The following questions were submitted during Primaris’ February Quality Reporting webinars. We’ve provided answers based on the 2015 Specifications Manual.

**WEBINAR: 2015 Inpatient and Outpatient Core Measures Specifications Update**

Q: For 2015 stroke discharges, did you get the impression that ONLY physician documentation should be reviewed for a history or current finding of a fib or a flutter? The new specs referenced the idea of “anywhere” in the record, but the new question refers specifically to physician/APN/PA documentation.

A: Yes, only physician/APN/PA documentation should be reviewed. The suggested data sources for this data element are limited to Physician/APN/PA documentation only.

Q: For Stroke, reason for not administering tPA, does returned to baseline have to be linked or is this a standalone reason?

A: Returned to baseline is not on the stand-alone reasons list for Reason for not Initiating IV thrombolytic. It would need to be linked to not giving the t-PA. Please refer to the Specifications Manual for National Hospital Quality Measures v4.4a for a list of the stand alone reasons. The manual can be found here: [https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1141662756099](https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1141662756099)

**WEBINAR: Perinatal Care 2015 Specifications Manual Update**

Q: The mother’s record apparently can no longer be used to determine the initial feeding plan even if electronically “copied” into the newborn record and in place prior to the first feeding. Correct? I was previously told this was acceptable. Our hospital has it set up this way so the chart is ready to go when the infant is born and contains the necessary information upon admission. Any clarification is appreciated. Thanks!

A: Yes, this is correct. This is a change to the Specifications Manual for 2015.

Q: Did I hear correctly during the webinar that the discussion of the mothers feeding plan prior to birth cannot be copied from the mothers record and pasted into the newborn record?

A: Yes, that is correct. The manual states: “The mother’s medical record cannot be used to determine the mother’s initial feeding plan. This documentation must appear in the newborn’s medical record without using the mother’s medical record to perform the abstraction even if there is a link between the mother and newborn medical records in the EHR.”

Q: RN performs initial counseling for those mothers whose initial feeding plan was breast and formula or formula feeding only. In order to pass this measure does the physician have to document that he is “aware of discussed counseling by RN, mother still chooses breast and formula or formula feeding only” or can the measure pass if the physician just comment only on the feeding choice “formula and breast feeding or formula feeding”? How specific does the physician documentation have to be when the RN does the counseling?

A: The Specifications Manual states “RN documentation of the discussion and the mother’s initial feeding plan to include formula discussed upon admission is acceptable ONLY if there is supporting documentation by the physician/APN/PA/CNM/IBCLC/CLC at some point during the hospitalization to corroborate the RN’s initial discussion with the mother.” There is no suggested verbiage of the physician documentation, but it must corroborate the RN’s documentation.
Q: The manual states that if the mom is using formula at all, then there must be documentation by the physician / APN / LC that the mother's initial feeding plan included formula upon admission. Does the physician / LC need to use this exact verbiage to meet the measure? Is it sufficient to have documentation or acknowledgment from the physician / LC that the infant is BF and supplementing with formula?

A: The Specifications Manual states “RN documentation of the discussion and the mother's initial feeding plan to include formula discussed upon admission is acceptable ONLY if there is supporting documentation by the physician/APN/PA/CNM/IBCLC/CLC at some point during the hospitalization to corroborate the RN's initial discussion with the mother.” There is no suggested verbiage of the physician documentation, but it must corroborate the RN’s documentation.

Q: Hi. I attended the Primaris webinar on 2/25 and enjoyed it very much. When I contacted a couple of the other abstractors and explained the new changes to Exclusive Breast feeding they do not think that it is applicable to us. We include a copy of the mother’s PN as part of the baby’s record; this PN is a discussion with DR on the mother’s choice of feeding. I tried to access the slides (to show that we will not be compliant now) and I could not. I also tried going on to Manual.JointCommission.org and that did not work either. Would you please explain how I can locate a copy of the slides or the new manual specs?

A: The updates to the Manual for 2015 for Perinatal Care are applicable to all Joint Commission hospitals with 1,100 births or more per year. The slides will be available along with this Q & A document. Here is a link to the location of the Joint Commission manual: http://www.jointcommission.org/specifications_manual_for_national_hospital_inpatient_quality_measures.aspx

Q: Are PC 4 and 5 required?

A: The Perinatal Care measures including the Newborn measures 4 and 5 are required to be submitted for Joint Commission hospitals with 1,100 births or more per year.

Q: For determining NICU stay. If the chart computerized forms say NICU but our hospital does not have a NICU how would this be counted? We are told the names of the forms cannot be changed without spending a large amount of money.

A: For the data element “Admission to NICU” the Allowable Value for “Yes” states: “There is documentation that the newborn was admitted to the NICU at this hospital at any time during the hospitalization”. In your situation, the record would have to indicate that your hospital does not have a NICU and that the infant did not receive critical care services.

Q: Is there any way to get a sample of the feeding plan that will be accepted?

A: The initial feeding plan is determined by clinician discussion with the mother and documented in the newborn's medical record prior to the first feeding. The mother’s plan may be exclusive breast milk feeding, a combination of breast milk and formula or formula only but documentation in the medical record must meet the requirements in order for you to select the appropriate Allowable Value for “Reason for Not exclusively Feeding Breast Milk”.

Q: Breast feeding. In the example you gave I thought you said we can't use the mother’s record but in the 5th bullet point of the example you refer to the mother’s record?

A: The first four bullets on the slide for “Reason for Not Exclusively Feeding Breast Milk” are outlining a scenario in which you would have appropriate documentation of the mother's initial feeding plan documented in the newborn's medical record. The fifth bullet is explaining a scenario in which the documentation would not be sufficient and states that “this documentation cannot be used.”
Q: A mom comes in for pre-admission testing in January, 2015. The electronic documentation that is included in the baby's chart shows that in January the mom chose BF and FF for the baby. The date and time are documented, as well as the discussion of the Risks / Benefits of BF vs. FF. When our expectant moms come for pre-admission instruction, typically 1-2 months before the expected delivery date, the nurses talk to them about the Risks / Benefits of Formula / Breastfeeding. This document is signed by the mom, dated and timed, and placed in the Mom's chart. When the baby is admitted, am I allowed to scan that document into the baby's chart to show that the Risks / Benefits discussion did take place? The mom comes in for her delivery in February. At that time she tells the Labor RN that she will breastfeed. She ultimately breastfeeds and supplements with formula. Do I have to abstract her latest feeding preference, or can I refer back to the one documented in January?

A: The mother's initial feeding plan must be documented in the newborn's record prior to the first feeding. The mother's record cannot be used to abstract the data element “Reason for Not Exclusively Feeding Breast Milk”, so you would not be allowed to scan this document into the newborn's record. If the mother's initial feeding plan was to feed breast milk upon admission, and the mother's plan changed later in the hospitalization to include formula, select Allowable Value “3” None of the Above or Unable to Determine.

Q: Infant admitted to NICU 26 weeks gestation. Physician documents in admit H&P, respiratory distress, R/O sepsis. Infant was started on antibiotics on admit to NICU. Initial blood cultures come back negative. Discharge diagnosis 3 weeks later states, suspected gram negative sepsis with bowel injury/necrosis. Would I be able to say yes to bloodstream infection present within 48 hrs., since the physician documented respiratory distress or does the R/O cause this chart to be an outlier?

A: For the data element “Bloodstream Infection Present on Admission” the physician would need to document that the newborn appeared septic or was showing signs and symptoms of sepsis in order to answer “Yes”. In your scenario the physician has documented R/O sepsis which is an exclusion for this data element. The documentation of suspected gram negative sepsis is outside the first 48 hours after admission.

WEBINAR: Hospital Based Inpatient Psychiatric Services 2015 Specifications Manual Updates

Q: Question about cognitive impairment over first 3 days of admit- Patient has dementia diagnosis and is not documented as oriented would this be cognitive impairment?

A: If there is documentation present in the medical record that the patient was not oriented during the entire three day assessment period, this would be sufficient to answer Allowable Value “6” for Tobacco Use Status – “Patient was not screened for tobacco use during the first three days of admission because of cognitive impairment”.

Q: There are 2 med lists only a single list is transmitted to NLOC would this pass measure even if they differ as list would not be confusing to NLOC?

A: The directions in the Specifications Manual state: “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.” In your scenario, you would need to determine if the medication list that was sent to the Next Level of Care provider was accurate in order to select Allowable Value “1” Yes.

Q: I have some questions-first for restraints the slide has start time of 2400 on second day should this be 0000 (as 2400 is at the end of a day)?

A: The example given in the slide regarding the data element “Event Date” is taken directly from the Joint Commission Specifications Manual. Since this data element is not asking for a clock time and only asking for the number of minutes, they have listed 2400 in the example which can be interchanged with 0000, as you would be using this as your start time in order to calculate the number of minutes that the patient was in a restraint or secluded.
Q: My understanding of the HBIPS requirements did not include TOB 3 only TOB 1 and 2. Can you clarify? Is the TOB measure a 2015 measure or is it a current 2014 measure?

A: The HBIPS webinar included all of the Tobacco (TOB) Measures, however only TOB-1 Tobacco Use Screening and TOB-2 and 2a Tobacco Use Treatment Provided or Offered are required for Inpatient Psychiatric Hospital Discharges beginning January 1, 2015.

Q: Someone is going to need to provide further information on all of this follow up that is being required. I thought the follow up was going to be tracked by UB from clinic visits. Does CMS have any idea of the burden this is placing on the abstractors if we are following up on all the patients discharged.

A: TOB-3 Tobacco Use Treatment Provided or Offered at Discharge and TOB-4 Tobacco Use: Assessing Status After Discharge are not required at this time. However, these may be a requirement in the future.

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