VHA EXTERNAL PEER REVIEW PROGRAM
ACUTE CORONARY SYNDROME INSTRUMENT
DISCHARGE MODULE
Third Quarter FY2014

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
1	aceidc	Was an angiotensin converting enzyme inhibitor (ACEI) prescribed at discharge? Examples of ACEI include, but are not limited to: • enalapril • captopril • lisinopril • benazipril • ramipril • combinations of ACEI with hydrochlorothiazide 1. Yes 2. No	1, 2 If 1, auto-fill noacewhy as 95, arbatdc as 95 and acsnoarb as 95 If 2, 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." • Disregard an ACEI documented only as a recommended medication for discharge (e.g., "Recommend sending pt home on Vasotec"). Documentation must be clear that the ACEI was actually prescribed. • Disregard documentation of ACEI prescribed at discharge when noted only by medication class (e.g., "ACEI Prescribed at Discharge: Yes" on a core measures form). The ACEI must be listed by name. **For a complete list of ACEI medications, refer to TJC Appendix C, Table 1.2 or a drug handbook.**
2	noacewhy	Does the record document any of the following reasons for not	1, 5, 95, 97, 98, 99	**Documentation of a reason anytime during hospital stay is acceptable.**

<table>
<tr><th>#</th><th>Name</th><th>QUESTION</th><th>Field Format</th><th>DEFINITION/DECISION RULES</th></tr>
<tr><td></td><td></td><td>prescribing an ACEI at discharge?
1. ACEI allergy
5. Moderate or severe aortic stenosis
95. Not applicable
97. Other reason documented by a physician/APN/PA or pharmacist for not prescribing an ACEI at discharge
98. Patient refusal of ACEIs documented by physician/APN/PA or pharmacist
99. No documented reason</td><td>Will be auto-filled as 95 if aceidc = 1</td><td>1. ACEI allergy/sensitivity: documented allergy or sensitivity documented at anytime during the hospital stay counts regardless of type of reaction noted (e.g. "Allergies: ACEI - cough"); allergy/sensitivity to one ACEI is acceptable as an allergy to all ACEIs.
5. Moderate or Severe Aortic Stenosis (AS): Findings may be taken from diagnostic test reports. May be either current diagnosis or history of AS, without mention of repair, replacement, valvuloplasty, or commissurotomy.
INCLUDE: AS described as moderate, severe, 3+, 4+, critical or significant; degree of severity not specified; aortic valve area of less than 1.0 square cm; subaortic stenosis, moderate/severe, or degree of severity not specified
EXCLUDE:
• Aortic insufficiency/regurgitation only
• AS described as 1+ or 2+
• Moderate/severe AS or any of the other moderate/severe AS inclusion terms, described using any of the following negative qualifiers or modifiers:
<table><tr><th colspan="2">JC Appendix H, Table 2.6 Qualifiers/Modifiers</th></tr><tr><td>Qualifiers: and/or, (+/-), cannot exclude, cannot rule out, could/may/might be, could/may/might have, could/may/might have been, could/may/might have had, could/may/might indicate, questionable (?), risk of, ruled out (r'd/o, r/o'd), suggestive of, suspect, or suspicious</td><td>Modifiers: borderline, insignificant, not significant, no significant, minor, scant, slight, sub-clinical, subtle, trace, trivial</td></tr></table>
97. Other reason(s) documented by a physician/APN/PA or pharmacist:
• Must explicitly link the noted reason with non-prescription of an ACEI.
• Should be considered implicit documentation for also not prescribing an ARB for the following five conditions ONLY:
◦ Angioedema
◦ Hyperkalemia
◦ Hypotension
◦ Renal artery stenosis</td></tr>
</table>

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
				◦ Worsening renal function/renal disease/dysfunction • Documentation of a hold/discontinuation of an ACEI during the hospital stay constitutes a "clearly implied" reason for not prescribing an ACEI at discharge (e.g., "Patient hypotensive. May start ACEI as outpatient"). **EXCEPTIONS:** ◦ Documentation of a **conditional** hold/discontinuation of an ACEI does not count as a reason for not prescribing at discharge **UNLESS** (1) it exists as a physician/APN/PA or pharmacist **order** to hold/discontinue the ACEI if BP falls outside certain parameters, AND (2) the ACEI was held due to BP outside the parameters. Nursing documentation is acceptable (e.g., Physician order: "Hold lisinopril for SBP < 90" and nurse documents: "lisinopril held for BP 80/50"). ◦ Discontinuation of a particular ACEI medication documented in combination with the start of a different ACEI medication (i.e., switch in type of ACEI medication) does not count as a reason for not prescribing an ACEI at discharge. Example: - "Stop benazepril" and "Start captopril 50 mg po bid" in same physician order. ◦ Discontinuation of an ACEI medication at a particular dose documented in combination with the start of a different dose of that ACEI (i.e., change in dosage) does not count as a reason for not prescribing an ACEI at discharge. Examples: - "Stop lisinopril 20 mg po q am" and "Start lisinopril 30 mg po q am" in same physician order - "Increase Altace 5 mg to 10 mg" in progress note • Documentation of both a plan to initiate/restart an ACEI and the reason/problem underlying the delay in starting/restarting ACEI constitutes a "clearly implied" reason for not prescribing ACEI at discharge (e.g., "Pt. hemodynamically unstable. May start ACEI as outpatient."). • **If the patient is on hydralazine and nitrates, <u>and</u> the record documents this drug therapy is a better option than ACEI or ARB for**

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
				the patient, this documentation is acceptable as "other reason." • 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 at discharge **ONLY** if the underlying reason is noted. • When conflicting documentation regarding a reason for not prescribing an ACEI at discharge is documented in the medical record, select "yes" for the applicable reason. • **Unacceptable Reasons:** ◦ Documentation of a conditional hold/discontinuation of an ACEI (e.g "Hold lisinopril if cough recurs.") without documentation the ACEI was held due to the specified reason. ◦ 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 **unless** underlying problem for deferral is noted (e.g., "cardiology to evaluate patient for ACEI" is **NOT** acceptable). **98. Patient refusal:** Documentation by a physician/APN/PA or pharmacist that the patient refused ACEI medications or all medications is acceptable. Documentation that the patient refused BP medications 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).

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
3	arbatdc	Was an angiotensin II receptor antagonist (ARB or AIIRA) prescribed at discharge? Examples of ARB include, but are not limited to: • candesartan • eprosartan • irbesartan • losartan • valsartan • combinations of ARB with hydrochlorothiazide 1. Yes 2. No 95. Not applicable	1, 2, 95 Will be autofilled as 95 if aceidc = 1. If 1, auto-fill acsnoarb as 95 If 2, 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 the discharge 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." • Disregard an ARB documented only as a recommended medication for discharge (e.g., "Recommend sending pt home on candesartan"). Documentation must be clear that the ARB was actually prescribed. • Disregard documentation of ARB prescribed at discharge when noted only by medication class (e.g., "ARB Prescribed at Discharge: Yes" on a core measures form). The ARB must be listed by name. **For a complete list of ARB medications, refer to TJC Appendix C, Table 1.7 or a drug handbook.**
4	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	1, 2, 95, 97, 98, 99 Will be auto-filled as 95 if arbatdc = 1 or if aceidc = 1	**Documentation of a reason anytime during hospital stay is acceptable.** **1. ARB allergy/sensitivity:** documented **allergy** or **sensitivity** counts regardless of type of reaction noted (e.g. "Allergies: ARB-cough"); allergy/sensitivity to one ARB is acceptable as allergy to all ARBs. **2. Moderate or Severe Aortic Stenosis (AS):** Findings may be taken from

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
		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		diagnostic test reports. May be either current diagnosis or history of AS, without mention of repair, replacement, valvuloplasty, or commissurotomy. **INCLUDE:** AS described as moderate, severe, 3+, 4+, critical or significant; degree of severity not specified; aortic valve area of less than 1.0 square cm; subaortic stenosis, moderate/severe, or degree of severity not specified **EXCLUDE:** • Aortic insufficiency/regurgitation only • AS described as 1+ or 2+ • Moderate/severe AS or any of the other moderate/severe AS inclusion terms, described using any of the following negative qualifiers or modifiers: **JC Appendix H, Table 2.6 Qualifiers/Modifiers** **Qualifiers: and/or, (+/-), cannot exclude, cannot rule out, could/may/might be, could/may/might have, could/may/might have been, could/may/might have had, could/may/might indicate, questionable (?), risk of, ruled out (r'd/o, r/o'd), suggestive of, suspect, or suspicious** **Modifiers: borderline, insignificant, not significant, no significant, minor, scant, slight, sub-clinical, subtle, trace, trivial** **97. Other reason(s) documented by a physician/APN/PA or pharmacist:** • Must explicitly link the noted reason with non-prescription of an ARB. • Should be considered implicit documentation for also not prescribing an ACEI for the following five conditions **ONLY:** ◦ Angioedema ◦ Hyperkalemia ◦ Hypotension ◦ Renal artery stenosis ◦ Worsening renal function/renal disease/dysfunction • Documentation of a hold/discontinuation of an ARB during the hospital stay constitutes a "clearly implied" reason for not prescribing an ARB at discharge (e.g., "Patient hypotensive. May start ARB as outpatient"). **EXCEPTIONS:**

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
				◦ Documentation of a **conditional** hold/discontinuation of an ARB does not count as a reason for not prescribing at discharge **UNLESS** (1) it exists as a physician/APN/PA or pharmacist **order** to hold/discontinue the ARB if BP falls outside certain parameters, AND (2) the ARB was held due to BP outside the parameters. Nursing documentation is acceptable (e.g., Physician order: "Hold losartan for SBP < 100"and/ nurse documents "losartan held for BP 80/50"). ◦ Discontinuation of a particular ARB medication documented in combination with the start of a different ARB medication (i.e., switch in type of ARB medication) does not count as a reason for not prescribing an ARB at discharge. Example: - "Change Diovan to Verdia" in progress note ◦ Discontinuation of an ARB medication at a particular dose documented in combination with the start of a different dose of that ARB (i.e., change in dosage) does not count as a reason for not prescribing an ARB at discharge. Examples: - "Do not continue after discharge" checked for Cozaar 25 mg and "Continue after discharge" checked for Cozaar 50 mg on a physician-signed discharge medication reconciliation form • Documentation of both a plan to initiate/restart an ARB and the reason/problem underlying the delay in starting/restarting ARB constitutes a "clearly implied" reason for not prescribing ARB at discharge (e.g., "Pt. hemodynamically unstable. May start ARB as outpatient."). • **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 acceptable as "other reason."** • 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 at discharge **ONLY** if the underlying reason is noted. • When conflicting documentation regarding a reason for not prescribing an ARB at discharge is documented in the medical record, select "yes" for the

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES

				applicable reason.
				• **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.
				  ◦ 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 **unless** underlying problem for deferral is noted (e.g., "cardiology to evaluate patient for ARB" is **NOT** acceptable).
				
				98. Patient refusal: Documentation by a physician/APN/PA or pharmacist that the patient refused ARB medications or all medications is acceptable. Documentation that the patient refused BP medications 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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5	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 TJC 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 <u>absence</u> 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." • Disregard aspirin documented only as recommended medication for discharge (e.g., "Recommend sending patient home on ASA"). Documentation must be more clear that aspirin was actually prescribed at discharge. **Exclude:** Aggrenox (aspirin/dipyridamole): Aggrenox contains only a sub-therapeutic amount of aspirin and does **NOT** count for aspirin.
6	aspdcnot	Does the record document any of the following reasons for not	1, 3, 95, 97, 98, 99	A reason for not prescribing aspirin at discharge may be documented anytime

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
		prescribing aspirin at discharge? 1. Aspirin allergy 3. One or more of the medications listed in the Inclusion List were prescribed at discharge 95. Not applicable 97. Other reason documented by physician, APN, PA, or pharmacist for not prescribing aspirin at discharge 98. Patient refusal of aspirin documented by physician/APN/PA or pharmacist 99. No documented reason	Will be auto-filled as 95 if asarxdc = 1	during the hospital stay. **1. Aspirin allergy:** "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. One or more of the medications listed in the Inclusion List were prescribed at discharge:** If one or more of the medications 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. **Inclusion List** (Discharge medications that count as an automatic reason for no aspirin): • apixaban (Eliquis) • dabigatran (Pradaxa) • rivaroxiban (Xarelto) • warfarin/warfarin sodium (Coumadin/Jantoven) **97. "Other reason" documented by <u>physician/APN/PA or pharmacist</u>:** • Reasons must be explicitly documented (e.g., "Chronic hepatitis - No ASA") or clearly implied (e.g., "GI bleeding with aspirin in past," "ASA contraindicated." aspirin on pre-printed order form is crossed out, "No aspirin" [no reason given]) • If reasons are not mentioned in the context of aspirin, do not make inferences. **Examples: (a) 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. (b)Do not assume that aspirin is not being prescribed because of patient's history of PUD.** • 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."). **<u>EXCEPTION:</u>** Documentation of a one-time hold, dose adjustment, switch

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				to a different aspirin medication, or conditional hold/discontinuation ("Hold ASA if fecal occult blood test is positive") should not be considered as a reason for not prescribing aspirin. • Documentation which refers to a more general medication class is not acceptable (e.g., "Hold all anticoagulants"). **EXCEPTION:** Documentation of a reason for not prescribing "antiplatelets" should be considered implicit documentation of a reason for no aspirin at discharge (e.g., "Antiplatelet therapy contraindicated"). • Documentation of a plan to initiate/restart aspirin, and the reason/problem underlying the delay in starting/restarting aspirin is also noted, this constitutes a "clearly implied" reason for not prescribing aspirin at discharge. • 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. **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.**
7	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. prasugrel (Effient) 7. ticagrelor (Brilinta) 99. none of these medications	1, 2, 3, 4, 5, 6, 7, 99 If <> 99, auto-fill contplat as 95, and go to blkatdc	Platelet aggregation inhibitors are drugs used to prevent clotting and thus reduce risk of further heart attack or stroke in patients with cardiovascular disease. Patients who have a true allergy to aspirin and no contraindication to antiplatelet therapy may be given drugs such as clopidogrel, ticlopidine, dypyridamole, prasugrel or ticagrelor.

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8	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.

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9	blkatdc	Was the patient prescribed a beta-blocker at discharge? Examples of beta-blockers include but are not limited to: • metropolol succinate or tartrate • carvedilol • atenolol • nadolol • propranolol • combination of beta-blockers with other drugs 1. yes 2. no	1, 2 **If 1, auto-fill blkrlate as 95, nodcbb as 95**	**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." • Disregard a beta-blocker medication documented only as a recommended medication for discharge (e.g., "Recommend sending patient home on sotalol"). Documentation must be more clear that a beta-blocker was actually prescribed at discharge. • Disregard documentation of beta-blocker prescribed at discharge when noted only by medication class (e.g., "Beta-Blocker Prescribed at Discharge: Yes" on a core measures form). The beta-blocker must be listed by name. **For a complete list of beta-blocker medications, refer to TJC Appendix C, Table 1.3 or a drug handbook.**

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
10	blkrlate	Was the patient prescribed a beta-blocker within seven days post-discharge? 1. yes 2. no 95. not applicable	1, 2, 95 If blkatdc = 1, will be auto-filled as 95 **If 2, 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.
11	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 9. Post-heart transplant patient 10. Severely decompensated heart failure documented by physician/APN/PA 95. Not applicable 97. Other reasons documented by a physician/APN/PA or pharmacist for not prescribing a beta-blocker at discharge 98. 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	**Documentation of reason anytime during hospital stay is acceptable.** **1. Beta-blocker (BB) allergy/sensitivity:** documented **allergy/sensitivity** counts regardless of type of reaction noted; allergy/sensitivity to one BB is acceptable as allergy to all BBs. **EXCLUDE:** Allergy to BB eye drops (e.g., Cosopt). **3. Second or third-degree heart block (HB):** • Findings on arrival ECG that does not show pacemaker findings **OR** findings without mention of pacemaker (e.g., "second-degree heart block" per ED report). • Disregard pacemaker findings if documentation suggests non-functioning pacemaker. • Any notation of 2nd/3rd degree HB and pacemaker findings on ECG report or other source is acceptable with/without physician/APN/PA signature. **INCLUDE: Stand alone/modified by "variable" or "intermittent":** Atrioventricular (AV) block described as 2:1, 3:1, 2nd degree, or 3rd degree; AV dissociation; HB described as 2:1, 3:1, complete (CHB), high degree, high grade, 2nd degree, 3rd degree; Mobitz Type 1 or 2; Wenckebach; Pacemaker findings of paced rhythm/spikes; pacing described as atrial, AV, dual chamber or ventricular. **EXCLUDE:** • atrial flutter • AV block • AV conduction block • 1st degree AV block • 1st degree HB • HB type/degree not specified

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- Intraventricular conduction delay (IVCD)
- HB, or any other 2nd/3rd degree HB inclusion terms described using any of the following negative qualifiers or modifiers:

JC Appendix H, Table 2.6 Qualifiers/Modifiers	
Qualifiers: and/or, (+/-), cannot exclude, cannot rule out, could/may/might be, could/may/might have, could/may/might have been, could/may/might have had, could/may/might indicate, questionable (?), risk of, ruled out (r'd/o, r/o'd), suggestive of, suspect, or suspicious	**Modifiers: borderline, insignificant, not significant, no significant, minor, scant, slight, sub-clinical, subtle, trace, trivial**

10. Severely decompensated heart failure: cardiac decompensation is marked by dyspnea, venous engorgement, and edema. Abstractor may not make this decision based on symptoms described in record. **There must be specific diagnosis by a physician/APN/PA.**

97. Other reason(s) documented by a physician/APN/ PA or pharmacist:

- Must explicitly link noted reason with non-prescription of BB.
- Documentation of hold/discontinuation of BB during admission constitutes a "clearly implied" reason for not prescribing at discharge (e.g., "BP still low. May start metoprolol as outpatient.").

  EXCEPTIONS:
  - Documentation of a **conditional** hold/discontinuation of BB does NOT count as reason for not prescribing BB at discharge **UNLESS** (1) it exists as an **order** to hold/discontinue if BP or HR falls outside certain parameters, AND (2) BB was held due to a BP/HR outside the parameters. Nursing documentation is acceptable (e. g., Physician order: "Hold atenolol for SBP < 100" and nurse documents "atenolol held for BP 90/50").
  - Discontinuation of a particular beta-blocker medication documented in combination with the start of a different beta-blocker medication (i.e., switch in type of beta-blocker medication) does not count as a

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				reason for not prescribing a beta-blocker at discharge. Examples: - "Stop sotalol" and "Start Tenormin 50 mg po qd" in same physician order - "Change Lopressor to Coreg" in progress note - "Do not continue after discharge" checked for metoprolol and "Continue after discharge" checked for Bystolic on aphysician-signed discharge medication reconciliation form ◦ Discontinuation of a beta-blocker medication at a particular dose documented in combination with the start of a different dose of that beta-blocker (i.e., change in dosage) does not count as a reason for not prescribing a beta-blocker at discharge. Examples: - "Stop Inderal 40 mg po bid" and "Start Inderal 40 mg po tid" in same physician order - "Increase Lopressor 50 mg to 100 mg" in progress note - "Do not continue after discharge" checked for Coreg 3.125 mg and "Continue after discharge" checked for Coreg 6.25 mg on a physician-signed discharge medication reconciliation form • Documentation of both a plan to initiate/restart BB and the reason/problem underlying delay in starting/restarting constitutes a "clearly implied" reason for not prescribing BB at discharge (e.g., "BPs low. May start atenolol as outpatient."). • Documentation of a pre-arrival hold/discontinuation or pre-arrival "other reason" for not prescribing BB counts as a reason for not prescribing BB at discharge **ONLY** if underlying reason is noted. • When conflicting documentation regarding a reason for not prescribing BB at discharge is documented in the medical record, select "yes" for the applicable reason. • **Unacceptable Reasons:** ◦ Documentation of a conditional hold/discontinuation of BB (e.g., "Stop metoprolol if SBP < 100.") **without** documentation BB was held due to the specified parameter (e.g. SBP < 100). ◦ Documentation of a hold which refers to a more general medication

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				class (e.g. "Hold all BP meds"). ◦ Deferral of BB from one prescriber to another does **NOT** count as a reason **unless** underlying problem for deferral is noted (e.g., "cardiology to evaluate patient for BB" is **NOT** acceptable). ◦ Documentation referring to eye drops containing BBs **98. Patient refusal:** Documentation by a physician/APN/PA or pharmacist that patient refused BB medications or all medications is acceptable. Documentation that patient refused BP medications 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).

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
12	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 1, go to end	**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." • Disregard a statin medication documented only as a recommended medication for discharge (e.g., "Recommend sending patient home on lovastatin"). Documentation must be clear that a statin was actually prescribed at discharge. • Disregard documentation of statin prescribed at discharge when noted only by medication class (e.g., "Statin Prescribed at Discharge: Yes" on a core measures form). The statin must be listed by name. **For a complete list of statin medications, refer to JC Appendix C, Table 8.1 or a drug handbook.**
13	nostawhy	Is there documentation of a reason for not prescribing a statin medication at discharge? 1. Statin medication allergy	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

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
		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		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"). **Other reasons:** • 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. **EXCEPTIONS:** ◦ 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. ◦ Discontinuation of a particular statin medication documented in combination with the start of a different statin medication (i.e., switch in type of statin medication) does not count as a reason for not prescribing a statin medication at discharge. Examples: - "Stop lovastatin" and "Start atorvastatin 80 mg po q hs" in same physician order - "Change Crestor to Lipitor" in progress note - "Do not continue after discharge" checked for Vytorin and "Continue after discharge" checked for Advicor on a physician - signed discharge medication reconciliation form

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
				○ Discontinuation of a statin medication at a particular dose documented in combination with the start of a different dose of that statin (i.e., change in dosage) does not count as a reason for not prescribing a statin medication at discharge. Examples: - "Stop Simvastatin 20 mg po q hs" and "Start Simvastatin 40 mg po q hs" in same physician order - "Increase Pravachol 40 mg to 80 mg" in progress note - "Do not continue after discharge" checked for Zocor 40 mg and "Continue after discharge" checked for Zocor 80 mg on a physician-signed discharge medication reconciliation form • Reason documentation which refers to a more general medication class is not acceptable (e.g., "No cholesterol-reducers", "Hold all lipid-lowering medications"). • 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. • Examples of reasons for not prescribing a statin medication at discharge include, but are not limited to: hepatic failure, hepatitis, myalgias, rhabdomyolysis

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
14	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:** 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, 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 <u>absence</u> 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."
15	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	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").

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
		98. Patient refusal of ALL non-statin lipid-lowering medications documented by physician/APN/PA or pharmacist 99. No documented reason		**Other Reasons:** • 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		