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| 1 | aceidc | Was an angiotensin converting enzyme inhibitor (ACE inhibitor) prescribed at discharge?   1. yes 2. no | 1,2  If 1, auto-fill noacewhy as 95  If 2, auto-fill onacedc as 95, and go to noacewhy | **In determining whether an ACEI was prescribed at discharge, review all discharge medication documentation available in the chart.**  If there is conflicting documentation among different medical record sources, the following guidelines apply:   * In cases where there is an ACEI in one source that is not mentioned in another source, it should be interpreted as a discharge medication unless documentation suggests that it was NOT prescribed at discharge. **Consider the ACEI a discharge medication in the absence of contradictory documentation (see below)**. * If documentation is **contradictory** (e.g., physician noted “dc lisinopril” in discharge orders, but lisinopril is listed in the discharge summary), or careful examination of the circumstances raises enough questions about whether an ACEI was prescribed at discharge, the case should be deemed unable to determine and answered as “2.” * Consider documentation of a “hold” on an ACEI after discharge as **contradictory** ONLY if the timeframe on the hold is **not defined (e.g., “Hold lisinopril” does not have a timeframe).** * If an ACEI is NOT listed as a discharge medication, and there is only documentation of a plan to delay initiation/restarting of an ACEI for a time period after discharge (e.g. “Start lisinopril as outpatient”), select “2.” |
| 2 | onacedc | Designate the ACE inhibitor prescribed at discharge.   1. enalapril 2. captopril 3. lisinopril 4. benazepril 5. fosinopril 6. quinapril 7. perindopril 8. moexipril 9. ramipril 10. trandolapril 11. other 12. enalapril/hydrochlorothiazide 13. enalapril/diltiazem 14. enalapril/felodipine 15. captopril/hydrochlorothiazide 16. lisinopril/hydrochlorothiazide 17. benazepril/hydrochlorothiazide 18. benazepril/amlodipine 19. fosinopril/hydrochlorothiazide 20. quinapril/hydrochlorothiazide 21. moexipril/hydrochlorothiazide 22. trandolapril/verapamil   95. not applicable | 1,2,3,4,5,6,7,8,9,10,  11,12,13,14,15,16,17,18,19,20,21,22,95  If aceidc = 2, will be auto-filled as 95 | **“Prescribed for this patient at discharge” = patient may or may not have been on this medication during hospitalization, and it was either continued or prescribed at the time of discharge.**  **ACEI**: Angiotensin converting enzyme inhibitors; ACEIs may be described as RAS (renin-angiotensin system) or RAAS (renin-angiotensin-aldosterone system) blockers/inhibitors.  ACEI names are listed by the generic name, as documented in VHA medical records. The brand name is displayed in parentheses after the generic name.  For a list of ACEI medications, refer to JC Appendix C, Table 1.2or a drug handbook.  The computer will auto-fill as 95 if aceidc = 2. |

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| 3 | noacewhy | Does the record document any of the following reasons for not prescribing an ACEI at discharge?  1. ACEI allergy   * 1. Moderate or severe aortic stenosis   95. Not applicable   * + 1. Other reason documented by a   physician/APN/PA or pharmacist for not prescribing an ACEI at discharge   * + 1. Patient refusal of ACEIs documented by physician/APN/PA or pharmacist  1. No documented reason | 1,5,95,97,98,99  Will be auto-filled as 95 if aceidc = 1 | **1. ACEI allergy** = An ACEI “allergy” or “sensitivity” documented at anytime during the hospital stay counts as an allergy regardless of what type of reaction might be noted (e.g. “Allergies: ACEI – cough” – select “1.”)  Documentation of an allergy/sensitivity to one particular ACEI is acceptable to take as an allergy to the entire class of ACEIs (e.g., “allergic to lisinopril”).  **5. Aortic stenosis** = notation of this diagnosis, with the description of moderate, severe, 3+, 4+, critical, or significant, in the record is acceptable. Finding of moderate or severe aortic stenosis may be taken from diagnostic test report. Includes both a current finding or a history of moderate or severe aortic stenosis without mention of repair, replacement, valvuloplasty, or commissurotomy. **Include:**  moderate/severe subaortic stenosis, or degree of severity not specified.  **Exclude:** aortic insufficiency only, aortic regurgitation only, aortic stenosis described as 1+ or 2+, aortic stenosis using one of the following qualifiers: cannot exclude, cannot rule out, may have, may have had, may indicate, possible, suggestive of, suspect, or suspicious.  **97. Other reason(s) documented by a physician/APN/ PA or pharmacist = Must explicitly link the noted reason with non-prescription of an ACEI.**  Documentation of a reason anytime during the hospital stay is acceptable. ACEIs may be described as RAS (renin-angiotensin system) or RAAS (renin-angiotensin-aldosterone system) blockers/inhibitors.  **Physician/APN/PA or pharmacist documentation of a reason for not prescribing an ACEI should be considered implicit documentation for not prescribing an ARB for the following five conditions ONLY:**   * Angioedema * Hyperkalemia * Hypotension * Renal artery stenosis * Worsening renal function/renal disease/dysfunction   Physician/APN/PA or pharmacist documentation of a hold/discontinuation of an ACEI during the hospital stay or of a plan to initiate/restart an ACEI and notation of the reason/problem underlying the delay in starting/restarting the ACEI constitutes a “clearly implied” reason for not prescribing an ACEI at discharge (e.g., “Patient hypotensive. May start ACEI as outpatient.”).  **Cont’d next page** |
|  |  |  |  | **Reasons for Not Prescribing ACEI cont’d**  **EXCEPTION:** Documentation of a **conditional** hold/discontinuation of an ACEI does not count as a reason for not prescribing an ACEI at discharge **UNLESS** (1) it exists as a physician/APN/PA or pharmacist **order** to hold/discontinue the ACEI if the blood pressure (BP) falls outside certain parameters, AND (2) the ACEI was held due to a BP outside the parameters. Nursing documentation is acceptable. E.g., “Hold lisinopril for SBP < 90” ordered and the nurse documents that the lisinopril was held for a BP of 80/50 – select “97.”  **If the patient is on hydralazine and nitrates, and the record documents this drug therapy is a better option than ACEI or ARB for the patient, this documentation is to be accepted as “other reason.”**  If there is conflicting documentation in the record regarding a reason for not prescribing an ACEI at discharge, accept as a “yes” for the applicable reason.  Physician/APN/PA or pharmacist documentation of a pre-arrival hold/ discontinuation of an ACEI or pre-arrival “other reason” for not prescribing an ACEI counts as a reason for not prescribing an ACEI at  discharge ONLY if the underlying reason is noted.  **98.** Documentation by a physician/APN/PA or pharmacist that the patient refused ACEI medications or refused all medications is acceptable.  Documentation that the patient refused BP medications is NOT acceptable.  **Unacceptable Reasons:**  Documentation of a conditional hold/discontinuation of an ACEI (e.g., (“Hold lisinopril if cough recurs”).  Documentation of a hold which refers to a more general medication class (e.g. “Hold all BP meds”).  Deferral of an ACEI from one prescriber to another does NOT count as a reason for not prescribing an ACEI at discharge unless the problem underlying the deferral is noted. For example, “cardiology to evaluate patient for ACEI” – is NOT acceptable.  **Excluded Data Sources:** Any documentation dated/timed after discharge, **except** discharge summary and operative/ procedure/ diagnostic test reports (from procedure done during hospital stay). |

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| 4 | arbatdc | | | Was an angiotensin II receptor antagonist (ARB or AIIRA) prescribed at discharge?   1. yes 2. no | | 1,2  If 1, auto-fill acsnoarb as 95 If 2, auto-fill specarb as 95, and go to acsnoarb | **In determining whether an ARB was prescribed at discharge, review all discharge medication documentation available in the chart.**  If there is conflicting documentation among different medical record sources, the following guidelines apply:   * In cases where there is an ARB in one source that is not mentioned in another source, it should be interpreted as a discharge medication unless documentation suggests that it was NOT prescribed at discharge. **Consider the ARB a discharge medication in the absence of contradictory documentation (see below)**. * If documentation is **contradictory** (e.g., physician noted “dc losartan” in discharge orders, but losartan is listed in thedischarge summary), or careful examination of the circumstances raises enough questions about whether an ARB was prescribed at discharge, the case should be deemed unable to determine and answered as “2.”Consider documentation of a “hold” on an ARB after discharge as **contradictory** ONLY if the timeframe on the hold is **not defined (e.g., “Hold losartan” does not have a timeframe).** * If an ARB is NOT listed as a discharge medication, and there is only documentation of a plan to delay initiation/restarting of an ARB for a time period after discharge (e.g. “Start losartan as outpatient”), select “2.” |
| 5 | specarb | | | Specify the ARB:   1. Candesartan (Atacand) 2. Candesartan/hydrochlorothiazide (Atacand HCT) 3. Eprosartan (Teveten) 4. Eprosartan/hydrochlorothiazide (Teveten HCT) 5. Irbesartan (Avalide) (Avapro) 6. Irbesartan/hydrochlorothiazide 7. Losartan (Cozaar) 8. Losartan/hydrochlorothiazide (Hyzaar) 9. Olmesartan (Benicar) 10. Olmesartan/hydrochlorothiazide (Benicar HCT) 11. Tasosartan (Verdia) 12. Telmisartan (Micardis) 13. Telmisartan/hydrochlorothiazide (Micardis HCT) 14. Valsartan (Diovan)   15. Valsartan/hydrochlorothiazide (Diovan HCT)  16. Other  95. not applicable | | 1,2,3,4,5,6,7,8,9,  10,11,12,13,  14,15,16,95  If arbatdc = 2, will be auto-filled as 95 | **ARB**: Angiotensin receptor blockers or angiotensin II receptor antagonists (AIIRA); ARBs may be described as RAS (renin-angiotensin system) or RAAS (renin-angiotensin-aldosterone system) blockers/inhibitors  ARB names are listed by the generic name, as documented in VHA medical records. The brand name is displayed in parentheses after the generic name.  For a list of ARB medications, refer to JC Appendix C, Table 1.7 or a drug handbook.  The computer will auto-fill as 95 if ARBATDC = 2. |
| 6 | | acsnoarb | Does the record document any of the following reasons for not prescribing an ARB at discharge?   * + 1. ARB (AIIRA) allergy or sensitivity     2. Moderate or severe aortic stenosis   95. Not applicable  97. Other reason(s) documented by a physician/APN/PA or pharmacist for not prescribing an ARB  98. Patient refusal of ARBs documented by physician/APN/PA or pharmacist  99. No documented reason | | 1,2,95,97,98,99  Will be auto-filled as 95 if arbatdc = 1 | | **1. ARB allergy** = An ARB “allergy” or “sensitivity” documented at anytime during the hospital stay counts as an allergy regardless of what type of reaction might be noted (e.g. “Allergies: ARB – cough” – select “1.”). Documentation of an allergy/sensitivity to one particular ARB is acceptable to take as an allergy to the entire class of ARBs (e.g., “allergic to losartan”).  5. Aortic stenosis = notation of this diagnosis, with the description of moderate, severe, 3+, 4+, critical, or significant in the record is acceptable. Finding of moderate or severe aortic stenosis may be taken from diagnostic test report. Includes both a current finding or a history of moderate or severe aortic stenosis without mention of repair, replacement, valvuloplasty, or commissurotomy. **Include:** moderate/severe subaortic stenosis, or degree of severity not specified.  **Exclude**: aortic insufficiency only, aortic regurgitation only, aortic stenosis described as 1+ or 2+, aortic stenosis using one of the following qualifiers: cannot exclude, cannot rule out, may have, may have had, may indicate, possible, suggestive of, suspect, or suspicious  **97. Other reason (s) documented by a physician/APN/ PA or pharmacist =** **Must explicitly link the noted reason with non-prescription of an ARB.** Documentation of a reason anytime during the hospital stay is acceptable. ARBs may be described as RAS (renin-angiotensin system) or RAAS (renin-angiotensin-aldosterone system) blockers/inhibitors.  **Physician/APN/PA documentation of a reason for not prescribing an ARB should be considered implicit documentation for not prescribing an ACEI for the following five conditions** **ONLY**:   * Angioedema * Hyperkalemia * Hypotension * Renal artery stenosis * Worsening renal function/renal disease/dysfunction   Physician/APN/PA or pharmacist documentation of a hold/discontinuation of an ARB during the hospital stay or of a plan to initiate/restart an ARB and notation of the reason/problem underlying the delay in starting/restarting the ARB constitutes a “clearly implied” reason for not prescribing an ARB at discharge (e.g., “Patient hypotensive. May start ARB as outpatient.”).  **Cont’d next page** |
|  | |  |  | |  | | **Reasons for Not Prescribing ARB cont’d**  **EXCEPTION:** Documentation of a **conditional** hold/discontinuation of an ARB does not count as a reason for not prescribing an ARB at discharge **UNLESS** (1) it exists as a physician/APN/PA or pharmacist **order** to hold/discontinue the ARB if the blood pressure (BP) falls outside certain parameters, AND (2) the ARB was held due to a BP outside the parameters. Nursing documentation is acceptable. E.g., “Hold losartan for SBP < 100” ordered and the nurse documents that the losartan was held for a BP of 90/50 – select “97.”  **If the patient is on hydralazine and nitrates, and the record documents this drug therapy is a better option than ACEI or ARB for the patient, this documentation is to be accepted as “other reason.”**  If there is conflicting documentation in the record regarding a reason for not prescribing an ARB at discharge, accept as a “yes” for the applicable  reason.  Physician/APN/PA or pharmacist documentation of a pre-arrival hold/ discontinuation of an ARB or pre-arrival “other reason” for not prescribing an ARB counts as a reason for not prescribing an ARB at discharge ONLY if the underlying reason is noted.  **98.** Documentation by a physician/APN/PA or pharmacist that the patient refused ARB medications or refused all medications is acceptable. Documentation that the patient refused BP medications is NOT acceptable.  **Unacceptable Reasons:**  Documentation of a conditional hold/discontinuation of an ARB (e.g., “Stop losartan if BP < 90 systolic.”) without documentation the ARB was held due to the specified parameter (e.g. SBP < 100).  Documentation of a hold which refers to a more general medication class (e.g. “Hold all BP meds.”).  Deferral of an ARB from one prescriber to another does NOT count as a reason for not prescribing an ARB at discharge unless the problem underlying the deferral is noted. For example, “cardiology to evaluate patient for ARB” – is NOT acceptable.  **Excluded Data Sources:** Any documentation dated/timed after discharge, **except** discharge summary and operative/ procedure/ diagnostic test reports (from procedure done during hospital stay). |

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| 7 | asarxdc | Was the patient prescribed aspirin at discharge?  1. yes  2. no | 1,2  If 1, auto-fill aspdcnot as 95 and go to platagdc | “Prescribed at discharge” also means recommended or instructed to take aspirin. OTC is equivalent to “prescribed,” but the instructions to take aspirin must be documented in the record.  For a list of aspirin and aspirin-containing medications, refer to JC Appendix C, Table 1.1 or a drug handbook.  **In determining whether aspirin was prescribed at discharge, review all discharge medication documentation available in the chart.**  If there is conflicting documentation among different medical record sources, the following guidelines apply:   * In cases where aspirin is in one source but is not mentioned in another source, it should be interpreted as a discharge medication unless documentation suggests that it was NOT prescribed at discharge. **Consider the aspirin a discharge medication in the absence of contradictory documentation (see below)**. * If documentation is **contradictory** (e.g., physician noted “dc ASA” in discharge orders, but aspirin is listed in the discharge summary), or careful examination of the circumstances raises enough questions about whether aspirin was prescribed at discharge, the case should be deemed unable to determine and answered as “2.” * Consider documentation of a “hold” on aspirin after discharge as **contradictory** ONLY if the timeframe on the hold is **not defined (e.g., “Hold aspirin” does not have a timeframe).** * If aspirin is NOT listed as a discharge medication, and there is only documentation of a plan to delay initiation/restarting of aspirin for a time period after discharge (e.g. “Start ASA as outpatient”), select “2.” |

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| 8 | aspdcnot | Does the record document any of the following reasons for not prescribing aspirin at discharge?   1. Aspirin allergy 2. Warfarin/Coumadin prescribed at discharge   95. Not applicable   1. Other reason documented by physician, APN, PA, or pharmacist for not prescribing aspirin at discharge 2. Patient refusal of aspirin documented by physician/APN/PA or pharmacist   99. No documented reason | 1,3,95,97,98,99  Will be auto-filled as 95 if asarxdc = 1 | 1 = Aspirin “allergy” or “sensitivity” documented at anytime during the hospital stay counts as an allergy regardless of what type of reaction might be noted (e.g. “Allergies: ASA – Upsets stomach” – select “1.”) Documentation of an allergy/sensitivity to one particular type of aspirin is acceptable.  3 = Warfarin/Coumadin prescribed at discharge. If Coumadin/warfarin is on hold at discharge but there is documentation of a plan to restart it after discharge, consider this as a reason for not prescribing aspirin at discharge.  **“Other reason” documented by physician/APN/PA or pharmacist must explicitly link the noted reason with non-prescription of aspirin. If the patient is taking clopidogrel (Plavix) or ticlopidine hydrochloride (Ticlid), clinician documentation must specify the use of this drug is the reason aspirin was not prescribed.**   * **If reasons are not mentioned in the context of aspirin, do not make inferences. (Do not assume that aspirin is not being prescribed because of patient’s history of PUD.)** * A reason for not prescribing aspirin at discharge may be documented anytime during the hospital stay. * Physician/APN/PA or pharmacist documentation of a hold/discontinuation of aspirin during the hospital stay or of a plan to initiate/restart aspirin and notation of the reason/problem underlying the delay in starting/restarting the ARB constitutes a “clearly implied” reason for not prescribing aspirin at discharge (e.g., “FOBT+. May start aspirin as outpatient.”).   **Exception:** Documentation of a **conditional** hold/discontinuation of aspirin does not count as a reason for not prescribing aspirin at discharge (e.g., “Hold ASA if blood in urine returns”).   * If there is conflicting documentation in the record regarding a reason for not prescribing aspirin at discharge, accept as a “yes” for the applicable reason. * Physician/APN/PA or pharmacist documentation of a pre-arrival hold/discontinuation of aspirin, or “other reason” counts as a reason for not prescribing aspirin at discharge ONLY if the underlying reason is noted.   **98.** Documentation by a physician/APN/PA or pharmacist that the patient refused aspirin or refused all medications is acceptable. |

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| 9 | platagdc | Was the patient prescribed a platelet aggregation inhibitor at discharge?   1. clopidogrel (Plavix) 2. ticlopidine (Ticlid) 3. dipyridamole (Persantine) 4. dipyridamole and aspirin (Aggrenox) 5. other 6. none of these medications | 1,2,3,4,5,99  If <> 99, auto-fill contplat as 95, and go to hepondc | Clopidogrel and ticlopidine are inhibitors of platelet aggregation. A variety of drugs that inhibit platelet function have been shown to decrease morbid events in patients with established athererosclerotic cardiovascular disease as evidenced by stroke, TIAs, and AMI. Patients who have a true allergy to aspirin and no contraindication to antiplatelet therapy may be given clopidogrel, ticlopidine, or dypyridamole. |
| 10 | contplat | Is there physician/APN/PA or pharmacist documentation of a reason for not prescribing a platelet aggregation inhibitor at discharge?   * 1. yes   2. no   95. Not applicable | 1,2,95  Will be auto-filled as 95 if platagdc <> 99 | There must be physician/APN/PA or pharmacist documentation of the reason a platelet aggregation inhibitor was not prescribed at discharge. Potential adverse effects of platelet aggregation inhibitors: nephrotic syndrome, hyponatremia, blood cell disorders, TTP (thrombotic thrombocytopenic purpura). The abstractor may not infer that a platelet aggregation inhibitor was not prescribed at discharge because one of these factors was present. |
| 11 | hepondc | Was the patient prescribed low molecular weight heparin at discharge?   1. yes 2. no | 1,2  If 1, auto-fill heprinno as 95, and go to blkatdc | Low molecular weight heparins are available as subcutaneous injections. Regular monitoring by blood test is not required for LMWH. The does is determined by body weight and correlates well with the desired anticoagulant effect.  **LMWH: enoxaparin (Lovenox), dalteparin (Fragmin), tinzaparin (Innohep), nadroparin (Fraxiparine), reviparin (Clivarin), and certoparin (Sandoparin).** |

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| 12 | heprinno | Does the record document any of the following reasons for not prescribing low molecular weight heparin at discharge?   1. active or recent bleeding 2. allergy, intolerance, or hypersensitivity to heparin 3. Platelet count < 100,000/mm3 4. ulcer or serious GI/GU bleeding 5. history of thrombocytopenia 6. decision not to treat 7. Do Not Resuscitate status 8. Patient in a clinical trial testing anticoagulants other than heparin   95. Not applicable   1. other reasons documented by a physician/APN/PA or pharmacist 2. Patient refusal of heparin documented by physician/APN/PA or pharmacist 3. No documented reason | 1,2,3,4,5,6,7,9,  95,97,99  Will be auto-filled as 95 if  hepondc = 1 | Abstractor may accept the following without specific physician/APN/PA or pharmacist documentation:   * allergy to heparin clearly noted in the record as patient drug allergy or intolerance * current diagnosis or history of thrombocytopenia, documented in the record or on a problem list * platelet count, as specified, on admission or at the time of onset of ACS if veteran was already an inpatient * DNR status in physician orders for this episode of care * Notation in record that patient is in an anticoagulant clinical trial   The severity of active or recent bleeding, ulcer or serious GI/GU bleeding, decision not to treat, or “other” must be documented by a physician/APN/PA or pharmacist and linked to the non-prescription of low molecular weight heparin. The abstractor may not use his/her judgment in determining whether the severity of a bleed, co-morbid illness, etc. precludes prescription of low molecular weight heparin. |

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| 13 | blkatdc | Was the patient prescribed a beta-blocker at discharge?   1. yes 2. no | 1,2  If 1, auto-fill blkrlate as 95, nodcbb as 95, and go to wichbbdc | **In determining whether a beta-blocker was prescribed at discharge, review all discharge medication documentation available in the chart.** If there is conflicting documentation among different medical record sources, the following guidelines apply:   * In cases where there is a beta-blocker in one source that is not mentioned in another source, it should be interpreted as a discharge medication unless documentation suggests that it was NOT prescribed at discharge. **Consider the beta-blocker a discharge medication in the absence of contradictory documentation (see below)**. * If documentation is **contradictory** (e.g., physician noted “dc metoprolol” in discharge orders, but metoprolol is listed in the discharge summary), or careful examination of the circumstances raises enough questions about whether a beta-blocker was prescribed at discharge, the case should be deemed unable to determine and answered as “2.” * Consider documentation of a “hold” on a beta-blocker after discharge as **contradictory** ONLY if the timeframe on the hold is **not defined (e.g., “Hold metoprolol” does not have a timeframe).** * If a beta-blocker is NOT listed as a discharge medication, and there is only documentation of a plan to delay initiation/restarting of a beta-blocker for a time period after discharge (e.g. “Start metoprolol as outpatient”), select “2.” |
| 14 | blkrlate | Was the patient prescribed a beta-blocker within seven days post-discharge?   1. yes 2. no 3. not applicable | 1,2,95  If blkatdc = 1, will be auto-filled as 95  **If 2, auto-fill wichbbdc as 95, and go to nodcbb** | Do not count the day of discharge. The seven-day period begins the day following discharge, i.e., the day after discharge is Day 1. Answer “yes” if a beta blocker was prescribed anytime during this period, even if on the 7th day. |

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| 15 | wichbbdc | Designate the beta blocker prescribed for the patient at discharge.   1. metoprolol succinate (Toprol-XL) 2. metoprolol tartrate 3. bisoprolol (Zebeta or Ziac) 4. carvedilol (Coreg) 5. atenolol (Tenoretic or Tenormin) 6. acebutolol (Sectral) 7. sotalol (Betapace) 8. betaxolol (Kerlone) 9. carteolol (Cartrol) 10. nadolol (Corgard) 11. nadolol/bendroflumethiazide (Corzide) 12. propranolol (Inderal) 13. propranolol hydrochloride (Inderide) 14. labetalol (Normodyne or Trandate) 15. penbutolol sulfate (Levatol) 16. metoprolol/hydrochlorothiazide (Lopressor HCT ) 17. pindolol (Visken) 18. timolol (Timolide or Blocadren) 19. timolol/hydrochlorothiazide 20. other 21. not applicable | 1,2,3,4,5,6,7,8,9,  10,11,12,13,  14,15,16,18,  19,20,21,95  If blkatdc = 2 and blkrlate = 2, will be auto-filled as 95 | **“Prescribed for this patient at discharge” = patient may or may not have been on this medication during hospitalization, and it was either continued or prescribed at the time of discharge.**  Beta blocker generic names are not capitalized. Brand names are capitalized. Enter the number corresponding to the generic name documented in the medical record.  For a list of beta-blocker medications, refer to JC Appendix C, Table 1.3or a drug handbook.  The computer will auto-fill as 95 if blkatdc = 2 and blkrlate = 2.  **Source**: discharge instructions, discharge orders, discharge summary |
| 16 | nodcbb | Does the record document any of the following reasons for not prescribing a beta-blocker at discharge?   1. Beta-blocker allergy   3. Second or third-degree heart block on ECG on arrival or during hospitalization and does not have a pacemaker   * 1. Post-heart transplant patient   2. Severely decompensated heart failure documented by physician/APN/PA   95. Not applicable   1. Other reasons documented by a physician/APN/PA or pharmacist for not prescribing a beta-blocker at discharge 2. Patient refusal of beta-blockers documented by physician/APN/PA or pharmacist   99.No documented reason | 1,3,9,10,95,  97,98,99  Will be auto-filled as 95 if blkatdc = 1 | **Beta-blocker allergy** = Where there is documentation of a beta- blocker “allergy” or “sensitivity”, regard this as documentation of a beta blocker allergy regardless of what type of reaction might be noted. Documentation of an allergy/sensitivity to one particular beta-blocker is acceptable to take as an allergy to the entire class of beta-blockers (e.g., “allergic to metoprolol”).  **Second or third-degree heart block** (see inclusion/exclusion table) = when determining whether there is second or third-degree heart block on ECG on arrival or during the hospital stay and does not have a pacemaker:   * Consider this true if there are findings of second or third degree heart block on the ECG and this same ECG does not show pacemaker findings OR documentation of a finding of second or third-degree heart block without mention of pacemaker findings (e.g., “second-degree heart block” per ED report). * Disregard pacemaker findings if documentation suggests the patient had a non-functioning pacemaker. * Heart block or pacemaker findings do not have to be taken from ECG interpretations. Any notation of second or third-degree heart block or pacemaker findings on an ECG report or other source is acceptable with or without physician/APN/PA signature.   **97. Other reason(s) documented by a physician/APN/ PA or pharmacist =** Must explicitly link the noted reason with non-prescription of a beta-blocker. Documentation of a reason anytime during the hospital stay is acceptable.  Physician/APN/PA or pharmacist documentation of a hold/discontinuation of a beta-blocker during the hospital stay or of a plan to initiate/restart a beta-blocker and notation of the reason/problem underlying the delay in starting/restarting the beta-blocker constitutes a “clearly implied” reason for not prescribing a beta-blocker at discharge (e.g., “BP still low. May start metoprolol as outpatient.”).  **EXCEPTION:** Documentation of a **conditional** hold/discontinuation of a beta-blocker does not count as a reason for not prescribing a beta-blocker at discharge **UNLESS** (1) it exists as a physician/APN/PA or pharmacist **order** to hold/discontinue the beta-blocker if the blood pressure (BP) or heart rate (HR) falls outside certain parameters, AND (2) the beta-blocker was held due to a BP/HR outside the parameters. **Cont’d next page** |
|  |  |  |  | **Reasons for Not Prescribing Beta-Blocker cont’d**  Nursing documentation that the beta-blocker was held due to a BP/HR outside set parameters is acceptable. E.g., Physician order noted, “Hold atenolol for SBP < 100” and the nurse documents that the atenolol was held for a BP of 90/50 – select “97.”  If there is conflicting documentation in the record regarding a reason for not prescribing a beta-blocker at discharge, accept as a “yes” for the applicable reason.  Physician/APN/PA or pharmacist documentation of a pre-arrival hold/ discontinuation of a beta-blocker or pre-arrival “other reason” for not prescribing a beta-blocker counts as a reason for not prescribing a beta-blocker at discharge ONLY if the underlying reason is noted.  **98.** Documentation by a physician/APN/PA or pharmacist that the patient refused beta-blocker medications or refused all medications is acceptable. Documentation that the patient refused BP medications is NOT acceptable.  **Unacceptable Reasons:**  Documentation of a conditional hold/discontinuation of a beta-blocker (e.g., “Stop metoprolol if SBP < 100.”) without documentation the beta-blocker was held due to the specified parameter (e.g. SBP < 100). .  Documentation of a hold which refers to a more general medication class (e.g. “Hold all BP meds”).  Deferral of a beta-blocker from one prescriber to another does NOT count as a reason for not prescribing a beta-blocker at discharge unless the problem underlying the deferral is noted. For example, “cardiology to evaluate patient for beta-blocker” – is NOT acceptable.  **Reason documentation which refers to eye drops containing beta-blocker is not acceptable.** |

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|  |  |  | Inclusion | Exclusion |
|  |  |  | 2nd/3rd degree heart blocks (HB) Note: the following inclusive terms may stand alone or be modified by “variable” or intermittent”.   * Atrioventricular (AV) block described as 2:1, 3:1, second-degree, or third-degree * Atrioventricular dissociation * Heart block (HB) described as 2:1, 3:1, complete (CHB), high degree, high grade, second-degree, or third-degree * Heart block, type/degree not specified * Mobitz Type 1 or 2 * Wenckebach   **Pacemaker Findings**:  Atrial pacing  AV pacing  Dual chamber pacing  Paced rhythm  Paced spikes  Ventricular pacing | Beta blocker allergy: Beta blocker allergy described using one of the following qualifiers: cannot exclude, cannot rule out, may have, may have had, may indicate, possible, suggestive of, suspect, or suspicious  **2nd/3rd degree heart blocks (HB)**   * 2nd/3rd degree heart blocks (HB), or any of the other 2nd/3rd degree heart block inclusion terms described using one of the following qualifiers: cannot exclude, cannot rule out, may have, may have had, may indicate, possible, suggestive of, suspect, or suspicious * Atrial flutter * Atrioventricular (AV) block * Atrioventricular (AV) conduction block * First-degree atrioventricular (AV) block * First-degree heart block (HB) * Intraventricular conduction delay (IVCD) |

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| 17 | statatdc | Was a statin medication prescribed at discharge?  Examples include, but are not limited to:   * atorvastatin calcium (Lipitor) * fluvastatin sodium (Lescol) * lovastatin (Mevacor) (Altocor) * pitavastatin (Livalo) * pravastatin sodium (Pravacol) * rosuvastatin calcium (Crestor) * simvastatin (Zocor) * ezetimibe/simvastatin (Vytorin)   1. Yes  2. No | 1,2  If 2, auto-fill statmed as 95, and go to nostawhy | **In determining whether a statin medication was prescribed at discharge, review all discharge medication documentation available in the chart.**  If there is conflicting documentation among different medical record sources, the following guidelines apply:   * In cases where there is a statin medication in one source that is not mentioned in another source, it should be interpreted as a discharge medication unless documentation suggests that it was NOT prescribed at discharge. **Consider the statin medication a discharge medication in the absence of contradictory documentation (see below)**. * If documentation is **contradictory** (e.g., physician noted “dc simvastatin” in discharge orders, but simvastatin is listed in the discharge summary), or careful examination of the circumstances raises enough questions about whether a statin medication was prescribed at discharge, the case should be deemed unable to determine and answered as “2.” * Consider documentation of a “hold” on a statin medication after discharge as **contradictory** ONLY if the timeframe on the hold is **not defined (e.g., “Hold lovastatin” does not have a timeframe).** * If a statin medication is not listed as a discharge medication, and there is only documentation of a plan to delay initiation/restarting of a statin for a time period after discharge (e.g. “Start simvastatin as outpatient”), select “2.”   For a complete list of statin medications, refer to JC Appendix C, Table 8.1 or a drug handbook. |

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| 18 | statmed | Enter the statin medication prescribed at discharge:   1. fluvastatin sodium (Lescol) 2. atorvastatin calcium (Lipitor) 3. lovastatin (Mevacor) (Altocor) 4. pravastatin sodium (Pravacol) 5. simvastatin (Zocor) 6. rosuvastatin calcium (Crestor) 7. pitavastatin (Livalo) 8. Not applicable | 1,2,3,4,5,6,7,95  Will be auto-filled as 95 if statatdc = 2  **If 1,2,3,4,5,6, or 7, go to end** | Indicate the name of the individual statin medication prescribed for the patient at discharge. If the patient is taking a combination medication (e.g. simvastatin/ezetimibe), select the statin component of the combination medication.  Statin names are listed by the generic name, as documented in VHA medical records. The brand name is displayed in parentheses after the generic name.  For a list of statin medications, refer to JC Appendix C, Table 8.1 or a drug handbook. |

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| 19 | nostawhy | Is there documentation of a reason for not prescribing a statin medication at discharge?   1. Statin medication allergy   97. Other reason documented by a physician/APN/PA or pharmacist for not prescribing a statin medication at discharge  98. Patient refusal of ALL statin medications documented by physician/APN/PA or pharmacist  99. No documented reason | 1,97,98,99 | **Statin medication allergy** = Where there is documentation of a statin medication “allergy” or “sensitivity”, regard this as documentation of a statin medication allergy regardless of what type of reaction might be noted. Documentation of an allergy/sensitivity to one particular statin medication is acceptable to take as an allergy to the entire class of statin medications (e.g., “allergic to atorvastatin”).   * Reasons for not prescribing a statin medication at discharge must be explicitly documented (e.g., “CPK elevated. Lipid lowering therapy contraindicated.”) or clearly implied (e.g., “Hx of muscle soreness with statins in the past.”) * If reasons are not mentioned in the context of statin medications, do not make inferences (e.g., do not assume that a statin medication is not prescribed because of the patient’s history of alcoholism or severe liver disease.) * Reasons do not need to be documented at the time of discharge or otherwise associated specifically with discharge prescription. Documentation of reasons anytime during the stay is acceptable. * Physician/APN/PA or pharmacist documentation of a hold on statin medication or discontinuation of a statin medication during hospitalization constitutes a “clearly implied” reason for not prescribing a statin medication at discharge. **EXCEPTION:** Physician/APN/PA or pharmacist documentation of a **conditional** hold/discontinuation of a statin medication (e.g., “hold simvastatin if diarrhea persists.”) does not count as a reason for not prescribing a statin medication at discharge. * If there is conflicting documentation in the record regarding a reason for not prescribing a statin med at discharge, accept as a “yes” for the applicable reason.   Physician/APN/PA or pharmacist documentation of a pre-arrival hold, discontinuation of a statin medication, or “other reason” counts as a reason for not prescribing a statin medication at discharge ONLY if the underlying reason is noted. |

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| 20 | nonstatdc | Was a non-statin lipid-lowering medication prescribed at discharge?   * **Cholesterol absorption inhibitors**: ezetimibe (Zetia) * **Nicotinic Acid:** niacin extended release tablets (Niaspan), Crystalline niacin, sustained or timed release niacin * **Bile Acid Sequestrants**: colestipol hydrochloride (Colestid), colesevelam hydrochloride (Welchol), cholestyramine (Questran) (Locholest) * **Fibrates**: clofibrate (Atromid-S) (Abitrate), gemfibrozil (Lopid) (Gemcor), fenofibrate (Tricor) (Lofibra), fenofibric acid (Fibricor) * **Omega- Fatty Acids (Fish Oils):** Marine-derived omega-3 fatty acid supplements (DHA/EPA)   1. Yes  2. No | 1,2  **If 1, auto-fill nolipwhy2 as 95**  **If 2, auto-fill lipdmed as 95, and go to nolipwhy2** | **In determining whether a non-statin lipid-lowering medication was prescribed at discharge, review all discharge medication documentation available in the chart.**  **Refer to a drug handbook for comprehensive list of non-statin lipid lowering medications.**  If there is conflicting documentation among different medical record sources, the following guidelines apply:   * In cases where there is a non-statin lipid-lowering medication in one source that is not mentioned in another source, it should be interpreted as a discharge medication unless documentation suggests that it was NOT prescribed at discharge. **Consider the lipid-lowering medication a discharge medication in the absence of contradictory documentation (see below)**. * If documentation is **contradictory** (e.g., physician noted “DC Niaspan” in discharge orders, but Niaspan is listed in the discharge summary), or careful examination of the circumstances raises enough questions about whether a lipid-lowering medication was prescribed at discharge, the case should be deemed unable to determine and answered as “2.” * Consider documentation of a “hold” on a non-statin lipid-lowering medication after discharge as **contradictory** ONLY if the timeframe on the hold is **not defined (e.g., “Hold Niaspan” does not have a timeframe).** * If a lipid-lowering medication is NOT listed as a discharge medication, and there is only documentation of a plan to delay initiation/restarting of a beta-blocker for a time period after discharge (e.g. “Start Niaspan as outpatient”), select “2.” |

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| 21 | lipdmed | Enter the non-statin lipid-lowering medication prescribed at discharge:   1. ezetimibe (Zetia) 2. Niaspan/lovastatin (Advicor) 3. niacin extended release tablets (Niaspan) 4. crystalline niacin 5. sustained or timed release niacin 6. colestipol hydrochloride (Colestid) 7. colesevelam hydrochloride (Welchol) 8. cholestyramine (Questran) (Locholest) 9. clofibrate (Atromid-S) (Abitrate) 10. gemfibrozil (Lopid) (Gemcor) 11. fenofibrate (Tricor) (Lofibra) 12. fenofibric acid (Fibricor) 13. marine-derived omega-3 fatty acid supplements (DHA/EPA) 14. Other non-statin medication 15. Not applicable | 1,2,3,4,5,6,7, 8,9,  10,11,12, 13,14,95  Will be auto-filled as 95 if  nonstatdc = 2 | Indicate the name of the non-statin lipid-lowering medication prescribed for the patient at discharge.  Lipid lowering medications are listed by the generic name, as documented in VHA medical records. The brand name is displayed in parentheses after the generic name.  Please refer to a drug handbook for a comprehensive list of non-statin lipid lowering medications.  The computer will auto-fill as 95 if nonstatdc = 2. |

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| 22 | nolipwhy2 | Is there documentation of a reason for not prescribing a non-statin lipid-lowering medication at discharge?   1. Non-statin lipid-lowering medication allergy   95. Not applicable  97. Other reason documented by a physician/APN/PA or pharmacist for not prescribing a non-statin lipid-lowering medication at discharge  98. Patient refusal of ALL non-statin lipid-lowering medications documented by physician/APN/PA or pharmacist  99. No documented reason | 1,95,97,98,99  Will be auto-filled as 95 if nonstatdc = 1 | **Non-statin lipid-lowering medication allergy** = Where there is documentation of a non-statin lipid-lowering medication “allergy” or “sensitivity”, regard this as documentation of a non-statin lipid-lowering medication allergy regardless of what type of reaction might be noted. Documentation of an allergy/sensitivity to one particular non-statin lipid-lowering medication is acceptable to take as an allergy to the entire class of non-statin lipid-lowering medications (e.g., “allergic to gemfibrozil”).   * Reasons for not prescribing a non-statin lipid-lowering medication at discharge must be explicitly documented (e.g., “Active PUD. Lipid lowering therapy contraindicated.”) or clearly implied (e.g., “Hx of flushing/itching with nicotinic acid in the past.”) * If reasons are not mentioned in the context of non-statin lipid-lowering medications, do not make inferences (e.g., do not assume that a non-statin lipid-lowering medication is not prescribed because of the patient’s history of alcoholism or severe liver disease.) * Reasons do not need to be documented at the time of discharge or otherwise associated specifically with discharge prescription. Documentation of reasons anytime during the stay is acceptable. * Physician/APN/PA or pharmacist documentation of a hold on a non-statin lipid-lowering medication or discontinuation of a non-statin lipid-lowering medication during hospitalization constitutes a “clearly implied” reason for not prescribing a lipid-lowering medication at discharge. **EXCEPTION:** Physician/APN/PA or pharmacist documentation of a **conditional** hold/discontinuation of a non-statin lipid-lowering medication (e.g., “hold Niaspan if itching persists”) does not count as a reason for not prescribing a non-statin lipid-lowering medication at discharge. * If there is conflicting documentation in the record regarding a reason for not prescribing a non-statin lipid-lowering med at discharge, accept as a “yes” for the applicable reason.   Physician/APN/PA or pharmacist documentation of a pre-arrival hold/ discontinuation of a non-statin lipid-lowering medication, or “other reason” counts as a reason for not prescribing a non-statin lipid-lowering medication at discharge ONLY if the underlying reason is noted. |
| **If age >= 65, enable Delirium Risk** | | | | |