|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  | **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 | arrvdate | Enter the **earliest** documented date the patient arrived at acute care at this VAMC. | mm/dd/yyyyAbstractor may enter 99/99/9999 if arrival date is unable to be determined

|  |
| --- |
| < = entradm and < = dtofdc |

 | **Arrival date is the earliest recorded date on which the patient arrived in the hospital’s acute care setting where care for heart failure could be most appropriately provided**. Arrival date may differ from admission date. * **Review the ONLY ACCEPTABLE SOURCES to determine the earliest date the patient arrived at the ED, nursing floor, or observation, or as a direct admit to the cath lab. Use the earliest date documented unless other documentation suggests the patient was not in the hospital on that date. The intent is to utilize any documentation which reflects processes that occurred in the ED or hospital.**
* If the patient was transferred from your hospital’s satellite/free-standing ED or from another hospital within your hospital’s system (as an inpatient or ED patient), and there is one medical record for the care provided at both facilities, use the arrival date at the first facility.
* In determining if there is documentation which suggests the patient was not in the hospital on a given date, sources outside of the ONLY ACCEPTABLE SOURCES list can be referenced. However, do not use dates described as hospital arrival on these sources for *Arrival Date*.
* The source “Emergency department record” includes any documentation from the time period that the patient was an ED patient – e.g., ED face sheet, ED consent/Authorization for treatment forms, ED/Outpatient Registration/sign-in forms, ED vital sign record, triage record, ED physician orders, ECG reports, telemetry/rhythm strips, laboratory reports, x-ray reports.
* For Observation Status:
	+ If the patient was admitted to observation from the ED of the hospital, use the date the patient arrived at the ED.
	+ If the patient was admitted to observation from an outpatient setting of the hospital, use the date the patient arrived at the ED or on the floor for observation care.
* If the patient is in an outpatient setting of the hospital (e.g., undergoing dialysis, chemotherapy) or a SNF unit of the hospital 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 the arrival date.
 |
|  |  |  |  | * For Direct Admits:
	+ If the patient is a “Direct Admit” to the cath lab, use the earliest date the patient arrived at the cath lab (or cath lab staging/holding area) as the arrival date.
	+ For “Direct Admits” to acute inpatient or observation, use the earliest date the patient arrived at the nursing floor or in observation (as documented in the ONLY ACCEPTABLE SOURCES) as the arrival date.

**ONLY ACCEPTABLE SOURCES:** Emergency Department record (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 (such as cardiac cath, bronchoscopy, endoscopy), vital signs graphic recordOnly enter 99/99/9999 if the arrival date is unable to be determined from the medical record documentation. 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, enter 99/99/9999. |
| 2 | arrvtime | Enter the **earliest** documented time the patient arrived at acute care at this VAMC. | \_\_\_\_\_UMT**If unable to find the time of arrival, the abstractor can enter 99:99**

|  |
| --- |
| < = entradm/hfadmtm and < dtofdc/whatime |

 | **Arrival time is the earliest recorded time the patient arrived in the hospital’s acute care setting where care for heart failure could be most appropriately provided.*** **Review the ONLY ACCEPTABLE SOURCES to determine the earliest time the patient arrived at the ED, nursing floor, or observation, or as a direct admit to the cath lab. Use the earliest time documented unless other documentation suggests the patient was not in the hospital on that date. The intent is to utilize any documentation which reflects processes that occurred in the ED or hospital.**
* If the patient was transferred from your hospital’s satellite/free-standing ED or from another hospital within your hospital’s system (as an inpatient or ED patient), and there is one medical record for the care provided at both facilities, use the arrival time at the first facility.
* In determining if there is documentation which suggests the patient was not in the hospital at a given time, sources outside of the ONLY ACCEPTABLE SOURCES list can be referenced. However, do not use times described as hospital arrival on these sources for *Arrival Time*.
* The source “Emergency department record” includes any documentation from the time period that the patient was an ED patient – e.g., ED face sheet, ED consent/Authorization for treatment forms, ED/Outpatient Registration/sign-in forms, ED vital sign record, triage record, ED physician orders, ECG reports, telemetry/rhythm strips, laboratory reports, x-ray reports.
* For Observation Status:
	+ If the patient was admitted to observation from the ED of the hospital, use the time the patient arrived at the ED.
	+ If the patient was admitted to observation from an outpatient setting of the hospital, use the time the patient arrived at the ED or 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.
* If the patient is in an outpatient setting of the hospital (e.g., undergoing dialysis, chemotherapy) or a SNF unit of the hospital and is subsequently admitted to acute inpatient, use the time the patient presents to the ED or arrives on the floor for acute inpatient care as the arrival time. If the time the patient arrived on the floor is not documented by the nurse, enter the admission time recorded in EADT.
 |
|  |  |  |  | * For Direct Admits:
	+ If the patient is a “Direct Admit” to the cath lab, use the earliest time the patient arrived at the cath lab (or cath lab staging/holding area) as the arrival time.
	+ For “Direct Admits” to acute inpatient or observation, use the earliest time the patient arrived at the nursing floor or in observation (as documented in the ONLY ACCEPTABLE SOURCES) as the arrival time.

**ONLY ACCEPTABLE SOURCES:** Emergency Department record (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 (such as cardiac cath, bronchoscopy, endoscopy), vital signs graphic record **If unable to determine the time of arrival, enter default time 99:99.** If the arrival time documented in the record is obviouslyin error (e.g. 33:00) and no other documentation is found that provides this information, enter 99:99. |
| 3 | entradm | Admission date:  | mm/dd/yyyyComputer will auto-fill

|  |
| --- |
| < = dtofdc |

 | **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 |
| 4 | hfadmtm | Admission time: | \_\_\_\_\_UMTComputer will auto-fill

|  |
| --- |
| < dtofdc/whatime |

 | **Auto-filled; can be modified** |
| 5 | dtofdc | Discharge date: | mm/dd/yyyyComputer will auto-fill | **Auto-filled. Cannot be modified** |
| 6 | whatime | Discharge time: | \_\_\_\_\_UMT

|  |
| --- |
| > entradm/hfadmtm |

 |  **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. |
| 7 | princode | Enter the ICD-9-CM principal diagnosis code. | \_\_ \_\_ \_\_. \_\_ \_\_(3 digits/decimal point/two digits

|  |
| --- |
| **Cannot enter 000.00, 123.45, or 999.99** |

**If code entered is not in JC Table 2.1, Appendix A, the record is excluded**. | **Will auto-fill from PTF with ability to change. Do NOT change the principal diagnosis code unless the principal diagnosis code documented in the record is not the code displayed in the software.****Principal diagnosis code must be one of the codes listed in Joint Commission Table 2.1 (Appendix A).**Heart failure codes include both acute and chronic failure.If the heart failure diagnosis documented at the time of discharge is qualified as "probable," "suspected," "likely," "questionable," "possible," or “still to be ruled out,” or other similar terms indicating uncertainty, coding conventions dictate that this terminology be coded as heart failure and is an acceptable diagnosis of heart failure (code the HF as if it existed or was established). **Exclusion Statement:****Heart Failure is not the principal diagnosis, as required for inclusion in the Joint Commission Heart Failure Quality Measures.** |
| 8 | dxchf | Is the diagnosis of heart failure confirmed by physician documentation?  | 1,2 | If the physician records a diagnosis of heart failure in the discharge summary or elsewhere in the medical record and heart failure is coded as the principal diagnosis, the case is to be reviewed. Either left-sided or right-sided failure is applicable. Answer “yes” if the diagnosis is chronic heart failure. Answer “no” if the diagnosis is history of heart failure. Any order in which heart failure is noted in the listing of discharge diagnoses is acceptable.If the heart failure diagnosis documented at the time of discharge is qualified as "probable," "suspected," "likely," "questionable," "possible," or “still to be ruled out,” or other similar terms indicating uncertainty, coding conventions dictate that this terminology be coded as heart failure and is an acceptable diagnosis of heart failure.  |
| 9 | entrcode1entrcode2entrcode3entrcode4entrcode5entrcode6entrcode7entrcode8entrcode9entrcode10entrcode11entrcode12 | Enter the ICD-9-CM other diagnosis codes:  | \_\_ \_\_ \_\_. \_\_ \_\_(3 digits/decimal point/two digits)Can enter 12 codes**Abstractor can enter xxx.xx in code field if no other dx found** | **Can enter 12 ICD-9-CM other diagnosis codes.** **Will auto-fill from the PTF with ability to change. If the “other diagnoses” codes are incorrect, enter the codes as documented in the medical record.** If entered manually, use the codes listed in discharge diagnosis (DD) under the reports tab. **Enter xxx.xx in code field if no other diagnoses codes exist for this record.**  |
| 10 | prinpx(code)prinpxdt(date) | Enter the ICD-9-CM principal procedure code and date the procedure was performed. Code Date

|  |  |
| --- | --- |
| \_\_ \_\_. \_\_ \_\_ | \_\_/\_\_/\_\_\_\_ |

 | \_\_ \_\_. \_\_ \_\_**Abstractor can enter xx.xx in code field and 99/99/9999 in date field if there is no principal procedure**

|  |
| --- |
| **Cannot enter 00.00** |

mm/dd/yyyy**Abstractor can enter 99/99/9999****If no principal procedure, auto-fill othrpx and othrpxdt with xx.xx and 99/99/9999** **If code is listed in Appendix A, Table 2.2, the case is excluded.**

|  |
| --- |
| > = entradm and < = dtofdc  |

 | Principal procedure= that procedure performed for definitive treatment, rather than for diagnostic or exploratory reasons, or was necessary to treat a complication. **The principal procedure is related to the principal diagnosis and needs to be accurately identified.*** VA records do not identify the principal procedure; use the above definition of principal procedure to determine the correct code to enter if there are multiple procedures during the episode of care. Ask for assistance from your RM or WVMI if you are uncertain.

**If no procedure was performed during the episode of care, fill ICD-9-CM code field with default code xx.xx. Do not enter 99.99 or 00.00 to indicate no procedure was performed.** **Date of the principal procedure is to be filled with 99/99/9999 if no procedure was performed.**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.**Exclusion: Patients who had a left ventricular assistive device (LVAD) or heart transplant procedure during the hospitalization are excluded (see Joint Commission Appendix A, Table 2.2 for LVAD and heart transplant ICD-9-CM procedure codes).****Exclusion Statement****Procedure code appearing in Joint Commission Table 2.2 excludes the case from the Heart Failure Hospital Quality Measures**  |
| 11 | othrpx1othrpx2othrpx3othrpx4othrpx5(codes)othrpxdt1othrpxdt2othrpxdt3othrpxdt4othrpxdt5(dates) | Enter the ICD-9-CM other procedure codes and dates the procedures were performed Code Date

|  |  |
| --- | --- |
| \_\_ \_\_. \_\_ \_\_ | \_\_/\_\_/\_\_\_\_ |
| \_\_ \_\_. \_\_ \_\_ | \_\_/\_\_/\_\_\_\_ |

 | \_\_ \_\_. \_\_ \_\_**Abstractor can enter xx.xx in code field and 99/99/9999 in date field if no other procedure was performed**mm/dd/yyyy**Abstractor can enter 99/99/9999****If code is listed in Appendix A, Table 2.2, the case is excluded.**

|  |
| --- |
| > = entradm and < = dtofdc  |

**Can enter 5 codes and dates** | **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. **If no other procedures were performed, enter default code xx.xx in the code field and default date 99/99/9999 in the date field.** **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. It is not necessary to 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.**Exclusion: Patients who had a left ventricular assistive device (LVAD) or heart transplant procedure during the hospitalization are excluded (see Joint Commission Appendix A, Table 2.2 for LVAD and heart transplant ICD-9-CM procedure codes).****Exclusion Statement****Procedure code appearing in Joint Commission Table 2.2 excludes the case from the Heart Failure Hospital Quality Measures** |
| 12 | admtype | Enter the priority/type of admission.1. Emergency
2. Urgent
3. Elective
	1. Information not available
 | 1,2,3,9 | 1. Emergency=the patient required immediate medical intervention as a result of severe, life threatening, or potentially disabling conditions. Generally, the patient was admitted through the emergency room.
2. Urgent=the patient required immediate attention for the care and treatment of a physical or mental disorder. Generally, the patient was admitted to the first available and suitable accommodations.
3. Elective=the patient’s condition permitted adequate time to schedule the availability of a suitable accommodation
	1. Information not available=the hospital cannot classify the type of admission. This code is used only on rare occasions.
 |
| 13 | 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”. **Suggested Data Sources:** Discharge instruction sheet, discharge planning notes, discharge summary, nursing discharge notes, physician orders, progress notes, social service notes, transfer record**Excluded Data Sources:** Any documentation prior to the day of or day before discharge  |
|  |  | **Acute Care** |  |  |
| 14 | 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

|  |
| --- |
| Warning if comfort = 2 |

 | **ONLY accept terms identified in the list of inclusions. No other terminology will be accepted. Day of arrival is day 0.**

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

* **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 care, patient/family request for comfort measures only, referral to hospice 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 hospice 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 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.

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

**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 IHF Hospital Quality measures. Abstraction of required data elements for VHA measures remains applicable.** |
| 15 | clntrial | During this hospital stay, was the patient enrolled in a clinical trial in which patients with heart failure were being studied? | \*1,2\*If 1, the record is excluded from the JC HF Hospital Quality Measures population.(Partial Abstraction Only)If 2, go to frstwt | **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 heart failure were being studied.** 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 the study population 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 heart failure excludes the case from the Joint Commission HF Hospital Quality Measures.**  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  | **Weight** |  |  |
| 16 | frstwt | Enter the patient’s first weight measured after acute care arrival. | \_\_\_\_\_**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, weightdc as zzz, wtunitdc as 95, and dcwtdt as 99/99/9999 and go to asesslvf | **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.** |
| 17 | wtunit3 | Unit of measure1. Pounds
2. Kilograms
3. Not applicable
 | 1,2,95If frstwt is z-filled, will be auto-filled as 95

|  |
| --- |
| Warning window when wtunit3 = 1 and weight < = 98 or > = 278When wtunit3 = 2, and weight < = 44 or > = 126 |

 |  |
| 18 | frstwtdt | Enter the date the first weight was measured. | mm/dd/yyyyWill be auto-filled as 99/99/9999 if frstwt is z-filled

|  |
| --- |
| > = arrvdate 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. |
| 19 | weightdc | Enter the patient’s weight measured on or prior to discharge.  | \_\_\_\_\_**Abstractor can enter default zzz if only one weight measured during this episode of care.**If z-filled, auto-fill wtunitdc as 95 and dcwtdt as 99/99/9999, and go to asesslvf | **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 only one weight was measured during this episode of care, enter default zzz.** |
| 20 | wtunitdc | Unit of measure1. Pounds2. Kilograms95. Not applicable | 1,2,95If weightdc is z-filled, will be auto-filled as 95

|  |
| --- |
| Warning window when wtunitdc = 1 and weight < = 98 or > = 278When wtunitdc = 2, and weight < = 44 or > = 126 |

 |  |
| 21 | dcwtdt | Enter the date the weight was measured on or prior to discharge. | mm/dd/yyyy**Will be auto-filled as 99/99/9999 if weightdc is z-filled**

|  |
| --- |
| > frstwtdt and < = dtofdc |

 | Enter the exact date. The use of 01 to indicate missing day or month is not acceptable. If the discharge weight is z-filled, DCWTDT will auto-fill as 99/99/9999. The abstractor cannot enter 99/99/9999 default date if a valid weight was entered. |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  | **Inpatient Admission Diagnostic Tests** |  |  |
| 22 | asesslvf | Is there documentation in the medical record of at least one of the following:* Left ventricular systolic function (LVSF) assessment at any time prior to arrival or during this hospitalization
* A plan for LVSF assessment after discharge
* A reason documented by a physician, nurse practitioner, or physician assistant for not assessing LVSF
	1. Yes
	2. No assessment at any time, no plan to assess after discharge, no reason documented, or unable to determine
1. Reason documented by a physician, APN, or PA for not assessing LVSF prior to arrival, during hospital stay, or planned after discharge.
 | 1,2,R**If 2 or R, auto-fill the following:** **lvfless as 95,** **inhowlvf as 95, efnumip as zz, efdecmip as z.zz, efcutpin as 95, and narlvsf as 95**  | **Left Ventricular Systolic Function (LVSF) assessment:** diagnostic measure of left ventricular contractile performance/wall motion. Ejection fraction (EF) is an index of LVSF. EFmay be recorded in quantitative (EF=30%) or qualitative (moderate left ventricular systolic dysfunction) terms.**LVSF assessments done any time prior to hospital arrival are acceptable (see Inclusion list).** * Infer a test was done if the patient’s LVSF is documented (e.g., “Pt. admitted with severe LV dysfunction”).
* Consider LVSF assessment as planned for after discharge ONLY if a definitive plan is documented (e.g., “Will do echo as outpatient”). Documentation which indicates only that an LVSF assessment after discharge will be considered is not sufficient.
* If there is documentation of both a reason for not assessing LVSF AND documentation that LVSF was assessed or that assessment is planned for after discharge, select “1.”

**Reasons for not performing LVSF assessment:*** **Reasons must be explicitly documented by a physician/APN/PA** (e.g.“ESRD. Will not measure EF”; Echo report has “Technically difficult study, LVSF could not be measured.”
* **Physician/APN/PA deferral of LVSF assessment to another physician/APN/PA does NOT count as a reason for not assessing LVSF unless the reason/problem underlying the deferral is also noted** (e.g., “Consulting cardiologist to evaluate pt. for echo” – select “No.”).

**Exclude**: akinesis, dyskinesis, or hypokinesis not described as left ventricular; cardiomyopathy **not** described as endstage; contractility/hypocontractility; left ventricular compliance, dilatation/dilation, hypertrophy; BNP blood test**Excluded Data Sources**: Any documentation dated/timed after discharge, except discharge summary and operative/ procedure/ diagnostic test reports (from procedure done during hospital stay). **Cont’d on next page - LVSF tests**  |
|  |  |  |  | **LVSF Assessment cont’d****Left Ventricular Systolic Function (LVSF) Assessment Inclusion list:** **Echocardiogram (echo)** * Cardiac ultrasound
* Transesophageal echo (TEE)
* Transthoracic echo (TTE)

**Cardiac Catheterization (cath) with Left Ventriculogram (LV gram)** * Cardiac cath with mention of LVSF
* Cardiac/coronary angiogram/arteriogram with LV gram or mention of LVSF
* Left heart cath with mention of LVSF
* Left ventriculogram (LV gram)

**Other LVSF Assessment Tests** * Cardiac MRI scan with mention of LVSF
* CT scan of chest with mention of LVSF
* Multiple gated acquisition scan (MUGA) or other cardiac imaging/testing described as gated or blood pool
* Other nuclear test (e.g., SPECT, PET) with mention of LVSF

**Left Ventricular Systolic Function (LVSF)** * Akinesis, dyskinesis, or hypokinesis described as left ventricular
* Diastolic dysfunction, failure, function, or impairment
* Dysfunction described as biventricular, left ventricular (LVD, LVSD), systolic, or ventricular
* Ejection fraction (EF, LVEF)
* Endstage cardiomyopathy
* Failure described as biventricular, left ventricular, systolic, or ventricular
* Function described as biventricular, left ventricular (LVF), systolic, or ventricular
 |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 23 | lvfless | Is the most recent left ventricular systolic function documented as an ejection fraction (EF) less than 40% or a narrative description consistent with moderate or severe systolic dysfunction (LVSD)?1. Yes
2. No
3. Not applicable
 | 1,2,95If asesslvf = 2 or R, will be auto-filled as 95**Abstractor may enter 95 if there was only a plan for LVSF assessment after discharge**  | **LVSD: impairment of LV performance. EF is an index of LVSF. Use the most recent description of EF/LVSF/LVSD found (test done closest to discharge). EF < 40% select “1”; EF ≥ 40% select “2”.****Guidelines for prioritizing EF/LVSF/LVSD documentation :**1) LVSF assessment test report findings take precedence over findings documented in other sources (e.g. progress notes) 2) Final report findings take priority over preliminary findings. Assume findings are final unless labeled as preliminary. 3) Conclusion (impression, interpretation, or final diagnosis) section of the report takes priority over other sections.**\*\*If test for EF/LVSF was not performed during hospital stay, look for documentation of pre-arrival EF/LVSF test results documented in the record. Apply guidelines 1 – 3 above.** **Priority order for conflicting documentation when there are 2 or more different descriptions of EF/LVSF:**1)Use the lowest calculated EF (e.g. 30%) 2) Use lowest estimated EF. Estimated EFs often use descriptors such as “about,” “approximate,” or “appears.” (e.g. EF appears to be 35%). Estimated EF may be documented as a range (use mid-point) or less than or greater than a given number.3) Use worst narrative description WITH severity specified (e.g., LVD/LVSD described as marked, moderate, moderate-severe, severe, significant, substantial, or very severe; EF described as low, poor, or very low)4) Use narrative description WITHOUT severity specified (e.g., biventricular dysfunction, LVD, LVSD, systolic dysfunction, left ventricular systolic failure, LVF/LVSF/EF) described as abnormal, compromised, decreased, reduced.**Cont’d next page** |
|  |  |  |  | **LVSD cont’d**5) Disregard the following terminology when reviewing the record for documentation of LVSF/LVSD. If documented, continue reviewing for LVSF/LVSD inclusions outlined in the Inclusion lists, o Diastolic dysfunction, failure, function, or impairment o Ventricular dysfunction not described as left ventricular or systolic  o Ventricular failure not described as left ventricular or systolic  o Ventricular function not described as left ventricular or systolic E.g., Impression section of echo report states only “diastolic dysfunction”. Findings section states “EF 35%”. Disregard “diastolic dysfunction” in the Impression section and answer “Yes” due to EF 35%.**Include:** * any terms (biventricular dysfunction; LVD/LVSD/systolic dysfunction; diffuse, generalized or global hypokinesis; LV akinesis/ hypokinesis/dyskinesis; LV systolic failure) described as marked, moderate, moderate-severe, severe, significant, substantial, or very severe; **OR** where severity is **NOT** specified
* biventricular heart failure described as moderate or severe
* **e**nd stage cardiomyopathy

**Exclude**: 1) any terms (see above) described as mild-moderate 2) any terms (see above) described using one of the following:* **Negative qualifiers:** cannot exclude, cannot rule out, could be, may have, may have had, may indicate, possible, suggestive of, suspect, or suspicious, OR
* **Negative modifiers**: borderline, insignificant, scant, slight, sub-clinical, subtle, trace, or trivial

**If LVSF was not assessed prior to arrival or during hospitalization, but there was a plan for LVSF assessment post-discharge, enter 95**. |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 24 | inhowlvfinhowlvf1inhowlvf2inhowlvf3inhowlvf4inhowlvf95 | During this inpatient admission, how was the most recent left ventricular systolic function documented in the record?**Select all that apply:*** 1. Ejection fraction as a percentage
	2. Ejection fraction as a decimal
	3. Ejection fraction with cut points (> or <)
	4. narrative description
		+ 1. Not applicable
 | 1,2,3,4,95If asesslvf= 2, will be auto-filled as 95If abstractor entered 1 for asesslvf and 95 for lvfless, auto-fill as 95 **Auto-fill as follows for answers not selected:****efnumip as zz, efdecmip as z.zz, efcutpin as 95,** **narlvsf as 95** | EF may be taken from any knowledge of EF or LVSD (left ventricular systolic dysfunction) documented in the inpatient record for this admission. **The question references the most recent EF or narrative description found in the record.**EF may be documented as a percentage (33%) or a decimal point (0.33). If an EF range is provided, enter EF as a percentage and use the midpoint.**The question applies only to this inpatient admission.****If LVSF was not assessed prior to arrival or during hospitalization, but there was a plan for LVSF assessment post-discharge, and ASESSLVF has been answered “1,” enter 95**  |
| 25 | efnumip | Enter EF percentage. | \_\_ \_\_%If inhowlvf <> 1, auto-fill as zz**If abstractor entered 1 for asesslvf and 95 for lvfless, auto-fill as default zz**

|  |
| --- |
| If lvfless = 1, cannot enter 40 or > |

|  |
| --- |
| If lvfless = 2, cannot enter < 40 |

 | If only a number is stated (and it is not a decimal), it may be assumed it is a percentage.**If LVSF was not assessed prior to arrival or during hospitalization, but there was a plan for LVSF assessment post-discharge, and ASESSLVF has been answered “1,” enter default zz.** |
| 26 | efdecmip | Enter the EF decimal value. | \_\_. \_\_ \_\_If inhowlvf <>2, auto-fill as z.zz**If abstractor entered 1 for asesslvf and 95 for lvfless, auto-fill as default z.zz**

|  |
| --- |
| If lvfless = 1, cannot enter .40 or > |

|  |
| --- |
| If lvfless = 2, cannot enter < 0.40 |

 | **If LVSF was not assessed prior to arrival or during hospitalization, but there was a plan for LVSF assessment post-discharge, and ASESSLVF has been answered “1,” enter default z.zz** |
| 27 | efcutpin | Enter the applicable EF cut point:1. < 40%1. < 30%
2. 40% or greater

95. Not applicable | 1,2,3,95If inhowlvf <>3, auto-fill as 95**If abstractor entered 1 for asesslvf and 95 for lvfless, auto-fill as 95**

|  |
| --- |
| If lvfless = 1, cannot enter option #3 |

|  |
| --- |
| If lvfless = 2, cannot enter 1 or 2 |

 | In normal individuals the ejection fraction is more than 50 percent and usually less than 80 percent. Ejection fraction is a ballpark figure – not a precise measurement. For this reason, the ejection fraction may be expressed as “less than” or “greater than” a figure rather than an exact percentage or decimal. **If LVSF was not assessed prior to arrival or during hospitalization, but there was a plan for LVSF assessment post-discharge, and ASESSLVF has been answered “1,” enter 95** |
| 28 | narlvsf | Enter the most recent description of LVSF documented during this admission:* 1. Moderately or moderately-to-severely reduced (or depressed, abnormal, or impaired)
	2. Severely reduced (or depressed, abnormal, or impaired)
1. Other description
2. Not applicable
 | 1,2,3,95If inhowlvf <> 4, auto-fill as 95**If abstractor entered 1 for asesslvf and 95 for lvfless, auto-fill as 95** | Do not include systolic dysfunction described using one of the following: * Negative qualifiers: cannot exclude, cannot rule out, could be, may have, may have had, may indicate, possible, suggestive of, suspect, or suspicious, OR
* Negative modifiers: borderline, insignificant, scant, slight, sub-clinical, subtle, trace, or trivial.

**The question applies only to this inpatient admission**.**If LVSF was not assessed prior to arrival or during hospitalization, but there was a plan for LVSF assessment post-discharge, and ASESSLVF has been answered “1,” enter 95** |
| 29 | funcap | Specify the patient’s most recent functional status or exercise tolerance documented during this admission.* 1. Asymptomatic or no limitation of physical activity (NYHA Class I)
	2. Slight limitation of physical activity (NYHA Class II)
	3. Marked limitation of physical activity (NYHA Class III)
	4. Unable to carry out any physical activity without discomfort or cardiac symptoms at rest (NYHA Class IV)

99. No documentation of functional status | 1,2,3,4,99 | 1. Ordinary physical activity does not cause undue fatigue, palpitation, or dyspnea (shortness of breath). For example, patient is able to perform strenuous exercise or climb 2 flights of stairs.2. Comfortable at rest, but ordinary activity results in fatigue, palpitation, or dyspnea. 3. Comfortable at rest, but less than ordinary activity causes fatigue, palpitation, or dyspnea. For example, patient reports that walking across room causes discomfort. 4. Symptoms of cardiac insufficiency at rest. If any physical activity is attempted, discomfort is increased.Abstractor can accept any of the above descriptions or NYHA Classification.**Only accept documentation of functional status/exercise tolerance from this inpatient admission.** |
| 30 | inptcmbinptcmb1inptcmb2inptcmb3inptcmb4inptcmb99 | Were any of the following documented during this admission?**Indicate all that apply:**1. Dementia
2. Metastatic or end stage malignancy
3. Do not resuscitate order (DNR) during current admission
4. Currently enrolled in hospice

99. No documentation of the above | 1,2,3,4,99 | **Documentation may be taken from the inpatient record for this admission.** Enter **ALL** conditions that apply. Any type of dementia is applicable, such as Alzheimer’s, vascular, dementia due to HIV, head trauma, Parkinson’s, Huntington’s Disease, or Creutzfeldt-Jakob Disease.  |
|  |  | **Inpatient Procedures** |  |  |
| 31 | icdpx | Is there documentation the patient had an implantable cardioverter-defibrillator (ICD) placed during this hospitalization? | 1,2If 2 auto-fill, icdpxt as 99/99/9999 and go to crtpx | An implantable cardioverter-defibrillator (ICD) is a device designed to quickly detect a life-threatening, rapid heartbeat coming from the ventricles of the heart. The ICD attempts to convert an abnormal rhythm back to normal by delivering an electrical shock to the heart. This action is called defibrillation. The device may also be referred to as an automatic implantable cardioverter-defibrillator (AICD).ICD-9-CM procedure code: 37.94.  |
| 32 | icdpxdt | Enter the date the ICD was implanted. | mm/dd/yyyyWill be auto-filled as 99/99/9999 if icdpx = 2

|  |
| --- |
| > = entradm and < = dtofdc |

 | Enter the exact date. The use of 01 to indicate missing month or day is not acceptable  |
| 33 | crtpx | Is there documentation the patient had implantation of a biventricular (BiV) pacemaker for cardiac resynchronization therapy (CRT) during this hospitalization? | 1,2If 2 auto-fill, crtpxdt as 99/99/9999  | Cardiac resynchronization therapy (CRT) is achieved by implantation of a biventricular pacemaker. The biventricular pacemaker simultaneouslypaces both the left and right ventricles in order to synchronize the pumping action of the ventricles. The CRT device may have 3 leads - one in the right atrium and one in each of the ventricles. If the device also has a defibrillator it may be referred to as a CRT-D.ICD-9-CM procedure codes: 00.50, 00.51 |
| 34 | crtpxdt | Enter the date the CRT device was implanted. | mm/dd/yyyyWill be auto-filled as 99/99/9999 if crtpx = 2

|  |
| --- |
| > = entradm and < = dtofdc |

 | Enter the exact date. The use of 01 to indicate missing month or day is not acceptable |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  | **Medications during Admission** |  |  |
| 35 | admace | During this admission, was the patient on an angiotensin converting enzyme inhibitor (ACEI)?Examples of ACEI include, but are not limited to:* enalapril
* captopril
* lisinopril
* benazipril
* ramipril
* combinations of ACEI with hydrochlorothiazide

1. Yes2. No  | 1,2If 1, auto-fill contace3 as 95If 2, go to contace3 | **During this admission:** refers to the ACEI being administered during this episode of care. ACEI: Angiotensin converting enzyme inhibitors; ACEIs may be described as RAS (renin-angiotensin system) or RAAS (renin-angiotensin-aldosterone system) blockers/inhibitors.**If there is a prescription for an ACEI to be started after discharge, but an ACEI was not administered prior to discharge, select “2.”**For a list of ACEI medications refer to TJC Appendix C, Table 1.2 or a drug handbook. |
| 36 | contace3 | Does the record document any of the following reasons for not prescribing an ACEI during this admission?  1. ACEI allergy or intolerance 5. Moderate or severe aortic stenosis95. Not applicable* 1. Other reasons documented by a physician/APN/PA or pharmacist
	2. Patient refusal of ACE inhibitors documented by physician/APN/PA or pharmacist

99. No documented reason | 1,5,95,97,98,99Will be auto-filled as 95 if admace = 1 | **Documentation of a reason anytime during hospital stay is acceptable.****1. ACEI allergy/sensitivity:** allergy/sensitivity documented anytime counts regardless of type of reaction noted (e.g. “Allergies: ACEI – cough”); allergy/sensitivity to one ACEI is acceptable as an allergy to all ACEIs.**5. Moderate or Severe Aortic Stenosis** (AS): Findings may be taken from diagnostic test reports. May be either current diagnosis or history of AS, without mention of repair, replacement, valvuloplasty, or commissurotomy. **INCLUDE:** AS described as moderate, severe, 3+, 4+, critical or significant; degree of severity not specified; aortic valve area of less than 1.0 square cm; subaortic stenosis, moderate/severe, or degree of severity not specified **EXCLUDE:** aortic insufficiency/regurgitation only; AS described as 1+ or 2+; AS using qualifiers: cannot exclude, cannot rule out, may have, may have had, may indicate, possible, suggestive of, suspect, or suspicious.**97. Other reason(s) documented by a physician/APN/PA or pharmacist:** * Must explicitly link the noted reason with non-prescription of an ACEI.
* Should be considered implicit documentation for also not prescribing an ARB for the following five conditions **ONLY:**
* Angioedema
* Hyperkalemia
* Hypotension
* Renal artery stenosis
* Worsening renal function/renal disease/dysfunction
* **If the patient is on hydralazine and nitrates, and the record documents this drug therapy is a better option than ACEI or ARB for the patient, this documentation is acceptable as “other reason.”**
* When conflicting documentation regarding a reason for not prescribing an ACEI is documented in the medical record, select “yes” for the applicable reason.

**98.** **Patient refusal:** Documentation by a physician/APN/PA or pharmacist that the patient refused ACEI medications or all medications is acceptable. Documentation that the patient refused BP medications is NOT acceptable. |
| 37 | admarb | During this admission, was the patient on an angiotensin II receptor antagonist (ARB or AIIRA)?Examples of ARB medications include, but are not limited to:* candesartan
* eprosartan
* irbesartan
* losartan
* valsartan
* combinations of ARB with hydrochlorothiazide
1. Yes
2. No

  | 1,2If 1, auto-fill contrarb1 as 95If 2, go to contrarb1 | **During this admission:** refers to the ARB being taken or prescribed during this episode of care. **ARB:** Angiotensin receptor blockers or angiotensin II receptor antagonists (AIIRA); ARBs may be described as RAS (renin-angiotensin system) or RAAS (renin-angiotensin-aldosterone system) blockers/inhibitors**If there is a prescription for an ARB to be started after discharge, but an ARB was not administered prior to discharge, select “2.”**For a list of ARB medications refer to TJC Appendix C, Table 1.7 or a drug handbook. |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 38 | contrarb1 | Does the record document any of the following reasons for not prescribing an ARB during this admission? 1. ARB (AIIRA) allergy or sensitivity 2. Moderate or severe aortic stenosis95. Not applicable* + - 1. Other reasons documented by a physician/APN/ PA or pharmacist for not prescribing an ARB

98. Patient refusal of ARBs documented by physician/APN/PA or pharmacist99. No documented reason | 1,2,95,97,98,99Will be auto-filled as 95 if admarb = 1 | **Documentation of a reason anytime during hospital stay is acceptable.** **1. ARB allergy/sensitivity:** any documented **allergy/sensitivity** counts, regardless of type of reaction noted (e.g. “Allergies: ARB–cough”); allergy/sensitivity to one ARB is acceptable as allergy to all ARBs.**2. Moderate or Severe Aortic Stenosis (AS):** Findings may be taken from diagnostic test reports. May be either current diagnosis or history of AS, without mention of repair, replacement, valvuloplasty, or commissurotomy. **INCLUDE:** AS described as moderate, severe, 3+, 4+, critical or significant; degree of severity not specified; aortic valve area of less than 1.0 square cm; subaortic stenosis, moderate/severe, or degree of severity not specified **EXCLUDE:** aortic insufficiency/regurgitation only; AS described as 1+ or 2+; AS using qualifiers: cannot exclude, cannot rule out, may have, may have had, may indicate, possible, suggestive of, suspect, or suspicious.**97. Other reason(s) documented by a physician/APN/PA or pharmacist:** * Must explicitly link the noted reason with non-prescription of an ARB.
* Should be considered implicit documentation for also not prescribing an ACEI for the following five conditions **ONLY:**
* Angioedema
* Hyperkalemia
* Hypotension
* Renal artery stenosis
* Worsening renal function/renal disease/dysfunction
* **If the patient is on hydralazine and nitrates, and the record documents this drug therapy is a better option than ACEI or ARB for the patient, this documentation is acceptable as “other reason.”**
* When conflicting documentation regarding a reason for not prescribing an ARB is documented in the medical record, select “yes” for the applicable reason.

**98.** **Patient refusal:** Documentation by a physician/APN/PA or pharmacist that the patient refused ARB medications or all medications is acceptable. Documentation that the patient refused BP medications is NOT acceptable. |
| 39 | admbb | Was the patient on a beta-blocker during this admission?Examples of beta-blockers include but are not limited to:* metropolol succinate or tartrate
* carvedilol
* atenolol
* nadolol
* propranolol
* combination of beta-blockers with other drugs
1. Yes
2. No

  | 1,2If 1, auto-fill contrabb as 95If 2, go to contrabb | **During this admission:** refers to the beta-blocker being taken or prescribed during this episode of care.**If there is a prescription for a beta-blocker to be started after discharge, but a beta-blocker was not administered prior to discharge, select “2.”**For a list of beta-blocker medications refer to TJC Appendix C, Table 1.3 or a drug handbook. |
| 40 | contrabb | Does the record document any of the following reasons for not prescribing a beta-blocker during this admission?1. Beta-blocker allergy
2. Bradycardia (heart rate less than 60 bpm) while not on a beta-blocker
3. Second or third degree heart block on ECG and does not have a pacemaker

9. Post-heart transplant patient10. Documentation of severely decompensated heart failure95. Not applicable97. Other reasons documented by a physician/APN/ PA or pharmacist98. Patient refusal of beta-blockers documented by physician/APN/PA or pharmacist99. No documented reason | 1,2,3,9,10,95,97,98,99Will be auto-filled as 95 if admbb = 1 | **Documentation of reason anytime during hospital stay is acceptable.****1. Beta-blocker (BB) allergy/sensitivity/intolerance:** documented **allergy/sensitivity/intolerance** counts regardless of type of reaction noted; allergy/sensitivity/intolerance to one BB is acceptable as allergy to all BBs. **EXCLUDE:** Allergy to BB eye drops (e.g., Cosopt). **2. Bradycardia:** must be documented by a clinician as the reason for non-use of a beta-blocker; however if record states “patient’s heart rate is consistently less than 60 bpm,” this is acceptable.**3. Second or third degree heart block:** Do not attempt to use the ECG tracing to answer this question. The ECG interpretation of second or third degree heart block must be documented in the record by a clinician or by electronic interpretation. Documentation of the ECG interpretation does not have to be linked specifically to contraindication to beta-blocker.**10. Severely decompensated heart failure:** cardiac decompensation is marked by dyspnea, venous engorgement, and edema. Abstractor may not make this decision based on symptoms described in record. There must be specific diagnosis by a physician/APN/PA.**97. Other reason(s) documented by a physician/APN/ PA or pharmacist:** * Must explicitly link the noted reason with non-prescription of a beta-blocker. Documentation of a reason anytime during the hospital stay is acceptable.
* When conflicting documentation regarding a reason for not prescribing BB is documented in the medical record, select “yes” for the applicable reason.

**98.** **Patient refusal:** Documentation by a physician/APN/PA or pharmacist that the patient refused beta-blocker medications or refused all medications is acceptable. Documentation that the patient refused BP medications is NOT acceptable. |
| 41 | aldostrx | Was the patient on an aldosterone antagonist (Examples: spironolactone, eplerenone) during this admission?1. Yes
2. No
 | 1,2If 1, auto-fill aldostno as 95 | **During this admission = patient received an aldosterone antagonist during this episode of care.****If there is a prescription for an aldosterone antagonist to be started after discharge, but an aldosterone antagonist was not administered prior to discharge, select “2.”**Brand name for spironolactone: AldactoneBrand name for eplerenone: InspraFor a list of aldosterone antagonist medications refer to a drug handbook. |
| 42 | aldostno | Does the record document any of the following reasons for not prescribing an aldosterone antagonist during this admission?1. Allergy, intolerance, or sensitivity
2. Renal insufficiency
3. Hyperkalemia

95. Not applicable97. Other reason documented by a physician/APN/ PA or pharmacist98. Patient refusal of aldosterone antagonist documented by physician/APN/PA or pharmacist1. No documented contraindication
 | 1,2,3,95,97,98,99Will be auto-filled as 95 if aldostrx = 1 | Documentation of aldosterone antagonist allergy or sensitivity or patient’s inability to tolerate one or more side effects is sufficient. Renal insufficiency: acute renal failure; arterionephrosclerosis; azotemia; chronic renal disorder; chronic renal failure (CRF); chronic renal insufficiency; diabetic kidney disease; hemodialysis or peritoneal dialysis. Hyperkalemia: serum potassium > 5.5 meq/L that cannot be reduced (not a transient event) |
| **If dcdispo = 2, 3, 4, 6, or 7 auto-fill all remaining questions as “95,”and go to end** |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  | Inpatient Discharge Medications |  |  |
| 43 | aceidc | Was an angiotensin converting enzyme inhibitor (ACEI) prescribed at discharge? Examples of ACEI include, but are not limited to:* enalapril
* captopril
* lisinopril
* benazipril
* ramipril
* combinations of ACEI with hydrochlorothiazide
1. Yes
2. No
 | 1,2,95If 1, auto-fill noacewhy as 95 and allerace as 95 If 2, go to noacewhy | **In determining whether an ACEI was prescribed at discharge, review all discharge medication documentation available in the chart.** If there is conflicting documentation among different medical record sources, the following guidelines apply:* In cases where there is an ACEI in one source that is not mentioned in another source, it should be interpreted as a discharge medication unless documentation suggests that it was NOT prescribed at discharge. **Consider the ACEI a discharge medication in the absence of contradictory documentation (see below)**.
* If documentation is **contradictory** (e.g., physician noted “dc lisinopril” in discharge orders, but lisinopril is listed in discharge summary), or careful examination of the circumstances raises enough questions about whether an ACEI was prescribed at discharge, the case should be deemed unable to determine and answered as “2.”
* Consider documentation of a “hold” on an ACEI after discharge as **contradictory** ONLY if the timeframe on the hold is **not defined (e.g., “Hold lisinopril” does not have a timeframe).**
* If an ACEI is NOT listed as a discharge medication, and there is only documentation of a plan to delay initiation/restarting of an ACEI for a time period after discharge (e.g. “Start lisinopril as outpatient”), select “2.”
* Disregard an ACEI documented only as a recommended medication for discharge (e.g., “Recommend sending pt home on Vasotec”). Documentation must be clear that the ACEI was actually prescribed.
* Disregard documentation of ACEI prescribed at discharge when noted only by medication class (e.g., “ACEI Prescribed at Discharge: Yes” on a core measures form). The ACEI must be listed by name.

For a list of ACEI medications refer to TJC Appendix C, Table 1.2 or a drug handbook. |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 44 | noacewhy | Does the record document any of the following reasons for not prescribing an ACEI at discharge? 1. ACEI allergy
	1. Moderate or severe aortic stenosis
2. Not applicable
	* 1. Other reasons documented by a physician/APN/ PA or pharmacist for not prescribing an ACEI at discharge

98. Patient refusal of ACE inhibitors documented by physician/APN/PA or pharmacist99. No documented reason | 1,5,95,97,98,99Will be auto-filled as 95 if aceidc = 1If <> 1, auto-fill allerace as 95, and go to arbatdc | **Documentation of a reason anytime during hospital stay is acceptable.****1. ACEI allergy/sensitivity:** documentedallergy or sensitivity documented at anytime during the hospital stay counts regardless of type of reaction noted (e.g. “Allergies: ACEI – cough”); allergy/sensitivity to one ACEI is acceptable as an allergy to all ACEIs. **5. Moderate or Severe Aortic Stenosis** (AS): Findings may be taken from diagnostic test reports. May be either current diagnosis or history of AS, without mention of repair, replacement, valvuloplasty, or commissurotomy. **INCLUDE:** AS described as moderate, severe, 3+, 4+, critical or significant; degree of severity not specified; aortic valve area of less than 1.0 square cm; subaortic stenosis, moderate/severe, or degree of severity not specified **EXCLUDE:** aortic insufficiency/regurgitation only; AS described as 1+ or 2+; AS using qualifiers: cannot exclude, cannot rule out, may have, may have had, may indicate, possible, suggestive of, suspect, or suspicious.**97. Other reason(s) documented by a physician/APN/PA or pharmacist:** * Must explicitly link the noted reason with non-prescription of an ACEI.
* Should be considered implicit documentation for also not prescribing an ARB for the following five conditions **ONLY:**
* Angioedema
* Hyperkalemia
* Hypotension
* Renal artery stenosis
* Worsening renal function/renal disease/dysfunction
* Documentation of a hold/discontinuation of an ACEI during the hospital stay constitutes a “clearly implied” reason for not prescribing an ACEI at discharge (e.g., “Patient hypotensive. May start ACEI as outpatient”).

**EXCEPTIONS:** * Documentation of a **conditional** hold/discontinuation of an ACEI does not count as a reason for not prescribing at discharge **UNLESS** (1) it exists as a physician/APN/PA or pharmacist **order** to hold/discontinue the ACEI if BP falls outside certain parameters, AND (2) the ACEI was held due to BP outside the parameters.
 |
|  |  |  |  | Nursing documentation is acceptable (e.g., Physician order: “Hold lisinopril for SBP < 90” and nurse documents: “lisinopril held for BP 80/50”).* Discontinuation of a particular ACEI medication documented in combination with the start of a different ACEI medication (i.e., switch in type of ACEI medication) does not count as a reason for not prescribing an ACEI at discharge.

 Examples: - “Stop benazepril” and “Start captopril 50 mg po bid” in same physician order. - “Do not continue after discharge” checked for Lotensin and “Continue after discharge checked for Zestril on a physician-signed discharge medication reconciliation form.* Discontinuation of an ACEI medication at a particular dose documented in combination with the start of a different dose of that ACEI (i.e., change in dosage) does not count as a reason for not prescribing an ACEI at discharge.

Examples: - “Stop lisinopril 20 mg po q am” and “Start lisinopril 30 mg po q am” in same physician order - “Increase Altace 5 mg to 10 mg” in progress note * Documentation of both a plan to initiate/restart an ACEI and the reason/problem underlying the delay in starting/restarting ACEI constitutes a “clearly implied” reason for not prescribing ACEI at discharge (e.g., "Pt. hemodynamically unstable. May start ACEI as outpatient.”).
* **If the patient is on hydralazine and nitrates, and the record documents this drug therapy is a better option than ACEI or ARB for the patient, this documentation is acceptable as “other reason.”**
* Documentation of a pre-arrival hold/discontinuation of an ACEI or pre-arrival “other reason” for not prescribing an ACEI counts as a reason for not prescribing at discharge **ONLY** if the underlying reason is noted.
* When conflicting documentation regarding a reason for not prescribing an ACEI at discharge is documented in the medical record, select “yes” for the applicable reason.
 |
|  |  |  |  | * **Unacceptable Reasons:**
* Documentation of a conditional hold/discontinuation of an ACEI (e.g. “Hold lisinopril if cough recurs.”) without documentation the ACEI was held due to the specified reason.
* Documentation of a hold which refers to a more general medication class (e.g. “Hold all BP meds”).
* Deferral of an ACEI from one prescriber to another does **NOT** count as a reason **unless** underlying problem for deferral is noted (e.g., “cardiology to evaluate patient for ACEI” is **NOT** acceptable).

**98.** **Patient refusal:** Documentation by a physician/APN/PA or pharmacist that the patient refused ACEI medications or all medications is acceptable. Documentation that the patient refused BP medications is NOT acceptable.**Excluded Data Sources:** Any documentation dated/timed after discharge, **except** discharge summary and operative/ procedure/diagnostic test reports (from procedure done during hospital stay). |
| 45 | allerace | Is there documentation of the ACEI allergy/adverse reaction in the allergy box on the CPRS cover sheet?1. Yes2. No95. Not applicable  | 1,2,95Will be auto-filled as 95 if aceidc = 1 or noacewhy <> 1 | The intent of the question is to determine if the allergy/adverse reaction to the ACE inhibitor was documented in the allergy package of CPRS.  |
| 46 | arbatdc | Was an angiotensin II receptor antagonist (ARB or AIIRA) prescribed at discharge?Examples of ARB include, but are not limited to:* candesartan
* eprosartan
* irbesartan
* losartan
* valsartan
* combinations of ARB with hydrochlorothiazide

1. Yes2. No  | 1,2,95If 1, auto-fill noarbdc as 95 and allerarb as 95If 2, go to noarbdc | **In determining whether an ARB was prescribed at discharge, review all discharge medication documentation available in the chart.** If there is conflicting documentation among different medical record sources, the following guidelines apply:* In cases where there is an ARB in one source that is not mentioned in another source, it should be interpreted as a discharge medication unless documentation suggests that it was NOT prescribed at discharge. **Consider the ARB a discharge medication in the absence of contradictory documentation (see below)**.
* If documentation is **contradictory** (e.g., physician noted “dc losartan” in discharge orders, but losartan is listed in discharge summary), or careful examination of the circumstances raises enough questions about whether an ARB was prescribed at discharge, the case should be deemed unable to determine and answered as “2.”
* Consider documentation of a “hold” on an ARB after discharge as **contradictory** ONLY if the timeframe on the hold is **not defined (e.g., “Hold losartan” does not have a timeframe).**
* If an ARB is NOT listed as a discharge medication, and there is only documentation of a plan to delay initiation/restarting of an ARB for a time period after discharge (e.g. “Start losartan as outpatient”), select “2.”
* Disregard an ARB documented only as a recommended medication for discharge (e.g., “Recommend sending pt home on candesartan”). Documentation must be clear that the ARB was actually prescribed.
* Disregard documentation of ARB prescribed at discharge when noted only by medication class (e.g., “ARB Prescribed at Discharge: Yes” on a core measures form). The ARB must be listed by name.

**For a complete list of ARB medications, refer to TJC Appendix C, Table 1.7 or a drug handbook.** |
| 47 | noarbdc | Does the record document any of the following reasons for not prescribing an ARB at discharge? 1. ARB (AIIRA) allergy or sensitivity 2. Moderate or severe aortic stenosis1. Not applicable
	1. Other reasons documented by a physician/ APN/PA or pharmacist for not prescribing an ARB

98. Patient refusal of ARBs documented by physician/APN/PA or pharmacist 99. No documented reason | 1,2,95,97,98,99Will be auto-filled as 95 if arbatdc = 1If <> 1, auto-fill allerarb as 95 and go to bbatdc | **Documentation of a reason anytime during hospital stay is acceptable.** **1. ARB allergy/sensitivity:** documented **allergy** or **sensitivity** anytime during the hospital stay counts regardless of type of reaction noted (e.g. “Allergies: ARB–cough”); allergy/sensitivity to one ARB is acceptable as allergy to all ARBs.**2. Moderate or Severe Aortic Stenosis (AS):** Findings may be taken from diagnostic test reports. May be either current diagnosis or history of AS, without mention of repair, replacement, valvuloplasty, or commissurotomy. **INCLUDE:** AS described as moderate, severe, 3+, 4+, critical or significant; degree of severity not specified; aortic valve area of less than 1.0 square cm; subaortic stenosis, moderate/severe, or degree of severity not specified **EXCLUDE:** aortic insufficiency/regurgitation only; AS described as 1+ or 2+; AS using qualifiers: cannot exclude, cannot rule out, may have, may have had, may indicate, possible, suggestive of, suspect, or suspicious.**97. Other reason(s) documented by a physician/APN/PA or pharmacist:** * Must explicitly link the noted reason with non-prescription of an ARB.
* Should be considered implicit documentation for also not prescribing an ACEI for the following five conditions **ONLY:**
* Angioedema
* Hyperkalemia
* Hypotension
* Renal artery stenosis
* Worsening renal function/renal disease/dysfunction
* Documentation of a hold/discontinuation of an ARB during the hospital stay constitutes a “clearly implied” reason for not prescribing an ARB at discharge (e.g., “Patient hypotensive. May start ARB as outpatient”).

**EXCEPTIONS:** * Documentation of a **conditional** hold/discontinuation of an ARB does not count as a reason for not prescribing at discharge **UNLESS** (1) it exists as a physician/APN/PA or pharmacist **order** to hold/discontinue the ARB if BP falls outside certain parameters, AND (2) the ARB was held due to BP outside the parameters.
 |
|  |  |  |  | Nursing documentation is acceptable (e.g., Physician order: “Hold losartan for SBP < 100”and/ nurse documents “losartan held for BP 80/50”).* Discontinuation of a particular ARB medication documented in combination with the start of a different ARB medication (i.e., switch in type of ARB medication) does not count as a reason for not prescribing an ARB at discharge.

 Examples: - “Change Diovan to Verdia” in progress note- “Do not continue after discharge” checked for Cozaar 25 mg and “Continue after discha25 mg and “Cont Cozaar50 mg on a physician-signed discharge medication reconciliation form* Discontinuation of an ARB medication at a particular dose documented in combination with the start of a different dose of that ARB (i.e., change in dosage) does not count as a reason for not prescribing an ARB at discharge. Examples:

- “Do not continue after discharge” checked for Cozaar 25 mg and “Continue after discharge” checked for Cozaar 50 mg on a physician-signed discharge medication reconciliation form* Documentation of both a plan to initiate/restart an ARB and the reason/problem underlying the delay in starting/restarting ARB constitutes a “clearly implied” reason for not prescribing ARB at discharge (e.g., "Pt. hemodynamically unstable. May start ARB as outpatient.”).
* **If the patient is on hydralazine and nitrates, and the record documents this drug therapy is a better option than ACEI or ARB for the patient, this documentation is acceptable as “other reason.”**
* Documentation of a pre-arrival hold/discontinuation of an ARB or pre-arrival “other reason” for not prescribing an ARB counts as a reason for not prescribing at discharge **ONLY** if the underlying reason is noted.
* When conflicting documentation regarding a reason for not prescribing an ARB at discharge is documented in the medical record, select “yes” for the applicable reason.
 |
|  |  |  |  | * **Unacceptable Reasons:**
* Documentation of a conditional hold/discontinuation of an ARB (e.g. “Stop losartan if BP < 90 systolic.”) without documentation the ARB was held due to the specified parameter.
* Documentation of a hold which refers to a more general medication class (e.g. “Hold all BP meds”).
* Deferral of an ARB from one prescriber to another does **NOT** count as a reason **unless** underlying problem for deferral is noted (e.g., “cardiology to evaluate patient for ARB” is **NOT** acceptable).

**98.** **Patient refusal:** Documentation by a physician/APN/PA or pharmacist that the patient refused ARB medications or all medications is acceptable. Documentation that the patient refused BP medications is NOT acceptable.**Excluded Data Sources:** Any documentation dated/timed after discharge, **except** discharge summary and operative/ procedure/diagnostic test reports (from procedure done during hospital stay). |
| 48 | allerarb | Is there documentation of the ARB allergy/adverse reaction in the allergy box on the CPRS cover sheet?1. Yes2. No95. Not applicable  | 1,2,95Will be auto-filled as 95 if arbatdc = 1 or noarbdc <> 1  | The intent of the question is to determine if the allergy/adverse reaction to the ARB was documented in the allergy package of CPRS.  |
| 49 | bbatdc | Was a beta-blocker prescribed at discharge?Examples of beta-blockers include but are not limited to:* metropolol succinate or tartrate
* carvedilol
* atenolol
* nadolol
* propranolol
* combination of beta-blockers with other drugs
1. Yes
2. No
 | 1,2,95If 1, auto-fill nobbatdc as 95 and allerbb as 95If 2, go to nobbatdc  | **In determining whether a beta-blocker was prescribed at discharge, review all discharge medication documentation available in the chart.** If there is conflicting documentation among different medical record sources, the following guidelines apply:* In cases where there is a beta-blocker in one source that is not mentioned in another source, it should be interpreted as a discharge medication unless documentation suggests that it was NOT prescribed at discharge. **Consider the beta-blocker a discharge medication in the absence of contradictory documentation (see below)**.
* If documentation is **contradictory** (e.g., physician noted “dc metoprolol” in discharge orders, but metoprolol is listed in discharge summary), or careful examination of the circumstances raises enough questions about whether a beta-blocker was prescribed at discharge, the case should be deemed unable to determine and answered as “2.”
* Consider documentation of a “hold” on a beta-blocker after discharge as **contradictory** ONLY if the timeframe on the hold is **not defined (e.g., “Hold metoprolol” does not have a timeframe).**
* If a beta-blocker is NOT listed as a discharge medication, and there is only documentation of a plan to delay initiation/restarting of a beta-blocker for a time period after discharge (e.g. “Start metoprolol as outpatient”), select “2.”

For a list of beta-blocker medications refer to TJC Appendix C, Table 1.3 or a drug handbook.**Acceptable Sources**: discharge instructions, discharge orders, discharge summary |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 50 | nobbatdc | Does the record document any of the following reasons for not prescribing a beta- blocker at discharge?1. Beta-blocker allergy

3. Second or third degree heart block on ECG on arrival or during hospitalization and does not have a pacemaker* 1. Post-heart transplant patient
	2. Severely decompensated heart failure documented by physician/APN/PA

95. Not applicable* + 1. Other reasons documented by a physician/APN/PA or pharmacist for not prescribing a beta blocker at discharge
		2. Patient refusal of beta-blockers documented by physician/APN/PA or pharmacist

99.No documented reason | 1,3,9,10,95,97,98,99Will be auto-filled as 95 if bbatdc = 1If <> 1, auto-fill allerbb as 95 | **Documentation of reason anytime during hospital stay is acceptable.****1. Beta-blocker (BB) allergy/sensitivity:** documented **allergy/sensitivity** counts regardless of type of reaction noted; allergy/sensitivity to one BB is acceptable as allergy to all BBs. **EXCLUDE:** Allergy to BB eye drops (e.g., Cosopt).**3. Second or third-degree heart block (HB):** * Findings on arrival ECG or ECG during hospitalization that does not show pacemaker findings **OR** findings without mention of pacemaker (e.g., “second-degree heart block” per ED report).
* Disregard pacemaker findings if documentation suggests non-functioning pacemaker.
* Any notation of 2nd/3rd degree HB and pacemaker findings on ECG report or other source is acceptable with/without physician/APN/PA signature.

**INCLUDE: Stand alone/modified by “variable” or “intermittent”:** Atrioventricular (AV) block described as 2:1, 3:1, 2nd degree, or 3rd degree; AV dissociation; HB described as 2:1, 3:1, complete (CHB), high degree, high grade, 2nd degree, 3rd degree; Mobitz Type 1 or 2; Wenckebach; Pacemaker findings of paced rhythm/spikes; pacing described as atrial, AV, dual chamber or ventricular.**EXCLUDE:** HB, or any other 2nd/3rd degree HB inclusion terms described using qualifiers: cannot exclude, cannot rule out, may have, may have had, may indicate, possible, suggestive of, suspect, or suspicious; atrial flutter; AV block; AV conduction block; 1st degree AV block; 1st degree HB; HB type/degree not specified; intraventricular conduction delay (IVCD).**10. Severely decompensated heart failure:** cardiac decompensation is marked by dyspnea, venous engorgement, and edema. Abstractor may not make this decision based on symptoms described in record. There must be specific diagnosis by a physician/APN/PA.**97. Other reason(s) documented by a physician/APN/ PA or pharmacist:*** Must explicitly link noted reason with non-prescription of BB.
* Documentation of hold/discontinuation of BB during admission constitutes a “clearly implied” reason for not prescribing at discharge (e.g., “BP still low. May start metoprolol as outpatient.”).
 |
|  |  |  |  | **EXCEPTION:** Documentation of a **conditional** hold/discontinuation of BB does NOT count as reason for not prescribing BB at discharge **UNLESS** (1) it exists as an **order** to hold/discontinue if BP or HR falls outside certain parameters, AND (2) BB was held due to a BP/HR outside the parameters. Nursing documentation is acceptable (e. g., Physician order: “Hold atenolol for SBP < 100” and nurse documents “atenolol held for BP 90/50”).* Documentation of both a plan to initiate/restart BB and the reason/problem underlying delay in starting/restarting constitutes a “clearly implied” reason for not prescribing BB at discharge (e.g., “BPs low. May start atenolol as outpatient.”).
* Documentation of a pre-arrival hold/discontinuation or pre-arrival “other reason” for not prescribing BB counts as a reason for not prescribing BB at discharge **ONLY** if underlying reason is noted.
* When conflicting documentation regarding a reason for not prescribing BB at discharge is documented in the medical record, select “yes” for the applicable reason.
* **Unacceptable Reasons:**
* Documentation of a conditional hold/discontinuation of BB (e.g., “Stop metoprolol if SBP < 100.”) **without** documentation BB was held due to the specified parameter (e.g. SBP < 100).
* Documentation of a hold which refers to a more general medication class (e.g. “Hold all BP meds”).
* Deferral of BB from one prescriber to another does **NOT** count as a reason **unless** underlying problem for deferral is noted (e.g., “cardiology to evaluate patient for BB” is **NOT** acceptable).
* Documentation referring to eye drops containing BBs.

**98. Patient refusal:** Documentation by a physician/APN/PA or pharmacist that patient refused BB medications or all medications is acceptable. Documentation that patient refused BP medications is NOT acceptable.**Excluded Data Sources:** Any documentation dated/timed after discharge, **except** discharge summary and operative/ procedure/diagnostic test reports (from procedure done during hospital stay). |
| 51 | allerbb | Is there documentation of the beta-blocker allergy/adverse reaction in the allergy box on the CPRS cover sheet?1. Yes2. No95. Not applicable  | 1,2,95Will be auto-filled as 95 if bbatdc = 1 or nobbatdc <> 1  | The intent of the question is to determine if the allergy/adverse reaction to the beta-blocker was documented in the allergy package of CPRS.  |
| 52 | aldantdc | Was an aldosterone antagonist (Examples: spironolactone, eplerenone) prescribed at discharge?1. Yes
2. No
3. Not applicable
 | 1,2,95If 1, auto-fill noaldant as 95 and allerald as 95If 2, go to noaldant | Prescribed at discharge: instructed to continue aldosterone antagonist taken at home prior to admission, or taken during the episode of care, or provided a new prescription at discharge.**Brand name for spironolactone: Aldactone****Brand name for eplerenone: Inspra**For a list of aldosterone antagonist medications refer to a drug handbook. |
| 53 | noaldant | Does the record document any of the following reasons for not prescribing an aldosterone antagonist at discharge?1. Allergy, intolerance, or sensitivity
2. Renal insufficiency
3. Hyperkalemia
4. Not applicable
	1. Other reason documented by a physician/APN/ PA or pharmacist
	2. Patient refusal of aldosterone antagonist documented by physician/APN/PA or pharmacist
5. No documented reason
 | 1,2,3,95,97,98,99Will be auto-filled as 95 if aldantdc = 1If <> 1, auto-fill allerald as 95, and go to afibdoc | Notation of aldosterone antagonist allergy or sensitivity is sufficient. Side effects of spironolactone include breast pain and swelling in men, and menstrual irregularities in women. Patient’s inability to tolerate one or more such side effects must be documented, if reason for not prescribing or discontinuing drug. Renal insufficiency: acute renal failure; arterionephrosclerosis; azotemia; chronic renal disorder; chronic renal failure (CRF); chronic renal insufficiency; diabetic kidney disease; hemodialysis or peritoneal dialysisHyperkalemia: serum potassium > 5.5 meq/L that cannot be reduced (not a transient event) |
| 54 | allerald | Is there documentation of the aldosterone antagonist allergy/adverse reaction in the allergy box on the CPRS cover sheet?1. Yes2. No95. Not applicable  | 1,2,95Will be auto-filled as 95 if aldantdc = 1 or noaldant <> 1  | The intent of the question is to determine if the allergy/adverse reaction to the aldosterone antagonist was documented in the allergy package of CPRS.  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  | **Atrial Fibrillation** |  |  |
| 55 | afibdoc | Was there documentation of chronic or recurrent atrial fibrillation during this hospitalization?* 1. Yes
	2. No
1. Not applicable
 | 1,2,95If 2, auto-fill warfardc as 95, nowardc as 95, and go to dcdoc as applicable | Atrial fibrillation is a heart rhythm disorder (arrhythmia). It usually involves a rapid heart rate, in which the upper heart chambers (atria) are stimulated to contract in a very disorganized and abnormal manner.If atrial fibrillation is documented in the record for this episode of care, answer “1.” Atrial fibrillation may be described as chronic, persistent, recurrent, or paroxysmal. Any notation of atrial fibrillation on an ECG report during this hospitalization or other source in the medical record is acceptable with or without physician/APN/PA signature. |
| 72 | warfardc | Was warfarin prescribed at discharge?1. Yes
2. No

95. Not applicable | 1,2,95Will be auto-filled as 95 if afibdoc = 2If 1, auto-fill nowardc as 95, and go to dcdoc | **Prescribed at discharge= patient may or may not have been on warfarin during hospitalization, and warfarin was either continued or prescribed at the time of discharge.** |
| 56 | nowardc | Does the record document any of the following reasons for not prescribing warfarin at discharge?* 1. Warfarin allergy
	2. Pregnancy
	3. Risk of bleeding documented by physician/APN/PA
	4. Risk of fall documented by physician/APN/PA
	5. Psychosocial concerns documented by physician/APN/PA
	6. Potential medical contraindications documented by physician/APN/PA

95. Not applicable* + 1. Other reasons documented by physician/APN/PA or pharmacist for not prescribing warfarin at discharge

98. Patient refusal of warfarin documented by physician/APN/PA or pharmacist99. No documented reason | 1,2,3,4,5,6,95,97,98,99Will be auto-filled as 95 if afibdoc = 2 or warfardc = 1

|  |
| --- |
| Cannot enter 2 if sex = 1 |

 | **Warfarin allergy** = Where there is documentation of a warfarin “allergy” or “sensitivity”, regard this as documentation of a warfarin allergy regardless of what type of reaction might be noted. **Risk of bleeding documented by physician/APN/PA linked to non-prescription of warfarin**. For example, physician documents “active peptic ulcer—no warfarin.”**Risk of fall documented by physician/APN/PA linked to non-prescription of warfarin.** For example, physician notes “patient high risk for falls; no warfarin.”**Psychosocial concerns documented by physician/APN/PA and linked to non-prescription of warfarin** such as alcoholism or active psychosis.**Potential medical contraindications documented by physician/APN/PA** **and linked to non-prescription of warfarin** such as seizure disorder, malignant hypertension, and intracranial aneurysm.**Other reasons documented by physician/APN/PA which explicitly links the noted reason with non-prescription of warfarin.** For example, physician documents, “problems with warfarin in the past.”**Documentation of reasons anytime during the hospitalization is acceptable.** |
| **If dcdispo = 1 or 99 go to dcdoc; else auto-fill all remaining questions as “95,” and go to end**  |
| 57 | dcdoc | Does the medical record contain a copy of written discharge instructions or documentation of educational material given to the patient or caregiver at discharge, addressing all of the following:* Activity level
* Diet/fluid intake
* Discharge medications
* Follow-up with physician/APN/PA
* Weight monitoring
* What do to if heart failure symptoms worsen

**Note:** instructions do not have to be individually tailored to each patient. | **Note: each element of discharge instruction is counted individually, but all six instruction categories must be addressed to meet the measure** | Written instructions given anytime during the hospital stay are acceptable. Hospitals may use pre-printed discharge instruction sheets, brochures, booklets, teaching sheets, videos, CDs, and /or DVDs to provide discharge instructions. **General documentation guidelines for discharge instructions (please see applicable question for specific requirements):*** Documentation must clearly convey that the patient/caregiver was given a copy of the material to take home. When the material is present in the medical record and there is no documentation which clearly suggests that a copy was given, the inference should be made that it was given **IF** the patient’s name or the medical record number appears on the material **AND** hospital staff or the patient/caregiver has signed the material.
* **Use only the documentation provided in the medical record itself.** Do not review and use outside materials in abstraction. Do not make assumptions about what content may be covered in material documented as given to the patient/caregiver.
* If the patient refused written discharge instruction or other educational material, answer “yes.”
* The caregiver is defined as the patient’s family or any other person (e.g., home health, prison official or other law enforcement provider) who will be responsible for care of the patient after discharge.
 |
| 58 | dcdocact | Activity level after discharge?1. Yes
2. No
	1. Not applicable
 | 1,2,95 | Consider the following as acceptable if clearly documented: Activity as tolerated, cardiac rehab, exercise instructions, no strenuous activity, physical therapy, regular activity, regular walking, rest, restrict activityIf a pre-printed discharge instruction sheet is present in the record, but the section addressing instruction for activity level is left blank, do not consider the specific instruction to have been given.  |
| 59 | dcdocdiet | Diet/fluid intake after discharge?1. Yes
2. No
3. not applicable
 | 1,2,95 | May indicate necessity of low sodium diet, but any diet or fluid intake instructions are acceptable. The diet/fluid intake instructions do not need to be specific to heart failure.If a pre-printed discharge instruction sheet is present in the record, but the section addressing instruction for diet/fluid intake is left blank, do not consider the specific instruction to have been given.  |
| 60 | dcdocmeds | All discharge medications?1. Yes
2. No
3. Not applicable
 | 1,2,95 | Instructions must include at least the **NAMES** of all discharge medications. Specific names are not required for laxatives, antacids, vitamins, or herbs. Oxygen is not considered a medication. **The patient must receive a written list of ALL his/her discharge medications, and the record should contain evidence the patient was educated regarding these medications.** **The best source of a patient’s discharge medications is the pharmacy discharge medication list.** **1) Determine all medications being prescribed at discharge from the medical record documentation.** **2) Review the written discharge medication instructions to verify that all discharge medications are on the list.** If there is conflicting documentation among different medical record sources, the following guidelines apply:* In cases where there is a medication in one source that is not mentioned in another source, it should be interpreted as a discharge medication unless documentation suggests that it was NOT prescribed at discharge. **Consider the medication a discharge medication in the absence of contradictory documentation (see below)**.
* If documentation is **contradictory** (e.g., physician noted “dc lisinopril” in discharge orders, but lisinopril is listed in discharge summary), or careful examination of the circumstances raises enough questions about whether a medication was prescribed at discharge, the case should be deemed unable to determine and answered as “2.”
* Disregard a medication documented **only** as a recommended medication for discharge E.g., “Recommend sending pt home on Vasotec” – Vasotec is not required in the discharge instructions (but if it is listed on the instructions, this is acceptable). Documentation must be clear that such a medication was actually prescribed.
* If there is documentation of a plan to start/restart a medication after discharge or a hold on a medication for a defined timeframe (e.g. “Start Plavix as outpatient”, “Hold furosemide for 2 days”) and the medication is NOT listed as a discharge medication elsewhere, the medication on hold is not required to be in the discharge instructions.
	+ If the medication IS listed as a discharge medication elsewhere, the medication is required to be in the discharge instructions.
 |
| 61 | dcdocappt | Follow-up with a physician, nurse practitioner, or physician’s assistant after discharge?1. Yes
2. No
3. Not applicable
 | 1,2.95 | Written discharge instructions for follow-up must indicate that the follow-up is to be with one of the designated health care providers or in an office or clinic setting. Follow-up in a disease or case management program is acceptable. Written instructions given to the patient/caregiver to call for an appointment is also acceptable. **Exclude:** Follow-up for ancillary service only, (e.g. lab, radiology, etc.), follow-up prn or as needed, follow-up noted as non-applicable, none, or left blank.If a pre-printed discharge instruction sheet is present in the record, but the section addressing instruction for follow-up is left blank, do not consider the specific instruction to have been given.  |
| 62 | dcdocwt | Weight monitoring after discharge?1. Yes
2. No
3. Not applicable
 | 1,2,95 | Include written discharge instructions/educational material which address weight monitoring after discharge.**Weight monitoring (examples)** * Call in weights
* Check weight
* Contact physician/advanced practice nurse/physician assistant (physician/APN/PA) if sudden weight gain
* Daily weights
* Watch weight
* Weigh patient
* Weigh self
* Weight check

**Exclusion Guidelines for Abstraction:** Instructions directed toward weight loss only (e.g., "Lose weight" or "Report weight loss"). If a pre-printed discharge instruction sheet is present in the record, but the section addressing instruction for weight monitoring is left blank, do not consider the specific instruction to have been given.  |
| 63 | dcdocsym | What to do if heart failure symptoms worsen?1. Yes
2. No
3. Not applicable
 | 1,2,95If dmflag = 1, go to insulin, else go to end | Include written discharge instructions/educational material which address what to do if heart failure symptoms recur or do not improve after discharge.**Examples:**-“Call the office if weight gain is greater than 2 pounds.”-“Come to the emergency room if you experience a problem with breathing.”-“Make an appointment if heart failure symptoms return.”**Exclude:** Instructions on what to do if symptoms worsen, problems occur, the patient’s condition changes or worsens, etc, **WITHOUT** being specified or described as heart failure in nature (e.g., “Call physician if symptoms get worse,” “Contact office with any problems”) or if left blank.If a pre-printed discharge instruction sheet is present in the record, but the section addressing instruction for what to do if symptoms worsen is left blank, do not consider the specific instruction to have been given.  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  | **Insulin Discharge Instructions** |  |  |
| 64 | insulin | Was insulin prescribed at discharge? | 1,2,95If 2, auto-fill dcdm1, dcdm2, dcdm3, and dcdm4 as 95, and go to end | **In determining whether insulin was prescribed at discharge, review all discharge medication documentation available in the chart.** If there is conflicting documentation among different medical record sources, the following guidelines apply:* In cases where insulin is in one source that is not mentioned in another source, it should be interpreted as a discharge medication unless documentation suggests that it was NOT prescribed at discharge. **Consider the insulin a discharge medication in the absence of contradictory documentation (see below)**.
* If documentation is **contradictory** (e.g., physician noted “dc insulin” in discharge orders, but insulin is listed in discharge summary), or careful examination of the circumstances raises enough questions about whether insulin was prescribed at discharge, the case should be deemed unable to determine and answered as “2.”
* If there is documentation that the patient was discharged on insulin(s) of ANY kind, ANY reference to insulin as a discharge medication in the written discharge instructions is acceptable to answer “yes”. E.g., D/C summary notes patient discharged on “Humulin Insulin” and “Insulin 70/30” is listed on the discharge instruction sheet.
* If there is documentation of a plan to start/restart insulin after discharge or a hold on insulin for a **defined** timeframe (e.g. “Start Humulin as outpatient”, “Hold Lantus for 2 days”) and the insulin is NOT listed as a discharge medication elsewhere, the insulin on hold is not required to be in the discharge instructions.
* If the insulin IS listed as a discharge medication elsewhere, the insulin is required to be in the discharge instructions).

**Examples of insulin include, but are not limited to:**insulin aspart (Novolog), insulin aspart protamine/insulin aspart (Novolog 70/30), insulin detemir (Letemir), insulin glargine (Lantus), insulin glulisine, insulin isophane human (Humulin), insulin isophane pork, insulin isophane-insulin regular, insulin lispro(Humalog), insulin lispro protamine/insulin lispro (Humalog Mix), insulin regular human, insulin regular pork, insulin zinc human, insulin zinc pork |
| 65 | dcdm1 | Does the medical record contain a copy of written discharge instructions or documentation of educational material given to the patient or caregiver at discharge addressing what to do if hypoglycemic symptoms occur? | 1,2,95 | Written instructions given anytime during the hospital stay are acceptable. Instructions on what to do if hypoglycemic symptoms occur may include, but are not limited to:* If patient is unconscious, a spouse or friend should call 911
* How and when to inject glucagon
* If conscious, treat immediately by eating a food or glucose replacement with 15-20 g of fast-acting carbohydrates (CHO)
* Check blood glucose in 15 minutes. If <70 mg/dL or symptoms have not subsided, take an additional 15g CHO.
* Eat a meal with CHO within 30 minutes
* If blood glucose is still <70 mg/dL and does not increase after eating, seek further medical help

If the patient refused written discharge instruction or other educational material, answer “yes.”**Use only the documentation provided in the medical record itself.** Do not review and use outside materials in abstraction. Do not make assumptions about what content may be covered in material documented as given to the patient/caregiver.Videos, CDs, and DVDs are acceptable for educational material if there is clear documentation that the material includes instructions on what to do if hypoglycemic symptoms occur **and** the patient was given a copy to take home. |
| 66 | dcdm2 | Does the medical record contain a copy of written discharge instructions or documentation of educational material given to the patient or caregiver at discharge addressing sick day rules? | 1,2,95 | Written instructions given anytime during the hospital stay are acceptable. Sick day rules may include, but are not limited to: * Take diabetes medication.
* Self-monitor blood glucose more frequently.
* Test urine ketones if DM type 1.
* Eat the usual amount of CHO divided into smaller meals and snacks if necessary—if blood glucose is >250 mg/dL, the usual CHO may be unnecessary.
* Drink fluids frequently, 8 oz per hour while awake.

If the patient refused written discharge instruction or other educational material, answer “yes.”**Use only the documentation provided in the medical record itself.** Do not review and use outside materials in abstraction. Do not make assumptions about what content may be covered in material documented as given to the patient/caregiver.Videos, CDs, and DVDs are acceptable for educational material if there is clear documentation that the material includes instructions related to sick day rules **and** the patient was given a copy to take home. |
| 67 | dcdm3 | Does the medical record document the patient/ caregiver’s ability to administer insulin was assessed?3. Documented assessment of patient/caregiver’s knowledge of insulin administration4. Documented the patient/caregiver demonstrated administration of insulin 5. Documented assessment of the patient/caregiver’s insulin administration knowledge and patient/caregiver demonstration of insulin administration95. Not applicable99. No documentation the patient/caregiver’s ability to administer insulin was assessed  | 3,4,5,95,99 | * If there is documentation that the patient/caregiver’s knowledge of insulin administration was assessed anytime during the hospital stay, answer “3.” For example, nurse documents, “insulin self-administration – no problems reported by patient.”
* If there is documentation the health care staff observed the patient/caregiver administering insulin, answer “4.” For example, “Witnessed patient administering insulin injection. Correct technique noted.”
* If there is documentation of assessment of patient/caregiver knowledge of insulin administration and patient/caregiver demonstration of insulin administration, answer “5.”
* If the patient/caregiver ability to administer insulin was not assessed during the hospital stay, answer “99.”

  |
| 68 | dcdm4 | Does the medical record document the patient or caregiver’s ability to perform self-monitoring of blood glucose (SMBG) was assessed?3. Documented assessment of patient/caregiver’s knowledge of self-monitoring of blood glucose4. Documented the patient/caregiver demonstrated self-monitoring of blood glucose 5. Documented assessment the patient/caregiver’s of self-monitoring of blood glucose and patient/caregiver demonstration of SMBG95. Not applicable99. No documentation the patient/caregiver’s ability to perform SMBG was assessed | 3,4,5,95,99 | * If there is documentation that the patient/caregiver’s knowledge of self-monitoring of blood glucose (SMBG) was assessed anytime during the hospital stay, answer “3.” For example, nurse documents, “patient states no problems with SBGM.”
* If there is documentation the health care staff observed the patient/caregiver performing SMBG, answer “4.” For example, “Witnessed patient performing SMBG. Correct technique noted.”
* If there is documentation of assessment of patient/caregiver knowledge of SMBG and patient/caregiver demonstration of SMBG, answer “5.”
* If the patient/caregiver ability to self-monitor blood glucose was not assessed during the hospital stay, answer “99.”
 |
| **Enable Medication Reconciliation Module as applicable and if age >= 65 enable Delirium Risk** |

|  |
| --- |
| **Joint Commission Appendix A: Table 2.1** **Codes applicable to Heart Failure:*** 1. malignant hypertensive heart disease with heart failure

402.11 benign hypertensive heart disease with heart failure402.91 unspecified hypertensive heart disease with heart failure* 1. malignant hypertensive heart and kidney disease with heart failure

404.03 malignant hypertensive heart and kidney disease with congestive heart failure and renal failure* 1. benign hypertensive heart and kidney disease with heart failure

404.13 benign hypertensive heart and kidney disease with congestive heart failure and renal failure* 1. hypertensive heart and kidney disease with congestive heart failure, unspecified

404.93 hypertensive heart and kidney disease with congestive heart failure and renal failure, unspecified1. heart failure

428.1 left heart failure* 1. unspecified systolic heart failure
	2. acute systolic heart failure
	3. chronic systolic heart failure
	4. acute on chronic systolic heart failure
	5. unspecified diastolic heart failure
	6. acute diastolic heart failure
	7. chronic diastolic heart failure
	8. acute on chronic diastolic heart failure
	9. unspecified combined systolic and diastolic heart failure
	10. acute combined systolic and diastolic heart failure
	11. chronic combined systolic and diastolic heart failure
	12. acute on chronic combined systolic and diastolic heart failure

428.9 heart failure, unspecified  |