 12.10)
- Patients for whom vaccination was indicated, but supply not received due to problems with production/distribution
- LOS >120 days
- Transferred or Discharged to another hospital
- Leave AMA
IMM-2 Influenza Immunization

Core Measure Data Elements:

• Admission Date
• Birthdate
• Discharge Date
• Discharge Disposition
• ICD-9 Principal and Other Procedure Codes
Influenza Vaccination Status

Allowable Values:

1. Influenza vaccine was given during this hospitalization.
2. Influenza vaccine was received prior to admission during the current flu season, not during this hospitalization.
3. Documentation of patient's or caregiver's refusal.
4. Documentation of an allergy/sensitivity to influenza vaccine, anaphylactic latex allergy or anaphylactic allergy to eggs OR is not likely to be effective because of bone marrow transplant within the past 6 months OR history of Guillain-Barré syndrome within 6 weeks after a previous influenza vaccination.
Influenza Vaccination Status

Allowable Values (cont.):

5 None of the above/Not documented/Unable to determine (UTD)

6 Only select this allowable value if there is documentation the vaccine has been ordered but has not yet been received by the hospital due to problems with vaccine production or distribution AND allowable values 1-5 are not selected
Influenza Vaccination Status

• Hospitals are only responsible for patient discharges October through March

• Caregiver is defined as the patient’s family or any other person (home health, VNA provider, prison official or other law enforcement personnel) who is responsible for the care of the minor or adult patient when that patient is unable to make decisions on his/her own

• In order to select “Influenza vaccine was given during this hospitalization”, there must be documentation either on the MAR, nursing notes, standing orders, etc., where the vaccine was dated and signed as administered
Influenza Vaccination Status

• In situations where there is documentation that would support more than one of the allowable values 1-4, select the smallest number.

• If there is no documentation to support any of the allowable values 1-4, and there is physician documentation that they will administer the vaccine after discharge, select value “5”.

• If there is documentation that the patient received the vaccine and only the current year is documented, i.e., no month or day, select value “2” (prior to admit).
Influenza Vaccination Status

- If there is documentation the patient received the vaccine the year prior to the current year and the discharge is not January, February or March, select value “5”

- If it is documented in the chart that a patient is “up to date” on their vaccines, you may select Allowable Value “2” - Note that documentation of the acronym “UTD” alone is not sufficient to select Allowable Value “2”
Influenza Vaccination Status

Inclusions - All patients discharged October- March

- Afluria
- FluMist
- FluLaval
- Flu shot
- Flu vaccine
- Fluarix
- Fluvirin
- Fluzone
- Fluzone High Dose
- Influenza virus vaccine
- Trivalent influenza vaccine
Influenza Vaccination Status

Exclusions:

• All patient discharges from April through September
• Patients with anaphylactic allergy to eggs, anaphylactic latex allergy or other specific allergy/sensitivity to the vaccine - should be accompanied by the exact complication - must be a specific allergy/sensitivity not just physician/advanced practice nurse/physician assistant (physician/APN/PA) preference
• Pandemic monovalent vaccine, e.g. H1N1
• Patients with an organ transplant during the current hospitalization (Appendix A, Table 12.10)
Abstraction services

Primaris provides

- Short-term, long-term and interim core measures and registry abstraction
- Retrospective quality measures validation audits
- Quality measures education and training
- Performance and clinical documentation improvement consulting and training

As required and optional measures continue to increase, Primaris has the flexibility to absorb your hospital’s changing needs.
Questions

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