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| **#** | **Name** | Past Medical History (Diagnoses in othrdx must be entered in pasthx4; however, abstractor may indicate additional dx not in othrdx) | |
|  |  | **Indicate all applicable diagnoses, past medical history, past cardiac procedures, and past history of MI for this patient as found in the H&P, discharge summary, progress notes, and nursing assessments for this episode of care. If coded, codes must be applicable.** | |
|  |  | **Name** | **ICD-9-CM Diagnosis Code** |
| 1 | pasthx4\_1 | Site of Infarct-Anterior or Anterolateral (this episode of care) 410.01, 410.11 | **Abstractor can override the hospital code, if code is non-specific and the** |
| 2 | pasthx4\_2 | Site of infarct –Subendocardial , (NSTEMI) (this episode of care) 410.71 | **site of infarct is documented as one of the sites listed in the first column** |
| 3 | pasthx4\_3 | Diabetes Mellitus | 250.01 –250.03, 250.10-250.93, 648.00-648.04 |
| 4 | pasthx4\_4 | Current Smoker | 305.1 |
| 5 | pasthx4\_5 | History of Smoking | V15.82 |
| 6 | pasthx4\_6 | Cancer | 140.0-208.91 |
| 7 | pasthx4\_7 | Chronic Cerebrovascular Disease | 437.0-437.9, 438.0-438.9 |
| 8 | pasthx4\_8 | Hypertensive Kidney Disease (w, w/o Kidney Failure) | 403.00, 403.01, 403.10, 403.11, 403.90, 403.91, 404.00, 404.01, 404.02, 404.03, 404.10, 404.11, 404.12, 404.13, 404.90, 404.91, 404.92, 404.93, 582.0-583.9, 585-587 |
| 9 | pasthx4\_9 | Chronic Liver Disease | 571.0-572.8 |
| 10 | pasthx4\_10 | Overweight and Obesity | 278.0, 278.00, 278.01, 278.02 |
| 11 | pasthx4\_11 | COPD | 491.21, 493.20, 493.21, 496 |
| 12 | pasthx4\_12 | Cardiomyopathy | 425.0-425.9 |
| 13 | pasthx4\_13 | Chronic Cardiac Conditions | 398.90, 398.91, 398.99, 402.00-402.91, 414.8, 414.9, 416.0-416.9,429.1,429.2,429.3, 443.81, 443.89, 443.9,V12.50, V15.1 |
| 14 | pasthx4\_14 | History of PTCA | V45.82 |
| 15 | pasthx4\_15 | History of CABG | V45.81 |
| 16 | pasthx4\_16 | Atherosclerosis and Lipid Disorders | 272.0-272.9, 414.0-414.05, 440.0-440.9 |
| 17 | pasthx4\_17 | Musculoskeletal Conditions | 714.0-714.33,715.00-715.98,720.0,721.90, |
| 18 | pasthx4\_18 | History of MI | 412 |
| 19 | pasthx4\_19 | Congestive Heart Failure | 398.91, 402.01, 402.11, 402.91, 404.01, 404.11, 404.91, 428.0-428.43, 428.9 |
| 20 | pasthx4\_20 | Valvular Disease | 093.20 – 093.24, 394.0 – 397.1, 424.0 – 424.91, 746.3 – 746.6, V42.2, V43.3 |
| 21 | pasthx4\_21 | Pulmonary Circulation Disorder | 416.0 – 416.9, 417.9 |
| 22 | pasthx4\_22 | Peripheral Vascular Disorder | 440.0 – 440.9, 441.0 – 441.9, 442.0 – 442.9, 443.1 – 443.9, 447.1, 557.1, 557.9, V43.4 |
| 23 | pasthx4\_23 | Hypertension (Uncomplicated) | 401.1, 401.9, 642.00 – 642.04 |
| 24 | pasthx4\_24 | Hypertension (Complicated) | 401.0, 402.00, 402.10, 402.90, 403.00, 403.10, 403.90, 404.00, 404.10, 404.90, 405.01, 405.09, 405.11, 405.19, 405.91, 405.99, 642.10 – 642.24, 642.70 – 642.94 |

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| 25 | pasthx4\_25 | Paralysis | 342.0 – 342.12, 342.9 – 344.9, ~~438~~.20 – 438.53 |
| 26 | pasthx4\_26 | Other Neurological | 330.0 – 331.9, 332.0, 333-333.99, 334.0 – 335.9, 340, 341.1 – 341.9, 345 – 345.11, 345.2 – 345.3, 345.40 – 345.91, 348.1, 348.3 – 348.39, 780.3, 780.39, 784.3 |
| 27 | pasthx4\_27 | Chronic Pulmonary Disease | 490 – 492.8, 493.00 – 493.92, 494 – 494.1, 495.0 – 505, 506.4 |
| 28 | pasthx4\_28 | Diabetes w/o Chronic Complications | 250.00 – 250.33, 648.00 – 648.04 |
| 29 | pasthx4\_29 | Diabetes w/ Chronic Complications | 250.40 – 250.93, 775.1 |
| 30 | pasthx4\_30 | Hypothyroidism | 243 – 244.2, 244.8, 244.9 |
| 31 | pasthx4\_31 | Kidney Disease | 403.01, 403.11, 403.91, 404.02, 404.03, 404.12, 404.13, 404.92, 404.93, 585-585.6, 585.9, 586, V42.0, V45.1, V56.0 – V56.2, V56.8 |
| 32 | pasthx4\_32 | Liver Disease | 070.22, 070.23, 070.32, 070.33, 070.44, 070.54, 456.0, 456.1, 456.20, 456.21, 571.0, 571.2, 571.3, 571.40 – 571.49, 571.5, 571.6, 571.8, 571.9, 572.3, 572.8, V42.7 |
| 33 | pasthx4\_33 | Peptic Ulcer Disease Including Bleeding | 531.41, 531.51, 531.61, 531.70, 531.71, 531.90, 531.91, 532.41, 532.51, 532.61, 532.70, 532.71, 532.90,532.91, 533.41, 533.51, 533.61, 533.70, 533.71, 533.90, 533.91, 534.41, 534.51, 534.61, 534.70, 534.71, 534.90, 534.91, V12.71 |
| 34 | pasthx4\_34 | HIV and AIDS | 042 – 044.9 |
| 35 | pasthx4\_35 | Lymphoma | 200.00 – 202.38, 202.50 – 203.01, 203.8 – 203.81, 238.6, 238.7, 273.3, V10.71, V10.72, V10.79 |
| 36 | pasthx4\_36 | Metastatic Cancer | 196.0 – 199.1 |
| 37 | pasthx4\_37 | Solid Tumor without Metastasis | 140.0 – 172.9, 174.0 – 175.9, 179 – 195.8, V10.00 – V10.59, V10.81 – V10.9 |
| 38 | pasthx4\_38 | Rheumatoid Arthritis/Collagen Vascular Diseases | 701.0, 710.0 – 710.9, 714.0 – 714.9, 720.0 – 720.9, 725 |
| 39 | pasthx4\_39 | Coagulopathy | 286.0 – 286.9, 287-287.1, 287.30 – 287.33, 287.39, 289.81 – 289.82 |
| 40 | pasthx4\_40 | Weight loss | 260 – 263.9 |
| 41 | pasthx4\_41 | Fluid and Electrolyte Disorder | 276.0 – 276.9, 276.50-276.52 |
| 42 | pasthx4\_42 | Blood Loss Anemia | 280.0, 648.20 – 648.24 |
| 43 | pasthx4\_43 | Deficiency Anemias | 280.1- 281.9, 285.21 – 285.29, 285.9 |
| 44 | pasthx4\_44 | Alcohol Abuse | 291.0 – 291.3, 291.5, 291.8, 291.81, 291.82, 291.9, 303.00 – 303.93, 305.00 – 305.03, V11.3 |
| 45 | pasthx4\_45 | Drug Abuse | 292.0, 292.81 – 292.85, 292.9, 304.00 – 304.93, 305.20 – 305.93, 648.30 – 648.34 |
| 46 | pasthx4\_46 | Psychoses | 295.00 – 298.9, 299.10, 299.11 |
| 47 | pasthx4\_47 | Depression | 300.4, 301.12, 309.0, 309.1, 311 |
| 48 | pasthx4\_99 | **None of these diagnoses** | **99** |

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| **#** | **Name** | **QUESTION** | **Field Format** | **DEFINITIONS/DECISION RULES** |
|  |  | Past Cardiac History |  |  |
| 49 | pastcva | Does the patient have a history of stroke within the past five years? | 1,2   |  | | --- | | Cannot = 2 if  conthth = 2 or  nogpbloc6 = -1 | | Codes which may be used to identify stroke within the past five years are: ICD-9 Code 436. Codes 438.0-438.42 and 438.81-438.9 indicate late effects of cerebrovascular disease. Old stroke without residuals is coded V12.59. Do not answer “yes” based on an old stroke code unless the record documents the stroke occurred within the past five years. |
| 50 | cathfive | Within the past five years, did the patient have a cardiac catheterization? | 1,2  **If 2, auto-fill blocath as 95 and cathdate as 99/99/9999** | Answer “2” if the patient did not have a cardiac catheterization or whether the patient had a cath is unknown. |
| 51 | blocath | At any cath done within the five-year period, was there a finding of > = 50% stenosis in any coronary artery?   1. yes 2. no 3. not applicable | 1,2,95  If cathfive = 2, will be auto-filled as 95  **If 2, auto-fill cathdate as 99/99/9999** | Stenosis = constriction or narrowing. Buildup of fat, cholesterol, and other substances over time may clog the coronary arteries. The question is applicable to blockage or stenosis of any of the coronary arteries. |
| 52 | cathdate | Enter the date the cath with a finding of > = 50% stenosis was performed. | mm/dd/yyyy  If blocath = 2 or 95, will be auto-filled as 99/99/9999   |  | | --- | | < = 5 years prior to or = acutedt | | Enter the exact date where possible. 01 may be used to designate day and month if only the year is available. |
| 53 | revasc1  revasc2  revasc99 | Did the patient have a revascularization procedure within the last six months?  **Indicate all that apply:**   1. PCI 2. CABG 3. No documentation of revascularization within the past six months. | 1,2,99   |  | | --- | | 99 cannot be entered with 1 or 2 |  |  | | --- | | If revasc1 = -1, cathfive must = 1 | | If revasc1 = -1, auto-fill pasthx4\_14 as -1 | | If revasc2 = -1, auto-fill pasthx4\_15 as -1 | | Within the last six months = from the last day of the study interval to the first day of the month six months previously. (Example: Study interval is 12/01/10 – 12/31/10. Six months previously is June 1, 2010.)  Look for documentation in the H&P or admitting note that a PTCA/PCI or CABG was performed within the past 6 months. Procedure may have been done at this or another VAMC, or at a private sector facility. |

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| 54 | priorx1  priorx2  priorx3  priorx4  priorx5  priorx6  priorx7  priorx8  priorx99 | Was the patient on any of the following medications prior to admission for this episode of care?  **Indicate all that apply**:   1. aspirin 2. beta blocker 3. ACE inhibitor 4. lipid-lowering medication 5. insulin 6. platelet aggregation inhibitor 7. low molecular weight heparin (LMWH) 8. ARB (AIIRA) 9. no documentation patient was on any of these medications | 1,2,3,4,5,6,7,8,99   |  | | --- | | 99 cannot be entered with any other number |  |  | | --- | | If priorx4 = -1, auto-fill lipidmed as 1 | | If priorx5 = -1 and pasthx4 = <> DM, Warning window:  Did not select hx of DM in pasthx4 | | The question refers to medications being taken routinely by the patient, at his/her place of residence, prior to admission for this episode of care. If the patient was a transfer from another VAMC or a community hospital, check clinic records for medications the patient may have been taking prior to admission to the first hospital. Do not include medications administered to the patient at the first hospital.  **Medications given once the patient has arrived at the hospital are excluded from the question.**  **1. Aspirin** = 81 to 325 mg daily; see Joint Commission (JC) Medication Table for listing of aspirin and aspirin-containing medications  **2. Beta-blocker** = see JC listing of beta blocker medications  **3. ACEI** = see JC listing of ACE inhibitor medications.  **4. Lipid-lowering Medications**  **HMG-CoA Reductase Inhibitors (Statins):** fluvastatin sodium (Lescol), atorvastatin calcium (Lipitor), lovastatin (Mevacor) (Altocor), pravastatin sodium (Pravacol), simvastatin (Zocor), rosuvastatin calcium (Crestor), pitavastatin (Livalo)  **Cholesterol absorption inhibitors**: ezetimibe (Zetia)  **Combination**: ezetimibe/simvastatin (Vytorin), Niaspan/lovastatin (Advicor)  **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)  **5. Insulin Synonyms/Inclusions:** 70/30, 50/50, Apidra, aspart, continuous subcutaneous, infusion of insulin (CS11), detemir, glulisine, HUMALOG, HUMULIN, ILETIN I or II, insulin pen, insulin pump, Lantus, LENTE, Levemir, LISPRO, MDI, NOVOLIN, NOVOLIN penfill, Novolog, NOVO NORDISK, NPH, Regular, SEMILENTE, ULTRALENTE, VELOSULIN  **6. Platelet aggregation inhibitors =** clopidogrel (Plavix), ticlopidine (Ticlid), dipyridamole (Persantine), dipyridamole and aspirin (Aggrenox), prasugrel (Effient)  **Cont’d next page** |

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|  |  |  |  | **Medication prior to admission cont’d**  **7. LMWH:** enoxaparin (Lovenox), dalteparin (Fragmin), tinzaparin (Innohep), nadroparin (Fraxiparine), reviparin (Clivarin), and certoparin  8. **ARB:** losartan potassium, valsartan, irbesartan, candesartan, telmisartan**,** eprosartan, and olmesartan. |
|  |  | **Patient Weight and Height** |  |  |
| 55 | frstwt | Enter the patient’s first weight measured during this episode of care. | \_\_ \_\_ \_\_ **Abstractor can enter default zzz if no weight measured during this episode of care.**  If z-filled, auto-fill wtunit3 as 95, frstwtdt as 99/99/9999, and go to height. | **Inpatient Sources**: Nursing admission assessment. H&P, admission note, progress notes, nursing notes. Assessment form and notes by Dietary Service are a good source of weight and height data.  **If no weight was measured during this episode of care, enter default zzz.** |
| 56 | wtunit3 | Unit of measure   1. pounds 2. kilograms 3. not applicable | 1,2,95  **Will be auto-filled as 95 if frstwt = zzz**   |  | | --- | | Warning window when wtunit3 = 1 and weight < = 98 or > = 278  When wtunit3 = 2, and weight < = 44 or > = 126 | | BMI is calculated in kilograms. If pounds are entered, the computer will convert pounds to kilograms in making the calculation. The resulting BMI is displayed on the computer screen as BMI. |
| 57 | frstwtdt | Enter the date the first weight was measured. | mm/dd/yyyy  **If frstwt is z-filled, auto-fill as 99/99/9999**   |  | | --- | | > = entradm and < = dtofdc | | Enter the exact date. The use of 01 to indicate missing day or month is not acceptable.  If the inpatient weight is z-filled, FRSTWTDT will auto-fill as 99/99/9999. The abstractor cannot enter 99/99/9999 default date if a valid weight was entered. |

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| **#** | **Name** | | **QUESTION** | | **Field Format** | | **DEFINITIONS/DECISION RULES** | |
| 58 | height | | Enter the patient’s height. | | \_\_\_\_\_ **The abstractor can enter default zz if no height available.**  **If z-filled, auto-fill htunit as 95** | | Height must be entered wholly in inches or centimeters. If pt. is 5 feet 8 inches, enter 68. 5ft = 60 in. 6ft = 72in.  **If no height can be found in the medical record, enter default zz.** | |
| 59 | htunit | | Unit of measure   1. inches 2. centimeters 3. not applicable | | 1,2,95  If height z-filled, will be auto-filled as 95   |  | | --- | | Warning window  when htunit = 1, and height < = 56 or > = 77  when htunit = 2, and height < = 156 or > = 191 | | | Height must be entered wholly in inches or centimeters. If pt. is 5 feet 8 inches, enter 68. 5ft = 60 in. 6ft = 72in.  If HEIGHT is z-filled, HTUNIT will be auto-filled as 95. Abstractor cannot enter 95 if HEIGHT contains a valid value. | |
| **If comm1tx =1 or comminpt = 1, go to hctone; otherwise, go to wichtrop** | | | | | | | | |
|  |  | **Laboratory Testing** | |  | |  | |
| 60 | wichtrop | Which troponin is used by this VAMC’s laboratory as a biomarker of myocardial injury?Troponin T  1. Troponin I 2. unable to determine | | 1,2,99 | | Troponin is a protein complex consisting of three isotypes, T, I, and C. Troponin has become the marker of choice for diagnosis of myocardial necrosis. **If unable to determine which troponin is measured by the facility laboratory, ask the EPRP Liaison to obtain this data. Default “99” should be used only if the laboratory cannot provide the information.** | |

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| **#** | **Name** | **QUESTION** | **Field Format** | **DEFINITIONS/DECISION RULES** |
| 61 | cutoff | What is the “cutoff point” (or lowest level at which troponin is considered positive) as determined by this facility’s bioassay? | **\_ \_ \_. \_ \_ \_**   |  | | --- | | Cutoff must be > 0 | | **The abstractor will have to work with the facility Liaison to determine the lowest level at which the concentration of troponin is considered to be positive. This level, which will likely vary from facility to facility, is critical to the determination of whether AMI occurred.** |
| 62 | dotrop | Was a troponin level obtained for this patient? | 1,2\*  \*If 2, go to hctone, else go to trophow | Troponin is a protein complex consisting of three isotypes, T, I, and C. Troponin has become the marker of choice for diagnosis of myocardial necrosis, and Troponin T and I are powerful tools for risk stratification. Portable devices allow bedside (point of care or POCT) cardiac marker determinations rapidly and accurately. Point of care systems have the advantage of reducing diagnostic delays due to transportation and processing in a central laboratory. |

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| 63 | trophow | How was the first troponin level obtained?   1. point of care testing 2. central laboratory assay | 1,2 | Point of care testing= blood sample drawn at the bedside and analyzed immediately for presence of troponin I or troponin T to identify unstable patients at high risk for occlusion.  **Read ED notes, admitting notes, and progress notes carefully to determine if POCT was used to obtain the first troponin level. Do not reference only the laboratory reports for the initial troponin level**.  **Troponin may be obtained within 15 minutes prior to acute care arrival, e.g., in the clinic setting, NHCU, or in the ambulance prior to arrival at the hospital.** |
| 64 | frstrslt | Enter the result of the first troponin level obtained for this patient. | **\_ \_ \_. \_ \_ \_**   |  | | --- | | If dotrop = 1, must be > 0 | | **If a level greater than 999.99 is entered, the computer will ask the abstractor to re-check his/her entry since a level over this value is likely to be a quality control issue.** |
| 65 | tropone | Indicate whether the result of the first troponin level was positive or negative.  1. positive (greater than or equal to cutoff point) 2. negative (less than cutoff point) | 3,4   |  | | --- | | If frstrslt > = cutoff, tropone <> 4 |  |  | | --- | | If frstrslt < cutoff, tropone <> 3 | | **Point of care bedside testing may only be reported as positive or negative. Values that are reported as an actual numeric value will need to be compared to the reference range to determine if the result exceeds the lowest level at which troponin is considered positive, according to the hospital’s laboratory parameters. Consult your liaison for help if you are unsure. If the value is greater than the normal value of the reference range, it is positive.** |

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| **#** | **Name** | **QUESTION** | **Field Format** | **DEFINITIONS/DECISION RULES** |
| 66 | entrord | Enter the date the first troponin level was ordered. | mm/dd/yyyy  **Abstractor can enter default date 99/99/99 if order date cannot be determined**   |  | | --- | | < = 15 minutes prior to or = acutedt and < = dcdate | | Order date = the date the first troponin level was ordered. If the sample was drawn at the point of care, look in physician orders for documentation of troponin order even if POCT is not specified. If POCT was done but no order was written, use the POCT date.  **Enter the actual order date if it is documented in the record.**  **Troponin order date can be 15 minutes prior to arrival date, and can occur on the date prior to the arrival date. If order date cannot be determined, abstractor can enter default date 99/99/9999.** |
| 67 | timeord | Enter the time the first troponin level was ordered. | \_\_\_\_\_ UMT  **Abstractor can enter default time 99:99 if order time cannot be determined**   |  | | --- | | < = 15 minutes prior to or = acutedt/acutetm and < = dcdate/dctime | | Order time = the time the first troponin level was ordered. If the sample was drawn at the point of care, look in physician orders for documentation of troponin order even if POCT is not specified. If POCT was done but no order was written, use the POCT time.  **Enter the actual order time if it is documented in the record. Troponin order time can be 15 minutes prior to arrival time.**  **If order time cannot be determined, abstractor can enter default time 99:99.** |
| 68 | reprtdt | Enter the date the first troponin level was reported. | mm/dd/yyyy  **Abstractor can enter default date 99/99/9999 if date of report cannot be determined**   |  | | --- | | If trophow = 2, > = entrord and < = dcdate. If entrord = 99/99/9999, default to > = acutedt and < = dcdate | | If trophow = 1, reprtdt = entrord. If entrord= 99/99/9999, < = 15 min prior to or = acutedt and < = dcdate | | **Troponin level report = the date the troponin results were available to the clinician**. This does not mean the results must be reported to the clinician. Report date is the date on which the results were completed by the lab and could be reported to the clinician if he/she called to ask for the results. If the sample was drawn at the point of care, and the results immediately available, look in the progress note for documentation of the outcome of POCT testing.  If the sample was drawn by the lab, use the lab report date.  **Enter the actual report date if it is documented in the record.**  **If report date cannot be determined, abstractor can enter default date 99/99/9999.**  **If the troponin was determined by point of care testing, the order date/time are the same as report date/time.** |

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| **#** | **Name** | **QUESTION** | **Field Format** | **DEFINITIONS/DECISION RULES** |
| 69 | reportme | Enter the time the first troponin level was reported. | \_\_\_\_\_ UMT  **Abstractor can enter default time 99:99 if report time cannot be determined**   |  | | --- | | If trophow = 2, > = entrord/timeord and < = dcdate. If entrord/timeord <> valid date, default to > = acutedt/acutetm and < = dcdate/dctime | | If trophow = 1, reportme = entrord/timeord. If entrord/timeord <> valid date, < = 15 min prior to or = acutedt/acutetm and < = dcdate/dctime | | If the troponin level was drawn by POCT and the result entered in the progress notes, use the time of the progress note unless the exact time the result was known is documented in the record.  **Enter the actual report time if it is documented in the record.**  **If report time cannot be determined, abstractor can enter default time 99:99.**  **If the troponin was determined by point of care testing, the order date/time are the same as report date/time.** |
| 70 | labever | Was a subsequent troponin level obtained? | 1,2\*  \*If 2, go to hctone, else go to tropos | Subsequent troponin level = additional samples drawn after the first troponin level. Serial troponin levels may be drawn at regular intervals, and may be obtained by POCT or laboratory assay. |
| 71 | tropos | Was any subsequent troponin level positive? | 1,2\*  \*If 2, go to peakdone, else go to poslvl | **Point of care bedside testing may only be reported as positive or negative. Values that are reported as an actual numeric value will need to be compared to the reference range to determine if the result exceeds the lowest level at which troponin is considered positive, according to the hospital’s laboratory parameters. Consult your liaison for help if you are unsure. If the value is greater than the normal value of the reference range, it is positive.** |
| 72 | poslvl | Enter the result of the first positive troponin level obtained after the initial troponin level. | \_ \_ \_. \_ \_ \_   |  | | --- | | > = cutoff | | **If a level greater than 999.99 is entered, the computer will ask the abstractor to re-check his/her entry since a level over this value is likely to be a quality control issue.** |

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| **#** | **Name** | **QUESTION** | **Field Format** | **DEFINITIONS/DECISION RULES** |
| 73 | troposdt | Enter the report date of the first positive troponin level obtained after the initial troponin level. | mm/dd/yyyy  **Abstractor can enter default date 99/99/9999 if date of report cannot be determined**   |  | | --- | | > = reprtdt and  < = dcdate  If reprtdt = 99/99/9999, > = acutedt and  < = dcdate | | **First PositiveTroponin level report after initial troponin level= the date the positive troponin results were available to the clinician**. This does not mean the results must be reported to the clinician. Report date is the date on which the results were completed by the lab and could be reported to the clinician if he/she called to ask for the results.  For example, the first troponin was done in the ED on arrival. Two days later the patient developed chest pain and a second troponin level was obtained. The second troponin level was negative, but the third troponin level was positive. Enter the report date of the third troponin level.  Enter the exact date. The use of 01 to indicate unknown month or day is not acceptable.  **Enter the actual report date if it is documented in the record.**  **If report date cannot be determined, abstractor can enter default date 99/99/9999.** |
| 74 | tropostm | Enter the report time of the first positive troponin level obtained after the initial troponin level. | \_\_\_\_\_  UMT  **Abstractor can enter default time 99:99 if report time cannot be determined**   |  | | --- | | > = reprtdt/ reportme and < = dcdate/dctime.  If reprtdt/ reportme <> valid date, > = acutedt/acutetm and < = dcdate/dctime | | **Enter the actual report time if it is documented in the record.**  **If report time cannot be determined, abstractor can enter default time 99:99.** |
| 75 | peakdone | How was the peak troponin level obtained?   1. point of care bedside testing 2. central laboratory assay | 1,2 | Point of care testing= blood sample drawn at the bedside and analyzed immediately for presence of troponin I or troponin T which identify unstable patients at high risk for occlusion. |
| 76 | lablvl | Enter the result of the highest/peak troponin level. | **\_ \_ \_. \_ \_ \_** | Highest/peak troponin level = of all the troponin samples obtained, enter the highest value reported for this patient. |

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| **#** | **Name** | **QUESTION** | **Field Format** | **DEFINITIONS/DECISION RULES** |
| 77 | tropref | Indicate whether the result of the highest/peak troponin level was positive or negative.  1. positive (greater than or equal to cutoff point) 2. negative (less than cutoff point) | 3,4   |  | | --- | | If lablvl > = cutoff, tropref <> 4 | | If lablvl < cutoff, tropref <> 3 | | If tropone = 3, tropref <> 4 | | **Point of care bedside testing may only be reported as positive or negative. Values that are reported as an actual numeric value will need to be compared to the reference range to determine if the result exceeds the lowest level at which troponin is considered positive, according to the hospital’s laboratory parameters. If the value is greater than the normal value of the reference range, it is positive.** |
| 78 | tropdt | Enter the report date of the peak level. | mm/dd/yyyy   |  | | --- | | > = reprtdt, or if reprtdt = 99/99/9999, > = entrord, or if entrord= 99/99/9999, > = acutedt and < = dcdate | | **Troponin level report = the date the troponin results were available to the clinician**. This does not mean the results must be reported to the clinician. Report date is the date on which the results were completed by the lab and could be reported to the clinician if he/she called to ask for the results.  Enter the exact date. The use of 01 to indicate unknown month or day is not acceptable. |
| 79 | trohitm | Enter the report time of the peak level. | \_\_\_\_\_ UMT  **Abstractor can enter default time 99:99 if report time cannot be determined**   |  | | --- | | > = reprtdt/reportme or if reprtdt/reportme <> valid date, > = entrord/timeord, or if entrord/timeord <> valid date, > = acutedt/acutetm and < = dcdate/dctime | | **Troponin level report = the time the troponin results were available to the clinician.** This does not mean the results must be reported to the clinician. Report time is the time when the results were completed by the lab and could be reported to the clinician if he/she called to ask for the results.  Time must be entered in Universal Military Time.  **The abstractor can enter default time 99:99 if report time cannot be determined.** |

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| **#** | **Name** | **QUESTION** | **Field Format** | **DEFINITIONS/DECISION RULES** |
| 80 | hctone | Enter the value of the first hematocrit obtained following hospital arrival. | \_ \_ \_.\_ \_ \_ **Abstractor can enter default zzz.zzz if no hematocrit done during stay**  **If z-filled, auto-fill hctunit as 95, dtofhct as 99/99/9999, and hctref as 95**   |  | | --- | | Mask 000 decimal point 000 | | The hematocrit is a measure of the percentage of red blood cells in the total blood volume.  Normal: Male: 42%-52% or 0.42-0.52 volume fraction (SI units) Female: 37%-47% or 0.37-0.47 volume fraction (SI units)  **If no hematocrit was done during the entire episode of care, enter default zzz.zzz** |
| 81 | hctunit | Enter the unit.  1. percent  2. volume fraction (SI units)  95. not applicable | 1,2,95  If hctone z-filled, will be auto-filled as 95   |  | | --- | | If 1, hctone cannot be > 100 | | Normal: Male: 42%-52% or 0.42-0.52 volume fraction (SI units) Female: 37%-47% or 0.37-0.47 volume fraction (SI units) |
| 82 | dtofhct | Enter the date this hematocrit was obtained. | mm/dd/yyyy  If hctone z-filled, will be auto-filled as 99/99/9999   |  | | --- | | > = acutedt and < = dcdate | | Enter the date the blood sample was drawn. Enter the exact date. The use of 01 to indicate unknown month or day is not acceptable. |
| 83 | hctref | Is this hematocrit value within the laboratory normal reference range?   1. within normal reference range 2. lower than the normal reference range 3. higher than the normal reference range 4. not applicable | 1,2,3,95  If hctone z-filled, will be auto-filled as 95 | The reference range may vary for each VAMC laboratory, so the question must be answered in accordance with the reference range for the facility in which the abstractor is working. Be certain the reference range is expressed in the same units in which the value was measured. |
| 84 | cretdone | Was a serum creatinine level obtained during this admission? | 1,2\*  \*If 2, go to ckmbhi, else go to frstcret | **Note that the question asks for a serum creatinine, not a urine creatinine.** |
| 85 | frstcret | Enter the value of the first serum creatinine obtained following hospital arrival. | \_ \_. \_   |  | | --- | | Must be > 00.0  Warning window:  Are you certain this is a serum creatinine and not a urine creatinine? | | The serum creatinine test is used to diagnose impaired renal function. Normal values: Male: 0.6-1.2 mg/dl; Female: 0.5-1.1 mg/dl. Possible critical values: >4mg/dl.  Serum creatinine value (as a surrogate for renal function) is a strong predictor for death. |

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| **#** | **Name** | **QUESTION** | **Field Format** | **DEFINITIONS/DECISION RULES** |
| 86 | dtcret | Enter the date this value was obtained. | mm/dd/yyyy   |  | | --- | | > = acutedt and < = dcdate | | Enter the date the blood sample was drawn. Enter the exact date. The use of 01 to indicate unknown month or day is not acceptable. |
| 87 | refcret | Was the initial serum creatinine value within the laboratory normal reference range?   1. within the normal reference range 2. lower than the normal reference range    1. higher than the normal reference range | 1,2,3 | The reference range may vary for each VAMC laboratory, so the question must be answered in accordance with the reference range for the facility in which the abstractor is working. Be certain the reference range is expressed in the same units in which the value was measured. |
| 88 | hicreat | Enter the highest serum creatinine value obtained during this episode of care? | \_ \_. \_   |  | | --- | | Must be > 00.0 and > = frstcret  Warning window:  Are you certain this is a serum creatinine and not a urine creatinine? | | The serum creatinine test is used to diagnose impaired renal function. Normal values: Male: 0.6-1.2 mg/dl; Female: 0.5-1.1 mg/dl. Possible critical values: >4mg/dl.  **Highest value may be the same as initial value**. |
| 89 | creatdt | Enter the date of this value. | mm/dd/yyyy   |  | | --- | | > = dtcret and < = dcdate | | Enter the date the blood sample was drawn. Enter the exact date. The use of 01 to indicate unknown month or day is not acceptable. |
| 90 | creatref | Was the highest serum creatinine value within the laboratory normal reference range?   1. within the normal reference range 2. lower than the normal reference range 3. higher than the normal reference range | 1,2,3   |  | | --- | | If refcret = 3, creatref <> 1 or 2 | | The reference range may vary for each VAMC laboratory, so the question must be answered in accordance with the reference range for the facility in which the abstractor is working. Be certain the reference range is expressed in the same units in which the value was measured. |

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| **#** | **Name** | **QUESTION** | **Field Format** | **DEFINITIONS/DECISION RULES** |
| 91 | ckmbhi | Enter the highest CK-MB value recorded during this episode of care. | \_\_\_\_\_\_ **Abstractor can enter default zzz if no CK-MB was done during the stay.**  **If z-filled, auto-fill ckmbunit as 95, ckmbdt as 99/99/9999, ckmbtm as 99:99, and ckmblab as 95**   |  | | --- | | 099 mask  >= 0 and < = 100  Warning window only | | Creatine kinase (CK) is found predominantly in heart muscle, skeletal muscle and brain. (Also called CPK.) CK-MB is more specific for myocardial cells.  Normal values CK-MB: 0-7 IU/L (less than 4%-6% of total CPK.)  **If no CK-MB was done during the episode of care, enter defalt zzz.** |
| 92 | ckmbunit | Enter the unit for CK-MB.  1. ng/mL  2. %  95. not applicable | 1,2,95  If ckmbhi z-filled, will be auto-filled as 95   |  | | --- | | If 2, ckmbhi cannot be > 100 | | ng = nanograms; unit measurement for CK-MB  A nanogram is one billionth of a gram.  ng/mL = nanograms per milliliter |
| 93 | ckmbdt | Enter the date of the highest value. | mm/dd/yyyy  If ckmbhi z-filled, will be auto-filled as 99/99/9999   |  | | --- | | > = acutedt and < = dcdate | | **Enter the draw date of the highest CK-MB value. If draw date cannot be determined, use the order date.** Enter the exact date. The use of 01 to indicate unknown month or day is not acceptable. |

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| **#** | **Name** | **QUESTION** | **Field Format** | **DEFINITIONS/DECISION RULES** |
| 94 | ckmbtm | Enter the time of the highest CK-MB value. | \_\_\_\_\_ UMT  If ckmbhi z-filled, will be auto-filled as 99:99   |  | | --- | | > = acutedt/acutetm and < = dcdate/dctime | | **Enter the draw time of the highest CK-MB value. If draw time cannot be determined, use the order time.** |
| 95 | ckmblab | Was the highest CK-MB value within the laboratory normal reference range?   1. within laboratory reference range 2. positive (higher than ULN for reference range)   95. not applicable | 1,3,95  If ckmbhi z-filled, will be auto-filled as 95 | The reference range may vary for each VAMC laboratory, so the question must be answered in accordance with the reference range for the facility in which the abstractor is working. Be certain the reference range is expressed in the same units in which the value was measured. |

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| **#** | **Name** | **QUESTION** | **Field Format** | **DEFINITIONS/DECISION RULES** |
| 96 | lipidmed | Is there documentation that the patient was on a lipid-lowering medication prior to hospital arrival?  1. Yes  2. No | 1,2  Will be auto-filled as 1 if priorx4 = -1   |  | | --- | | If 1, priorx4  must = -1 | | If there is documentation that the patient was on a lipid-lowering medication prior to arrival, select “1.” For cases where the patient was prescribed a lipid-lowering medication at home, but there is documentation the lipid-lowering medication was on temporary hold or the patient had been non-complaint/self-discontinued their medication (e.g., refusal, side effects, cost), select “1.”  If conflicting information about whether the patient was on a lipid-lowering medication prior to arrival is documented in the record, select “1.”  **Lipid-lowering Medications**  **HMG-CoA Reductase Inhibitors (Statins):** fluvastatin sodium (Lescol), atorvastatin calcium (Lipitor), lovastatin (Mevacor) (Altocor), pravastatin sodium (Pravachol), simvastatin (Zocor), rosuvastatin calcium (Crestor), pitavastatin (Livalo)  **Cholesterol absorption inhibitors**: ezetimibe (Zetia)  **Combination**: ezetimibe/simvastatin (Vytorin), Niaspan/lovastatin (Advicor)  **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) |

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| **#** | **Name** | **QUESTION** | **Field Format** | **DEFINITIONS/DECISION RULES** |
| 97 | inptldl | Was an LDL-cholesterol (LDL-c) test in mg/dL (or mg/100ml) performed during this hospital stay? | 1,2  **If 2, auto-fill ldldate as 99/99/9999, ldltime as 99:99, inptldlv as zzz, and ldlqual as 95** | Do not include an LDL-c value, LDL-c qualitative description, or lipid testing if it cannot be determined that the testing was actually done during this hospital stay.  Do not include lipid testing or qualitative descriptions of lipid test results if it can be determined that LDL-c measurement was not part of the lipid testing.   |  |  | | --- | --- | | **Inclusion** | **Exclusion** | | Low den lipoprotein | VLDL | | Low density lipoprotein | Alpha lipoproteinemia | | **Qualitative Description** |  | | Chol. Low, normal, elevated, ↑ |  | | Dyslipidemia (presence or absece) |  | | Dyslipoproteinemia (same) |  | | Hyperbetalipoproteinemia (same) |  | | Hypercholesterolemia (same) |  | | Hyperlipemia |  | | Hyperlipidemia |  | | Hyperlipoproteinemia |  | | LDL low, normal, elevated, ↑ |  | | LDL above goal, below Target |  | |

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| **#** | **Name** | **QUESTION** | **Field Format** | **DEFINITIONS/DECISION RULES** |
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| 98 | ldldate | Enter the date of the first LDL-cholesterol done after hospital arrival. | mm/dd/yyyy  Will be auto-filled as 99/99/9999 if inptldl=2   |  | | --- | | > = acutedt and < = dcdate | | Exact date must be entered. The use of default 01 to indicate missing day or month is not acceptable. |
| 99 | ldltime | Enter the time of the first LDL-cholesterol done after hospital arrival. | \_\_\_\_\_\_  Will be auto-filled as 99:99 if inptldl = 2   |  | | --- | | > = acutedt/acutetm and <= dcdate/dctime | | Use the laboratory report time. Enter time in Universal Military Time. |
| 100 | inptldlv | Enter the value of the first LDL-c in mg/dL or mg/100ml performed after hospital arrival. | \_\_ \_\_ \_\_  Will be auto-filled as zzz if inptldl = 2  **If test was done but LDL-c value is not known, abstractor**  **can enter zzz**   |  | | --- | | Cannot enter  leading zero |   **If inptldl = 1 but inptldlv = zzz or 0, go to ldlqual**  **If valid value entered in inptldlv, auto-fill ldlqual as 95, and go out of module** | If unable to determine which LDL-c test was performed first, enter the highest value.  Direct and calculated LDL-c values are acceptable. If both direct and calculated LDL-c values are documented for the same specimen date/time, enter the direct LDL-c value.  If the LDL-c value on the laboratory report conflicts with that from another source of documentation for the same specimen, use the value from the laboratory report.  **If progress notes or order indicate an LDL-c level was obtained, but the value cannot be found, enter default zzz.**  **If high triglycerides render the LDL-c calculation inaccurate, enter “0.”** |

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| **#** | **Name** | **QUESTION** | **Field Format** | **DEFINITIONS/DECISION RULES** |
| 101 | ldlqual | How did the physician, APN, or PA qualitatively describe the results of the first LDL-cholesterol (LDL-c) performed after hospital arrival?  1. Elevated LDL-c  2. No elevated LDL-c   1. Not applicable 2. Not documented | 1,2,95,99  **If inptldl = 1 and ldlqual = <> 99, go out of module**  **If inptldl = 2, or if inptldl = 1 and ldlqual = 99, go to priorldl** | If unable to determine which LDL-c test was performed first, select “1” if any of the descriptions are consistent with elevated LDL-c.  If there are discrepant qualitative descriptions documented for the same specimen (e.g., one description consistent with elevated LDL-c and one not consistent with elevated LDL-c), select “Elevated LDL-c.”   |  |  | | --- | --- | | **Inclusion** | **Exclusion** | | Low den lipoprotein | VLDL | | Low density lipoprotein | Alpha lipoproteinemia | | **Qualitative Description** |  | | Cholesterol described as elevated, ↑ | Elevated LDL-c or any of the other elevated LDL-c inclusion terms using a negative qualifier such as: | | Dyslipidemia | cannot exclude | | Dyslipoproteinemia | cannot rule out | | Hyperbetalipoproteinemia | may have, may have had | | Hypercholesterolemia | May indicate | | Hyperlipemia | possible | | Hyperlipidemia | suggestive of, suspect | | Hyperlipoproteinemia | suspicious | | LDL described as elevated, high, or ↑ |  | | LDL above goal or target |  | | Lipids described as elevated, high, ↑ |  | |

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| **#** | **Name** | **QUESTION** | **Field Format** | **DEFINITIONS/DECISION RULES** |
| 102 | priorldl | Does the record document an LDL-cholesterol (LDL-c) test in mg/dL or mg/100ml was performed within one year prior to acute care arrival?   1. Yes 2. No   99. Not documented/unable to determine | 1,2,99  **If 2 or 99, auto-fill preldldt as 99/99/9999, preldlvl as zzz, and prequal as 95** | If there is documentation that LDL-c/lipid testing was done prior to arrival, but the exact timeframe is not specified or cannot be determined, enter “2.” The exact date does not have to be known, but the abstractor must be certain the LDL-c test was done within the past year or may make the inferences hereafter described:  **In the absence of explicit documentation that an LDL-c test was or was not performed within one year prior to arrival, it should be inferred that a test was done within one year if:**   * There is documentation of an LDL-c value from a test performed within one year prior to arrival (e.g., “LDL-c in November”), or * There is clinician documentation which qualitatively describes the patient’s LDL-c from a test performed one year prior to arrival (e.g., “Labs last month showed elevated lipids,” “CABG in June. Cholesterol levels now good on Lipitor.”)   Documentation must suggest that the qualitative description is from a test done within one year prior to arrival. Do not make assumptions. Examples when “2” should be entered: “Risk factor – dyslipidemia,” “Pt. denies hypercholesterolemia,” “No hx hyperlipidemia.”  Do not include pre-arrival lipid testing or qualitative descriptions of pre-arrival test results if it can be determined that LDL-c measurement was not part of the lipid testing.  **Exclusions:** VLDL (very low density lipoprotein), Alpha lipoproteinemia (presence or absence), elevated LDL-c or any of the other elevated LDL-c inclusion terms described using a negative qualifier such as cannot exclude, cannot rule out, may have, may have had, may indicate, possible, suggestive of, suspect, suspicious |
| 103 | preldldt | Enter the date of the LDL-cholesterol performed closest to the date of hospital arrival | mm/dd/yyyy  Will be auto-filled as 99/99/9999 if priordld = 2 or 99   |  | | --- | | < = 1 year prior to or = acutedt | | Enter month and year at a minimum. If day is unknown, default 01 may be used. |

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| **#** | **Name** | **QUESTION** | **Field Format** | **DEFINITIONS/DECISION RULES** |
| 104 | preldlvl | Enter the LDL-c value in mg/dL or mg/100ml from the test performed within one year prior to arrival. | \_\_ \_\_ \_\_  Will be auto-filled as zzz if priorldl = 2 or 99  **If test was done but LDL-c value is not known, abstractor can enter zzz**   |  | | --- | | Cannot enter  leading zero |   **If priorldl = 1 but preldlvl = zzz or 0, go to prequel**  **If valid value entered in preldlvl, auto-fill prequal as 95, and go out of module** | If more than one LDL-c value from the past year is documented, use the test performed closest to the time of hospital arrival.  Direct and calculated LDL-c values are acceptable. If both direct and calculated LDL-c values are documented for the same specimen date/time, enter the direct LDL-c value.  If the LDL-c on the pre-arrival laboratory report conflicts with that from another source of documentation, use the value from the laboratory report.  **If progress notes indicate an LDL-c level was obtained in the past year, but the value cannot be found, enter zzz as the default value.**  **If high triglycerides rendered the LDL-c calculation inaccurate, enter “0.”**   |  |  | | --- | --- | | **Inclusion** | **Exclusion** | | Low den lipoprotein | Very low density lipoprotein | | Low density lipoprotein (LDL) |  | | Value described as “bad cholesterol” |  | |

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| **#** | **Name** | **QUESTION** | **Field Format** | **DEFINITIONS/DECISION RULES** |
| 105 | prequal | How did the physician, APN, or PA qualitatively describe the patient’s LDL-cholesterol (LDL-c) from the test performed within one year prior to arrival?   1. Elevated LDL-c 2. No elevated LDL-c   95. Not applicable  99. Not documented | 1,2,95,99  Will be auto-filled as 95 if valid value entered in preldlvl  **If priorldl = 1 and prequal = <> 99, go out of module**  **If priorldl = 2, or if priorldl = 1 and prequal = 99, go to ldlplan** | When more than one qualitative description of the patient’s LDL-c from the past year is documented, use the description of the LDL-c from the test performed closest to hospital arrival. If unable to determine which qualitative description refers to the time closest to hospital arrival, select “Elevated LDL-c” if any of the descriptions are consistent with elevated LDL-c.  If there are discrepant qualitative descriptions documented for the same pre-arrival specimen (e.g., one description consistent with elevated LDL-c and one not consistent with elevated LDL-c), select “Elevated LDL-c.”  Inclusions/Exclusions same as in question LDLQUAL. |
| 106 | ldlplan | Is there documentation of a plan to do LDL-cholesterol testing after discharge?   1. Yes 2. No   95. Not applicable | 1,2,95  **If 1, auto-fill whynoldl as 95** | There must be documentation of a definitive plan to do LDL-c testing after discharge (e.g., “Will do cholesterol testing after discharge.”). Documentation which indicates only that LDL-c testing after discharge will be considered (e.g., “May do cholesterol testing at next office visit.”) is not sufficient.  In the absence of explicit documentation of a plan to do LDL-c testing after discharge, it should be inferred that LDL-c testing is planned if there is documentation of a plan to do lipid testing after discharge.  **Excluded data sources**: Any documentation dated/timed after discharge, except discharge summary and operative/procedure/diagnostic test reports (from procedure done during hospital stay.)  **Excluded**: VLDL |

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| **#** | **Name** | **QUESTION** | **Field Format** | **DEFINITIONS/DECISION RULES** |
| 107 | whynoldl | Is there a reason documented by a physician, APN, or PA for not doing LDL-cholesterol (LDL-c) testing?  1. Yes  2. No  95. Not applicable | 1,2,95  Will be auto-filled as 95 if ldlplan = 1 | Reasons why no LDL-c testing was done or planned must be explicitly documented (e.g., ESRD, life expectancy < one month – will not do LDL:HDL) or clearly implied (e.g., “Patient refusing labs, “Limited life expectancy, will not do any further evaluation,” “Lipid testing not indicated”).  If reasons are not mentioned in the context of LDL-c testing, do not make inferences (e.g., do not assume the physician is not doing LDL-c testing because the patient is of an advanced age. If the physician/APN/PA defers LDL-c testing to another clinician, a reason for the deferral of testing must be documented. (e.g., “Consulting cardiologist to evaluate patient for LDL-c testing” 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.)  **Excluded**: VLDL |
| **If comm1tx = 1 or comminpt = 1, go to ACS Transfer from Community Hospital Module**  **If comm1tx = 2 and comminpt = 2 and inptacs = 2, go to ACS at Initial Presentation Module**  **If comm1tx = 2 and comminpt = 2 and inptacs = 1, go to ACS After Admission** | | | | |