|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  |  | | | **Organizational Identifiers** |  |  |
|  | VAMC  CONTROL  QIC  BEGDTE  REVDTE | | | Facility ID Control Number  Abstractor ID  Abstraction Begin Date  Abstraction End Date | Auto-fill  Auto-fill  Auto-fill  Auto-fill  Auto-fill |  |
|  |  | | | Patient Identifiers |  |  |
|  | SSN  PTNAMEF  PTNAMEL  BIRTHDT  SEX  MARISTAT  RACE | | | Patient SSN First Name  Last Name  Birth Date  Sex  Marital Status  Race | Auto-fill: no change  Auto-fill: no change  Auto-fill: no change  Auto-fill: no change  Auto-fill: **can change**  Auto-fill: no change  Auto-fill: no change |  |
|  |  | | | **Administrative Data** |  |  |
| 1 | arrvdate | | | Enter the **earliest** documented date the patient arrived at acute care at this VAMC. | mm/dd/yyyy  Abstractor 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**. The intent of the arrival data elements is to capture the earliest date and time the patient was in this VAMC. Arrival date may differ from admission date.   * Do not include documentation from external sources (e.g., ambulance records, clinic records, physician office record, or lab reports) obtained prior to arrival to determine arrival date. The intent is to utilize documentation that reflects processes that occurred in the ED or hospital. * For patients in observation status and subsequently admitted to hospital:   + If the patient was admitted to observation from the ED of the hospital, use the date the patient presented to ED.   + If the patient was admitted to observation from an outpatient setting of the hospital, use the date the patient presented to ED or arrived on the floor for observation care.   + If the patient was a direct admit to observation, use the earliest date the patient arrived at the hospital. * If the patient is in an outpatient setting of the hospital (e.g., undergoing dialysis, chemotherapy) 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” to acute inpatient, use the earliest date the patient arrived at the hospital.   **ONLY ACCEPTABLE SOURCES:** Any ED documentation (includes ED vital sign record, ED Outpatient Registration form, triage record, ECG, lab or x-ray reports, etc., if these services were rendered while the patient was an ED patient), nursing admission assessment /admitting note, observation record, procedure notes (such as bronchoscopy, endoscopy), vital signs graphic record  Only 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**. **Determine the earliest time the patient arrived at this VHA hospital, such as in the ED or observation unit**.   * Do not include documentation from external sources (e.g., ambulance records, clinic records, physician office record, or lab reports) obtained prior to arrival to determine arrival time. The intent is to utilize documentation that reflects processes that occurred in the ED or hospital. * For patients in observation status and subsequently admitted to hospital:   + If the patient was admitted to observation from the ED of the hospital, use the time the patient presented to ED.   + If the patient was admitted to observation from an outpatient setting of the hospital, use the time the patient presented to ED or arrived on the floor for observation care.   + If the patient was a direct admit to observation, use the earliest time the patient arrived at the hospital. * If the patient is in an outpatient setting of the hospital (e.g., undergoing dialysis, chemotherapy) 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” to acute inpatient, use the earliest time the patient arrived at the hospital.   **ONLY ACCEPTABLE SOURCES:** Any ED documentation (includes ED vital sign record, ED Outpatient Registration form, triage record, ECG, lab or x-ray reports, etc., if these services were rendered while the patient was an ED patient), nursing admission assessment /admitting note, observation record, procedure notes (such as 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 obviously in error (e.g. 33:00) and no other documentation is found that provides this information, enter 99:99. |
| 3 | entradm | | | Admission date: | mm/dd/yyyy Computer will auto-fill   |  | | --- | | < = dtofdc | | **Auto-filled; can be modified if abstractor determines that the date is incorrect.**  **Exclusion:** admit to observation, arrival date  Admission 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: | \_\_\_\_\_ UMT  Computer will auto-fill   |  | | --- | | < dtofdc/whatime | | **Auto-filled; can be modified** |
| 5 | dtofdc | | | Discharge date: | mm/dd/yyyy  Computer 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 | entrcode1  entrcode2  entrcode3  entrcode4  entrcode5  entrcode6  entrcode7  entrcode8  entrcode9  entrcode10  entrcode11  entrcode12 | | | 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 entered manually, use the codes listed in the discharge summary for this inpatient episode of care.  **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. Related to the principal diagnosis.  Enter the ICD-9-CM code principal procedure code assigned by the VAMC, even if it does not meet the strict definition noted above.  **If no procedure was performed during the episode of care, fill ICD-9-CM code field with default code xx.xx**  **Date of the principal procedure is to be filled with 99/99/9999 if no procedure was performed or no date is available.**  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 | othrpx1  othrpx2  othrpx3  othrpx4  othrpx5  (codes)  othrpxdt1  othrpxdt2  othrpxdt3  othrpxdt4  othrpxdt5  (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 procedure was performed, the other procedure code fields may be filled with xx.xx and the date field with 99/99/9999**. **If a valid procedure code is entered, a valid date must be entered.**  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 | | hfedpt | Did the patient receive care/services in the Emergency Department of this VAMC?  1. Yes  2. No | | 1,2  If 2, auto-fill hfobsrv as 95, hfdecdt as 99/99/9999, hfdectm as 99:99, hfedcdt as 99/99/9999, hfedctm as 99:99, and go to dcdispo | **For the purposes of this data element an Emergency Department (ED) patient is defined as any patient receiving care or services in the ED of this VAMC.**  If the patient presents to the ED for outpatient services such as lab work and the patient receives the service in the ED, enter “1”.  A patient seen in an Urgent Care, ER Fast Track, etc. is NOT considered an ED patient unless the patient received services in the Emergency Department at this VAMC (e.g., patient treated at an urgent care and transferred to the main campus ED is considered an ED patient, but a patient seen at the urgent care and transferred to the hospital as a direct admit would not be considered an ED patient).  For patients presenting to the ED who do NOT receive care or services in the ED, enter “2” (e.g., patient is sent to hospital from physician office and presents to ED triage and is instructed to proceed straight to floor).  **Exclude:** Urgent Care, fast track ED, terms synonymous with Urgent Care |
| 14 | | hfobsrv | Was there documentation the patient was placed in observation services in the Emergency Department of this VAMC?  1. Yes  2. No  95. Not applicable | | 1,2  Will be auto-filled as 95 if hfedpt = 2 | **The intent is to capture emergency department patients placed into observation services in this Emergency Department prior to admission to the facility as an inpatient.**  If there is documentation the patient was placed into observation services and received care in observation provided by the Emergency Department or in an observation unit of the ED, select “1.”  If there is documentation the patient is being admitted for observation outside the Emergency Department, select “2.”  If there is no documentation the patient received observation services in the ED of this VAMC, select “2.”  **ONLY ALLOWABLE SOURCE: ED record** |
| 15 | | hfdecdt | Enter the earliest documented date of the decision to admit the patient. | | mm/dd/yyyy  Will be auto-filled as 99/99/9999 if  hfedpt = 2  Abstractor can enter 99/99/9999  If arrvdate = entradm, computer will auto-fill = arrvdate   |  | | --- | | > =arrvdate and < = entradm | | **For purposes of this data element, Decision to Admit Date is the date on which the physician/APN/PA makes the decision to admit the patient from the Emergency Department to the hospital as an inpatient.** This will not necessarily coincide with the date the patient is officially admitted to inpatient status.  **ONLY ACCEPTABLE SOURCE: ED record. Do not include any documentation from external sources (e.g., ambulance record, clinic note) obtained prior to arrival.**   * If there are multiple dates documented for the decision to admit abstract the earliest date. * If it can be determined that the patient arrived on the same date and departed on the same date, the arrival date can be used as the decision to admit date. * If the decision to admit the patient is made, but the actual request for a bed is delayed until an inpatient bed is available, record the date the physician/APN/PA made the decision to admit. * If the decision to admit date is dated prior to the date of patient arrival or after the date of departure, enter 99/99/9999. * If the date of the decision to admit is unable to be determined from medical record documentation, enter 99/99/9999.   If the admission date is the same date as arrival, Decision to Admit date will be auto-filled by the computer software.  The medical record must be abstracted as documented (i.e., face value). When the date documented is obviously in error (e.g. 11/42/20XX) or outside the parameters of care (e.g., after discharge date) and no other documentation is found that provides this information, enter 99/99/9999.  **Excludes, but is not limited to:** Bed assignment date, Admit Orders date, Admit to Observation date |
| 16 | | hfdectm | Enter the earliest documented time of the decision to admit the patient. | | \_\_\_\_  UMT  Will be auto-filled as 99:99 if  hfedpt = 2  Abstractor can enter 99:99   |  | | --- | | > =arrvdate/arrvtime and < = entradm/hfadmtm | | **For purposes of this data element “decision to admit time” is the time the physician/APN/PA communicates the decision to admit the patient from the Emergency Department to the hospital as an inpatient.** The decision to admit time will not necessarily coincide with the time the patient is officially admitted to inpatient status.  **ONLY ACCEPTABLE SOURCE: ED record, Do not include any documentation from external sources (e.g., ambulance record, clinic note) obtained prior to arrival.**   * If there are multiple times documented for the decision to admit abstract the earliest time. * If the decision to admit the patient is made, but the actual request for a bed is delayed until an inpatient bed is available, record the time the physician/APN/PA communicated the decision to admit. * Do not use admit order time for the Decision to Admit Time unless documentation clearly indicates this is the time the provider communicated the decision. If the documentation does not clearly indicate this was the time of the decision, enter 99:99. * If documentation of the decision to admit time is prior to arrival or after departure from the ED, enter 99:99.   If the time of the decision to admit is unable to be determined from medical record documentation, enter 99:99. The medical record must be abstracted as documented (i.e., at face value). When the time documented is obviously in error (e.g. 33:00), and no other documentation is found that provides this information, enter 99:99. **Excludes, but is not limited to:** Bed ass**ignment time, Admit Orders time,** Report Called Time, Admit to Observation time |
| 17 | | hfedcdt | Enter the date the patient departed from the emergency department. | | mm/dd/yyyy  Will be auto-filled as 99/99/9999 if  hfedpt = 2  Abstractor can enter 99/99/9999   |  | | --- | | > =arrvdate or = entradm and <= 3 days after entradm | | **ONLY ACCEPTABLE SOURCE: ED record**   * If the date of departure from the ED is not documented, but the date of departure can be determined from other documentation, (e.g., you are able to identify from documentation the patient arrived and was transferred to medical unit on the same day), enter this date. * For patients who are placed into observation under the services of the Emergency Department, abstract the date of departure from the observation services (e.g., patient is seen in the ED and admitted to an observation unit of the ED on 05/01/20XX then is discharged from the observation unit on 5/02/20XX abstract 5/02/20XX as the departure date). * For patients who are placed into observation outside the services of the Emergency Department, abstract the date of departure from the ED. * If there is documentation the patient left against medical advice and it cannot be determined what date the patient left against medical advice, enter 99/99/9999. * If the date the patient departed from the ED is unable to be determined from medical record documentation, enter 99/99/9999. * The medical record must be abstracted as documented (i.e., face value). When the date documented is obviously in error (e.g. 11/42/20XX) or outside the parameters of care (e.g., after discharge date) and no other documentation is found that provides this information, enter 99/99/9999.   **Includes, but is not limited to:** ED departure date, ED discharge date, ED leave date |
| 18 | | hfedctm | Enter the time the patient departed from the emergency department. | | \_\_\_\_  UMT  Will be auto-filled as 99:99 if  hfedpt = 2  Abstractor can enter 99:99   |  | | --- | | > = arrvdate/arrvtime and < = 72 hours after entradm/hfadmtm | | **ED Departure Time is the time the patient physically left the Emergency Department.** **The intention is to capture the latest time at which the patient was receiving care in the ED, under the care of Emergency Department services, or awaiting transport to another service/unit.**   * When more than one acceptable ED departure/discharge time is documented, abstract the **latest time**.   For example: Two departure times are found in the ED nurse’s notes: 12:03 via wheelchair and 12:20 via wheelchair. Enter the later time of 12:20 as ED departure time.   * If patient expired in the ED, use the time of death as the departure time. * For patients who are placed into observation under the services of the emergency department, abstract the time of departure from the ED observation services. For example, the patient is seen in the ED and admitted to an observation unit of the ED, then discharged from the observation unit. Enter the time the patient departed from the ED observation unit. * For patients who are placed into observation outside the services of the emergency department, abstract the time of departure from the emergency department. * Do not use the time the discharge order was written because it may not represent the actual time of departure.   If the time the patient departed from the ED is unable to be determined from medical record documentation, enter 99:99.The medical record must be abstracted as documented (i.e., at face value). When the time documented is obviously in error (e.g. 33:00), and no other documentation is found that provides this information, enter 99:99.  **Includes, but is not limited to:** ED Leave time, ED Discharge time, ED Departure time, ED Check Out time  **Excludes, but is not limited to: Report Call**ed time  **ONLY ACCEPTABLE SOURCE:** ED record |
| 19 | | 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 – Home  3. 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. Expired  7. Left Against Medical Advice/AMA  99. 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 |
|  | |  | **Antecedent Care** | |  |  |
| 20 | | preadmhf | Within 24 months period prior to this inpatient admission, did the patient have a VHA outpatient encounter or an acute care inpatient admission in which a diagnosis of heart failure was noted?  **Indicate all that apply:**   1. HF noted at prior inpatient acute care admission to VHA facility 2. HF noted at VHA outpatient encounter 3. No VHA encounter 4. No diagnosis of heart failure noted at any VHA encounter | | 1,2,3\*,99\*  \*If 3 or 99, go to comfort  If 1 or 2, go to educwt   |  | | --- | | Cannot enter 3 or 99 with any other number | | Twenty-four month period = from the admission date for this inpatient episode of care retrospective to the first day of the same month two years previously. (Example: admission date is 3/24/09. Twenty-four month period is 3/01/07 to 3/24/09).  **Diagnosis noted = documented as patient diagnosis in clinic or other outpatient note, or acute care inpatient progress notes or discharge summary, or entered on problem list.** Diagnosis of heart failure may be a principal or secondary diagnosis, or noted as “history of CHF.”  **Excluded: C&P visits; Employee Health 999 clinic stop codes.**  **Encounter must have been an inpatient acute care episode or a face-to-face outpatient encounter. Pharmacy visits, laboratory visits, or telephone calls are not applicable.**  The admission under review is not applicable. Inpatient admission must be a previous episode of care. |
| 21 | | educwt | At any inpatient or outpatient encounter within the twenty-four months prior to this admission, was instruction in weight monitoring provided to the patient or caregiver? | | 1,2  **If 2, auto-fill edwtdt as 99/99/9999** | HF Weight Instruction: Education and instruction for monitoring weight.  **Weight monitoring instructions given at discharge from an inpatient episode of care, occurring during the 24-month period prior to this admission, are acceptable to answer “1.”**  **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"). |
| 22 | | edwtdt | Enter the date of the most recent instruction in weight monitoring. | | mm/dd/yyyy  If educwt = 2, will be auto-filled as 99/99/9999   |  | | --- | | < = 24 mos prior or = entradm | | **If no instruction in weight monitoring was provided during the 24-month period, EDWTDT will be auto-filled as 99/99/9999.**  If weight monitoring instruction was provided, the month and year must be entered, at a minimum. |
|  | |  | **Acute Care** | |  |  |
| 23 | | 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 unclear  99. 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 | Hospice | | Comfort care | Hospice Care | | Comfort measures | Organ harvest | | Comfort measures only (CMO) | Palliative care | | Comfort only | Palliative measures | | DNR-CC | Terminal care | | End of life care |  |  * **Determine the earliest day the physician/APN/PA DOCUMENTED comfort measures only in the ONLY ACCEPTABLE SOURCES.** Do not factor in when comfort measures only was actually instituted. E.g., “Discussed comfort care with family on arrival” noted in day 2 progress note – Select “2.” * **Consider comfort measures only documentation in the discharge summary as documentation on the last day of the hospitalization, regardless of when the summary is dictated.** * **Physician/APN/PA documentation of comfort measures only mentioned in the following context is acceptable:** comfort measures only recommendation, order for consultation/evaluation by hospice/palliative care, patient/family request for comfort measures only, referral to hospice/palliative care service. * If any of the inclusions are documented in the ONLY ACCEPTABLE SOURCES, select option “1,” “2,” or “3,” accordingly, unless otherwise specified.   **Disregard documentation of an Inclusion term in the following situations:**   * Inclusion term clearly described as negative (e.g. “No comfort care,” “Not appropriate for hospice care,” “Declines palliative care”).   **Note:** If an Inclusion term is clearly described as negative in one source and NOT described as negative in another source, the second source would count for comfort measures only. (e.g. On Day 0, the physician documents, “The patient is not a hospice candidate.” On Day 3, the physician orders a hospice consult. Select “2.”)  **(Cont’d next page)** |

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|  | |  |  | |  | **(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 |  |   **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.** | |
| 24 | 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 frstbnp | | **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.** |
| 25 | frstbnp | | | Enter the result of the first BNP (b-type natriuretic peptide) or NT-proBNP test obtained closest to time of acute care arrival. | \_ \_ \_ \_ \_. \_ \_  **Abstractor may enter default zzzzz.zz if BNP not done**  If z-filled, auto-fill bnpunit as 95 and bnpdt as 99/99/9999 | | B-type natriuretic peptide (BNP) is a hormone released from the ventricles of the heart in response to increased wall tension. A BNP test or NT-proBNP test may be ordered to help diagnose heart failure or to assist with determination of a diagnosis when a patient presents with acute shortness of breath.    If no BNP was done during the episode of care, enter default zzzzz (decimal point) zz. |
| 26 | bnpunit | | | Enter the unit for the BNP or NT-proBNP value.  1. ng/ml of BNP  g/ml (micrograms/ml) of BNP  3. pg/ml of BNP  4. ng/nl of NT-proBNP  5. ug/ml (micrograms/ml) of NT-proBNP  6. pg/ml of NT-proBNP  95. Not applicable | 1,2,3,4,5,6,95  Will be auto-filled  as 95 if frstbnp  is z-filled | | If unsure of whether the BNP test was a NT-proBNP test or the unit of measurement used at this facility, check with the EPRP Liaison. |
| 27 | bnpdt | | | Enter the date of the first BNP or NT-proBNP value. | mm/dd/yyyy  Will be auto-filled as 99/99/9999 if frstbnp is z-filled   |  | | --- | | < = 48 hrs prior to or = entradm and  < = dtofdc | | | Enter the exact date the blood sample was drawn. |
|  |  | | | **Weight** |  | |  |
| 28 | 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.** |
| 29 | wtunit3 | | | Unit of measure   1. Pounds 2. Kilograms 3. Not applicable | 1,2,95  If frstwt is z-filled, will be auto-filled as 95   |  | | --- | | Warning window when wtunit3 = 1 and weight < = 98 or > = 278  When wtunit3 = 2, and weight < = 44 or > = 126 | | |  |
| 30 | frstwtdt | | | Enter the date the first weight was measured. | mm/dd/yyyy  Will 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. |
| 31 | 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.** |
| 32 | wtunitdc | | | Unit of measure  1. Pounds  2. Kilograms  95. Not applicable | 1,2,95  If weightdc is z-filled, will be auto-filled as 95   |  | | --- | | Warning window when wtunitdc = 1 and weight < = 98 or > = 278  When wtunitdc = 2, and weight < = 44 or > = 126 | | |  |
| 33 | 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. |

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|  |  | **Inpatient Admission Diagnostic Tests** |  |  |
| 34 | 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 |

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| 35 | 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 | 1,2,95  If 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 contractile performance/wall motion/systolic function. 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**  **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) diastolic dysfunction, failure, function or impairment  3) ventricular dysfunction, failure, or function NOT described as **left** ventricular  4) 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**. |

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| 36 | inhowlvf  inhowlvf1  inhowlvf2  inhowlvf3  inhowlvf4  inhowlvf95 | | 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 | 1,2,3,4,95  If asesslvf= 2, will be auto-filled as 95  If 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** |
| 37 | 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.** |
| 38 | 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** |
| 39 | efcutpin | | Enter the applicable EF cut point:  1. < 40%   1. < 30% 2. 40% or greater   95. Not applicable | 1,2,3,95  If 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** |
| 40 | 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 | 1,2,3,95  If 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** |
| 41 | | 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.** |
| 42 | | inptcmb  inptcmb1  inptcmb2  inptcmb3  inptcmb4  inptcmb99 | 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** |  |  |
| 43 | | icdpx | Is there documentation the patient had an implantable cardioverter-defibrillator (ICD) placed during this hospitalization? | 1,2  If 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.  ICD-9-CM procedure code: 37.94. |

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| 44 | icdpxdt | Enter the date the ICD was implanted. | mm/dd/yyyy  Will 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 |
| 45 | crtpx | Is there documentation the patient had implantation of biventricular pacemaker (cardiac resynchronization therapy) during this hospitalization? | 1,2  If 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.  ICD-9-CM procedure codes: 00.50, 00.51 |
| 46 | crtpxdt | Enter the date the CRT device was implanted. | mm/dd/yyyy  Will 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** |  |  |
| 47 | admace | During this admission, was the patient on an ACE inhibitor?   1. Yes 2. No | 1,2  If 1, auto-fill contace3 as 95  If 2, auto-fill acename2 as 95, and go to contace3 | During this admission = ACEI the patient received during this episode of care.  **If there is a prescription for an ACEI to be started after discharge, but an ACEI was not administered prior to discharge, select “2.”** |
| 48 | acename2 | Specify the ACE inhibitor administered during this admission:   1. enalapril 2. captopril 3. lisinopril 4. benazepril 5. fosinopril 6. quinapril 7. perindopril 8. moexipril 9. ramipril 10. trandolapril 11. other 12. enalapril/hydrochlorothiazide 13. enalapril/diltiazem 14. enalapril/felodipine 15. captopril/hydrochlorothiazide 16. lisinopril/hydrochlorothiazide 17. benazepril/hydrochlorothiazide 18. benazepril/amlodipine 19. fosinopril/hydrochlorothiazide 20. quinapril/hydrochlorothiazide 21. moexipril/hydrochlorothiazide 22. trandolapril/verapamil   95. Not applicable | 1,2,3,4,5,6,7,8,9,10,11, 12,13,14,15,16,17,18,  19,20,21,22,95  Will be auto-filled as 95  if admace = 2 | ACEI: Angiotensin converting enzyme inhibitors; ACEIs may be described as RAS (renin-angiotensin system) or RAAS (renin-angiotensin-aldosterone system) blockers/inhibitors.  If the patient is on an ACEI, but it is not one of the designated ACE inhibitors, answer “11.” Be certain the “other” is not a brand name for one of the generic ACEIs listed.  For a list of ACEI medications refer to JC Appendix C, Table 1.2or a drug handbook.  **Question is applicable to the ACEI being administered during this episode of care. If the patient’s ACEI was changed during the episode of care, but prior to discharge, designate the newly prescribed ACEI that was administered.** |
| 49 | contace3 | Does the record document any of the following reasons for not prescribing an ACEI during this admission?  1. ACEI allergy or intolerance   1. Moderate or severe aortic stenosis   95. 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 | 1,5,95,97,98,99  Will be auto-filled as 95 if admace = 1 | **1. ACEI allergy** = An ACEI “allergy” or “sensitivity” documented at anytime during the hospital stay counts as an allergy regardless of what type of reaction might be noted (e.g. “Allergies: ACEI – cough” – select “1.”)  Documentation of an allergy/sensitivity to one particular ACEI is acceptable to take as an allergy to the entire class of ACEI (e.g., “allergic to lisinopril”).  **5. Aortic stenosis** = notation of this diagnoses, with the description of moderate, severe, 3+, 4+, critical, or significant, in the record is acceptable. Finding of moderate or severe aortic stenosis may be taken from diagnostic test report Includes a current finding OR a history of moderate or severe aortic stenosis without mention or repair, replacement, valvuloplasty, or commissurotomy. **Include**: subaortic stenosis, moderate/severe or degree of severity not specified.  **Exclude:** aortic insufficiency only, aortic regurgitation only, aortic stenosis described as 1+ or 2+, aortic stenosis using one of the following qualifiers: cannot exclude, cannot rule out, may have, may have had, may indicate, possible, suggestive of, suspect, or suspicious.  **97. Other reason(s) documented by a physician/APN/ PA or pharmacist =** Must explicitly link the noted reason with non-prescription of an ACEI. Documentation of a reason anytime during the hospital stay is acceptable**.** ACEIs may be described as RAS (renin-angiotensin system) or RAAS (renin-angiotensin-aldosterone system) blockers/inhibitors.  **Physician/APN/PA or pharmacist documentation of a reason for not prescribing an ACEI should be considered implicit documentation for not prescribing an ARB for the following five conditions** **ONLY**:   * Angioedema * Hyperkalemia * Hypotension * Renal artery stenosis * Worsening renal function/renal disease/dysfunction   **Cont’d next page** |
|  |  |  |  | **Reasons for no ACEI cont’d**  If the patient is on hydralazine and nitrates, and the record documents this drug therapy is a better option than ACEI or ARB for the patient, this documentation is to be accepted asa reason for not prescribing an ACEI.  If there is conflicting documentation in the record regarding a reason for not prescribing an ACEI during this admission, accept as a “yes” for the applicable reason.  **98.** Documentation by a physician/APN/PA or pharmacist that the patient refused ACEI medications or refused all medications is acceptable. Documentation that the patient refused BP medications is NOT acceptable. |
| 50 | admarb | During this admission, was the patient on an angiotensin II receptor antagonist (ARB or AIIRA)?   1. Yes 2. No | 1,2  If 1, auto-fill contrarb1 as 95  If 2, auto-fill specarb1 as 95, and go to contrarb1 | During this admission = ARB the patient received during this episode of care.  **If there is a prescription for an ARB to be started after discharge, but an ARB was not administered prior to discharge, select “2.”**  AIIRA or ARB = Generic name: losartan potassium, Brand name: Cozaar; others include valsartan, irbesartan, candesartan, telmisartan**,** eprosartan, and olmesartan. |
| 51 | specarb1 | Specify the ARB:   1. Candesartan (Atacand) 2. Candesartan/hydrochlorothiazide (Atacand HCT) 3. Eprosartan (Teveten) 4. Eprosartan/hydrochlorothiazide (Teveten HCT) 5. Irbesartan (Avalide) (Avapro) 6. Irbesartan/hydrochlorothiazide 7. Losartan (Cozaar) 8. Losartan/hydrochlorothiazide (Hyzaar) 9. Olmesartan (Benicar) 10. Olmesartan/hydrochlorothiazide (Benicar HCT) 11. Tasosartan (Verdia) 12. Telmisartan (Micardis) 13. Telmisartan/hydrochlorothiazide (Micardis HCT) 14. Valsartan (Diovan) 15. Valsartan/hydrochlorothiazide (Diovan HCT) 16. Other     1. not applicable | 1,2,3,4,5,6,7,8,9,10,11, 12,13,14,15,16,95  If admarb = 2, will be auto-filled as 95 | ARB: Angiotensin receptor blockers or angiotensin II receptor antagonists (AIIRA); ARBs may be described as RAS (renin-angiotensin system) or RAAS (renin-angiotensin-aldosterone system) blockers/inhibitors  ARB names are listed by the generic name, as documented in VHA medical records. The brand name is displayed in parentheses after the generic name.  For a list of ARB medications refer to JC Appendix C, Table 1.7 or a drug handbook.  **Question is applicable to the ARB being taken or prescribed during this episode of care. If the patient’s ARB was changed during the episode of care, but prior to discharge, designate the newly prescribed ARB that was administered.** |

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| 52 | 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 stenosis   95. 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 | 1,2,95,97,98,99  Will be auto-filled as 95 if admarb = 1 | **1. ARB allergy** = An ARB “allergy” or “sensitivity” documented at anytime during the hospital stay counts as an allergy regardless of what type of reaction might be noted.  Documentation of an allergy/sensitivity to one particular ARB is acceptable to take as an allergy to the entire class of ARB (e.g., “allergic to losartan”).  **5. Aortic stenosis** = notation of this diagnoses, with the description of moderate, severe, 3+, 4+, critical, or significant, in the record is acceptable. Finding of moderate or severe aortic stenosis may be taken from diagnostic test report Includes a current finding OR a history of moderate or severe aortic stenosis without mention or repair, replacement, valvuloplasty, or commissurotomy. **Include**: subaortic stenosis, moderate/severe or degree of severity not specified.  **Exclude:** aortic insufficiency only, aortic regurgitation only, aortic stenosis described as 1+ or 2+, aortic stenosis using one of the following qualifiers: cannot exclude, cannot rule out, may have, may have had, may indicate, possible, suggestive of, suspect, or suspicious.  **97. Other reason(s) documented by a physician/APN/ PA or pharmacist =** Must explicitly link the noted reason with non-prescription of an ARB. Documentation of a reason anytime during the hospital stay is acceptable. ARBs may be described as RAS (renin-angiotensin system) or RAAS (renin-angiotensin-aldosterone system) blockers/inhibitors.  **Physician/APN/PA or pharmacist documentation of a reason for not prescribing an ARB should be considered implicit documentation for not prescribing an ACEI for the following five conditions** **ONLY**:   * Angioedema * Hyperkalemia * Hypotension * Renal artery stenosis * Worsening renal function/renal disease/dysfunction   If the patient is on hydralazine and nitrates, and the record documents this drug therapy is a better option than ACEI or ARB for the patient, this documentation is to be accepted as a reason for not prescribing an ARB.  **Cont’d next page** |
|  |  | | | |  |  | **Reasons for no ARB cont’d**  If there is conflicting documentation in the record regarding a reason for not prescribing an ARB during this admission, accept as a “yes” for the applicable reason.  **98.** Documentation by a physician/APN/PA or pharmacist that the patient refused ARB medications or refused all medications is acceptable. Documentation that the patient refused BP medications is NOT acceptable. |
| 53 | admbb | | | | Was the patient on a beta-blocker during this admission?   1. Yes 2. No | 1,2  If 1, auto-fill contrabb as 95  If 2, auto-fill bbname3 as 95, and go to contrabb | **During this admission = Beta-blocker the patient received 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.”** |
| 54 | bbname3 | | | | Specify the beta-blocker:   1. metoprolol succinate (Toprol-XL) 2. metoprolol tartrate 3. bisoprolol (Zebeta or Ziac) 4. carvedilol (Coreg) 5. atenolol (Tenoretic or Tenormin) 6. acebutolol (Sectral) 7. sotalol (Betapace) 8. betaxolol (Kerlone) 9. carteolol (Cartrol) 10. nadolol (Corgard) 11. nadolol/bendroflumethiazide (Corzide) 12. propranolol (Inderal) 13. propranolol hydrochloride (Inderide) 14. labetalol (Normodyne or Trandate) 15. penbutolol sulfate (Levatol) 16. metoprolol/hydrochlorothiazide (Lopressor HCT )     1. pindolol (Visken)     2. timolol (Timolide or Blocadren)     3. timolol/hydrochlorothiazide     4. Other     5. Not applicable | 1,2,3,4,5,6,7,8,9,10,11,12,13,14,15,16,17,18, 19,20,95  If admbb = 2, will be auto-filled as 95 | Beta-blocker generic names are not capitalized. Brand names are capitalized.  Enter the number corresponding to the generic name documented in the medical record.  For a list of beta-blocker medications refer to JC Appendix C, Table 1.3 or a drug handbook.  **Question is applicable to the beta blocker being taken or prescribed during this episode of care. If the patient’s beta blocker medication was changed during the episode of care, but prior to discharge, designate the newly prescribed beta-blocker that was administered.** |
| 55 | | 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 patient  10. Documentation of severely decompensated heart failure  95. Not applicable  97. Other reasons documented by a physician/APN/ PA or pharmacist  98. Patient refusal of beta-blockers documented by physician/APN/PA or pharmacist  99. No documented reason | | 1,2,3,9,10,95,97,98,99  Will be auto-filled as 95 if admbb = 1 | **Option Rules**:  Beta-blocker allergy = must be specific reference in the record to allergy or intolerance to beta-blockers  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.  Second or third degree heart block = Do not attempt to use the EKG tracing to answer this question. The EKG interpretation of second or third degree heart block must be documented in the record by a clinician or by electronic interpretation. Documentation of the EKG interpretation does not have to be linked specifically to contraindication to beta-blocker.  **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.  If there is conflicting documentation in the record regarding a reason for not prescribing a beta-blocker during this admission, accept as a “yes” for the applicable reason.  **98.** Documentation by a physician/APN/PA or pharmacist that the patient refused beta-blocker medications or refused all medications is acceptable. Documentation that the patient refused BP medications is NOT acceptable.  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. |
| 56 | aldostrx | | | Was the patient on an aldosterone antagonist (spironolactone, eplerenone) during this admission?   1. Yes 2. No | | 1,2  If 1, auto-fill aldostno as 95, and go to smokcigs | **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: Aldactone  Brand name for eplerenone: Inspra |
| 57 | 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 applicable  97. Other reason documented by a physician/APN/ PA or pharmacist  98. Patient refusal of aldosterone antagonist documented by physician/APN/PA or pharmacist   1. No documented contraindication | | 1,2,3,95,97,98,99  Will 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) |
|  |  | | | Inpatient Admission Patient Education | |  |  |
| 58 | smokcigs | | | Did the adult patient smoke cigarettes any time during the year prior to hospital arrival?   1. Yes 2. No or unable to be determined from medical record documentation | | 1,2  **If 2, auto-fill tobcess as 95** | This question refers only to smoking cigarettes and is not pertinent to other forms of tobacco**. If the record documents “tobacco use” or “+smoker” but the type of product is not specified, assume this refers to** **cigarette smoking unless documentation in another Only Acceptable Source suggests that the tobacco product is pipe, cigar, or chewing tobacco.**  If there is definitive documentation anywhere in the **ONLY ACCEPTABLE SOURCES** that the patient either currently smokes or is an ex-smoker that quit less than one year prior to hospital arrival, select “Yes,” **regardless of whether or not there is conflicting documentation.**  Examples of smoking within the past year include, but are not limited to:  “Former smoker. Quit recently.”  “History – quit smoking 7 months ago”  “Quit smoking several months ago”  “Social habits = current smoking”  “Tobacco history – current cigarette smoker”  **If there is NO definitive documentation of current smoking or smoking within one year prior to arrival in any of the ONLY ACCEPTABLE SOURCES select “No.”** The following examples would **not count** as inclusions (**select “No”**):   * “Smoked in the last year: ?” * “Probable smoker” * “Most likely quit 3 months ago”   Disregard documentation of smoking history or history of tobacco use if current smoking status or timeframe that patient quit is not defined (e.g., “20 pk/yr smoking history”, “History of tobacco abuse”).  Do not include documentation of smoking history referenced as a risk factor (e.g., “risk factor: tobacco,” “risk factor: smoking,”), where current smoking status is indeterminable.  **ONLY ACCEPTABLE SOURCES:** Emergency department record, history and physical, nursing admission assessment/nursing admission notes, respiratory therapy notes, Smoking/Tobacco Use assessment forms  **Exclude:** Documentation from a transferring facility or a previous admission |
| 59 | tobcess | | | Did the patient/caregiver receive smoking/tobacco use cessation advice or counseling during the hospitalization?   1. Yes 2. No 3. Not applicable | | 1,2,95  If smokcigs = 2, will be auto-filled as 95 | 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.  **Adult Smoking Counseling:**  Documentation indicating the patient/caregiver received one of the following:   * Direct discussion with patient/caregiver to stop smoking (stop using tobacco) whether or not the patient is currently smoking * Viewing a smoking/tobacco use cessation video * Given brochure or handouts on smoking/tobacco use cessation * Referred to a smoking cessation class or clinic * Prescribed a smoking cessation aid, e.g., Habitrol, Nicoderm, Nicorette, Nicotrol, Prostep, Zyban, or Chantix during hospital admission or at discharge * Prescription of Wellbutrin/bupropion during hospital stay or at discharge, if specifically prescribed as a smoking cessation aid.   If the patient smoked within the year prior to arrival but does not currently smoke, they should still be advised not to smoke. Cessation counseling is still required.  **Respond “1” if the patient/caregiver was given advice, a brochure, pamphlet, or video relative to smoking cessation even if the patient uses another form of tobacco**.  **If the patient refused smoking cessation advice or counseling during this hospital stay, answer “1.”**  2 = advice/counseling not done, or unable to determine from medical record documentation  **Suggested Data Sources**: Consultation notes, Discharge instruction sheet, Discharge summary, ED record, H&P, Medication administration record, Nursing notes, Progress notes, Respiratory therapy notes, Teaching sheet  **Exclude:** Any documentation dated/timed after discharge, **except** discharge summary and operative/procedure/diagnostic test reports (from procedure done during hospital stay) |
| **If dcdispo = 2, 3, 4, 6, or 7 auto-fill all remaining questions as “95,”and go to end** | | | | | | | |
|  | | |  | Inpatient Discharge Medications | |  |  |
| 60 | | | aceidc | Was an angiotensin converting enzyme inhibitor (ACE inhibitor) prescribed at discharge?   1. Yes 2. No 3. Not applicable | | 1,2,95  If 1, auto-fill noacewhy as 95 and allerace as 95  If 2, auto-fill onacedc as 95, getaceva as 95, and go to noacewhy | **In determining whether an ACEI was prescribed at discharge, review all discharge medication documentation available in the chart.**  If there is conflicting documentation among different medical record sources, the following guidelines apply:   * In cases where there is an ACEI in one source that is not mentioned in another source, it should be interpreted as a discharge medication unless documentation suggests that it was NOT prescribed at discharge. **Consider the ACEI a discharge medication in the absence of contradictory documentation (see below)**. * If documentation is **contradictory** (e.g., physician noted “dc lisinopril” in discharge orders, but lisinopril is listed in 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.” |

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| 61 | onacedc | Specify the ACE inhibitor:   1. enalapril 2. captopril 3. lisinopril 4. benazepril 5. fosinopril 6. quinapril 7. perindopril 8. moexipril 9. ramipril 10. trandolapril 11. other 12. enalapril/hydrochlorothiazide 13. enalapril/diltiazem 14. enalapril/felodipine 15. captopril/hydrochlorothiazide 16. lisinopril/hydrochlorothiazide 17. benazepril/hydrochlorothiazide 18. benazepril/amlodipine 19. fosinopril/hydrochlorothiazide 20. quinapril/hydrochlorothiazide 21. moexipril/hydrochlorothiazide 22. trandolapril/verapamil   95. Not applicable | 1,2,3,4,5,6,7,8,9,10,11, 12,13,14,15,16,17,18,  19,20,21,22,95  If aceidc = 2, will be auto-filled as 95 | **Patient may or may not have been on this medication during hospitalization, and it was either continued or prescribed at the time of discharge.** |
| 62 | getaceva | Does the record document the patient obtained the ACE inhibitor from the VA?  1. Yes  2. No  95. Not applicable | 1,2,95  Will be auto-filled as 95 if aceidc = 2  Go to arbatdc | Check the pharmacy records to see if the ACEI prescription was filled by the VA. |

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| 63 | 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 pharmacist  99. No documented reason | 1,5,95,97,98,99  Will be auto-filled as 95 if aceidc = 1  If <> 1, auto-fill allerace as 95, and go to arbatdc | **1. ACEI allergy** = An ACEI “allergy” or “sensitivity” documented at anytime during the hospital stay counts as an allergy regardless of what type of reaction might be noted (e.g. “Allergies: ACEI – cough” – select “1.”). Documentation of an allergy/sensitivity to one particular ACEI is acceptable to take as an allergy to the entire class of ACEI (e.g., “allergic to lisinopril”).  5. **Aortic stenosis** = notation of this diagnoses, with the description of moderate, severe, 3+, 4+, critical, or significant, is acceptable. Finding of moderate or severe aortic stenosis may be taken from diagnostic test report. Includes both a current finding or a history of moderate or severe aortic stenosis (without mention of repair, replacement, valvuloplasty, or commissurotomy), moderate/severe subaortic stenosis (or degree of severity not specified). **Exclude:** aortic insufficiency only, aortic regurgitation only, aortic stenosis described as 1+ or 2+, aortic stenosis using one of the following qualifiers: cannot exclude, cannot rule out, may have, may have had, may indicate, possible, suggestive of, suspect, or suspicious.  **97. Other reason(s) documented by a physician/APN/ PA or pharmacist = Must explicitly link the noted reason with non-prescription of an ACEI.**  Documentation of a reason anytime during the hospital stay is acceptable. ACEIs may be described as RAS (renin-angiotensin system) or RAAS (renin-angiotensin-aldosterone system) blockers/inhibitors.  **Physician/APN/PA or pharmacist documentation of a reason for not prescribing an ACEI should be considered implicit documentation for not prescribing an ARB for the following five conditions ONLY:**   * Angioedema * Hyperkalemia * Hypotension * Renal artery stenosis * Worsening renal function/renal disease/dysfunction   **Cont’d next page** |
|  |  | |  |  | **Reasons for Not Prescribing ACEI cont’d**  Physician/APN/PA or pharmacist documentation of a hold/discontinuation of an ACEI during the hospital stay or of a plan to initiate/restart an ACEI and notation of the reason/problem underlying the delay in starting/restarting the ACEI constitutes a “clearly implied” reason for not prescribing an ACEI at discharge (e.g., “Patient hypotensive. May start ACEI as outpatient.”). **EXCEPTION:** Documentation of a **conditional** hold/discontinuation of an ACEI does not count as a reason for not prescribing an ACEI at discharge **UNLESS** (1) it exists as a physician/APN/PA or pharmacist **order** to hold/discontinue the ACEI if the blood pressure (BP) falls outside certain parameters, AND (2) the ACEI was held due to a BP outside the parameters.  Nursing documentation is acceptable. E.g., “Hold lisinopril for SBP < 90” ordered and the nurse documents that the lisinopril was held for a BP of 80/50 – select “97.”  **If the patient is on hydralazine and nitrates, and the record documents this drug therapy is a better option than ACEI or ARB for the patient, this documentation is to be accepted as “other reason.”**  If there is conflicting documentation in the record regarding a reason for not prescribing an ACEI at discharge, accept as a “yes” for the applicable reason.  **98.** Documentation by a physician/APN/PA or pharmacist that the patient refused ACEI medications or refused all medications is acceptable. Documentation that the patient refused BP medications is NOT acceptable  **Unacceptable Reasons:**  Documentation of a conditional hold/discontinuation of an ACEI (e.g., “Hold lisinopril if cough recurs”).  Documentation of a hold which refers to a more general medication class (e.g. “Hold all BP meds”).  Deferral of an ACEI from one prescriber to another does NOT count as a reason for not prescribing an ACEI at discharge unless the problem underlying the deferral is noted. For example, “cardiology to evaluate patient for ACEI” – is NOT acceptable.  **Excluded Data Sources:** Any documentation dated/timed after discharge, **except** discharge summary and operative/ procedure/ diagnostic test reports (from procedure done during hospital stay). |
| 64 | allerace | Is there documentation of the ACEI allergy/adverse reaction in the allergy box on the CPRS cover sheet?  1. Yes  2. No  95. Not applicable | | 1,2,95  Will 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. |
| 65 | arbatdc | Was an angiotensin II receptor antagonist (ARB or AIIRA) prescribed at discharge?   1. Yes 2. No 3. Not applicable | | 1,2,95  If 1, auto-fill noarbdc as 95 and allerarb as 95  If 2, auto-fill dcarb as 95, getarbva as 95, and 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.” |
| 66 | dcarb | Specify the ARB:   1. Candesartan (Atacand) 2. Candesartan/hydrochlorothiazide (Atacand HCT) 3. Eprosartan (Teveten) 4. Eprosartan/hydrochlorothiazide (Teveten HCT) 5. Irbesartan (Avapro) 6. Irbesartan/hydrochlorothiazide (Avalide) 7. Losartan (Cozaar) 8. Losartan/hydrochlorothiazide (Hyzaar) 9. Olmesartan (Benicar) 10. Olmesartan/hydrochlorothiazide (Benicar HCT) 11. Tasosartan (Verdia) 12. Telmisartan (Micardis) 13. Telmisartan/hydrochlorothiazide (Micardis HCT) 14. Valsartan (Diovan) 15. Valsartan/hydrochlorothiazide (Diovan HCT) 16. Other 17. Not applicable | | 1,2,3,4,5,6,7,8,9,10,11, 12,13,14,15,16,95  If arbatdc = 2, will be auto-filled as 95 | ARB names are listed by the generic name, as documented in VHA medical records. The brand name is displayed in parentheses after the generic name. |
| 67 | getarbva | Does the record document the patient obtained the ARB from the VA?  1. Yes  2. No  95. Not applicable | | 1,2,95  Will be auto-filled as 95 if arbatdc = 2  Go to bbatdc | Check the pharmacy records to see if the ARB prescription was filled by the VA. |
| 68 | 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 stenosis 3. 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 | | 1,2,95,97,98,99  Will be auto-filled as 95 if arbatdc = 1  If <> 1, auto-fill allerarb as 95 and go to bbatdc | **1. ARB allergy** = An ARB “allergy” or “sensitivity” documented at anytime during the hospital stay counts as an allergy regardless of what type of reaction might be noted. Documentation of an allergy/sensitivity to one particular ARB is acceptable to take as an allergy to the entire class of ARBs (e.g., “allergic to losartan”).  5. **Aortic stenosis** = notation of this diagnosis, with the description of moderate, severe, 3+, 4+, critical, or significant, in the record is acceptable. Finding of moderate or severe aortic stenosis may be taken from diagnostic test report. Includes both a current finding or a history of moderate or severe aortic stenosis (without mention of repair, replacement, valvuloplasty, or commissurotomy), moderate/severe subaortic stenosis (or degree of severity not specified). **Exclude**: aortic insufficiency only, aortic regurgitation only, aortic stenosis described as 1+ or 2+, aortic stenosis using one of the following qualifiers: cannot exclude, cannot rule out, may have, may have had, may indicate, possible, suggestive of, suspect, or suspicious  **97. Other reason (s) documented by a physician/APN/ PA or pharmacist =** **Must explicitly link the noted reason with non-prescription of an ARB.** ARBs may be described as RAS (renin-angiotensin system) or RAAS (renin-angiotensin-aldosterone system) blockers/inhibitors.  Documentation of a reason anytime during the hospital stay is acceptable. **Physician/APN/PA or pharmacist documentation of a reason for not prescribing an ARB should be considered implicit documentation for not prescribing an ACEI for the following five conditions** **ONLY**:   * Angioedema * Hyperkalemia * Hypotension * Renal artery stenosis * Worsening renal function/renal disease/dysfunction   Physician/APN/PA or pharmacist documentation of a hold/discontinuation of an ARB during the hospital stay or of a plan to initiate/restart an ARB and notation of the reason/problem underlying the delay in starting/restarting the ARB constitutes a “clearly implied” reason for not prescribing an ARB at discharge (e.g., “Patient hypotensive. May start ARB as outpatient.”).  **Cont’d next page** |
|  |  |  | |  | **Reasons for Not Prescribing ARB cont’d**  **EXCEPTION:** Documentation of a **conditional** hold/discontinuation of an ARB does not count as a reason for not prescribing an ARB at discharge **UNLESS** (1) it exists as a physician/APN/PA or pharmacist **order** to hold/discontinue the ARB if the blood pressure (BP) falls outside certain parameters, AND (2) the ARB was held due to a BP outside the parameters.  Nursing documentation is acceptable. E.g., “Hold losartan for SBP < 100” ordered and the nurse documents that the losartan was held for a BP of 90/50 – select “97.”  **If the patient is on hydralazine and nitrates, and the record documents this drug therapy is a better option than ACEI or ARB for the patient, this documentation is to be accepted as “other reason.”**  If there is conflicting documentation in the record regarding a reason for not prescribing an ARB at discharge, accept as a “yes” for the applicable reason.  **98.** Documentation by a physician/APN/PA or pharmacist that the patient refused ARB medications or refused all medications is acceptable. Documentation that the patient refused BP medications is NOT acceptable.  **Unacceptable Reasons:**  Documentation of a conditional hold/discontinuation of an ARB (e.g., “Stop losartan if BP < 90 systolic.”) without documentation the ARB was held due to the specified parameter (e.g. SBP < 100).  Documentation of a hold which refers to a more general medication class (e.g. “Hold all BP meds.”).  Deferral of an ARB from one prescriber to another does NOT count as a reason for not prescribing an ARB at discharge unless the problem underlying the deferral is noted. For example, “cardiology to evaluate patient for ARB” – is NOT acceptable.  **Excluded Data Sources:** Any documentation dated/timed after discharge, **except** discharge summary and operative/ procedure/ diagnostic test reports (from procedure done during hospital stay). |
| 69 | allerarb | | Is there documentation of the ARB allergy/adverse reaction in the allergy box on the CPRS cover sheet?  1. Yes  2. No  95. Not applicable | 1,2,95  Will 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. |
| 70 | bbatdc | | Was a beta-blocker prescribed at discharge?   1. Yes 2. No 3. Not applicable | 1,2,95  If 1, auto-fill nobbatdc as 95 and allerbb as 95  If 2, auto-fill wichbbdc as 95, getbbva as 95, and 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.” |
| 71 | wichbbdc | | Designate the beta-blocker prescribed at discharge.   1. metoprolol succinate (Toprol-XL) 2. metoprolol tartrate 3. bisoprolol (Zebeta or Ziac) 4. carvedilol (Coreg) 5. atenolol (Tenoretic or Tenormin) 6. acebutolol (Sectral) 7. sotalol (Betapace) 8. betaxolol (Kerlone) 9. carteolol (Cartrol) 10. nadolol (Corgard) 11. nadolol/bendroflumethiazide (Corzide) 12. propranolol (Inderal) 13. propranolol hydrochloride (Inderide) 14. labetalol (Normodyne or Trandate) 15. penbutolol sulfate (Levatol) 16. metoprolol/hydrochlorothiazide (Lopressor HCT ) 17. pindolol (Visken) 18. timolol (Timolide or Blocadren) 19. timolol/hydrochlorothiazide 20. Other 21. Not applicable | 1,2,3,4,5,6,7,8,9,10,11,12,13,14,15,16,17, 18,19,20,95  If bbatdc = 2, will be auto-filled as 95 | Beta-blocker generic names are not capitalized. Brand names are capitalized.  Enter the number corresponding to the generic name documented in the medical record.  **“Prescribed for this patient at discharge” = patient may or may not have been on this medication during hospitalization, and it was either continued, to be taken post-discharge, or prescribed at the time of discharge.**  **Source**: discharge instructions, discharge orders, discharge summary |
| 72 | getbbva | | Does the record document the patient obtained the beta-blocker from the VA?  1. Yes  2. No  95. Not applicable | 1,2,95  Will be auto-filled as 95 if bbatdc 2  Go to aldantdc | Check the pharmacy records to see if the prescription was filled by the VA. |

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| 73 | 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,  97,98,99  Will be auto-filled as 95 if bbatdc = 1  If <> 1, auto-fill allerbb as 95 | **Beta-blocker allergy** = Where there is documentation of a beta- blocker “allergy” or “sensitivity”, regard this as documentation of a beta-blocker allergy regardless of what type of reaction might be noted. Documentation of an allergy/sensitivity to one particular beta-blocker is acceptable to take as an allergy to the entire class of beta-blockers (e.g., “allergic to Lopressor”).  **Second or third degree heart block** = when determining whether there is second or third-degree heart block on ECG on arrival or during the hospital stay and does not have a pacemaker:   * Consider this true if there are findings of second or third degree heart block on the ECG and this same ECG does not show pacemaker findings OR documentation of a finding of second or third-degree heart block without mention of pacemaker findings (e.g., “second-degree heart block” per ED report). * Disregard pacemaker findings if documentation suggests the patient had a non-functioning pacemaker. * Heart block or pacemaker findings do not have to be taken from ECG interpretations. Any notation of second or third-degree heart block or pacemaker findings on an ECG report or other source is acceptable with or without physician/APN/PA signature.   **97. Other reason(s) documented by a physician/APN/ PA or pharmacist =** **Must explicitly link the noted reason with non-prescription of a beta-blocker. Documentation of a reason anytime during the hospital stay is acceptable.**  Physician/APN/PA or pharmacist documentation of a hold/discontinuation of a beta-blocker during the hospital stay or of a plan to initiate/restart a beta-blocker and notation of the reason/problem underlying the delay in starting/restarting the beta-blocker constitutes a “clearly implied” reason for not prescribing a beta-blocker at discharge (e.g., “BP still low. May start metoprolol as outpatient.”). **Cont’d next page** |
|  |  |  | |  | **Reasons for not prescribing beta-blocker cont’d**  **EXCEPTION:** Documentation of a **conditional** hold/discontinuation of a beta-blocker does not count as a reason for not prescribing a beta-blocker at discharge **UNLESS** (1) it exists as a physician/APN/PA or pharmacist **order** to hold/discontinue the beta-blocker if the blood pressure (BP) or heart rate (HR) falls outside certain parameters, AND (2) the beta-blocker was held due to a BP/HR outside the parameters. Nursing documentation is acceptable. E.g., “Hold atenolol for SBP < 100” ordered and the nurse documents that the atenolol was held for a BP of 90/50 – select “97.”  If there is conflicting documentation in the record regarding a reason for not prescribing a beta-blocker at discharge, accept as a “yes” for the applicable reason.  **98.** Documentation by a physician/APN/PA or pharmacist that the patient refused beta-blocker medications or refused all medications is acceptable. Documentation that the patient refused BP medications is NOT acceptable.  **Unacceptable Reasons:**  Documentation of a conditional hold/discontinuation of a beta-blocker (e.g., “Stop metoprolol if SBP < 100”) without documentation the beta-blocker was held due to the specified parameter (e.g. SBP < 100).  Documentation of a hold which refers to a more general medication class (e.g. “Hold all BP meds”).  Deferral of a beta-blocker from one prescriber to another does NOT count as a reason for not prescribing a beta-blocker at discharge unless the problem underlying the deferral is noted. For example, “cardiology to evaluate patient for beta-blocker” – is NOT acceptable.  **Excluded Data Sources:** Any documentation dated/timed after discharge, **except** discharge summary and operative/ procedure/ diagnostic test reports (from procedure done during hospital stay). |
| 74 | allerbb | Is there documentation of the beta-blocker allergy/adverse reaction in the allergy box on the CPRS cover sheet?  1. Yes  2. No  95. Not applicable | | 1,2,95  Will 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. |
| 75 | aldantdc | Was an aldosterone antagonist (spironolactone, eplerenone) prescribed at discharge?   1. Yes 2. No 3. Not applicable | | 1,2,95  If 1, auto-fill noaldant as 95 and allerald  as 95  If 2, auto-fill getaldva as 95, and 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** |
| 76 | getaldva | Does the record document the patient obtained the aldosterone antagonist from the VA? | 1,2,95  Will be auto-filled as 95 if aldantdc = 2  Go to afibdoc | | Check the pharmacy records to see if the prescription was filled by the VA. |
| 77 | 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 | 1,2,3,95,97,98,99  Will be auto-filled as 95 if aldantdc = 1  If <> 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 dialysis  Hyperkalemia: serum potassium > 5.5 meq/L that cannot be reduced (not a transient event) |
| 78 | allerald | Is there documentation of the aldosterone antagonist allergy/adverse reaction in the allergy box on the CPRS cover sheet?  1. Yes  2. No  95. Not applicable | | 1,2,95  Will 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** | |  |  |
| 79 | afibdoc | Was there documentation of chronic or recurrent atrial fibrillation during this hospitalization?   * 1. Yes   2. No  1. Not applicable | | 1,2,95 | 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. |
| 80 | warfardc | Was warfarin prescribed at discharge?   1. Yes 2. No   95. Not applicable | | 1,2,95  If 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.** |
| 81 | 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 pharmacist  99. No documented reason | | 1,2,3,4,5,6,95,97,98,99  Will be auto-filled as 95 if 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** | | | | | |
|  | 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. |
| 82 | 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 activity  If 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. |
| 83 | 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. |
| 84 | 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.” * 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. |
| 85 | 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. |
| 86 | 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. |
| 87 | dcdocsym | What to do if heart failure symptoms worsen?   1. Yes 2. No 3. Not applicable | | 1,2,95  If 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** | |  |  |
| 88 | insulin | Was insulin prescribed at discharge? | | 1,2,95  If 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 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 |
| 89 | 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.”  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. |
| 90 | 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.”  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. |
| 91 | 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 administration  4. Documented the patient/caregiver demonstrated administration of insulin  5. Documented assessment the patient/caregiver’s of insulin administration knowledge and patient/caregiver demonstration of insulin administration  95. Not applicable  99. 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.” |
| 92 | 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 glucose  4. 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 SMBG  95. Not applicable  99. 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** | | | | | |

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| **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 failure  402.91 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, unspecified   1. 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 |