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|  |  | **Organizational Identifiers** |  |  |
|  | VAMCCONTROLQICBEGDTEREVDTE | Facility IDControl NumberAbstractor IDAbstraction Begin DateAbstraction End Date | Auto-fillAuto-fillAuto-fillAuto-fillAuto-fill |  |
|  |  | Patient Identifiers |  |  |
|  | SSNPTNAMEFPTNAMELBIRTHDTSEXMARISTATRACE | Patient SSNFirst NameLast NameBirth DateSexMarital StatusRace | Auto-fill: no changeAuto-fill: no changeAuto-fill: no changeAuto-fill: no changeAuto-fill: **can change**Auto-fill: no changeAuto-fill: no change |  |
|  |  | **Administrative Data** |  |  |
| 1 | cardrest | Either at initial presentation to the hospital or during inpatient care, was the first cardiac symptom for this patient a cardiac arrest? | 1,2**If 2, auto-fill survive as 95**  | **The question refers to the patient who had no previous cardiac symptoms. The initial symptom is a cardiac arrest. (Examples: patient who arrives in the ED with a cardiac arrest; patient recovering from hip fracture has a cardiac arrest during rehabilitation therapy.) The question does not apply to patients presenting with or receiving any care for cardiac symptoms.**  |
| 2 | survive | Did the patient survive the resuscitation attempt?1. yes
2. no
3. not applicable
 | 1,2\*, 95If cardrest = 2, will be auto-filled as 95 \*If 2, exclude the record. | Applicable only to cases in which the patient could not be resuscitated and expired during resuscitation efforts or the effort was abandoned. If no resuscitation was attempted, answer “2.”**Exclusion Statement****Cardiac arrest occurring in this case precluded abstraction of the data elements required for the AMI National Hospital Quality Measures.** |
| 3 | ritecode | Do the diagnostic codes for this episode of care include one of the following AMI ICD-9-CM codes, 410.0 - 410.9, with a fifth digit of 1 or 0?**410** acute myocardial infarction (sudden, severe death of heart muscle due to decreased coronary blood flow; classification is based on the location of the affected tissue, when known)**ST elevation (STEMI) and non-ST elevation**  **(NSTEMI) myocardial infarction****410.01 or 410.00** of anterolateral wall  **ST elevation myocardial infarction (STEMI) of anterolateral wall****410.11** **or 410.10** of other anterior wall **ST elevation myocardial infarction (STEMI) of other anterior wall****410.21** **or 410.20** of inferolateral wall **ST elevation myocardial infarction (STEMI) of inferolateral wall****410.31** **or 410.30** of inferoposterior wall **ST elevation myocardial infarction (STEMI) of inferoposterior wall****410.41 or 410.40** of other inferior wall **ST elevation myocardial infarction (STEMI) of other inferior wall****410.51or 410.50** of other lateral wall **ST elevation myocardial infarction (STEMI) of other lateral wall****410.61 or 410.60** true posterior wall infarction **ST elevation myocardial infarction (STEMI) of true posterior wall****410.71 or 410.70** subendocardial infarction  **Non-ST elevation myocardial infarction** **(NSTEMI)****410.81or 410.80** of other specified sites **ST elevation myocardial infarction (STEMI) of other specified sites** **410.91 or 410.90** unspecified site **Myocardial infarction NOS** | 1,2**If 2, auto-fill amiprin as 95** | The fifth digit of 1 = initial episode of care for an AMI. Used to designate the first episode of care (regardless of facility site) for a newly diagnosed myocardial infarction. The fifth digit 1 is assigned regardless of the number of times a patient may be transferred during the initial episode of care. The fifth digit of 0 = episode of care unspecifiedThe fifth digit of 2 = subsequent episode of care. Used to designate an episode of care following the initial episode when the patient is admitted for further observation, evaluation, or treatment for a myocardial infarction that has received initial treatment but is still less than 8 weeks old. **Note: if the AMI code is 410.x2, answer “2.” Cases coded with a fifth digit of 2 are not to be reviewed.**  |
| 4 | amiprin | Was AMI the principal diagnosis for this episode of care?1. yes
2. no
3. not applicable

The principal diagnosis is defined in the Uniform Hospital Discharge Data Set (UHDDS) as “that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care.” | 1,2,95 | **The question refers to the principal diagnosis at the facility in which the case is being reviewed. (Example: patient is admitted to first VAMC for surgery, has an AMI after surgery, and is transferred to VAMC #2 for AMI care. AMI is not the principal diagnosis at the first VAMC, but is the principal diagnosis at VAMC #2.)****The abstractor should be guided by the principal diagnosis assigned by the VAMC and submitted to the Austin PTF.****Catnum 10 AMI records are selected from cases discharged with a diagnosis code of 410.0 – 410.9, with a fifth digit of 1, designated as the principal diagnosis.****Catnum 42 records are selected from the same codes, but may be designated as principal or primary diagnosis. In these cases, AMI should be regarded as the principal diagnosis unless the AMI occurred when the veteran was admitted to the hospital for another reason or was already an inpatient when the AMI occurred.****Answer “1” to “amiprin” if AMI was correctly assigned as principal or primary diagnosis by the VAMC and enter the code assigned by the VAMC in the question “aprocode.”** **Answer “no” to “amiprin” if AMI was or should have been a secondary diagnosis (example: the veteran was admitted for a strangulated hernia and the AMI occurred following surgery; however, AMI was submitted as the principal diagnosis.) The abstractor must use another code entered by the VAMC as the principal diagnosis and may not assign codes not used by the facility.****It is strongly suggested that abstractor use one of the following sources from CPRS to find the facility-assigned codes: under the Reports tab, go to EADT (expanded admission/ discharge transfer) or under the Ad Hoc Menu, look in MAS Discharges.** |
| 5 | truami | Is there evidence in the medical record that the patient had an acute myocardial infarction? | 1,2 | **Evidence in the medical record the patient had an AMI**:1)  Review the discharge summary first to determine if there was a diagnosis of AMI (may also be called Non-STEMI, NSTEMI, STEMI, or Acute Coronary Syndrome.) 2) If the discharge summary is **NOT** present, other physician documentation must record a diagnosis of myocardial infarction (or Non-STEMI, NSTEMI, STEMI, or ACS.)  **EXCEPTION:** **3) In cases of conflicting documentation when the discharge summary documents AMI as a final diagnosis and the record is coded as an AMI, but a cardiologist documented that an AMI did not occur, accept the discharge summary diagnosis as valid and enter “1.”** Most likely to occur if the diagnosis is NSTEMI.Any order in which AMI is noted in the listing of discharge diagnoses is acceptable. If the AMI diagnosis documented at the time of discharge is qualified as "probable," "suspected," "likely," "questionable," "possible," “still to be ruled out,” or other similar terms indicating uncertainty, coding conventions dictate that this terminology be coded as an AMI and is an acceptable diagnosis of AMI (code the AMI as if it existed or was established). **Note: if the AMI code is 410.x2, answer “2.” Cases coded with a fifth digit of 2 are not to be reviewed.**  |

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| 6 | aprocode | Enter the ICD-9-CM principal diagnosis code.

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| **Only enter the principal diagnosis code as documented in the record.**  |

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| **Warning: If amiprin = 1 and aprocode <> 410.x1 or 410.x0 code**  |
| **Cannot enter 000.00, 123.45, or 999.99** |

**If aprocode is not on Table 1.1 AND truami = 2, the case is excluded.** | **If the principal diagnosis code is auto-filled, the abstractor may change the code if it is incorrect and enter the principal diagnosis code as documented in the medical record.****If AMI is the correct principal diagnosis, use the code assigned by the VAMC**. **Do not attempt to code the AMI by any code other than that assigned by the facility**.If AMI was incorrectly submitted as the principal diagnosis, and AMI is actually the secondary diagnosis, the abstractor may change the principal diagnosis code by entering the correct principal diagnosis from one of the codes submitted by the facility. Do not attempt to code a diagnosis that was not coded by the VAMC. If AMI was submitted as a secondary diagnosis when it is actually the principal diagnosis, the abstractor may enter the AMI code as the principal diagnosis.**Exclusion Statement****Although coding indicated the patient had a diagnosis of Acute Coronary Syndrome, documentation in the medical record does not support either an AMI diagnosis.** |
| 7 | othrdx1othrdx2othrdx3othrdx4othrdx5othrdx6othrdx7othrdx8othrdx9othrdx10othrdx11othrdx12 | Enter the ICD-9-CM other diagnosis codes selected for this medical record. | \_ \_ \_. \_ \_

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| Auto-fill pasthx4, as applicable, from othrdx codes entered |

Can enter 12 codes**Abstractor can enter xxx.xx in code field if no other dx found** | **If the “other diagnoses” codes are auto-filled, the abstractor may change those codes that are incorrect.**Enter ALL of the ICD-9-CM other diagnosis codes selected for this medical record**. If AMI was a secondary diagnosis, enter the AMI code in “othrdx.”****Includes V codes: V64.1, V64.2, and V64.3. The presence of one of these V codes indicates a surgical or other procedure was not carried out because of a contraindication, patient’s decision, or other reason.**  |
| 8 | acutedt | Enter the **earliest** documented date the patient arrived at this or another VAMC. | mm/dd/yyyyAbstractor may enter 99/99/9999 if arrival date is unable to be determined

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| Warning window if acutedt > = 6 mos prior to dcdate and hard edit <= admdt |

 | **Arrival date is the earliest recorded date on which the patient arrived in the hospital’s acute care setting where care for ACS could be most appropriately provided. Determine the earliest date the patient arrived at a VHA hospital, such as in the ED or observation unit**. Do not use ambulance records to determine arrival date. The following rules apply:1. If the patient presented to the acute care hospital (for example to the ED, an observation bed, or any inpatient bed section), the date first entered by a clerical person or other individual logging the patient in is the arrival date.
	1. If the patient was seen by an immediate response chest pain team, assembled by the hospital to provide acute chest pain triage, rapid intervention, and quick disposition of suspected ACS patients, the time when the team first saw the patient is the arrival time.
2. For patients presenting to a scheduled clinic visit, who are subsequently sent to the acute care setting for treatment of ACS, the arrival date is the date when the patient arrived at the acute care setting.
3. For patients with unscheduled presentation (walk-ins to urgent care, etc.) the arrival date is the date of the unscheduled walk-in presentation.
4. If the patient first presented to a VAMC other than the facility under review, use the date/time of arrival at the first VAMC.

6. For patients in observation status and subsequently admitted to hospital: * + If the patient was admitted to observation from the ED of the hospital, use the date the patient presented to ED.
	+ If the patient was admitted to observation from an outpatient setting of the hospital, use the date the patient presented to ED or arrived on the floor for observation care.

**Cont’d next page** |
|  |  |  |  | **Acute Care Arrival Date cont’d**7. If the patient is in an outpatient setting of the hospital (e.g., undergoing dialysis, chemotherapy, cardiac cath) and is subsequently admitted to acute inpatient, use the date the patient presents to the ED or arrives on the floor for acute inpatient care as arrival date.8. If the patient is a “Direct Admit” to the cath lab, as a transfer from another ED or acute care hospital, use the date the patient presents to the cath lab as the arrival date.9. For “Direct Admits” to acute inpatient, use the earliest date the patient arrives at the hospital.**ONLY ACCEPTABLE SOURCES (****ONLY ACCEPTABLE SOURCES:** Any ED documentation(includes ED vital sign record, ED Outpatient Registration form, triage record, ECG, lab or x-ray reports, etc., if these services were rendered while the patient was an ED patient), nursing admission assessment/admitting note, observation record, procedure notes (e.g., cardiac cath, endoscopy), vital signs graphic recordOnly enter 99/99/9999 if the arrival date is unable to be determined from the medical record documentation or if the arrival date documented in the record is obviously in error (e.g. 02/42/20XX) and no other documentation is found that provides this information. |
| 9 | acutetm | Enter the **earliest** documented time the patient arrived at this or another VAMC. | \_\_\_\_UMTAbstractor may enter 99:99 if arrival time is unable to be determined

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| Warning if > 6 mos prior to dcdate/dctime and hard edit < = admdt/admtime |

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| Warning if acutetm > 48 hrs prior to admdt/admtime |

 | Do not use ambulance records to determine arrival time. The earliest possible time the patient arrived at the hospital may differ from the formal admission time.**The following rules apply**:1. If the patient presented to the acute care hospital (for example to the ED, an observation bed, or any inpatient bed section), the earliest time that indicated the patient was in the facility is the arrival time. This may be the time vital signs were recorded or an ECG done if this action preceded the paperwork, i.e., the time the patient’s arrival was logged in by a clerical person.
2. If the patient was seen by an immediate response chest pain team, assembled by the hospital to provide acute chest pain triage, rapid intervention, and quick disposition of suspected ACS pts, the time when the team first saw the patient is the arrival time.
3. For patients presenting to a scheduled clinic visit, who are subsequently sent to the acute care setting for treatment of ACS, the arrival time is the time when the patient arrived at the acute care setting.
4. For patients with unscheduled presentation (walk-ins to urgent care, etc. where care could be provided) the arrival time is the time of the unscheduled walk-in presentation.
5. If the patient first presented to a VAMC other than the facility under review, use the date and time of arrival at the first VAMC.
6. For patients in observation status and subsequently admitted to hospital:
* If the patient was admitted to observation from the ED of the hospital, use the time the patient presented to ED.
* If the patient was admitted to observation from an outpatient setting of the hospital, use the time the patient presented to ED or arrived on the floor for observation care.
* If the patient was a direct admit to observation, use the earliest time the patient arrived at the hospital.

**Acute Care Arrival Time cont’d next page** |
|  |  |  |  | Acute Care Arrival Time cont’d1. If the patient is in an outpatient setting of the hospital (e.g., undergoing dialysis, chemotherapy, cardiac cath) and is subsequently admitted to the hospital, use the time the patient presents to the ED or arrives on the floor for inpatient care as arrival time. If the time the patient arrived on the floor is not documented by the nurse, enter the admission time recorded in EADT.
2. If the patient is a “Direct Admit” to the cath lab, as a transfer from another ED or acute care hospital, use the time the patient presents to the cath lab as the arrival time.
3. For “Direct Admits” to the hospital, use the earliest time the patient arrives at the hospital.

**ONLY ACCEPTABLE SOURCES:** Any ED documentation(includes ED vital sign record, ED Outpatient Registration form, triage record, ECG, lab or x-ray reports, etc., if these services were rendered while the patient was an ED patient), nursing admission assessment/admitting note, observation record, procedure notes (e.g., cardiac cath, endoscopy), vital signs graphic recordOnly enter 99:99 if the arrival time is unable to be determined from the medical record documentation or if the arrival time documented in the record is obviously in error (e.g. 33:00) and no other documentation is found that provides this information. |
| 10 | admdt | Enter the date the patient was formally admitted to inpatient status at this VAMC. | mm/dd/yyyyComputer will auto-fill

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| > = acutedt and < = dcdate |

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| Warning window if admdt > 6 mos prior to dcdate |

 | **Auto-filled; can be modified if abstractor determines that the date is incorrect.****Exclusion:** admit to observation, arrival dateAdmission date is the date the patient was actually admitted to acute inpatient care. For patients who are admitted to Observation status and subsequently admitted to acute inpatient care, abstract the date that the determination was made to admit to acute inpatient care and the order was written. Do not abstract the date that the patient was admitted to Observation. If there are multiple inpatient orders, use the order that most accurately reflects the date that the patient was admitted. The admission date should not be abstracted from the earliest admission order without regards to substantiating documentation. If documentation suggests that the earliest admission order does not reflect the date the patient was admitted to inpatient care, this date should not be used. **ONLY ALLOWABLE SOURCES:** Physician orders, face sheet |
| 11 | admtime | Enter the time the patient was formally admitted to inpatient status at this VAMC. | \_\_\_\_\_UMTComputer will auto-fill

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| > = acutetm and < = dcdate |

 | **Auto-filled; can be modified**Admission time = time when the patient was formally admitted to inpatient status. Excluded: arrival time admission to observation time.Enter time in Universal Military TimeIf the time is in the a.m., conversion is not required.If the time is in the p.m., add 12 to the clock time hour. |
| 12 | dcdate | Enter the date of discharge.  | mm/dd/yyyyComputer will auto-fill | **Will be auto-filled by computer and cannot be modified.** |
| 13 | dctime | Enter the time of discharge. | \_\_\_\_\_UMT

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| > admdt/admtime |

 | **Does not auto-fill. Discharge time must be entered.** **Includes the time the patient was discharged from acute care, left against medical advice (AMA), or expired during this stay.**If the patient expired, use the time of death as the discharge time.**Suggested sources for patient who expire:**Death record, resuscitation record, physician progress notes, physician orders, nurses notes**For other patients:**If the time of discharge is NOT documented in the nurses notes, discharge/transfer form, or progress notes, enter the discharge time documented in EADT under the “Reports Tab.” Enter time in Universal Military Time: a 24-hour period from midnight to midnight using a 4-digit number of which the first two digits indicate the hour and the last two digits indicate the minute.Converting time to military time:If time is in the a.m., no conversion is required.If time is the p.m., add 12 to the clock hour time.  |
| 14 | dcdispo | What was the patient’s discharge disposition on the day of discharge?1. Home* Assisted Living Facilities
* Court/Law Enforcement – includes detention facilities, jails, and prison
* Board and care, domiciliary, foster or residential care, group or personal care homes, and homeless shelters
* Home with Home Health Services
* Outpatient Services including outpatient procedures at another hospital, outpatient Chemical Dependency Programs and Partial Hospitalization

2. Hospice – Home3. Hospice – Health Care Facility* General Inpatient and Respite, Residential and Skilled Facilities, and Other Health Care Facilities

4. Acute Care Facility* Acute Short Term General and Critical Access Hospitals
* Cancer and Children’s Hospitals
* Department of Defense and Veteran’s Administration Hospitals

5. Other Health Care Facility* Extended or Immediate Care Facility (ECF/ICF)
* Long Term Acute Care Hospital (LTACH)
* Nursing Home or Facility including Veteran’s Administration Nursing Facility
* Psychiatric Hospital or Psychiatric Unit of a Hospital
* Rehabilitation Facility including Inpatient Rehabilitation Facility/Hospital or Rehabilitation Unit of a Hospital
* Skilled Nursing Facility (SNF), Sub-Acute Care or Swing Bed
* Transitional Care Unit (TCU)

6. Expired7. Left Against Medical Advice/AMA99. Not documented or unable to determine | 1,2,3,4,5,6,7,99 | **Discharge disposition: The final place or setting to which the patient was discharged on the day of discharge.****Notes for Abstraction:** * **Only use documentation from the day of or the day before discharge when abstracting this data element.** For example: Discharge planning notes on 04-01-20xx document the patient will be discharged back home. On 04-06-20xx, the nursing discharge notes on the day of discharge indicate the patient was being transferred back to skilled care. Enter “5”.
* **Consider discharge disposition documentation in the discharge summary or a post-discharge addendum as day of discharge documentation, regardless of when it was dictated/written.**
* **If documentation is contradictory, use the latest documentation. If there is documentation that further clarifies the level of care that documentation should be used to determine the correct value to abstract.** For example: Nursing discharge note documents that the patient is being discharged to “XYZ” Hospital. The Social Service notes from the day before discharge further clarify that the patient will be transferred to the rehab unit of “XYZ” Hospital, select option “5”.
* **If the medical record states only that the patient is being discharged to another hospital and does not reflect the level of care that the patient will be receiving, select “4”.**
* **To select option “7” there must be explicit documentation that the patient left against medical advice.** Examples:

Progress notes state that patient requests to be discharged but that discharge was medically contraindicated at this time. Nursing notes reflect that patient left against medical advice and AMA papers were signed, select value “7”. Physician order written to discharge to home. Nursing notes reflect that patient left before discharge instructions could be given, select value “1”. **Excluded Data Sources:** Any documentation prior to the day of or day before discharge Cont’d next page |
|  |  |  |  | **Discharge disposition cont’d****Suggested Data Sources:** Discharge instruction sheet, discharge planning notes, discharge summary, nursing discharge notes, physician orders, progress notes, social service notes, transfer record |
| 1516 | pxcodeprinpxdt | Enter the ICD-9-CM principal procedure code and date the procedure was performed. Code Date

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| **Determine whether the patient had a PCI before attempting to enter any procedure code.**  |

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| **Only enter the principal procedure code as documented in the record.**  |

 | \_\_ \_\_. \_\_ \_\_**If there is no principal procedure, the abstractor can enter xx.xx in code field and 99/99/9999 in the date field**

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| **Cannot enter 00.00** |

mm/dd/yyyy**Abstractor can enter 99/99/9999** **If there is no principal procedure, auto-fill othrpx and othrpxdt with xx.xx and 99/99/9999**

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| > = acutedt and < = dcdate  |

 | Principal procedure= that procedure performed for definitive treatment, rather than for diagnostic or exploratory reasons, or was necessary to treat a complication. Related to the principal diagnosis.Enter the ICD-9-CM code principal procedure code assigned by the VAMC, even if it does not meet the strict definition noted above.**If a principal procedure code is not documented, enter default code xx.xx in code field and default date 99/99/9999 in date field.**Codes for stent placement (36.06) or drug-eluting stent (36.07) may now be entered in either enter PXCODE or OTHRPXS if the procedure is applicable. **Codes 36.06 and 36.07 contain instructions that PCI code 00.66 should also be used. If a PCI was performed, but the 00.66 PCI code is not documented in the medical record, enter xx.xx in the code field.**If the principal procedure date is unable to be determined from the medical record documentation, or if the procedure date documented in the record is obviously in error (e.g. 02/42/20XX) and no other documentation is found that provides this information, enter 99/99/9999. |
| 1718 | othrpxs1othrpxs2othrpxs3othrpxs4othrpxs5othrdts1 othrdts2 othrdts3 othrdts4 othrdts5 | Enter the ICD-9-CM other procedure codes and dates the procedures were performed Code Date

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 | \_\_ \_\_. \_\_ \_\_**If no other procedure was performed, the abstractor can enter xx.xx in code field** mm/dd/yyyy**Abstractor can enter 99/99/9999**

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| > = acutedt and < = dcdate |

**Can enter 5 codes and dates** | **Only enter procedure codes as documented in the medical record.****Can enter 5 procedure codes, other than the principal procedure code.** Enter the ICD-9-CM codes and dates corresponding to each of the procedures performed, beginning with the procedure performed most immediately following the admission.Other procedures=may be PCI, if not designated as the principal procedure, cardiac cath, CABG, or other unrelated procedure.Procedure must be performed at this VAMC or at an affiliated hospital and the patient returned to this facility within 12 hours **If no other procedure was performed, the other procedure code fields may be filled with xx.xx and the date field with 99/99/9999**. If no other procedures were performed, it is only necessary to complete the xx.xx and 99/99/9999 default entries for the first code and date. Do not complete the default entry five times.If the date of a procedure is unable to be determined from the medical record documentation, or if the procedure date documented in the record is obviously in error (e.g. 02/42/20XX) and no other documentation is found that provides this information, enter 99/99/9999. |
| 19 | transin2 | Was the patient received as a transfer from inpatient, outpatient or emergency/observation department of another hospital OR from an ambulatory surgery center?1. Patient received as a transfer from an inpatient department of another hospital2. Patient received as a transfer from an outpatient department of another hospital (excludes emergency/observation departments)3. Patient received as a transfer from the emergency/observation department of another hospital4. Patient received as a transfer from an ambulatory surgery center* 1. None of the above or unable to determine from medical record documentation.
 | 1,2,3,4,99If 1,2,4, or 99, auto-fill tranvaed as 95 and go to acsedpt | **If a patient is transferred in from the emergency department or observation unit of ANY outside hospital, select value “3”, regardless of whether the two hospitals are close in proximity, part of the same hospital system, have a shared medical record or provider number, etc.** * If a patient is transferred in from a Disaster Medical Assistance Team (DMAT), which provides emergency medical assistance following a catastrophic disaster or other major emergency, select value “3.”
* The emergency department includes free-standing and satellite emergency departments/rooms. If the medical record reflects only that the patient was received as a transfer from another hospital and the abstractor is unable to determine if the patient was in an inpatient or an outpatient department, select value “1.”

**Exclusion Statement** **Transfer from an inpatient, outpatient, or emergency/observation department of another hospital OR ambulatory surgery center partially excludes the case from the Joint Commission AMI National Hospital Quality Measures. Smoking counseling, pneumococcal vaccination, and influenza vaccination remain applicable measures.** |
| 20 | tranvaed | Was the patient received from the emergency department of another VAMC?1. Yes2. No95. Not applicable | 1,2,95Will be auto-filled as 95 if transin2 = 1,2,4, or 99 | **Note: the emergency department of another VAMC includes both emergency room AND observation bed/unit stays at that hospital**. |
| 21 | acsedpt | Did the patient receive care/services in the Emergency Department of this VAMC? 1. Yes2. No | 1,2If 2, auto-fill acsobsv as 95, acsdecdt as 99/99/9999, acsdectm as 99:99, acsdcdt as 99/99/9999, acsdctm as 99:99, and go to comfort | **For the purposes of this data element an Emergency Department (ED) patient is defined as any patient receiving care or services in the ED of this VAMC.** If the patient presents to the ED for outpatient services such as lab work and the patient receives the service in the ED, enter “1”.A patient seen in an Urgent Care, ER Fast Track, etc. is NOT considered an ED patient unless the patient received services in the Emergency Department at this VAMC (e.g., patient treated at an urgent care and transferred to the main campus ED is considered an ED patient, but a patient seen at the urgent care and transferred to the hospital as a direct admit would not be considered an ED patient). For patients presenting to the ED who do NOT receive care or services in the ED, enter “2” (e.g., patient is sent to hospital from physician office and presents to ED triage and is instructed to proceed straight to floor). **Exclude:** Urgent Care, fast track ED, terms synonymous with Urgent Care |
| 22 | acsobsv | Was there documentation the patient was placed in observation services in the Emergency Department of this VAMC? 1. Yes2. No95. Not applicable | 1,2Will be auto-filled as 95 if acsedpt = 2 | **The intent is to capture emergency department patients placed into observation services in this Emergency Department prior to admission to the facility as an inpatient.** If there is documentation the patient was placed into observation services and received care in observation provided by the Emergency Department or in an observation unit of the ED, select “1.”  If there is documentation the patient is being admitted for observation outside the Emergency Department, select “2.” If there is no documentation the patient received observation services in the ED of this VAMC, select “2.”**ONLY ALLOWABLE SOURCE: ED record** |

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| 23 | acsdecdt | Enter the earliest documented date of the decision to admit the patient. | Mm/dd/yyyyWill be auto-filled as 99/99/9999 if acsedpt = 2Abstractor can enter 99/99/9999If acutedt = admdt, computer will auto-fill = acutedt

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| > =acutedt and < = admdt |

 | **For purposes of this data element, Decision to Admit Date is the date on which the physician/APN/PA makes the decision to admit the patient from the Emergency Department to the hospital as an inpatient.** This will not necessarily coincide with the date the patient is officially admitted to inpatient status. **ONLY ACCEPTABLE SOURCE: ED record. Do not include any documentation from external sources (e.g., ambulance record, clinic note) obtained prior to arrival.** * If there are multiple dates documented for the decision to admit abstract the earliest date.
* If it can be determined that the patient arrived on the same date and departed on the same date, the arrival date can be used as the decision to admit date.
* If the decision to admit the patient is made, but the actual request for a bed is delayed until an inpatient bed is available, record the date the physician/APN/PA made the decision to admit.
* If the decision to admit date is dated prior to the date of patient arrival or after the date of departure, enter 99/99/9999.
* If the date of the decision to admit is unable to be determined from medical record documentation, enter 99/99/9999.

If the admission date is the same date as arrival, Decision to Admit date will be auto-filled by the computer software.The medical record must be abstracted as documented (i.e., face value). When the date documented is obviously in error (e.g. 11/42/20XX) or outside the parameters of care (e.g., after discharge date) and no other documentation is found that provides this information, enter 99/99/9999.**Excludes, but is not limited to:** Bed assignment date, Admit Orders date, Admit to Observation date |
| 24 | acsdectm | Enter the earliest documented time of the decision to admit the patient. | \_\_\_\_\_UMTWill be auto-filled as 99:99 ifacsedpt = 2Abstractor can enter 99:99

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| >=acutedt/acutetm and < = admdt/admtime |

 | **For purposes of this data element “decision to admit time” is the time the physician/APN/PA communicates the decision to admit the patient from the Emergency Department to the hospital as an inpatient.** The decision to admit time will not necessarily coincide with the time the patient is officially admitted to inpatient status. **ONLY ACCEPTABLE SOURCE: ED record. Do not include any documentation from external sources (e.g., ambulance record, clinic note) obtained prior to arrival.** * If there are multiple times documented for the decision to admit abstract the earliest time.
* If the decision to admit the patient is made, but the actual request for a bed is delayed until an inpatient bed is available, record the time the physician/APN/PA communicated the decision to admit.
* Do not use admit order time for the Decision to Admit Time unless documentation clearly indicates this is the time the provider communicated the decision. If the documentation does not clearly indicate this was the time of the decision, enter 99:99
* If documentation of the decision to admit time is prior to arrival or after departure from the ED, enter 99:99.
* If the time of the decision to admit is unable to be determined from medical record documentation, enter 99:99.

The medical record must be abstracted as documented (i.e., at face value). When the time documented is obviously in error (e.g. 33:00), and no other documentation is found that provides this information, enter 99:99.**Excludes, but is not limited to:** Bed assignment time, Admit Orders time, Report Called Time, Admit to Observation time |
| 25 | acsedcdt | Enter the date the patient departed from the emergency department. | Mm/dd/yyyyWill be auto-filled as 99/99/9999 if acsedpt = 2Abstractor can enter 99/99/9999

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| > =acutedt or = admdt and <= 3 days after admdt |

 | **ONLY ACCEPTABLE SOURCE: ED record*** If the date of departure from the ED is not documented, but the date of departure can be determined from other documentation, (e.g., you are able to identify from documentation the patient arrived and was transferred to medical unit on the same day), enter this date.
* For patients who are placed into observation under the services of the Emergency Department, abstract the date of departure from the observation services (e.g., patient is seen in the ED and admitted to an observation unit of the ED on 05/01/20XX then is discharged from the observation unit on 5/02/20XX abstract 5/02/20XX as the departure date.
* For patients who are placed into observation outside the services of the Emergency Department, abstract the date of departure from the ED.
* If there is documentation the patient left against medical advice and it cannot be determined what date the patient left against medical advice, enter 99/99/9999.
* If the date the patient departed from the ED is unable to be determined from medical record documentation, enter 99/99/9999.

The medical record must be abstracted as documented (i.e., face value). When the date documented is obviously in error (e.g. 11/42/20XX) or outside the parameters of care (e.g., after discharge date) and no other documentation is found that provides this information, enter 99/99/9999.**Includes, but is not limited to:** ED departure date, ED discharge date, ED leave date |
| 26 | acsedctm | Enter the time the patient departed from the emergency department. | \_\_\_\_\_UMTWill be auto-filled as 99:99 ifacsedpt = 2Abstractor can enter 99:99

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| < = acutedt/acutetm and < = 72 hours after admdt/admtime |

 |  **ED Departure Time is the time the patient physically left the Emergency Department.** **The intention is to capture the latest time at which the patient was receiving care in the ED, under the care of Emergency Department services, or awaiting transport to another service/unit.** * When more than one acceptable ED departure/discharge time is documented, abstract the **latest time**.

For example: Two departure times are found in the ED nurse’s notes: 12:03 via wheelchair and 12:20 via wheelchair. Enter the later time of 12:20 as ED departure time. * If patient expired in the ED, use the time of death as the departure time.
* For patients who are placed into observation under the services of the emergency department, abstract the time of departure from the ED observation services. For example, the patient is seen in the ED and admitted to an observation unit of the ED, then discharged from the observation unit. Enter the time the patient departed from the ED observation unit.
* For patients who are placed into observation outside the services of the emergency department, abstract the time of departure from the emergency department.
* Do not use the time the discharge order was written because it may not represent the actual time of departure.
* If the time the patient departed from the ED is unable to be determined from medical record documentation, enter 99:99.

The medical record must be abstracted as documented (i.e., at face value). When the time documented is obviously in error (e.g. 33:00), and no other documentation is found that provides this information, enter 99:99.**Includes, but is not limited to:** ED Leave time, ED Discharge time, ED Departure time, ED Check Out time **Excludes, but is not limited to**: Report Called time **ONLY ACCEPTABLE SOURCE:** ED record |

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| 27 | comfort | When is the earliest physician, APN, or PA documentation of comfort measures only?1. Day of arrival (day 0) or day after arrival (day 1)2. Two or more days after arrival (day 2 or greater) 3. Comfort measures only documented during hospital stay, but timing unclear99. Comfort measures only was not documented by the physician/APN/PA or unable to determine  | 1,2,3,99

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| Warning if comfort = 2 |

If 3 or 99, auto-fill plcaredt as 99/99/9999 | **ONLY accept terms identified in the list of inclusions. No other terminology will be accepted. Day of arrival is day 0.**

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| **Inclusion (Only acceptable terms)** |
| Brain death/dead | Hospice |
| Comfort care | Hospice care |
| Comfort measures | Organ harvest |
| Comfort measures only CMO) | Palliative care |
| Comfort only | Palliative measures |
| DNR-CC | Terminal care |
| End of life care |  |

* **Determine the earliest day the physician/APN/PA DOCUMENTED comfort measures only in the ONLY ACCEPTABLE SOURCES.** Do not factor in when comfort measures only was actually instituted. E.g., “Discussed comfort care with family on arrival” noted in day 2 progress note – Select “2.”
* **Consider comfort measures only documentation in the discharge summary as documentation on the last day of the hospitalization, regardless of when the summary is dictated.**
* **Physician/APN/PA documentation of comfort measures only mentioned in the following context is acceptable:** comfort measures only recommendation, order for consultation/evaluation by hospice/palliative care, patient/family request for comfort measures only, referral to hospice/palliative care service.
* If any of the inclusions are documented in the ONLY ACCEPTABLE SOURCES, select option “1,” “2,” or “3,” accordingly, unless otherwise specified.

**Disregard documentation of an Inclusion term in the following situations:*** Inclusion term clearly described as negative (e.g. “No comfort care,” “Not appropriate for hospice care,” “Declines palliative care”).

**Note:** If an Inclusion term is clearly described as negative in one source and NOT described as negative in another source, the second source would count for comfort measures only (e.g. On Day 0, the physician documents, “The patient is not a hospice candidate.” On Day 3, the physician orders a hospice consult. Select “2.”)**Cont’d next page** |
|  |  |  |  | **Comfort measures only cont’d*** Do not use documentation that is dated prior to arrival or documentation which refers to the pre-arrival time period (e.g., comfort measures only order in previous hospitalization record, “Pt. on hospice at home” in discharge summary).

**EXCEPTION:** State-authorized portable orders (SAPOs). SAPOs are specialized forms, Out-of-Hospital DNR (OOH DNR) or Do Not Attempt Resuscitation (DNAR) orders, or identifiers authorized by state law, that translate a patient’s preferences about specific-end-of-life treatment decisions into portable medical orders. **Examples:** DNR-Comfort Care form, MOLST (Medical Orders for Life-Sustaining Treatment), POLST (Physician Orders for Life-Sustaining Treatment) * Inclusion terms not clearly selected on a pre-printed order form, even if orders are signed by physician/APN/PA.

**Examples:** Home Health/Hospice order form - “Hospice” not circled or selected; DNR-Comfort Care order form - option “Comfort Care” not checked or selected.

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| **Exclusion (Only acceptable exclusion terms)\*:** |
| DNR-CCA | DNRCC-Arrest |
| DNR-Comfort Care Arrest | DNRCCA |
| DNRCC-A |  |

**ONLY ACCEPTABLE SOURCES:** Discharge summary, DNR/MOLST/POLST forms, Physician orders, Progress notes**Excluded Data Source:** Restraint order sheet**Exclusion Statement: Clinician documentation of “comfort measures only” excludes the case from Joint Commission designated AMI Hospital Quality measures. Abstraction of required data elements for VHA measures remains applicable** |

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| 28 | plcaredt | Enter the date of documentation of comfort measures only. | mm/dd/yyyyIf comfort = 3 or 99, will be auto-filled as 99/99/9999If comfort = 1, auto-fill donotx as 95, notx1dt as 99/99/9999, notx1tm as 99:99, and go to comm1tx

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| > = acutedt and < = dcdate |

 | Sources: Admitting physician orders, Consultation notes, ED record, H&P, Physician admitting note, Physician orders, Progress notes. Enter the exact date. The use of 01 to indicate missing day or month is not acceptable**.** |
| 29 | donotx | Is there explicit documentation of the decision not to treat during this episode of care? 1. Yes2. No95. Not applicable | 1,2,95Will be auto-filled as 95 if comfort = 1If 2, auto-fill notx1dt as 99/99/9999 and notx1tm as 99:99, and go to comm1tx | **Decision not to treat** = the record clearly documents that the patient, patient’s family, or legal representative wishes comfort measures only, and/or there is agreement that the patient’s cardiac condition and co-morbid conditions preclude further treatment.**Include: physician documentation that care is limited to comfort only at family’s request or due to patient’s age or chronic illness; supportive care only****The question does not mean that there is a decision not to treat aggressively or to treat only with medical management due to classification of AMI or unstable angina as low risk.** **Exclude: Documentation of DNR or living will without documentation that the patient’s cardiac condition and co-morbid conditions preclude further treatment.** |
| 30 | notx1dt | Enter the date the decision not to treat was documented in the record.  | mm/dd/yyyyWill be auto-filled as 99/99/9999 if comfort = 1 or donotx = 2

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| > = acutedt and < = dcdate |

 | Enter the exact date. The use of 01 to indicate missing day or month is not acceptable**.** |
| 31 | notx1tm | Enter the time the decision not to treat was documented in the record. | UMTWill be auto-filled as 99:99 if comfort = 1 or donotx = 2

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| > = acutedt/acutetm and < = dcdate/dctime |

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| 32 | comm1tx | Did the patient present initially to a community hospital where he/she received all or part of the first 24 hours of care for ACS? | 1,2**If 1, auto-fill inptacs as 95**

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| **If 1, transin2 must = 1, 2, or 3**  |

 | To answer “1,” the patient must have been treated at the community hospital for ACS symptoms. If the patient was transferred to a VAMC from a community hospital but was treated initially for another medical problem not related to ACS, answer “2.” **If the patient was transferred from the community hospital to a VAMC, then subsequently transferred to another VAMC, and the case is being reviewed at the second VAMC, the initial presentation and ACS care at a community hospital applies, and the abstractor should answer “1.”**  |
| 33 | comminpt | Was the patient a transfer from a community hospital where he/she was an inpatient for ACS care? | 1,2**If 1, auto-fill inptacs as 95**

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| **If 1, transin2 must = 1**  |

 | The question is not limited to initial presentation, but is intended to address situations in which the patient was transferred from the VAMC to a community hospital and returned to the VAMC after a stay of 24 hours or more.Patient may be transferred to a community hospital for a cardiac cath, PCI or other service not available at the VAMC, then returned to the VAMC for further recuperation.  |
| 34 | inptacs | Was the veteran already a VAMC inpatient when ACS occurred?1. yes
2. no
3. not applicable
 | 1,2, 95

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| If comm1tx = 1, inptacs cannot = 1 |

 | Already an inpatient = the veteran had already been formally admitted to this VAMC, either for an unrelated problem or for related symptoms such as unstable angina**. In either event, to answer “1,” documentation in the record must clearly indicate ACS occurred after the patient had been formally admitted to a VAMC as an inpatient.** |
| 35 | clntrial | During this hospital stay, was the patient enrolled in a clinical trial in which patients with acute myocardial infarction (AMI) were being studied?**(Includes AMI, STEMI, NSTEMI, or heart attack)** | \*1, 2**\*If 1, the record is excluded.** | **In order to answer “Yes”, BOTH of the following must be documented:**1. **There must be a signed consent form for the clinical trial.** For the purposes of abstraction, a clinical trial is defined as an **experimental study** in which research subjects are recruited and assigned a treatment/intervention and their outcomes are measured based on the intervention received; **AND** 2**. There must be documentation on the signed consent form that during this hospital stay the patient was enrolled in a clinical trial in which patients with AMI were being studied** (e.g., enrollment of the patient with AMI in a clinical trial studying stents). Patients may be newly enrolled in a clinical trial during the hospital stay or enrolled in a clinical trial prior to arrival and continued active participation in that clinical trial during this hospital stay.**In the following situations, select "No":**1. **There is a signed patient consent form for an observational study only**. Observational studies are non-experimental and involve no intervention (e.g., registries). 2. **It is not clear whether the study described in the signed patient consent form is experimental or observational**.3. **It is not clear which study population the clinical trial is enrolling**. Assumptions should not be made if it is not specified.**ONLY ACCEPTABLE SOURCE**: Signed consent form for clinical trial**Exclusion Statement: Enrollment of the patient in a clinical trial during this hospital stay relevant to AMI excludes the case from the JC AMI Hospital Quality Measures.**  |
| **Go to History & Assessment Module** |