Practitioner Orientation Checklist -HIM

Practitioner Name: _____Specialty: _____

Email: _____Cell: _____

Date of Orientation: _____HIM Employee:_____

_____ Acceptable Abbreviations / Policy

_____ Suspension

_____ Forwarding/Refusing documents to sign and documents to dictate instructions given.

_____ Inbox Training

_____ Outside link instructions given (for PC or IPad)

_____ Laptops

_____ CDI Documentation training

_
_____

***By signing below, I agree that I was trained in the above areas and/or provided information.**

Signature of trainee

Revised 03/17/2020

MONONGALIA GENERAL HOSPITAL
POLICY & PROCEDURE
MANUAL: Administrative
SECTION: Information Management
SUBJECT: Acceptable Abbreviations
Policy #: IM-079

Effective: 07/08/2015
Last Review: 07/08/2015
JC Standard: IM.02.02.01
Approved:
Replaces: IM-079 Dated: 7/17/12

POLICY:
It is the policy of Mon General Hospital that to avoid misinterpretation, only those symbols and abbreviations listed in Stedman's Medical Abbreviations, Acronyms & Symbols are to be used in the medical record by those authorized to make entries in the medical record.

RESPONSIBILITY:
Health Information Management (HIM) Director, Medical Record Committee, Medical Executive Committee

PROCEDURE:
1. The Medical Record Committee will monitor the use of abbreviations in the medical record.
2. The Chart Review Committee, Performance Improvement Analysts, and designated HIM Clerk will review medical records for use of unacceptable abbreviations and report their findings to the Medical Record Committee, who will then take any necessary action.
3. Current copies of Stedman's Medical Abbreviations, Acronyms & Symbols will be available for reference as Mon General Hospital's approved abbreviation guide in the HIM Department, as well as the House Supervisor's Office.
4. There are abbreviations, acronyms, and symbols that have been shown to be prone to cause confusion and subsequent medication errors. The list of abbreviations, acronyms, and symbols approved by the medical staff that should not be used is attached.

REFERENCES:
Joint Commission E-dition. July 1, 2015. Information Management Chapter. Standard IM.02.02.01.

Stedman's Medical Abbreviations, Acronyms & Symbols

APPROVALS:
Committee Name Approval Date
Information Management Council 06-10-15
Medical Executive Committee 07-08-15

IM-079 Acceptable Abbreviations, Attachment to Policy

Official "Do Not Use" List

Do Not Use	Potential Problem	Use Instead
U or u (unit)	Mistaken for "0" (zero), the Number "4" (four) or cc	Write "unit"
IU (International Unit)	Mistaken for IV (intravenous) or the number 10 (ten)	Write "International Unit"
Q.D., QD, q.d., qd (daily) Q.O.D., QOD, q.o.d. qod (every other day)	Mistaken for each other Period after the Q mistaken for "I" and "O" mistaken for "I"	Write "daily" Write "every other day"
Trailing zero (X.0 mg)* Lack of leading zero (.X mg)	Decimal point is missed	Write X mg Write 0.X mg
MS $MgSO_4$ and MSO_4	Can mean morphine sulfate Or magnesium sulfate Confused for one another	Write "morphine sulfate" Write "magnesium sulfate"

* **EXCEPTION:** A trailing zero may be used only where required to demonstrate the level of precision of the value being reported, such as for laboratory results, imaging studies that report size of lesions, or catheter/tube sizes. It may not be used in medication orders or other medication-related documentation.

Original Approval Date: 07-17-12
Last Review Date (no changes) 06-10-2015

APPROVALS

COMMITTEE NAME / APPROVAL DATE
Information Management Council 06-10-2015
Medical Executive Committee 07-08-2015

Revised 03/17/2020

DOCUMENTATION GUIDE FOR CONTENT OF REPORT TYPES

H&P/SHORT STAY
CHIEF COMPLAINT
HISTORY OF PRESENT ILLNESS
PAST MEDICAL HISTORY
PAST SURGICAL HISTORY
ALLERGIES
FAMILY HISTORY
SOCIAL HISTORY
REVIEW OF SYSTEMS
PHYSICAL EXAMINATION
MEDICATIONS
LABORATORY DATA/STUDIES
IMPRESSION
PLAN

CONSULTATION REPORT
REASON FOR CONSULTATION
IMPRESSION
PLAN
HISTORY OF PRESENT ILLNESS
PAST MEDICAL HISTORY
PAST SURGICAL HISTORY
ALLERGIES
FAMILY HISTORY
SOCIAL HISTORY
REVIEW OF SYSTEMS
PHYSICAL EXAMINATION
MEDICATIONS
LABORATORY DATA/STUDIES

OPERATIVE REPORT
DATE OF PROCEDURE
PREOPERATIVE DIAGNOSIS
POSTOPERATIVE DIAGNOSIS
OPERATIVE PROCEDURE
SURGEON
ASSISTANT
ANESTHESIOLOGIST
SPECIMEN
ESTIMATED BLOOD LOSS
DRAINS
COMPLICATIONS

PROGRESS NOTES
DATE OF SERVICE
SUBJECTIVE
OBJECTIVE
ASSESSMENT
PLAN

DISCHARGE SUMMARY
DISCHARGE DIAGNOSES
REASON FOR HOSPITALIZATION
HOSPITAL COURSE
LABORATORY DATA/STUDIES
DISCHARGE MEDICATIONS
CONDITION ON DISCHARGE
DISCHARGE INSTRUCTIONS

MEDICAL STAFF BYLAWS, POLICIES, AND RULES AND REGULATIONS OF MON GENERAL HOSPITAL
(pertaining to Delinquent Medical Records)

2.7. Delinquent Medical Records:

(a) It is the responsibility of each physician to prepare and complete medical records in a timely fashion in accordance with the specific provisions of these Rules and Regulations and other relevant policies of the Hospital.

(b) Each medical record, including short stay medical records, will be dictated within 21 days following discharge. If the record is incomplete 14 days after discharge, the medical records department will notify the physician, in writing, of the due date for completing the record. If the record remains incomplete 28 days following discharge, the physician will be notified in writing of the delinquency and that his or her clinical privileges have been automatically relinquished. The relinquishment will remain in effect until all of the physician's records are no longer delinquent.

(c) Failure to complete the medical records that caused the automatic relinquishment of clinical privileges three months from the relinquishment will constitute an automatic resignation of appointment from the Medical Staff and of all clinical privileges.

(d) Any requests for special exceptions to the above requirements will be submitted by the physician to the medical records department and considered by the Executive Committee.

(e) Except in rare circumstances, when approved by the Chief Executive Officer and the Chief of Staff, no physician or other individual will be permitted to complete a medical record on an unfamiliar patient in order to retire that record.

Appendix A (Med Staff Bylaws)		
COUNTERSIGNATURE VS NO COUNTERSIGNATURE BY STATUS **- HP**		
STATUS	**NEEDS CONTERSIGNED BY MD**	**DOES NOT NEED COUNTERSIGNED BY MD**
Physician Assistants	**X**	
Midwives		**X**
Fellows	**X**	
Residents	**X**	
Nurse Practitioners	**X**	
Students	**X (must be countersigned prior to being considered complete)**	

Appendix B (Med Staff Bylaws)		
COUNTERSIGNATURE VS NO COUNTERSIGNATURE BY STATUS **- PHYSICIAN ORDERS**		
STATUS	**NEEDS CONTERSIGNED BY MD**	**DOES NOT NEED COUNTERSIGNED BY MD**
Physician Assistants	**X**	
Midwives		**X**
Fellows		**X**
Residents	**X**	
Nurse Practitioners	**X**	
Students	**X (prior to implementation)**	

Appendix C (Med Staff Bylaws)		
COUNTERSIGNATURE VS NO COUNTERSIGNATURE BY STATUS **- DISCHARGE**		
STATUS	**NEEDS CONTERSIGNED BY MD**	**DOES NOT NEED COUNTERSIGNED BY MD**
Physician Assistants	**X**	
Midwives		**X**
Fellows	**X**	
Residents	**X**	
Students	**X**	
Nurse Practitioners	**X**	

VACATION / LEAVE OF ABSENCE

Prior to leaving on vacation or taking a leave of absence, complete all charts in your inbox and notify the HIM Department so that any incoming charts will be placed on hold until you return to work.

TERMINATION OF EMPLOYMENT

If your employment ends, you should check back after a couple of weeks to make sure you don't have any charts that are still incomplete. If you leave charts in an incomplete status it will be documented in your credentialing file and you won't be eligible for rehire.

Cerner Outside Link Instructions for your computer

1. Open up Internet Explorer or Web browser and go to https://mnglwv.cernerworks.com/prod
2. Click on Add to Favorites to bookmark it.
3. Click on the Citrix ICA Web Client for Windows
4. Click the Open button (It will download the client)
5. Just follow the defaults on the next several screen, and finish
6. In the username field type *mnglwv*; in the password field type: *usermnglwv*
7. This will now get you to the point where you can click on the powerchart icon.

OR

Instructions for accessing Cerner from IPAD or IPhone

1. Go to ITunes App store and download the latest version of Citrix receiver.
2. Click on the Citrix receiver and click on add connection (right side)
3. For address type in the following information
   https://mnglwv.cernerworks.com/pnagent/config.xml
   For the username type in User: *mnglwv*
   Password: *usermnglwv*
4. Domain: *cernerasp*
5. Click on the save and connect and you should see a powerchart icon tap on it to connect.

Please use your normal logon credentials from here. Good Luck!

If your password is disabled by trying to sign on more than three times or if it has been more than 30 days since you last signed on, you may have to call the IT department (304-598-1327) and ask them to reset your password to the same thing as your username, (your username is the first three letters of your last name and your five digit physician number). You would type it in the username slot, then in the password slot and enter. Another signon screen will appear and you will type your old password (which is your username), your new password (your new password must be at least 6 digits long and contain at least one number), then repeat the new password). This will get you into your Cerner inbox. If you have any questions or need any help, please call 304-598-1375 for assistance.

Revised 03/17/2020

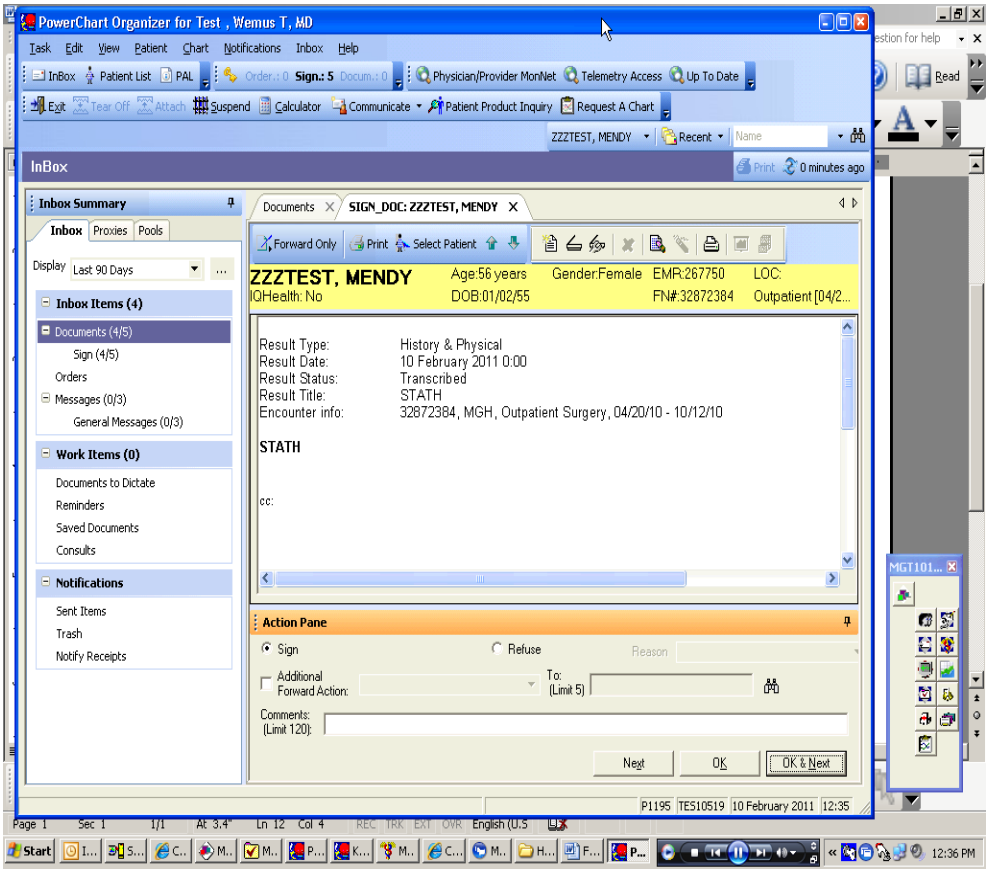
SIGNING and FORWARDING or REFUSING A DOCUMENT

To sign and forward for cosign or correspondence, please complete the following steps:

1. With your Inbox open, select the Documents to sign.
2. Open the signature document by double clicking on it.
3. Click on "OK" to sign before forwarding (do not use Ok & next or you won't be able to forward)
4. To forward a document, select the "Additional Forward Action" option, for "sign" only. (never use review…this will not remove it from your inbox)
5. In the "TO:" box. Enter the name of the healthcare professional to who you are sending the request. (Click the binoculars to look up the person by name or ID).
6. Select Sign, from the list in the Requested Action box.
7. Enter a comment about the request.
8. Click OK.

To refuse a document that has been sent to you for signature or dictation

1. Select the "Refuse" for "sign"option. (Even if a Dictation)
2. Enter a comment in the Comment box (required).
3. TO: Him Dept (always refuse to the HIM dept for reanalysis) Hit "ok".



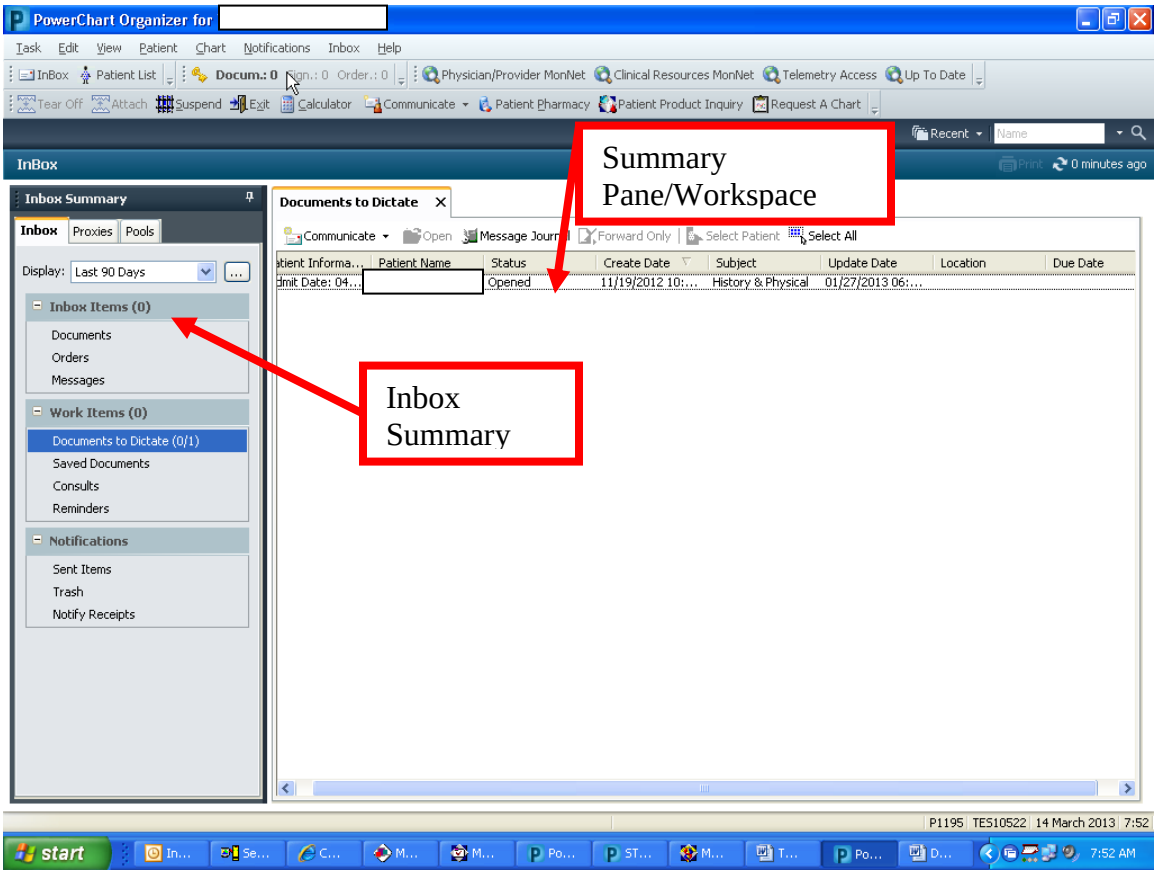
Revised 03/17/2020

Overview of Inbox Messaging

- All messages and notifications that require your attention, review or signature are routed to your Inbox and are organized in folders.
- Your Inbox can be accessed from any computer on your network that has Cerner Millennium installed on it.

Inbox Basics

Inbox Overview



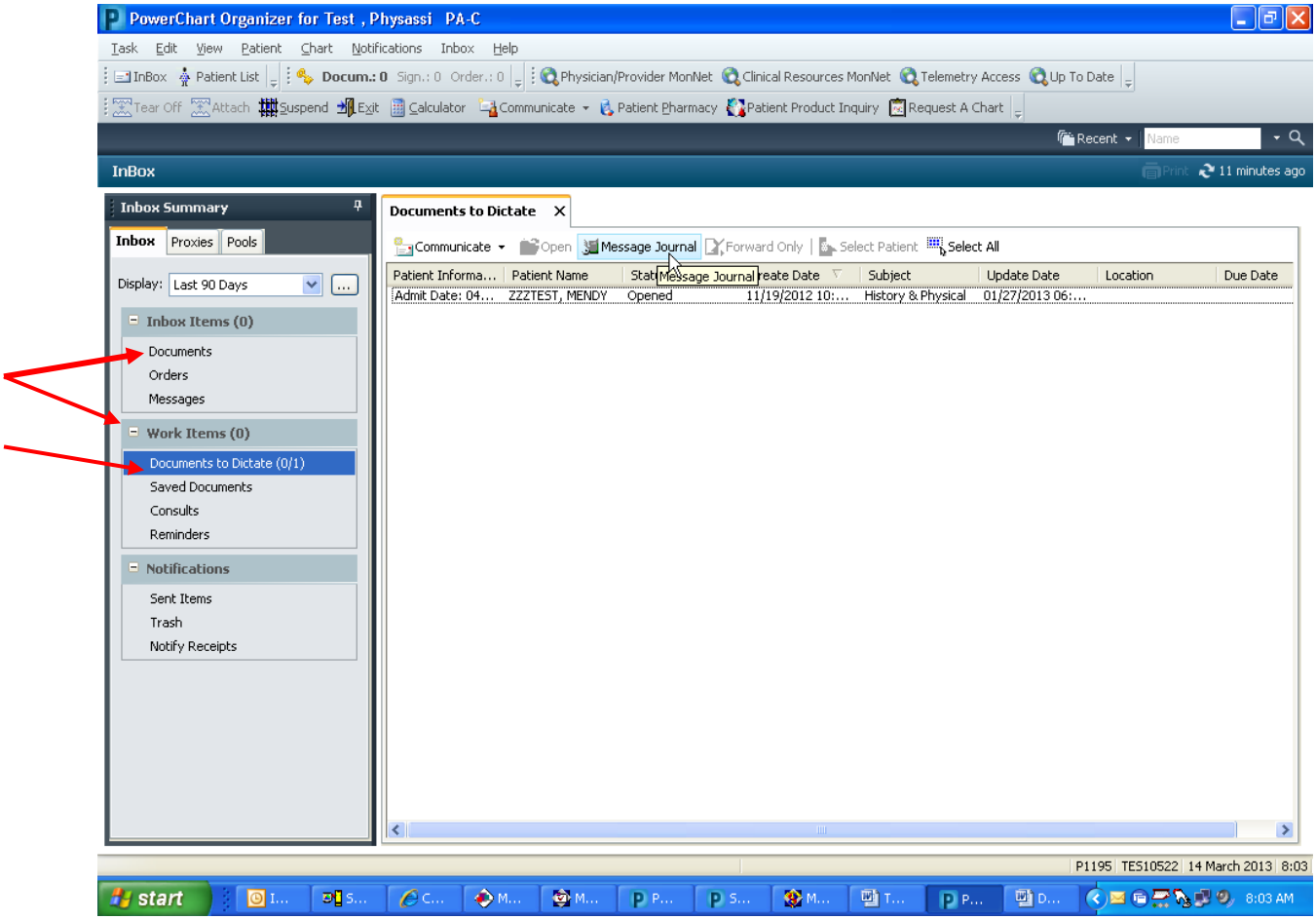
Inbox Summary

The Inbox Summary allows you to access any message or result in Inbox. Inbox notifications are divided into categories or folders; the number adjacent to the category name indicates the number of Inbox items in that category that are unread.

Summary Pane/Workspace

The summary pane lists the individual Inbox items (messages, documents and so forth) contained in the folders in the Inbox Summary. Double-clicking an Inbox item in the Summary Pane opens the workspace for that item.

INBOX – HOW TO PROCESS



This is a normal view of an Inbox.

On the left-hand side of the viewing pane, you will find the folder list with all folder names showing in the medium blue/gray boxes. There is a deficiency count, in parenthesis, for "new" and opened items. If an item has been opened, it will stay in the inbox until processed, but will no longer show bold in the inbox. The subfolders will be listed beneath the folder title.

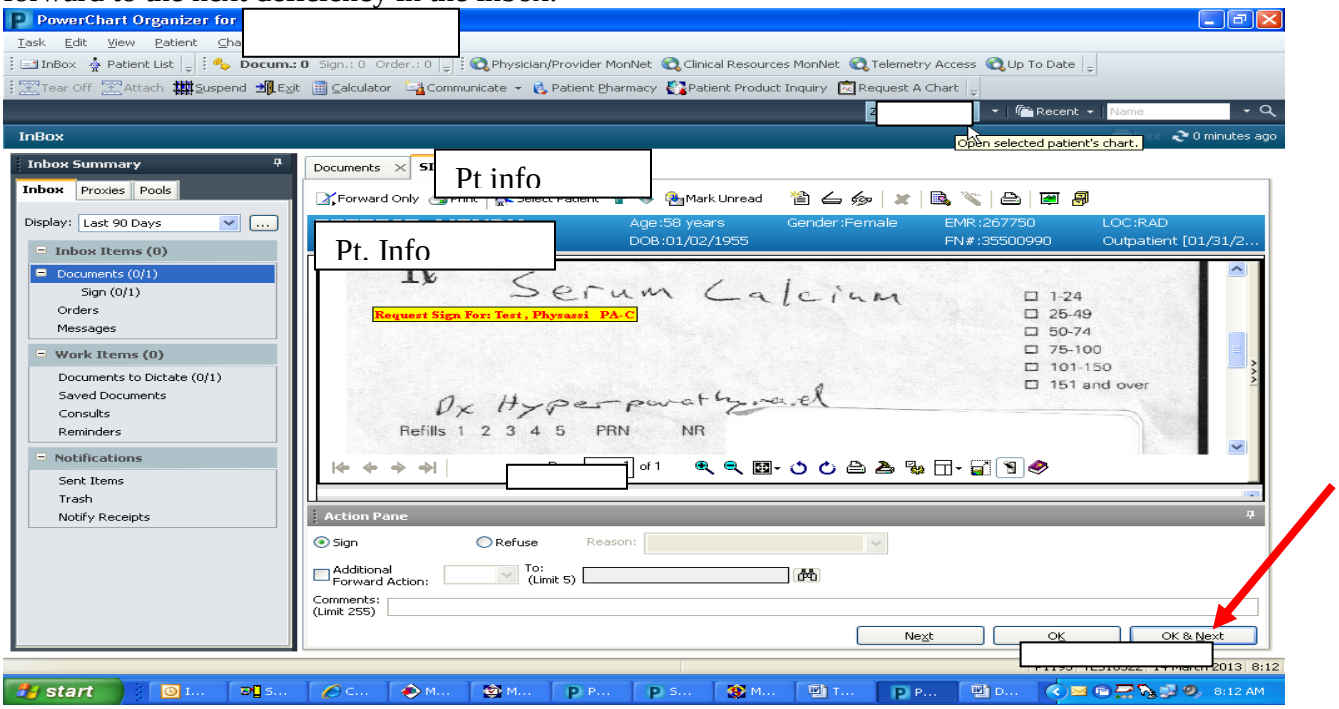
Inbox items: This folder includes all "Documents" (documents to sign, forwarded documents to sign and forwarded documents to review), "Orders" to sign (CPOE….**C**omputerized **P**hysician **O**rder **E**ntry) and any "Messages" that are sent to you by another person with a Cerner Inbox.

Work items: This folder includes the subfolders "Documents to Dictate" (self explanatory), and "Saved Documents" (Documents you created or modified that you saved instead of signing. These will stay in this folder until you sign them.)

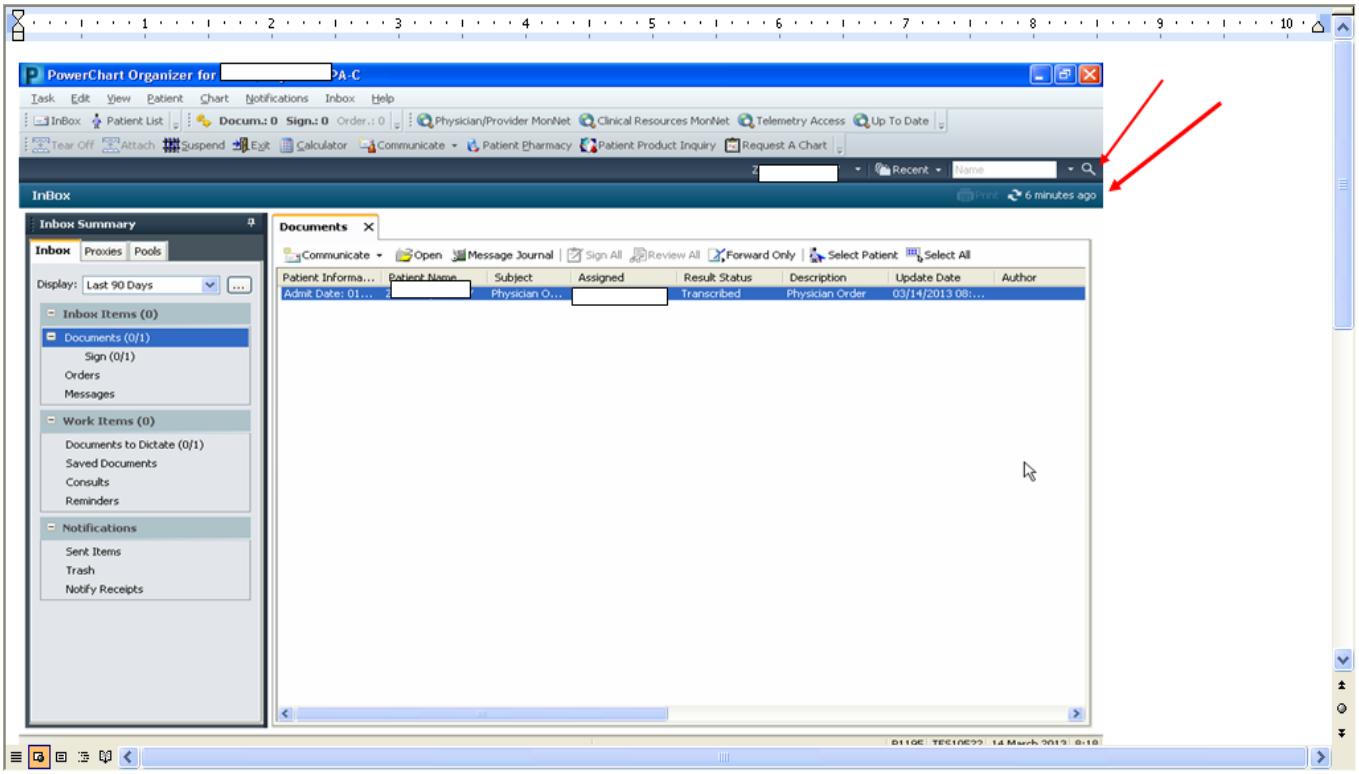
Most saved documents can not be viewed by anyone except the author, until signed. Keep this in mind when saving a document.

Revised 03/17/2020

Double click on an item to open the processing window. If you wish to sign an item, you don't need to change anything as it is usually defaulted properly. Just click on "OK & Next". This will sign the deficiency and move forward to the next deficiency in the inbox.

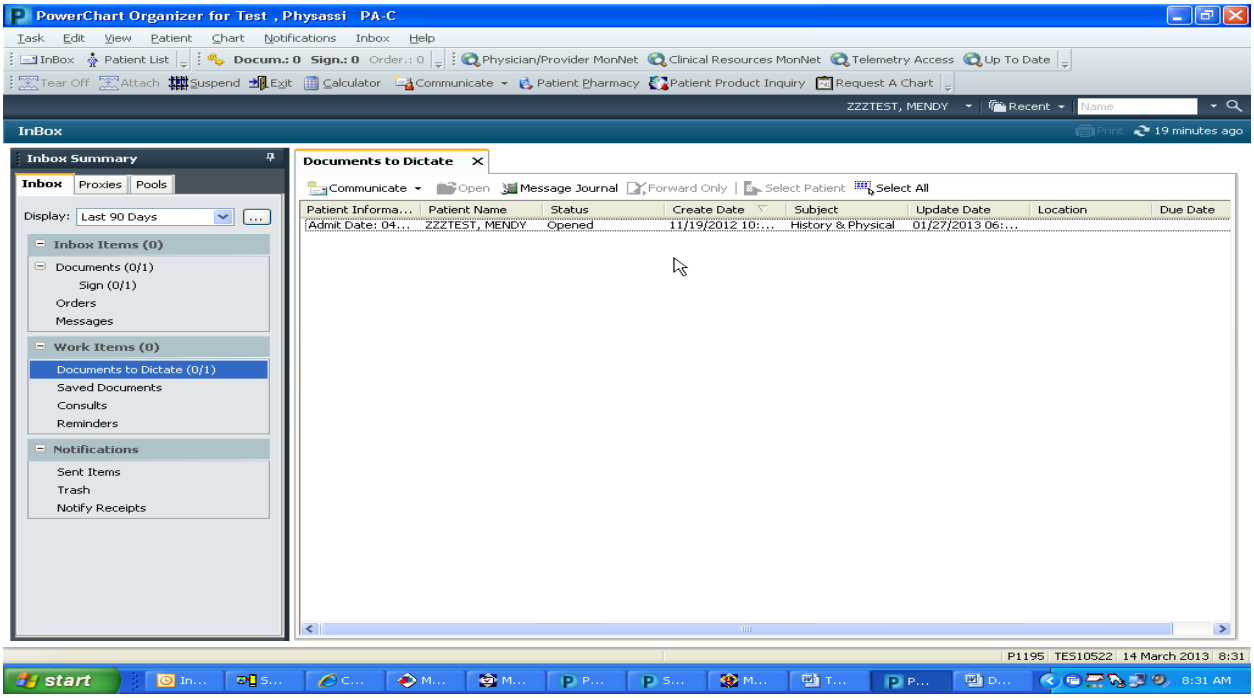


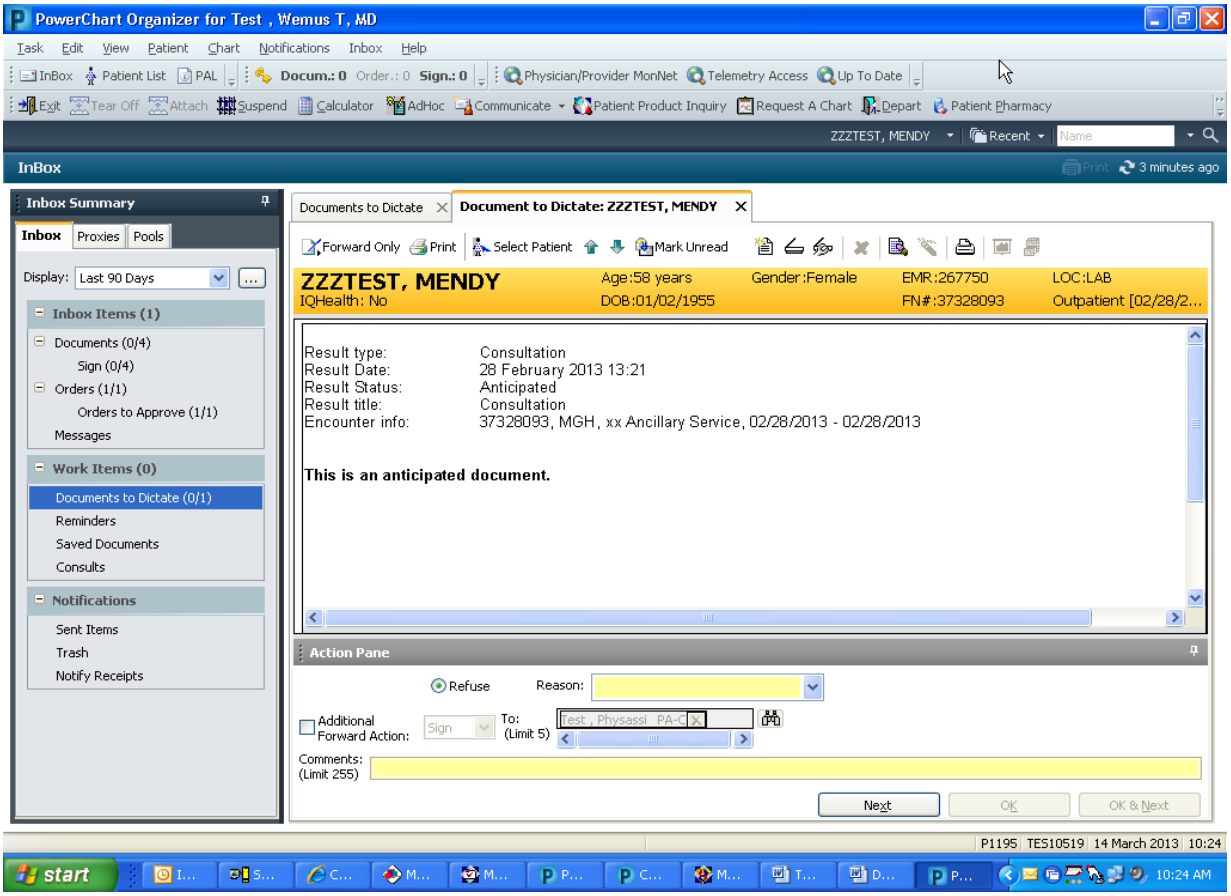
The refresh button is located on the upper right hand side of the screen (# minutes ago).
Click on the magnifying glass to access the search screen. These buttons are located in the same area of the window regardless of what application you are in. (Inbox or Powerchart)



Revised 03/17/2020

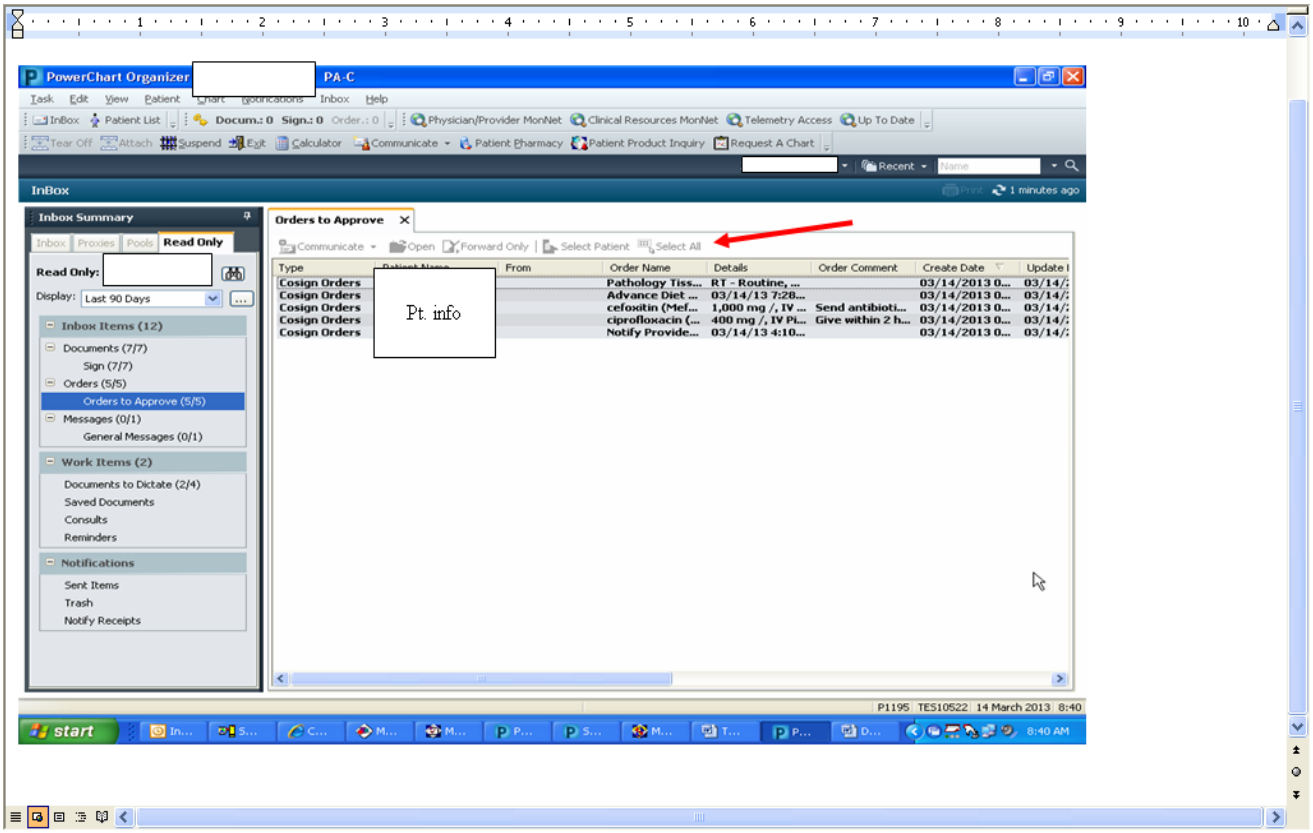
“Documents to Dictate” are listed just like documents to sign but you do not need to open the dictate deficiency window. You just click on the item **once** (which highlights the item), then right click for the menu. Click on “open patient chart”, and choose “notes and documents”. This will take you to Powerchart Notes and Documents so that you can review the rest of the chart. When you double click and open a “Document to Dictate” item, it only says “this is an anticipated document” because you have not yet dictated. (See second screen shot). Once an item has been dictated, using the correct FIN number, it will leave your inbox (after you refresh). The deficiency will automatically update in Powerchart to “this is a dictated document”.

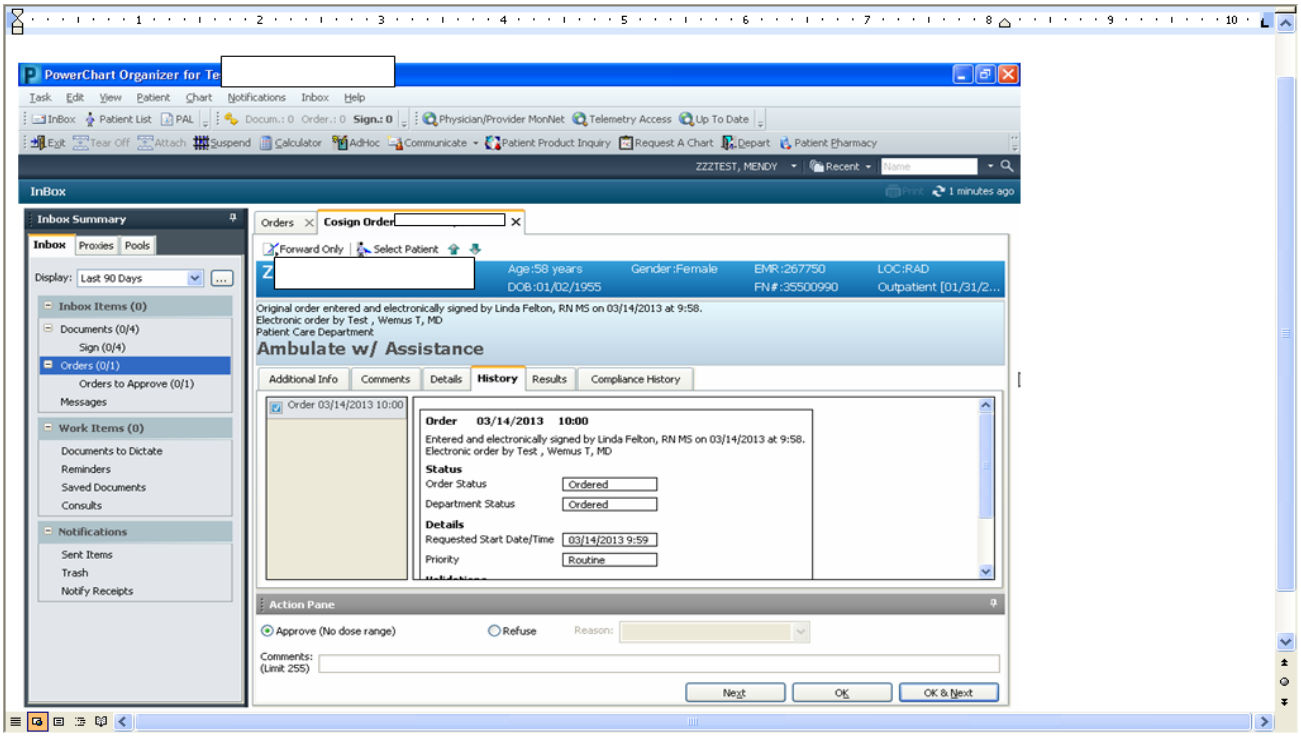




Documents in the “Orders” folder process just like “Documents to sign” (But look a little different when opened). See second screen shot. Just click Ok & next to process one by one, or if you wish to “sign all”, highlight one, right click, and choose “Approve” (no dose range checking). It may take several minutes to process all orders depending on how many are in your inbox.

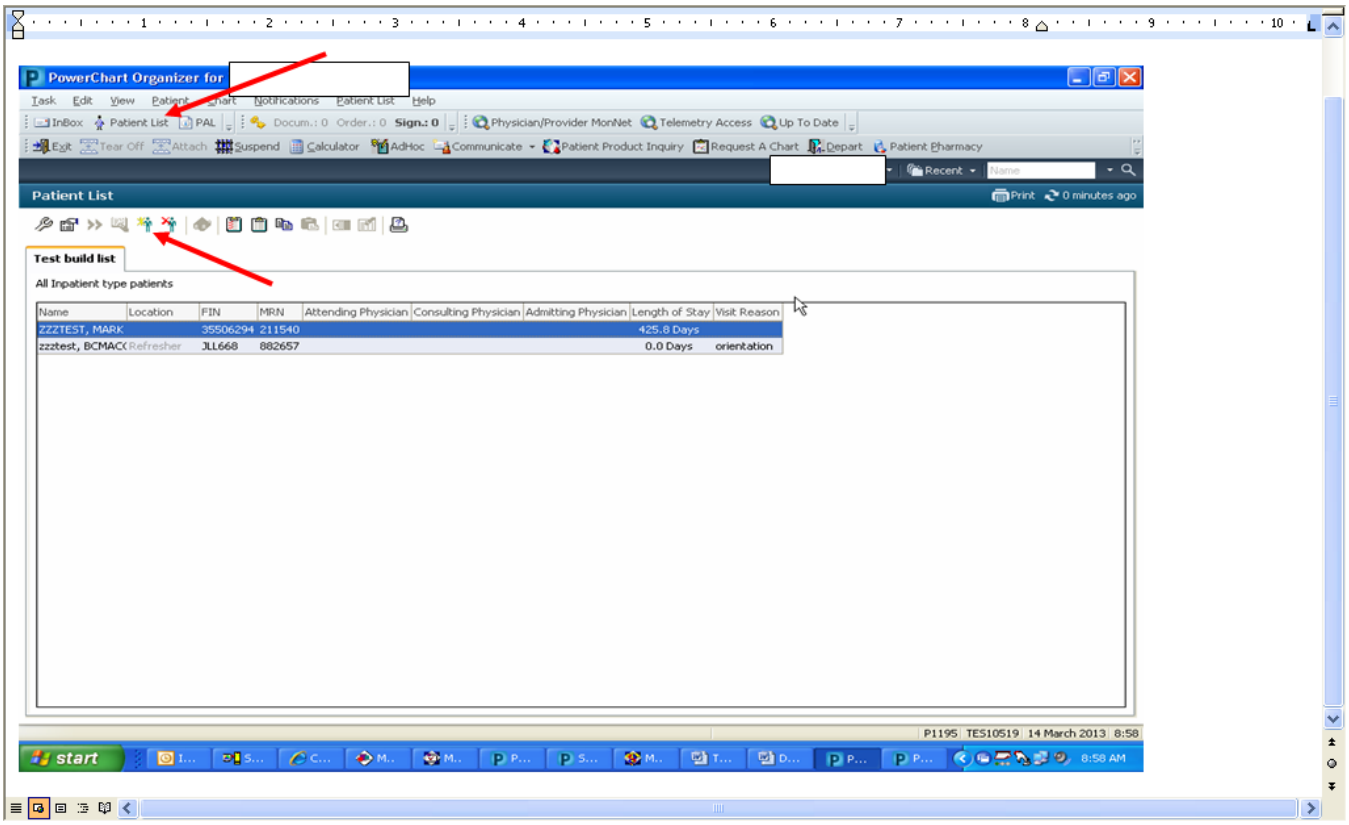
Revised 03/17/2020

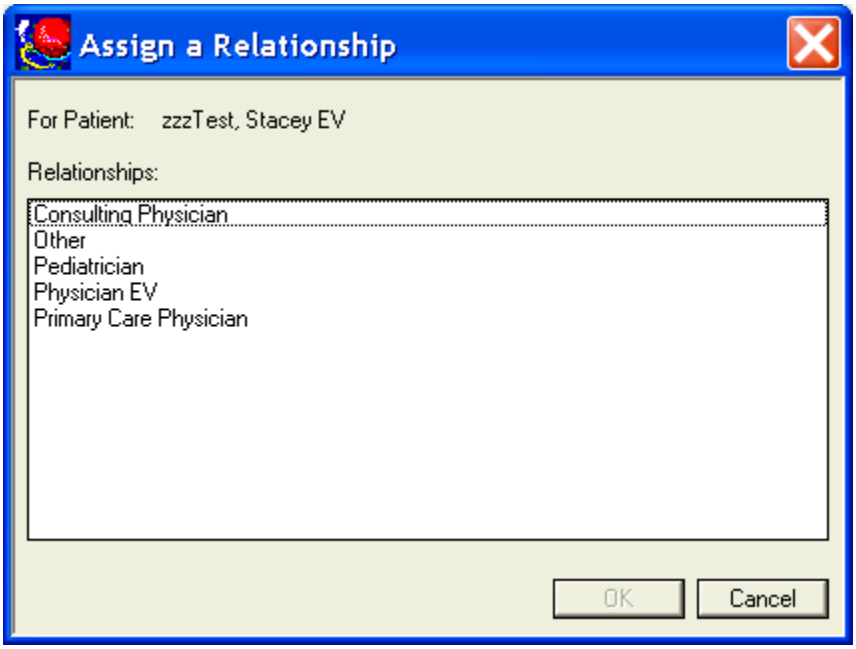




Revised 03/17/2020

You can go to the “Patient List” section of your Inbox by clicking on “Patient List” in the tool bar. This will allow you to do the following: view all patient lists that you created, add or remove someone to/from your list and even open a patient chart by double clicking on a patient name. (When you open a patient chart this way, you may be asked to choose a relationship to the patient. See second screen shot). To add a patient to your list, click on the icon that looks like a person with a star, and to remove/inactivate a patient from the list, click on the person with the red X…see arrow.

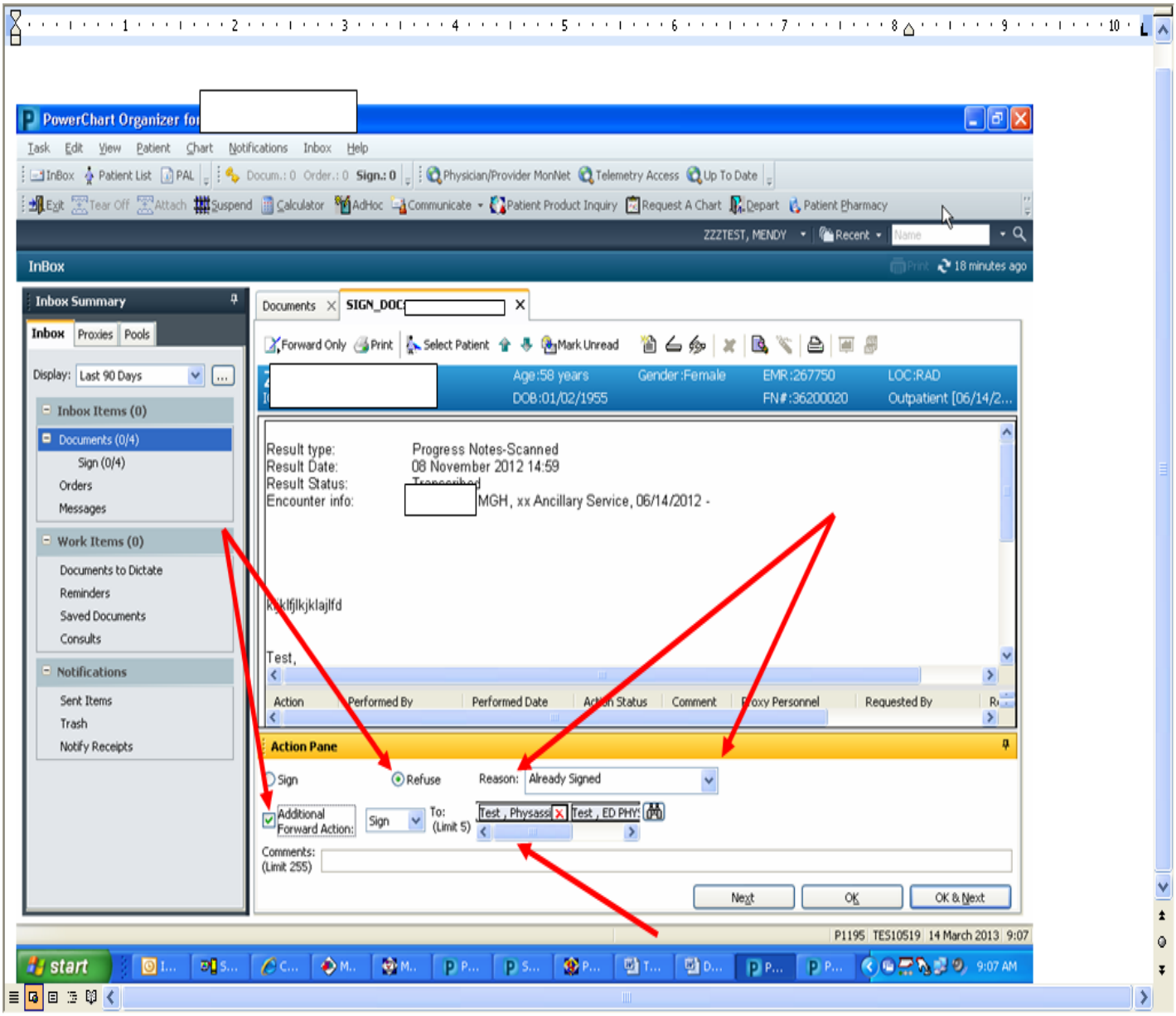




Click on the relationship and then click “OK”.

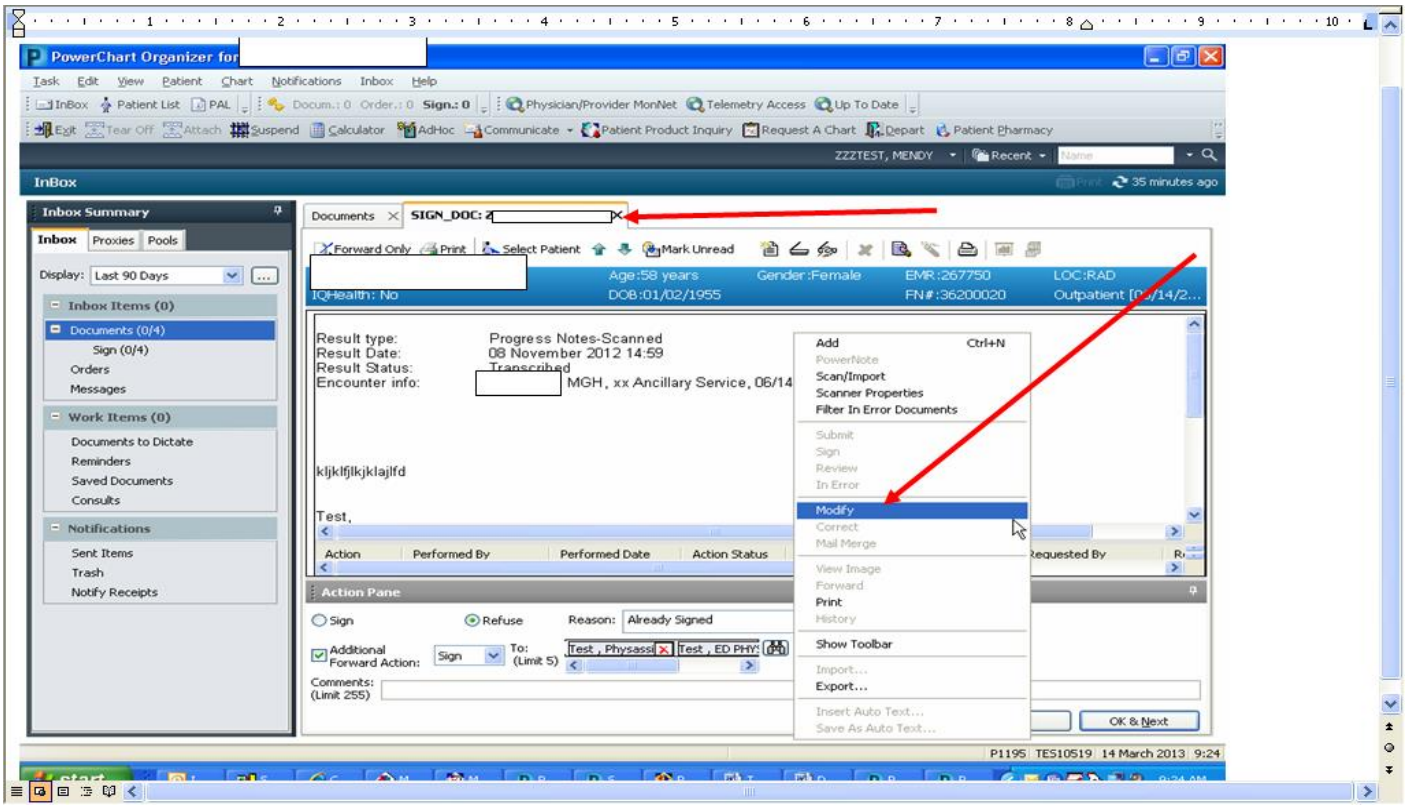
Revised 03/17/2020

To refuse a deficiency, follow these steps.
Click “refuse” for “sign” (The “additional forward action” should always be “sign”…**.never “review**”), choose a reason (from the drop down box to the right of “refuse”). In the “To” box it should always say, “HIM, Dept EV”. There is a box for additional comments, if you wish to type something; however, it is not required.



Revised 03/17/2020

A user can only "modify" an electronic document that has not been signed. (It can be sent to the user through an interface or created by the user and "saved"). You must open the electronic document, right click on the document and choose "modify" from the pop-up menu. (See below). Once you click on "modify", a separate window opens. The user would make changes in this window, and then click "OK". This will close the modification window, but leave the original window open. You must then close that patient's document by clicking on the "X" in the tab at the top of the document window.



This will close the current completed deficiency and open the next deficiency. If a deficiency has been "opened" (but not processed) it will still show in your inbox, but will no longer show in bold type.
A user has the capability to "sign all" electronic document deficiencies in his inbox (one folder at a time) without first reviewing them. This does not apply however to deficiencies on scanned documents. Scanned document deficiencies will not process when a user uses the "sign all" functionality. They must be completed one at a time.

If it has been more than 30 days since you have accessed Cerner, your password will automatically be disabled. (It may also be disabled if you enter the wrong username or password three consecutive times). You must call the I.T. helpdesk and ask them to reset your Cerner password……which will then be the same as your user name. You will be required to set a new password, which has to be at least six digits long and contain at least one number. A physician's username usually consists of the first three letters of their last name and their physician number.

Major Complications / Comorbid Conditions (MCC)

Cardiovascular / Cerebrovascular:

Brain Death
CHF – Acute (or Acute on Chronic); Systolic or Diastolic or Combined
Cor Pulmonale, Acute
CVA / Stroke / Cerebral Infarct or Hemorrhage
Cerebral Edema, Brain Compression
Coma *(except w/ ICB)*
Myocarditis, Acute
MI, Acute (all types 1-5)
Pulmonary Embolism, Acute
Rupture, Chordae Tendineae or Papillary Muscle

MCC if D/C Alive:

Cardiac Arrest
Cardiogenic Shock
Respiratory Arrest
Ventricular Fibrillation
Hypovolemic Shock

Respiratory & Infectious Disease:

HIV Disease / AIDS
Pneumonia
Pulmonary Edema, Acute (Noncardiogenic)
Respiratory Failure, Acute
Respiratory Failure, Acute Following Trauma / Surgery
Sepsis, Severe Sepsis, Septic Shock
Spontaneous Tension Pneumothorax

Complete documentation is needed to get credit for severity of illness and risk adjustment.

Other MCCs:

Acute Renal Failure with Acute Tubular Necrosis (ATN)
Acute Liver Failure
Aplastic Anemia due to drugs / chemo, infection, radiation
Diabetic Ketoacidosis, Diabetes w/ Hyperosmolarity or Other Coma
Emaciation *due to malnutrition*
Encephalopathy – Metabolic, Toxic, Other or Unspecified
End Stage Renal Disease
GI Disorder w/ Hemorrhage (Gastritis, Duodenitis, Diverticular Disease)
GI Ulcer w/ Perforation, Hemorrhage
Ischemic Colitis, Acute
Locked-In State
Major Injuries
Malnutrition, Severe
Pancreatitis, Acute
Pancytopenia, Chemo or Drug-Induced
Peritonitis
Pressure Ulcer, Stage III or IV *(if POA)*
Quadriplegia, Functional Quadriplegia
SIRS due to Noninfectious Process w/ Acute Organ Dysfunction
Volvulus

Reportable Secondary Diagnoses

Document all conditions that affect patient care in terms of:

- clinical evaluation; **or**
- therapeutic treatment; **or**
- diagnostic procedures; **or**
- extended length of hospital stay; **or**
- increased nursing care and/**or** monitoring

Compliments of:
Administrative Consultant Service, LLC
P.O. Box 3368
Shawnee, OK 74802
www.acsteam.net
(405) 878-0118 F: (405) 878-0411

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Complications / Comorbid Conditions (CC)

Cardiovascular & Vascular

Acute Coronary Syndrome
Angina, Unstable
Atrial Flutter; Atrial Fibrillation - Persistent
Block – Complete AV,Trifascicular, BBBB
CAD of Bypass Graft w/o Angina
CAD of Bypass Graft w/ Angina *(if specified as autologous vein / artery or nonautologous)*
Cardiac Tamponade
Cardiomyopathy *(except ischemic)*
CHF-if specified as Systolic or Diastolic
Chronic Total Occlusion – Extremity Artery
Endocarditis
Heart Failure, Left
Hypertensive Crisis; Hypertensive Urgency
Hypertensive Encephalopathy
Hypertensive Heart & Kidney Dz w/ CHF
In-Stent Stenosis (Cardiac Stent); Stent Jail
Ischemia – Acute Myocardial w/o MI; Demand
Pleural Effusion
Post MI Syndrome
Shock
Tachycardia - Paroxysmal Supraventricular
Tachycardia - Paroxysmal Ventricular *(Not if nonsustained)*
Thrombophlebitis *(deep veins, lower extremity)*
Venous Thrombosis *(specify acute or chronic)*

Cerebrovascular, Nervous, Behavioral

Aphasia *(not post-stroke)*
Bipolar Disorder *(except unspecified or in remission)*
Dementia, Senile w/ Acute Confusional State
Dementia w/ Behavioral Disturbance, Sundowning
Epilepsy, Intractable Seizures, Post-Traumatic
Hallucinations *(auditory, drug/alcohol induced)*
Hemiplegia; Hemiparesis, Paraplegia
Left Sided Neglect
Normal Pressure Hydrocephalus
Schizophrenia *(except unspecified, undifferentiated)*
Suicidal Ideation
TIA Vertebrobasilar Insufficiency
Weakness – unilateral *due to stroke*
Withdrawal – Alcohol or Drug *including Nicotine*

Hematologic & Oncology

Acute Blood Loss Anemia; Postop Anemia due to Blood Loss
Aplastic Anemia Acquired Hemophilia
Bleeding Disorder secondary to Anticoagulant
Hypercoagulable State
Lymphoma & Leukemia *(also in remission)*
Malignant Neoplasm *(most sites–not breast/ prostate)*
Pancytopenia
Secondary Neuroendocrine Tumors

Metabolic

Acidosis / Alkalosis
Adult BMI ≤19, Adult BMI ≥40
Hypernatremia / Hyponatremia
Malnutrition *(unless severe)*; Cachexia
Obesity Hypoventilation Syndrome

Gastrointestinal

Ascites
Attention to Gastrostomy
C. Diff Enteritis
Cholelithiasis w/ Cholecystitis
Colitis, Ischemic or Ulcerative
Colostomy / Enterostomy Complications
Crohn's Disease
Diverticulitis
Gastroenteritis – Toxic or due to Radiation
Gluten Sensitivity (non-celiac)
GI Bleed; Melena; Hematemesis; Hemoptysis
Hernia w/ Obstruction Ileus
Intestinal Infection: Viral, Bacterial, E. Coli, Staph, Pseudomonas, etc.
Intestinal Malabsorption
Jaundice Megacolon
Pancreatitis, Chronic

Other

Bacteremia; CLABSI
Complication / Infection of Device, Implant, Graft
Shock – postop *w/o specifying type*
Thrush, *oral (except NB)*
Transplant Status – *most organs*

Nephrology & Genitourinary

Acute Renal Failure / Acute Kidney Injury
Calculus of Ureter
Chronic Kidney Disease, Stage 4 or 5
Cystostomy Complications
Hydronephrosis / Hydroureter
Polycystic Kidney
Pyelonephritis
UTI

Orthopedic & Skin

Abscess
Cellulitis *(except fingers, toes)*
Compartment Syndrome, Nontraumatic
Complications of Prosthetic Joint
Fractures, Pathologic; Traumatic, Closed – *many sites*
Gangrene
Osteomyelitis, Acute, Chronic, or Unspecified
Stasis Ulcer – *inflamed or infected*
Ulcer of Skin, Lower Extremity *(except foot)*

Respiratory

Acute Respiratory Distress Syndrome (ARDS)
Aspiration Bronchitis
Asthma Exacerbation
Atelectasis
COPD w/ Acute Exacerbation
Emphysema w/ Exacerbation of Chronic Bronchitis
Hemoptysis
Interstitial Lung Disease
Pulmonary Edema - *noncardiogenic*
Respiratory Alkalosis / Acidosis
Respiratory Failure, Chronic
Respirator Weaning or Dependence

FY18

Clinical Validation Reference

Sepsis (Severe Sepsis, or Sepsis with Organ Dysfunction)

- Suspected infection, with body fluid cultures and antibiotics AND documentation of organ dysfunction associated with infection (severe sepsis).
- Acute increase of ≥ 2 SOFA points as proxy for organ dysfunction. Baseline SOFA score can be assumed to be zero in patients not known to have preexisting organ dysfunction.

Sequential [Sepsis-Related] Organ Failure Assessment Score[1]

	1	2	3	4
Respiratory: PaO_2/FIO_2	<400	<300	<200 with respiratory support	< 100 with respiratory support
Coagulation: Platelets	<150	<100	<50	<20
Liver: Bilirubin	1.2-1.9	2.0-5.9	6.0-11.9	>12.0
Cardiovascular	MAP < 70 mmHg	Dopamine < 5 or dobutamine (any dose)	Dopamine 5.1-15 or epinephrine (or norepinephrine) ≤ 0.1	Dopamine >15 or epinephrine (or norepinephrine) > 0.1
CNS: Glasgow Coma Scale	13-14	10-12	6-9	<6
Renal: Creatinine	1.2-1.9	2.0-3.4	3.5-4.9	>5.0
Urine Output	N/A	N/A	<500	<200
Per SEP-1/2 (Not SOFA)	INR > 1.5		aPTT > 60 sec	Lactate > 2

[1]The Third International Consensus Definitions for Sepsis and Septic Shock. *JAMA*. 2016:315(8):801-810; Surviving Sepsis Campaign 12/16

AHRQ Vasopressors for Septic Shock

- Norepinephrine / Levophed; Epinephrine / Adrenalin;
- Phenylephrine / Neosynephrine, Vazculep
- Dopamine / Inotropin Vasopressin / Pitressin

Septic Shock

- Persistent hypotension after crystalloid fluid administration:
  - SBP < 90 or MAP < 65 or decrease in SBP by > 40 **or**
  - Initial Lactate ≥ 4 mmol/L

Acute Respiratory Failure

One from each category recommended:

Diagnostic Criteria: *one of the following*

- pO2 <60 mm Hg OR SpO2 (pulse ox) <91% breathing room air
- pCO2 >50 and pH <7.35
- P/F ratio (pO2 / FIO2) <300
- pO2 ↓ or pCO2 ↑ ≥10 mmHg from baseline *(if known)*
- For acute on chronic respiratory failure:
  - pH < 7.35 / respiratory acidosis
  - greater hypoxemia / worsening symptoms

Clinical Criteria: *such as the following:*

- Respiratory distress, tachypnea, dyspnea, shortness of breath, wheezing, use of accessory muscles

Treatment: *more than required to treat chronic condition, such as*

- Mechanical ventilation
- BiPAP / CPAP
- High flow oxygen per nasal cannula
- Oxygen ≥ 40% (5 L/min); non-rebreather mask

CHEST 2017; 151(4):764-775
Revising Respiratory Failure. ACP Hospitalist, Oct-Nov 2013

Complex Pneumonias

HCAP Pneumonia

Was antibiotic selection for treatment of probable multidrug-resistant pneumonia – suspect gram negative vs Staph aureus? (Zosyn, Imipenem, Vancomycin, etc.)

Risk Factors for Gram Neg Cause

Diabetes COPD CHF
ESRD Extreme Debility
Malignancy treated w/ cytotoxic agents
Patchy infiltrate on chest x-ray
Long-term corticosteroid therapy
Chronic alcoholism

Probable Aspiration Pneumonia

Risk Factors: Abnormal barium swallow, difficulty swallowing, vomiting, CVA history, cerebrovascular disease, dementia, tracheostomy, etc. (Clindamycin, Cleocin)

Clinical Validation Reference

Acute Renal Failure / Acute Kidney Injury

KDIGO Clinical Practice Guideline for Acute Kidney Injury defines AKI as any one of the following:

- Increase in serum creatinine by > 0.3 mg/dl within 48 hours, or
- Increase in serum creatinine to > 1.5 times baseline, known/ presumed within the prior 7 days, or
- Urine volume of < 0.5 ml/kg/h for 6 hours

Acute Renal Failure w/ Acute Tubular Necrosis

Acute renal failure along with urinalysis suggestive of ATN, such as the presence of multiple granular and epithelial cell casts w/ free epithelial cells.

CKD Kidney Disease Quality Outcomes Initiative

Stage	GFR	Description
1	90+	Kidney damage, normal or ↑ GFR
2	60-89	Kidney damage, mild ↓ GFR
3	30-59	Moderate ↓ GFR
4	15-29	Severe ↓ GFR
5	<15	Kidney failure
ESRD	Kidney failure with chronic dialysis or renal replacement required	

Anemia Due To?

- Malignancy? Chemotherapy?
- Chronic Kidney Disease?
- Other Chronic Disease? (specify)
- Acute Blood Loss? Significant drop in HGB and/or HCT representing acute change:
  - **2 gm HGB drop**; *result below 9.5*
  - **6% HCT drop**

Serial H&H monitoring or transfusion support coding.

Heart Failure

	Systolic	Diastolic
EF	Reduced (< 40%)	Preserved
Echo	Dilated Left Ventricle Systolic Dysfunction	Dilated Left Atrium Diastolic Dysfunction
	HFrEF	HFpEF

Acute, Chronic, Acute on Chronic?
With Hypertension? Report Hypertensive Heart Dz

Cerebrovascular Disease

- tPA given here or at transferring facility?
- TIA vs CVA – how long did deficits persist?
- TIA due to cerebral thrombus / embolus?
- Documentation or imaging ID stroke vessel?
- Clinically significant cerebral edema or brain compression / herniation?
- Unilateral weakness due to stroke = hemiparesis.
- Aborted CVA arrested w/ tPA = CVA.
- Impending CVA = TIA unless further clarified
- Report NIHSS and Glasgow Coma Scale (individual scores).

Atrial Fibrillation

Paroxysmal: Terminates spontaneously or with intervention within 7 days of onset; may recur with variable frequency.

Persistent: Continuous AF that is sustained >7 days. *Longstanding persistent if > 12 mo in duration.*

Pt can have both paroxysmal & persistent a fib.

Permanent / Chronic: Both patient and clinician make joint decision to stop further attempts to restore and/or maintain sinus rhythm.

2014 AHA/ACC/HRS Guideline for the Management of Patients with Atrial Fibrillation

Ulcers

Physician documentation required for site, and type of ulcer, and the stage of pressure ulcer that was present on admission.

What is depth of non-pressure ulcers?

Malnutrition in Acute Illness

*Characterized by 2 or more of the following**

Criteria	Non-Severe	Severe
Energy Intake Requirements	< 75% for > 7 days	< 50% for > 5 days
Weight Loss	1-2% In 1 wk 5% in 1 mo 7.5% in 3 mo	< 2% in 1 wk > 5% in 1 mo > 7.5% in 3 mo
Body Fat	Mild	Moderate
Muscle Loss	Mild	Moderate
Fluid Accumulation	Mild	Moderate to Severe
↓ Grip Strength	N/A	Measurably reduced

**2012 Consensus Statement of AND / ASPEN*

Morbid Obesity: BMI ≥ 40

Hypertensive Crisis

- Hypertensive crisis can present as hypertensive urgency or hypertensive emergency
- Hypertensive urgency – severely elevated BP without end organ damage, generally treated as OP
- Hypertensive emergency – severely elevated BP with end organ damage
  - Systolic BP > 180 or Diastolic BP > 120 or lower levels in pts w/o prior elevated BP

Source: American Heart Association

Revised 03/17/2020

Classification of Secondary Diagnoses

BOLDED CONDITIONS = MCC
Regular Font = CC
Non-CC Can Impact Risk Adjustment

Abscess
Acidosis / Alkalosis
Acute Coronary Syndrome
Acute Liver Failure
Acute Renal Failure / AKI
Acute Renal Failure with Acute Tubular Necrosis
Acute Respiratory Distress Syndrome
Air Leak
Alcohol Abuse or Use w/ Intoxication Delirium, Alcohol-Induced Anxiety or Mood Disorder *(also Cocaine, Cannabis, or Opioid)*
Alcohol Dependence, Uncomplicated or In Remission
Alcoholic Cirrhosis; Alcoholic Liver Disease
Amputation Status, *most sites*
Anemia, Aplastic
Anemia, Deficiency [B12, folate, protein]
Anemia – due to acute blood loss
Aneurysm, Aortic, w/ Rupture or Dissection
Aneurysm, all sites
Angina
Angina, Unstable *(accelerated, crescendo, worsening effort)*
Anorexia Nervosa
Aphasia *(not post-stroke)*
Aplastic Anemia due to drugs / chemo, infection, radiation
Arthritis, Rheumatoid
Ascites
Asthma Exacerbation or Status Asthmaticus
Atelectasis
Atheroembolism
Atrial Fibrillation
Atrial Fibrillation – Persistent
Atrial Flutter
Attention to Gastrostomy
Bacteremia
Bipolar Disorder *(except unspecified or in remission)*
Bleeding Disorder due to Extrinsic Circulating Anticoagulant
Block – Complete AV,Trifascicular, BBBB, 2nd Degree
BMI ≤19, ≥40 (adult)
Brain Compression / Herniation
Brain Death
Bronchitis, Chronic
C. Diff Enteritis
Cachexia
CAD w/ Angina
CAD of Bypass Graft w/ Angina *(if specified as autologous vein / artery or nonautologous)*
CAD of Bypass Graft w/o Angina
Calculus of Ureter
Cardiac Arrest *(if D/C alive)*
Cardiac Arrest, Intraoperative
Cardiac Tamponade
Cardiomyopathy *(except ischemic)*
CAUTI
Cellulitis *(except fingers, toes)*
Cerebral Edema
Cerebral Ischemia
Cerebral Palsy
Cerebral Palsy w/ Spastic Quadriplegia
Cerebral Palsy w/ Spastic Diplegia or Hemiplegia
CHF – Acute (or Acute on Chronic); Systolic (HFrEF) or Diastolic (HFpEF) or Combined
CHF-if specified as Systolic or HFrEF
CHF-if specified as Diastolic or HFpEF
Cholelithiasis w/ Cholecystitis
Chronic Kidney Diseases, Stage 1-2-3, unspecified
Chronic Kidney Disease, Stage 4 or 5
Chronic Total Occlusion – Extremity Artery
CLABSI
Colostomy / Enterostomy / Cystostomy Complications
Coma *(except w/ ICB)*
Compartment Syndrome, Nontraumatic
Complication / Infection of Device, Implant, Graft
Concussion w/ Loss of Consciousness
COPD
COPD w/ Acute Exacerbation
Cor Pulmonale, Acute
Critical Illness Myopathy
Crohn's Disease
CVA / Stroke / Cerebral Infarct or Hemorrhage
Delirium Tremens
Demand Ischemia
Dementia
Dementia, Alcoholic w/ Alcohol Dependence
Dementia w/ Behavioral Disturbance
Dementia, Senile w/ Acute Confusional State
Diabetic Ketoacidosis, Diabetes w/ Hyperosmolarity or Other Coma
Diabetic Complications
Diabetes with Hyperglycemia *(poorly or not controlled)*
Diverticulitis
Emphysema
Encephalopathy – Metabolic, Toxic or Unspecified
Encephalopathy, Hepatic
Encephalopathy, Hypertensive
End Stage Renal Disease
Endocarditis
Epilepsy
Epilepsy, Intractable
Esophageal Perforation or Ulcer w/ Bleed
Esophageal Varices w/o Bleed
Fluid Overload
Fractures, Sequela
Fractures, Pathologic; Traumatic, Closed *(many sites)*
Gangrene; **Gas Gangrene**
Gastroenteritis – Toxic or due to Radiation
GI Bleed; Melena; Hematemesis; Hemoptysis
GI Disorder w/ Hemorrhage *(gastritis, duodenitis, diverticular disease)*
GI Ulcer w/ Perforation, Hemorrhage
Glasgow Coma Scale, total scores
Glasgow Coma Scale *(worst 2 scores per eyes, verbal, motor)*
Gluten Sensitivity / Intolerance (non-celiac)
Graft-versus-Host Disease
Hallucinations *(auditory, drug/alcohol induced)*
Heart Failure, Left
Hemarthrosis
Hemiplegia; Hemiparesis, Paraplegia
Hemoptysis
Hepatitis: Acute, Chronic, or Carrier, viral *(except Hep C)*
Hepatitis C, Chronic Viral
Hepatomegaly
Hernia w/ Obstruction
HIV, Asymptomatic
HIV Disease / AIDS
Hydrocephalus, Normal Pressure
Hydronephrosis / Hydroureter

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Revised 03/17/2020

Classification of Secondary Diagnoses

Hyperammonemia
Hypercoagulable State
Hypercalcemia / Hypocalcemia
Hyperkalemia
Hypernatremia / Hyponatremia
Hyperparathyroidism, Secondary
Hypertensive Crisis / Hypertensive Emergency
Hypertensive Encephalopathy
Hypertensive CKD
Hypertensive Heart Disease
Hypertensive Heart & Kidney Dz w/ CHF
Hypoparathyroidism
Hypotension
Hypovolemic Shock *(if D/C alive)*
Ileus
Impaction, Fecal
In-Stent Stenosis *(cardiac / vascular stent)*; Stent Jail
Infectious Gastroenteritis
Injuries, Major
Interstitial Lung Disease
Intestinal Infection: Viral, Bacterial, E. Coli, Staph, Pseudomonas, etc.
Intestinal Malabsorption
Ischemia – Acute Myocardial w/o MI
Ischemic Colitis, Acute
Ischemic Colitis
Jaundice
Left Sided Neglect
Locked-In State
Lymphoma & Leukemia *(also in remission)*
Major Depressive Disorder *(specified as mild, moderate, severe; either single episode or recurrent)*
Malignant Neoplasm *(most sites–not breast/ prostate)*
breast/ prostate)
Mallory-Weiss Syndrome / Tear
Malnutrition; Mild, Moderate, Unspecified
Malnutrition, Severe
Megacolon
Meningitis
Multiple Sclerosis
Myelodysplastic Syndrome
Myelopathy
MI, Acute *(all types 1-5)*
Myocarditis, Acute
Neurogenic Bladder
Neutropenia
Obesity Hypoventilation Syndrome
Obesity, Morbid
Osteomyelitis, Acute, Chronic, or Unspecified
Ostomy Status *(trach, colostomy, cystostomy, etc.)*
Oxygen Dependent
Pancreatitis, Acute
Pancreatitis, Chronic
Pancreatitis, Gallstone
Pancytopenia; **Pancytopenia, Chemo or Drug-Induced**
Parkinson's Disease
Perforation or Obstruction of Bile Duct
Perforation of Intestine *(nontraumatic)*
Peripheral Vascular Disease
Peritonitis
Pleural Effusion
Pneumonia; Pneumonia, Ventilator Associated
Pneumothorax; **Pneumothorax, Spontaneous Tension**
Polycystic Kidney
Postinfarction Angina; Post MI Syndrome
Preinfarction Syndrome; Intermediate Coronary Synd
Pressure Ulcer, *all stages*
Pressure Ulcer, Stage III or IV
Pulmonary Edema *(noncardiogenic)*
Pulmonary Edema, Acute *(noncardiogenic)*
Pulmonary Embolism, Acute
Pulmonary Hypertension, Primary
Pyelonephritis
Quadriplegia, Functional Quadriplegia
Respiratory Alkalosis / Acidosis
Respiratory Alkalosis / Acidosis
Respiratory Arrest *(if D/C alive)*
Respiratory Failure, Acute
Respiratory Failure, Acute Following Trauma / Surgery
Respiratory Failure, Chronic
Rhabdomyolysis
Rupture, Chordae Tendineae or Papillary Muscle
Schizophrenia *(except unspecified, undifferentiated)*
Schizophrenia, Unspecified
Secondary Neuroendocrine Tumors
Seizures: Febrile, Intractable or Post-Traumatic
Seizure
Sepsis, Severe Sepsis
Shock *(without specificity as to type)*
Shock, Cardiogenic, Hypovolemic, Septic *(if D/C alive)*
SIADH
Sick Sinus Syndrome
Sickle Cell Crisis
Sickle Cell Disease, Trait
SIRS due to Noninfectious Process w/o Acute Organ Dys
SIRS due to Noninfectious Process w/ Acute Organ Dysfunction
Splenomegaly
Stenosis, Carotid Artery
Stenosis, Spine *C or T*
Suicidal Ideation
Sundowning
Tachycardia - Paroxysmal Supraventricular
Tachycardia - Paroxysmal Ventricular *(not if nonsustained)*
Thiamine Deficiency
Thrombocytopenia
Thrombophilia
Thrombophlebitis *(deep veins, lower extremity)*
Thrombosis *(specify acute or chronic)*
Thrush, *oral (except NB)*
TIA
Transplant Status *(most organs)*
Twiddler's Syndrome
Ulcer, Acute – Gastric, Duodenal, Peptic
Ulcer, Skin, Foot
Ulcer, Skin, Lower Extremity
Ulcer, Stasis *(inflamed or infected)*
Ulcerative Colitis
UTI
Varicose Veins of Lower Ext w/ Ulcer & Inflammation
Varicose Veins of Lower Ext w/ Ulcer & Inflammation
Ventricular Fibrillation *(if D/C alive)*
Vertebrobasilar Insufficiency
Volvulus
Weakness – unilateral *due to stroke*
Withdrawal – Alcohol or Drug *(includes Nicotine)*

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Major Complications / Comorbid Conditions (MCC)

Cardiovascular / Cerebrovascular:

Brain Death
CHF – Acute (or Acute on Chronic); Systolic or Diastolic or Combined
Cor Pulmonale, Acute
CVA / Stroke / Cerebral Infarct or Hemorrhage
Cerebral Edema, Brain Compression
Coma *(except w/ ICB)*
Myocarditis, Acute
MI, Acute (all types 1-5)
Pulmonary Embolism, Acute
Rupture, Chordae Tendineae or Papillary Muscle

MCC if D/C Alive:

Cardiac Arrest
Cardiogenic Shock
Respiratory Arrest
Ventricular Fibrillation
Hypovolemic Shock

Respiratory & Infectious Disease:

HIV Disease / AIDS
Pneumonia
Pulmonary Edema, Acute (Noncardiogenic)
Respiratory Failure, Acute
Respiratory Failure, Acute Following Trauma / Surgery
Sepsis, Severe Sepsis, Septic Shock
Spontaneous Tension Pneumothorax

Complete documentation is needed to get credit for severity of illness and risk adjustment.

Other MCCs:

Acute Renal Failure with Acute Tubular Necrosis (ATN)
Acute Liver Failure
Aplastic Anemia due to drugs / chemo, infection, radiation
Diabetic Ketoacidosis, Diabetes w/ Hyperosmolarity or Other Coma
Emaciation *due to malnutrition*
Encephalopathy – Metabolic, Toxic, Other or Unspecified
End Stage Renal Disease
GI Disorder w/ Hemorrhage (Gastritis, Duodenitis, Diverticular Disease)
GI Ulcer w/ Perforation, Hemorrhage
Ischemic Colitis, Acute
Locked-In State
Major Injuries
Malnutrition, Severe
Pancreatitis, Acute
Pancytopenia, Chemo or Drug-Induced
Peritonitis
Pressure Ulcer, Stage III or IV *(if POA)*
Quadriplegia, Functional Quadriplegia
SIRS due to Noninfectious Process w/ Acute Organ Dysfunction
Volvulus

Reportable Secondary Diagnoses

Document all conditions that affect patient care in terms of:

- clinical evaluation; **or**
- therapeutic treatment; **or**
- diagnostic procedures; **or**
- extended length of hospital stay; **or**
- increased nursing care and/**or** monitoring

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