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| --- | --- | --- | --- | --- | --- |
|  |  |  | **Organizational Identifiers** |  |  |
|  |  | VAMCCONTROLQICBEGDTEREVDTE | Facility IDControl NumberAbstractor IDAbstraction Begin DateAbstraction End Date | Auto-fillAuto-fillAuto-fillAuto-fillAuto-fill |  |
|  |  |  | Patient Identifiers |  |  |
|  |  | SSNPTNAMEFPTNAMELBIRTHDTSEXMARISTATRACE | Patient SSNFirst NameLast NameBirth DateSex Marital StatusRace | Auto-fill: no changeAuto-fill: no changeAuto-fill: no changeAuto-fill: no changeAuto-fill: **can change**Auto-fill: no changeAuto-fill: no change |  |
|  |  |  | Administrative Data |  |  |

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| 1 | STK4 | edpt | Did the patient receive care/services in the Emergency Department of this VAMC?1. Yes2. No | 1,2 | **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** |
| 2 | STK4STK5 | arrvdate | Enter the **earliest** documented date the patient arrived at acute care at this VAMC. | mm/dd/yyyyAbstractor may enter 99/99/9999 if arrival date is unable to be determined

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| < = 6 mos prior to or = admdt and < = dcdate  |

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| Warning if > 3 days prior to admdt |

 | **Arrival date is the earliest recorded date on which the patient arrived in the hospital’s acute care setting where care for stroke could be most appropriately provided**. **Arrival date may differ from admission date.** **ONLY ACCEPTABLE SOURCES:** Emergency Department record (includes ED Face Sheet, Consent/Authorization for treatment forms, Registration/sign-in forms, vital sign record, triage record, physician orders, ECG reports, telemetry/rhythm strips, laboratory reports, x-ray reports); Nursing admission assessment/admitting note; Observation record; Procedure notes (such as cardiac cath, endoscopies, surgical procedures); Vital signs graphic record* **Review the ONLY ACCEPTABLE SOURCES to determine the earliest date the patient arrived at the ED, nursing floor, observation, or as a direct admit to the cath lab. The intent is to utilize any documentation which reflects processes that occurred after arrival at the ED or after arrival to the nursing floor/observation/cath lab for a direct admit.**
* If the patient was transferred from your hospital’s satellite/free-standing ED or from another hospital within your hospital’s system (as an inpatient or ED patient), and there is one medical record for the care provided at both facilities, use the arrival date at the first facility.
* Arrival date should NOT be abstracted simply as the earliest date in one of the ONLY ACCEPTABLE SOURCES, without regard to other substantiating documentation. When looking at the ONLY ACCEPTABLE SOURCES, if the earliest date documented appears to be an obvious error, this date should not be abstracted.

EXAMPLE: ED MAR has a med documented as 1430 on **11**-03-20xx. All other dates in ED record are **12**-03-20xx. The 11-03-20xx would not be used because it appears to be an obvious error.* For Observation Status:
	+ If the patient was admitted to observation from the ED of the hospital, use the date the patient arrived at the ED.
	+ If the patient was admitted to observation from an outpatient setting of the hospital, use the date the patient arrived at the ED or on the floor for observation care.
* If the patient is in an outpatient setting of the hospital (e.g., undergoing dialysis, chemotherapy) or a SNF unit of the hospital and is subsequently admitted to acute inpatient, use the date the patient presents to the ED or arrives on the floor for acute inpatient care as the arrival date.
* For Direct Admits:
	+ If the patient is a “Direct Admit” to the cath lab, use the earliest date the patient arrived at the cath lab (or cath lab staging/holding area) as the arrival date.
	+ For “Direct Admits” to acute inpatient or observation, use the earliest date the patient arrived at the nursing floor or in observation (as documented in the ONLY ACCEPTABLE SOURCES) as the arrival date.

**If unable to determine the date of arrival,** **enter default 99/99/9999.** 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. |

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| 3 | STK5 | 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**

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| --- |
| <= 6 mos prior to or = admdt and < dcdate |
| Warning if > 72 hours prior to admdt |

 | **Arrival time is the earliest recorded time the patient arrived in the hospital’s acute care setting where care for stroke could be most appropriately provided. Arrival time may differ from admission time.****ONLY ACCEPTABLE SOURCES:** Emergency Department record (includes ED Face Sheet, Consent/Authorization for treatment forms, Registration/sign-in forms, vital sign record, triage record, physician orders, ECG reports, telemetry/rhythm strips, laboratory reports, x-ray reports); Nursing admission assessment/admitting note; Observation record; Procedure notes (such as cardiac cath, endoscopies, surgical procedures); Vital signs graphic record* **Review the ONLY ACCEPTABLE SOURCES to determine the earliest time the patient arrived at the ED, nursing floor, observation, or as a direct admit to the cath lab. The intent is to utilize any documentation which reflects processes that occurred after arrival at the ED or after arrival to the nursing floor/observation/cath lab for a direct admit.**
* If the patient was transferred from your hospital’s satellite/free-standing ED or from another hospital within your hospital’s system (as an inpatient or ED patient), and there is one medical record for the care provided at both facilities, use the arrival time at the first facility.
* Arrival time should NOT be abstracted simply as the earliest time in one of the ONLY ACCEPTABLE SOURCES, without regard to other substantiating documentation. When looking at the ONLY ACCEPTABLE SOURCES, if the earliest time documented appears to be an obvious error, this time should not be abstracted.

EXAMPLE: ED Face Sheet lists arrival time 1320. ED registration 1325. ED triage 1330 ED consent to treat form has 1:17 with “AM” circled. ED record documentation suggests the 1:17 AM is an obvious error. Enter 1320 for Arrival Time.* For Observation Status:
	+ If the patient was admitted to observation from the ED of the hospital, use the time the patient arrived at the ED.
	+ If the patient was admitted to observation from an outpatient setting of the hospital, use the time the patient arrived at the ED or on the floor for observation care.
* If the patient is in an outpatient setting of the hospital (e.g., undergoing dialysis, chemotherapy) or a SNF unit of the hospital and is subsequently admitted to acute inpatient, use the time the patient presents to the ED or arrives on the floor for acute inpatient care as the arrival time. If the time the patient arrived on the floor is not documented by the nurse, enter the admission time recorded in EADT.
* For Direct Admits:
	+ If the patient is a “Direct Admit” to the cath lab, use the earliest time the patient arrived at the cath lab (or cath lab staging/holding area) as the arrival time.
	+ For “Direct Admits” to acute inpatient or observation, use the earliest time the patient arrived at the nursing floor or in observation (as documented in the ONLY ACCEPTABLE SOURCES) as the arrival time.

**If unable to determine the time of arrival, enter default time 99:99.** If the arrival time documented in the record is obviouslyin error (e.g. 33:00) and no other documentation is found that provides this information, enter 99:99. |

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| 4 | ALL | admdt | Admission date:  | mm/dd/yyyyComputer will auto-fill

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| --- |
| < = dcdate |

 | **Auto-filled; can be modified if abstractor determines that the date is incorrect.*** 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.

**Exclusion:** Admit to observation; Arrival date**ONLY ALLOWABLE SOURCES:** Physician orders (priority data source), Face Sheet |
| 5 | ALL | dcdate | Discharge date: | mm/dd/yyyy**Auto-filled: cannot be modified**> = admdt | **Auto-filled. Cannot be modified**The computer auto-fills the discharge date from the OABI pull list. This date cannot be modified in order to ensure the selected episode of care is reviewed.  |
| 6 | ALL | princode | ICD-10-CM principal diagnosis code: | \_\_ \_\_ \_\_. \_\_ \_\_ \_\_ \_\_(3 alpha-numeric characters/decimal point/four alpha-numeric characters)

|  |
| --- |
| **Cannot enter 000.0000, 123.4567, or 999.9999** |

\***If code is not listed in TJC Appendix A, Table 8.1 or 8.2, 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 Appendix A, Table 8.1 or 8.2.**

**Exclusion Statement:****Although coding designated the case for inclusion in the Joint Commission Stroke National Hospital Inpatient Quality Measures population, documentation in the record does not confirm an ICD-10-CM principal diagnosis code of stroke.**  |
| 9 | ALL | othdx1othdx2othdx3othdx4othdx5othdx6othdx7othdx8othdx9othdx10othdx11othdx12othdx13othdx14othdx15othdx16othdx17othdx18othdx19othdx20othdx21othdx22othdx23othdx24 | ICD-10-CM other diagnosis codes: | \_\_ \_\_ \_\_. \_\_ \_\_ \_\_ \_\_(3 alpha-numeric characters/decimal point/four alpha-numeric characters)**Auto-filled: cannot be modified****If enabled, can enter up to 24 codes****If enabled, abstractor can enter xxx.xxxx in code field if no other diagnosis codes found** | **Will be auto-filled from PTF with up to 24 ICD-10-CM other diagnosis codes. Cannot be modified.****If no other diagnosis codes are received from PTF, abstractor is to verify codes documented in the record and enter. If no other diagnosis codes are found in the record, enter xxx.xxxx.** |
| 10 | ALL | prinpxprinpxdt | Enter the ICD-10-CM principal procedure code and date. Date

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

 | \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_**(Must be 7 alpha-numeric characters)****If there is no principal procedure, the abstractor can enter xxxxxxx in code field and** **99/99/9999 in date field**

|  |
| --- |
| **Cannot enter 0000000** |

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

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| > = admdt and < = dcdate |

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

**If no procedure was performed during the episode of care, fill ICD-10-CM code field with default code xxxxxxx. Do not enter 99.99 or 0000000 to indicate no procedure was performed.** **Date of the principal procedure is to be filled with 99/99/9999 if no procedure was performed.**If the principal procedure date is unable to be determined from the medical record documentation, or the 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. |
| 11 | ALL | othrpx1othrpx2othrpx3othrpx4othrpx5(codes)othpxdt1othpxdt2othpxdt3othpxdt4othpxdt5(dates) | Enter the ICD-10-CM other procedure codes and dates. Code Date

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

 | \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_**(Must be 7 alpha-numeric characters)****If no other procedure was performed, the abstractor can enter xxxxxxx in code field and 99/99/9999 in date field**

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| **Cannot enter 0000000** |

mm/dd/yyyy**Abstractor can enter 99/99/9999****Can enter 5 codes and dates**

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| > = admdt and < = dcdate |

 | **Can enter 5 procedure codes, other than the principal procedure code.** Enter the ICD-10-CM codes and dates corresponding to each of the procedures performed, beginning with the procedure performed most immediately following the admission.* If no other procedures were performed, enter default code xxxxxxx in the code field and default date 99/99/9999 in the date field.
* If no other procedure was performed, it is only necessary to complete the xxxxxxx 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. |

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| 12 | ALL | dcdispo | What was the patient’s discharge disposition on the day of discharge?1. Home* Assisted Living Facilities (ALFs) – includes assisted living care at nursing home/facility
* Court/Law Enforcement – includes detention facilities, jails, and prison
* Home – includes board and care, domiciliary, foster or residential care, group or personal care homes, retirement communities, 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 (or other home setting as listed in #1 above)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)
* Veteran’s Home

6. Expired7. Left Against Medical Advice/AMA99. Not documented or unable to determine | 1,2,3,4,5,6,7,99

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| Warning if 99 |

 | **Discharge disposition: The final place or setting to which the patient was discharged on the day of discharge.*** **Only use documentation written on the day prior to discharge or the day of 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 to skilled care. Enter “5”.
* **Discharge disposition documentation in the discharge summary, post-discharge addendum, or a late entry, may be considered if written within 30 days after discharge date and prior to pull list date.**
* **If there is documentation that further clarifies the level of care that documentation should be used to determine the correct value to abstract.** **If documentation is contradictory, use the latest documentation.** For example: Discharge planner note from day before discharge states “XYZ Nursing Home”. Nursing discharge note on day of discharge states “Discharged: Home.” Select “1”.
* If documentation is contradictory, and you are unable to determine the latest documentation, select the disposition ranked highest (top to bottom) in the following list.
* Acute Care Facility
* Hospice – Health Care Facility
* Hospice – Home
* Other Health Care Facility
* Home
* Values “2” and “3” hospice includes discharges with hospice referrals and evaluations
* 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”.
* If the medical record identifies the facility the patient is being discharged to by name only (e.g., Park Meadows) and does not reflect the type of facility or level of care, select “5”.
* If the medical record states only that the patient is being discharged and does not address the place or setting to which the

patient was discharged, select “1”.* **Selection of option “7” (left AMA)**:
* **Explicit “left against medical advice” documentation is not required** (e.g., “Patient is refusing to stay for continued care”- select “7”). For the purposes of this data element, a signed AMA form is not required.
	+ If any source states the patient left against medical advice, select value “7”, regardless of whether the AMA documentation was written last.
	+ Documentation suggesting that the patient left before discharge instructions could be given without “left AMA” documentation does not count.

**Excluded Data Sources:** Any documentation prior to the last two days of hospitalization; coding documents**Suggested data sources:** Discharge instruction sheet, discharge planning notes, discharge summary, nursing discharge notes, physician orders, progress notes, social service notes, transfer record |
|  |  |  | **ADMITTING SERVICE** |  |  |
|  |  | admitserv | **Admitting Service**  | Text(Limit to 30 characters)

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| **Warning if left blank** |

 | **Free text entry. In determining the Service (e.g. Surgery, Cardiology, Medicine, etc.) or facility unit (ICU, CCU, etc.) to which the patient was admitted, the abstractor should be guided by Admission Orders, Progress Notes, Discharge Summary, etc.**If unable to make a definitive decision, consult with the facility Liaison for help in determining the Admitting Service. |

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|  |  |  | **CMO/Clinical Trial** |  |  |
| 13 | STK1STK2STK3STK5STK6STK8STK10 | comfort | When is the earliest physician, APN, or PA documentation of comfort measures only?1. Day of arrival (day 0) or day after arrival (day 1)2. Two or more days after arrival (day 2 or greater) 3. Comfort measures only documented during hospital stay, but timing unclear99. Comfort measures only was not documented by the physician/APN/PA or unable to determine  | 1,2,3,99

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| Warning if comfort = 2 |

 | **Comfort Measures Only (CMO):** refers to medical treatment of a dying person where the natural dying process is permitted to occur while assuring maximum comfort; includes attention to psychological and spiritual needs of patient and support for patient and family; commonly referred to as “comfort care” by general public. It is not equivalent to physician order to withhold emergency resuscitative measures such as Do Not Resuscitate (DNR). **ONLY accept terms identified in the list of inclusions. No other terminology will be accepted.**

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

* **Determine the earliest day the physician/APN/PA DOCUMENTED CMO. If any of the inclusion terms are documented by the physician/APN/PA, select option “1,” “2,” or “3,” accordingly.**

Example: “Discussed comfort care with family on arrival” noted in day 2 progress note – Select “2.” * **Physician/APN/PA documentation of CMO mentioned in the following context is acceptable:**
	+ Comfort measures only recommendation
	+ Order for consultation/evaluation by hospice care
	+ Patient/family request for comfort measures only
	+ Plan for comfort measures only
	+ Referral to hospice care service
* Discussion of comfort measures
* **State-authorized portable orders (SAPOs):**
* SAPOs = specialized forms/identifiers authorized by state law; translate 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); Out-of-Hospital DNR (OOH DNR)* SAPO in the record, dated and signed prior to arrival with any inclusion term checked, select value “1.”
* SAPO listing any CMO option, select value “1,” “2,” or “3” as applicable
* Use only the most recently dated/signed SAPO if more than one in record. Disregard undated SAPOs.
* If a SAPO is dated prior to arrival and there is documentation on day of arrival or day after arrival that patient does not want CMO, and no other documentation regarding CMO is found in the record, disregard the SAPO.
* **Disregard documentation of an Inclusion term in the following situations:**
* Documentation (other than SAPOs) 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 physician ED note).
* Inclusion term clearly described as negative or conditional (**Examples:** “No comfort care,” “Not appropriate for hospice care,” “Family requests CMO should the patient arrest.”)
* If documentation makes clear it is not being used as an acronym for Comfort Measures Only (e.g., “hx dilated CMO” - Cardiomyopathy context).
* **If there is physician/APN/PA documentation of an inclusion term in one source that indicates the patient is CMO, AND there is physician/APN/PA documentation of an inclusion term in another source that indicates the patient is NOT CMO, the source that indicates the patient is CMO would be used to select value “1,” “2,” or “3” for this data element.**

Examples:* Physician documents in progress note on day 1 “The patient has refused Comfort Measures” AND then on day 2 the physician writes an order for a Hospice referral. Select value “2.”
* ED physician documents in a note on day of arrival “Patient states they want to be enrolled in Hospice” AND then on day 2 there is a physician progress note with documentation of “Patient is not a Hospice candidate.” Select value “1.”

**Suggested Data Sources:** Consultation notes,Discharge summary, DNR/MOLST/POLST forms, Emergency Department record, History and physical Physician orders, Progress notes**Excluded data source:** Restraint order sheet  |

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| 14 | ALL  | clntrial | During this hospital stay, was the patient enrolled in a clinical trial in which patients with stroke were being studied?1. Yes2. No | 1,2If 1, the case is excluded. If 2, go to ecarintv | **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 stroke 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: Documentation during this hospital stay of enrollment of the patient in a clinical trial relevant to stroke excludes the case from The Joint Commission Stroke Hospital Quality Measures.**  |

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|  |  |  | **Carotid Intervention** |  |  |
| 15 | ALL  | ecarintv | Is there documentation that this admission was for the sole purpose of performance of an elective carotid intervention procedure (e.g., elective carotid endarterectomy, carotid angioplasty, carotid stenting)?1. Yes2. No | 1\*,2**Warning if 1 and prinpx or othrpx is not an ICD-10-CM Code on TJC Table 8.3****\*If 1, case is excluded.** | **Patients admitted for an acute stroke are not considered to have been admitted solely for the purpose of the performance of elective carotid intervention.** * If the patient was admitted for an acute stroke, even if a carotid intervention was performed after admission, select “No”.
* When documentation of the procedure is not linked with “elective”, select “No”.
* When the patient is directly admitted to the hospital post-procedure following an elective carotid intervention performed as an outpatient, select “Yes”. **Example:**

Patient scheduled for elective carotid endarterectomy right side on 05/17/20xx at 08:30. Patient checks into outpatient surgery at 06:13 and proceeds to the O.R., then to PACU. Patient status is changed to inpatient at 11:35 on 05/17/20xx. Patient discharged home on 05/18/20xx. **EXCEPTION:**Patients with documentation of an elective carotid intervention performed and discharged from the outpatient setting prior to hospital admission for stroke. **Example:**Pt. scheduled for outpatient placement of an elective right carotid stent on 05/17/20xx. Patient discharged home on 05/17/20xx following the procedure. Patient arrives in the ED two days later with complaints of syncope and left-sided numbness, and is admitted to the hospital on 05/19/20xx. Select “No.” * When documentation clearly indicates that the carotid intervention is elective, (e.g., admitting orders to obtain informed consent for a carotid procedure; pre-operative testing completed prior to admission; surgical orders for carotid endarterectomy dated prior to arrival; physician office visit documentation prior to arrival stating, “CEA with Dr. X planned in the near future”), select “Yes”.
* **Inclusion Terms for Elective:** Anticipated, asymptomatic, evaluation, non-emergent, planned, pre-admission, pre-arranged, pre-planned, pre-scheduled, preventive, previously arranged, prophylactic, scheduled, work-up

**Cont’d next page****Elective Carotid Intervention cont’d** If a patient has an ICD-10 procedure code(s) on TJC Table 8.3 Carotid Intervention Procedures and documentation indicates that the patient is also being treated for an acute stroke during this hospitalization, select “No”.**Suggested Data Sources:** History and physical, OR report, physician orders, progress notes**Exclusion Statement: Documentation that this patient was admitted solely for the performance of elective carotid intervention excludes the case from The Joint Commission designated Stroke Hospital Quality measures. Refer to Appendix A, Table 8.3 Carotid Intervention Procedures for examples of acceptable ICD-10-PCS procedure codes.** |

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|  |  |  | **Thrombolytic Therapy** |  |  |
| 16 | STK4 | lstknwl | Is there documentation that the date AND time of last known well was witnessed or reported?1. Yes2. No | 1,2If 2, go to iviatpa as applicable | **Last Known Well:** The date and time prior to hospital arrival at which it was witnessed or reported that the patient was last known to be without the signs and symptoms of the current stroke or at his or her baseline state of health.* **Select “Yes,” if BOTH a Date Last Known Well and a Time Last Known Well are documented.**
* Select “No” if there is ANY physician/APN/PA documentation that Last Known Well is “UNKNOWN.” Documentation must explicitly state that the Time Last Known Well is unknown/uncertain.
* Select “No” if the time last known well is clearly greater than 2 hours prior to hospital arrival AND no specific time is documented, Example: “Patient OK last night.” Select “No” because no other documentation of a specific time/time range/time reference was present in the medical record and the time is required for the Time Last Known Well (LSTKNWLTM).
* Select “No” if documentation of Last Known Well or stroke symptoms occurred at a date or time following hospital arrival, (e.g., in-house stroke).

**Inclusion Terms for Signs/Symptoms of Stroke****All include Sudden:*** numbness or weakness of face, arm or leg, especially on one side of the body
* confusion, trouble speaking or understanding
* trouble seeing in one or both eyes
* trouble walking, dizziness, loss of balance or coordination
* severe headache

**Suggested Data Sources:** Ambulance record, Code Stroke form/template, ED records, History and physical, IV flow sheets, Medication administration record, Nursing flow sheets, Progress notes, Transfer sheet |

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| 17 | STK4 | lstknwldt | Enter the date at which the patient was last known to be well or at his or her baseline state of health. | mm/dd/yyyy

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| --- |
| <= 3 days prior to or =arrvdate and <= arrvdate |

Abstractor may enter 99/99/9999 | **Enter the date associated with the Time Last Known Well.*** If the date last known well is unable to be determined from the medical record documentation, enter 99/99/9999.
* The medical record must be abstracted as documented (taken at “face value”). When the date documented is obviously in error (not a valid date/format) and no other documentation is found that provides this information, the abstractor should enter 99/99/9999

**Example:** Documentation indicates the date last known well was 03-42-20xx. No other documentation in the medical record provides a valid date. Since this is not a valid date, the abstractor should enter 99/99/9999.* If the date last known well is documented as a specific date and entered as Date Last Known Well on a “Code Stroke” form or stroke-specific electronic template, enter that date as the date last known well. Documentation of Date Last Known Well on a stroke-specific form or template should be selected regardless of other dates last known well documented elsewhere in the medical record.
* References in relation to Arrival date are acceptable (e.g., today, tonight, this evening, and this morning). The Date Last Known Well and the Arrival Date may be the same date or a different date.

Examples:* “Wife reports patient normal this evening until approximately 9 PM.” Hospital arrival is 0030 on 12-10-20xx.” Date Last Known Well is 12-09-20xx.
* “Patient states he felt perfectly fine earlier today. At noon he began to have trouble seeing.” Hospital arrival is 3:59 PM on 12-10-20xx. Date Last Known Well is 12-10-20xx.
* If a reference to date last known well is documented without a specific date, enter that date for the Date Last Known Well. If multiple dates last known well are documented, select the earliest date.

Examples:* “Patient last known well today (day of arrival).” Select Arrival Date for Date Last Known Well.
* Patient normal yesterday (day before arrival) documented in H&P and consult note documents that patient was last known well on Monday (two days prior to arrival).” Select Monday’s date for Date Last Known Well.

**Suggested Data Sources:** Ambulance record,Code Stroke form/template,ED records, History and physical, IV flow sheets, Medication Administration record, Nursing notes, Progress notes, Transfer sheet |

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| 18 | STK4 | lstknwltm | Enter the time at which the patient was last known to be well or at his or her baseline state of health. | \_\_\_\_\_UMT

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| --- |
| <= 72 hours prior to arrvtime and <= arrvtime |

 Abstractor may enter 99:99 | * **If the time last known well is unable to be determined from medical record documentation, enter 99/99/9999. EXCEPTION:**

If the only time last known well is documented as a time immediately before hospital arrival without a specific time range in minutes, e.g., “symptoms started just prior to ED arrival,” and no other documentation mentioning time last know well is available, use the Arrival Time for Time Last Known Well.* The medical record must be abstracted as documented (taken at “face value”). When the time documented is obviously in error (not a valid time) and no other documentation is found that provides this information, the abstractor should 99:99.

**Example:** Documentation indicates the time last known well was 3300. No other documentation in the medical record provides a valid time. Since the time last known well is not a valid time, the abstractor should enter 99:99.* If the time last known well is documented as a specific time and entered as Time Last Known Well on a “Code Stroke” form or stroke-specific electronic template, enter that time as the time last known well. Documentation of Time Last Known Well on a stroke-specific form or template should be selected regardless of other times last known well documented elsewhere in the medical record.
* If the time last known well is documented as being a specific number of hours prior to arrival (e.g., felt left side go numb 2 hours ago) rather than a specific time, subtract that number from the time of ED arrival and enter that time as the time last known well.
* If the time last known well is noted to be a range of time prior to ED arrival (e.g., felt left side go numb 2-3 hours ago), assume the maximum time from the range (e.g., 3 hours), and subtract that number of hours from the time of arrival to compute the time last known well.
* If both the time last known well and the time of symptom onset are documented, select the Time Last Known Well*.*

Examples: * H&P states, “Patient watching TV with family and complained of blurred vision in both eyes at 8:30 PM.” ED MD notes, “Patient normal at 8:30 PM.” Time Last Known Wellis 2030.
* “Patient was doing well at 4:30 PM – noticed difficulty speaking around 6 PM.” Time Last Known Wellis 1630.
* Patient normal at 2200 before going to bed. Awoke at 0200 with headache and took two aspirin before returning to sleep. OK at 0700 and went to work. Felt confused, unable to speak without slurring at 0800. Time Last Known Well is 0700.
* If the only time documented is time of symptom onset without mention of when the patient was last known well, use the time of symptom onset for time last known well.

Example: “Sudden onset headache one hour before ED arrival,” documented by EDMD. Arrival time 19:24. No other documentation referencing time last known well available in medical record. Time Last Known Well18:24.* If there are multiple times of last known well documented in the absence of the Time Last Known Well explicitly documented on a “Code Stroke” form, use physician documentation first before other sources, e.g., nursing, EMS.

Example: “Patient last seen normal this morning at 1000” per H&P. ED nurse documented 09:50 as time last well. Time Last Known Well is 1000* If multiple times of last known well are documented by different physicians or by the same provider, use the earliest time documented.
* If there is documentation of one or more episodes of stroke symptoms **AND** documentation of symptom resolution between episodes, use the time of the most recent (last) episode prior to arrival, regardless if all symptoms resolved prior to arrival.

 Examples: * “Patient reported right hand paresthesia two days ago that resolved spontaneously after a few minutes. New onset of symptoms today around 0700 involving right arm and right leg.” Time Last Known Wellis 0700.
* “Wife states that he was having trouble with slurred speech and confusion yesterday. Symptom free this morning. Return of symptoms with facial droop noted around noon.” Time Last Known Well is 1200.
* “Wife noticed slurred speech at 8:30 last night. Without symptoms early this morning. Wife noticed slurred speech again at 0900 during breakfast conversation.” Time Last Known Well is 0900.
* “Wife noticed slurred speech at 8:30 last night. Symptom-free this morning. Came to ED to get checked out.” Time Last Known Well is 2030.

**Suggested Data Sources:** Ambulance record, Code Stroke form/template, ED records, History and physical, IV flow sheets, Medication administration record, Nursing notes, Progress notes, Transfer sheet |
| 19 | STK4 | ivtpa | Is there documentation that IV thrombolytic therapy was initiated at this hospital?1. Yes2. No | 1,2If 1, auto-fill ynoivtpa as 95 and iviatpa as 1 If 2, auto-fill ivtpadt as 99/99/9999 and ivtpatm as 99:99, extpatm as 95, and go to ynoivtpa  | **IV thrombolytic therapy:** intravenous administration of tissue plasminogen activator (t-PA) a protein involved in the breakdown of blood clots.* When a “hang time” or “infusion time” for IV thrombolytic is documented in the medical record, select “Yes.”
* If IV thrombolytic therapy was administered at another hospital and patient was subsequently transferred to this hospital, select “No.”
* If the patient was transferred to this hospital with IV thrombolytic infusing, select “No.”

**ONLY Acceptable (FDA-approved) Thrombolytic Therapy for Stroke:*** alteplase (Activase)
* IV t-PA
* Recombinant t-PA (tissue plasminogen activator)

**Exclude:** Intra-arterial (IA) t-PA; thrombolytic administration to flush, open, or maintain patency of a central line, e.g., PICC line**Suggested Data sources:** ED records, IV Flow sheets, Medication administration records, Progress notes |
| 20 | STK4 | ivtpadt | Enter the date that IV thrombolytic therapy was initiated at this hospital. | mm/dd/yyyy

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| --- |
| >= arrvdate and <= 3days after arrvdate |

Will be auto-filled as 99/99/9999 if ivtpa = 2If ivtpadt = valid date, auto-fill tpadt as ivtpadtAbstractor may enter 99/99/9999 | * Use the date at which initiation of the IV thrombolytic was first documented. If a discrepancy exists in date documentation from different sources, choose nursing documentation first before other sources. If multiple dates are documented by the same individual, use the earliest date recorded by that person.
* If the date IV thrombolytic therapy was initiated is unable to be determined from medical record documentation, enter 99/99/9999.
* The medical record must be abstracted as documented (taken at “face value”). When the date documented is obviously in error (not a valid date/format) and no other documentation is found that provides this information, the abstractor should enter 99/99/9999. **Example:** Documentation indicates the IV thrombolytic initiation date was 03-42-20xx. No other documentation in the medical record provides a valid date. Since the IV thrombolytic initiation date is not a valid date, the abstractor should enter 99/99/9999.

**Suggested Data sources:** ED records, IV flow sheets, Medication administration records, Nursing flow sheets, Progress notes |
| 21 | STK4 | ivtpatm | Enter the time that IV thrombolytic therapy was initiated at this hospital. | \_\_\_\_\_UMT

|  |
| --- |
| >= arrvdate/arrvtime and <= 72 hours after arrvdate/arrvtime  |

If ivtpadt/ivtpatm minus lstknwldt/lstknwltm >= 0 and <= 180 minutes, auto-fill extpatm as 95, auto-fill iviatpa as 1, and go to antithrom, as applicableWill be auto-filled as 99:99 if ivtpa = 2If ivtpatm = valid time, autofill tpatm as ivtpatmAbstractor may enter 99:99 | * Use the time at which initiation of the IV thrombolytic was first documented. If a discrepancy exists in time documentation from different sources, choose nursing documentation first before other sources. If multiple times are documented by the same individual, use the earliest time recorded by that person.
* The use of “hang time” or “infusion time” is acceptable as IV thrombolytic initiation time when other documentation cannot be found.
* IV thrombolytic initiation time refers to the time the thrombolytic bolus/infusion was started.
* Do not use physician orders unless there is documentation with the order that it was administered.
* If the time IV thrombolytic therapy was initiated is unable to be determined from medical record documentation, enter 99:99.
* The medical record must be abstracted as documented (taken at “face value”). When the time documented is obviously in error (not a valid time) and no other documentation is found that provides this information, the abstractor should enter 99:99. **Example:** Documentation indicates the IV thrombolytic initiation time was 3300. No other documentation in the medical record provides a valid time. Since the IV thrombolytic initiation time is not a valid time, the abstractor should 99:99.

**Suggested Data sources:** ED records, IV flow sheets, Medication administration records, Nursing flow sheets, Progress notes |

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| 22 | STK4 | extpatm | Is there documentation on the day of or day after hospital arrival of a reason for extending the initiation of IV thrombolytics to 3 to 4.5 hours from Time Last Known Well?**Reasons for extending the initiation of IV thrombolytic to 3 to 4.5 hours:*** Documentation of treatment to lower blood pressure, (e.g., nicardipine, hydralazine, prior to IV thrombolytic initiation
* Documentation of patient/family refusal of IV thrombolytic which was recanted/reversed prior to IV thrombolytic initiation
* Documentation of cardiac arrest, respiratory arrest, cardiopulmonary resuscitation, defibrillation, or intubation in the emergency department prior to IV thrombolytic initiation
* Other reasons documented by physician/APN/PA or pharmacist

1. Yes2. No95. Not applicable | 1,2,95Will be auto-filled as 95 if ivtpa = 2 | **Documentation of a reason for extending the initiation of IV thrombolytic to 3 to 4.5 hours must be done on the day of or the day after hospital arrival and must refer to the time period prior to IV thrombolytic initiation. It is not necessary to review documentation outside of this timeframe to answer this data element.** * The following are acceptable as **stand-alone reasons** for extending the initiation of IV thrombolytics - IV thrombolytic therapy linkage is not needed:
* Documentation of treatment to lower blood pressure, (e.g., nicardipine, hydralazine, prior to IV thrombolytic initiation
* Documentation of patient/family refusal of IV thrombolytic which was recanted/reversed prior to IV thrombolytic initiation
* Documentation of cardiac arrest, respiratory arrest, cardiopulmonary resuscitation, defibrillation, or intubation in the emergency department prior to IV thrombolytic initiation
* “Other” reasons for extending the initiation of IV thrombolytic therapy to 3 to 4.5 hours must be documented by a physician/APN/PA or pharmacist.

**EXCEPTION:** Nursing documentation of a telemedicine/teleneurology reasonfor extending the initiation of IV thrombolytic therapy to 3 to 4.5 hours is acceptable.* **If “other” reasons are not mentioned in the context of IV thrombolytics, do not make inferences** (e.g., do not assume that IV thrombolytic was initiated in 3 to 4.5 hours because patient consent could not be obtained from family in 3 hours unless explicitly documented).

**System reasons are not acceptable as “other” reasons, regardless of any linkage to IV thrombolytics:*** Equipment-related (e.g., CT not available, IV pump malfunction)
* Pharmacy-related (e.g., thrombolytic agent not available from pharmacy)
* Staff-related (e.g., unable to contact consulting MD)

**Suggested Data Sources:** Consultation notes, ED records, History and physical, Medical transport records, Medication reconciliation form, Nurse’s notes, Physician orders, Progress notes, Transfer forms |
| 23 | STK4 | ynoivtpa | Is there documentation on the day of or day after hospital arrival of a reason for not initiating IV thrombolytic therapy?**Reasons for not initiating IV Thrombolytic:*** Documentation that intravenous (IV) or intra-arterial (IA) thrombolytic was initiated by a transferring hospital or EMS prior to hospital arrival
* Documentation of patient/family refusal of IV thrombolytic
* Documentation of NIHSS score of zero in the emergency department
* Documentation of cardiac arrest, respiratory arrest, cardiopulmonary resuscitation, defibrillation, or intubation in the emergency department
* Comfort Measures Only documented by a physician/APN/PA
* Other reasons documented by a physician/APN/PA or pharmacist

1. Yes2. No95. Not applicable | 1,2,95Will be autofilled as 95 if ivtpa = 1 | **Documentation of a reason for not initiating IV thrombolytic must be done on the day of or the day after hospital arrival. It is not necessary to review documentation outside of this timeframe to answer this data element.** * The following are acceptable as stand-alone reasons for not initiating IV thrombolytics - IV thrombolytic therapy linkage is not needed:
* Documentation that intravenous (IV) or intra-arterial (IA) thrombolytic was initiated by a transferring hospital or EMS prior to hospital arrival
* Documentation of patient/family refusal of IV thrombolytic
* Documentation of NIHSS score of zero in the emergency department
* Documentation of cardiac arrest, respiratory arrest, cardiopulmonary resuscitation, defibrillation, or intubation in the emergency department
* Comfort Measures Only documented by a physician/APN/PA
* “Other” reasons for not initiating IV thrombolytic therapy must be documented by a physician/APN/PA or pharmacist.

**EXCEPTION:**Nursing documentation of a telemedicine/teleneurology reason for not initiating IV thrombolytic therapy is acceptable.* **If other reasons are not mentioned in the context of IV thrombolytics, do not make inferences** (e.g., do not assume that an IV thrombolytic was not initiated because of a bleeding disorder unless documentation explicitly states so).

Acceptable examples (select “Yes”):* “Frail 95 year old – will not give thrombolytics due to age”
* “Patient with Stage IV cancer – No t-PA”
* “Increased risk of bleeding – hold t-PA for further evaluation”
* Documentation by a physician/APN/PA or pharmacist that the patient is not a t-PA candidate, not eligible for IV thrombolytic therapy, thrombolytics are not indicated, or t-PA is contraindicated, without mention of the underlying reason, is acceptable as an “other” reason if it is documented on the day of or day after hospital arrival.
* Documentation by a physician/APN/PA that the patient has no neurological deficits, e.g., “normal neuro exam,” “neurological exam has returned to baseline” at the time of presentation to the emergency department, is acceptable as an “other” reason if it is documented on the day of or day after hospital arrival.
* Reason documentation which refers to intravenous medications only (e.g., “Hold IV medications,” “No IVs”), is not acceptable.
* **System reasons are not acceptable as “other” reasons, regardless of any linkage to IV thrombolytics:**
* Equipment-related (e.g., CT not available, IV pump malfunction)
* Pharmacy-related (e.g., thrombolytic agent not available from pharmacy)
* Staff-related (e.g., unable to contact consulting MD)

**Exclusion Guidelines for Abstraction:*** **Delay in stroke diagnosis**
* **Hold IV thrombolytic without a documented reason**
* **No IV access**

**Suggested Data sources:** Consultation notes, ED records, History and physical, Medical transport records, Medication reconciliation form, Nurse’s notes, Physician orders, Progress notes, Transfer forms |
| **If Comfort = 1, go to end. If Comfort <>1 and (DCDATE minus ARRVDATE) >= 2 days, go to iviatpa; else go to afib as applicable** |
| 24 | STK5 | iviatpa | Did the patient receive intravenous (IV) or intra-arterial (IA) thrombolytic (t-PA) therapy at this VAMC or within 24 hours prior to arrival?1. Yes2. No | 1,2Will be auto-filled as 1 if ivtpa = 1If 2, go to antithrom, as applicable  | Documentation in the medical record must reflect that the patient received IV or IA thrombolytic (t-PA) therapy at this VAMC or within 24 hours prior to arrival, (i.e., drip and ship).**ONLY Acceptable Thrombolytic Therapy for Stroke:**Activase, Alteplase, Intra-arterial (IA) t-PA, Intravenous (IV) t-PA, Recombinant t-PA (Tissue plasminogen activator)This question will be auto-filled as 1 if ivtpa = 1.**Exclude:** Heparin flush, Heparin lock, Thrombolytic administration to flush, open or maintain patency of a central line, e.g., PICC line**Suggested data sources:** Emergency room record, medication records, progress notes, transfer forms, medical transport records |
| 25 | STK5 | tpadt | Enter the date thrombolytic (t-PA) therapy was administered. | mm/dd/yyyy

|  |
| --- |
| <= 1 day prior to or = arrvdate and <= 3 days after arrvdate |

Will be auto-filled as ivtpadt if ivtpadt = valid date | The date of t-PA administration must be known and entered accurately  |
| 26 | STK5 | tpatm | Enter the time thrombolytic (t-PA) therapy was administered. | \_\_\_\_\_\_UMT

|  |
| --- |
| <= 24 hours prior to or = arrvtime and <= 72 hours after arrvtime |

Will be auto-filled as ivtpatm if ivtpatm = valid time | The time of t-PA administration must be known and entered accurately. |
| **If COMFORT = 1, go to end. If COMFORT <> 1 and (DCDATE minus ARRVDATE) >= 2 days, go to ANTITHROM; else go to afib as applicable.** |
|  |  |  | **Antithrombotic Therapy** |  |  |
| 27 | STK5 | antithrom | Was antithrombotic therapy administered by the end of hospital day 2?**Examples of antithrombotic therapy include, but are not limited to: Aspirin, clopidogrel (Plavix), warfarin (Coumadin), dabigatran, enoxaparin, fondaparinux, heparin IV, ticlopidine, Zorprin**1. Yes2. No | 1,2If 1, auto-fill noanthrom as 95 and go to vtepro | * **To compute end of hospital day 2, count the arrival date as hospital day 1. If antithrombotic therapy was administered by 11:59 P.M. of hospital day two, select “Yes” for this data element.**
* **Documentation of antithrombotic administration must be found within the timeframe of arrival to the end of hospital day 2*. It is not necessary to review documentation outside of this timeframe to answer this data element.***
* For antithrombotic therapy administered in the Emergency Department/observation area prior to the end of hospital day 2, select “Yes”.
* Antithrombotic therapy administration information must demonstrate actual administration of the medication.

Example: Do not use physician orders as they do not demonstrate administration of the antithrombotic therapy (in the ED this may be used if signed/initialed by a nurse). * When antithrombotic is noted as a “home” or “current” medication or documentation indicates that it was received prior to hospital arrival only, select “No”.

**Refer to TJC Appendix C, Table 8.2 for a list of medications used for antithrombotic therapy.****Exclude:** Heparin flush, Heparin SQ, Hep-Lock**Suggested data sources:** Emergency department record, Medication administration record, Progress notes, Nursing flow sheet/notes, **Excluded data sources:** EMS or ambulance documentation,any documentation dated/timed prior to hospital arrival or after hospital day 2 |
| 28 | STK5 | noanthrom | Is there documentation by a physician/APN/PA or pharmacist in the medical record of a reason for not administering antithrombotic therapy by end of hospital day 2?1. Allergy to ALL antithrombotic medications2. Physician/APN/PA or pharmacist documentation of a reason for not prescribing antithrombotic therapy by end of hospital day 295. Not applicable98. Patient/family refusal99. No documented reason | 1,2,95,98,99Will be auto-filled as 95 if antithrom = 1 | * **Documentation for allowable values “1, 2, or 98” must be found within the timeframe of arrival to the end of hospital day 2. It is not necessary to review documentation outside of this timeframe.**
* **To compute end of hospital day 2, count the arrival date as hospital day 1. Hospital day 2 ends at 11:59 P.M. on day 2.**
* **With exception of allergy and patient/family refusal, reason for not administering antithrombotic therapy must be documented by a physician/APN/PA or pharmacist.**
* **If reasons are not mentioned in the context of antithrombotics, do not make inferences** (e.g., do not assume that antithrombotic therapy was not administered because of a bleeding disorder unless documentation explicitly states so).
* Reasons must be explicitly documented (e.g., “Hemorrhagic transformation – do not give aspirin,” “Active GI bleed – antithrombotic therapy contraindicated,” “H/O bleeding disorder – anticoagulation therapy contraindicated,” “Low platelet count - do not give antiplatelet medications,” “No ASA” [no reason given]).
* Physician/APN/PA or pharmacist documentation of a hold on an antithrombotic medication or discontinuation of an antithrombotic medication that occurs the day of or day after hospital arrival constitutes a “clearly implied” reason for not administering antithrombotic therapy by end of hospital day 2. A hold/discontinuation of all p.o. medications counts if an antithrombotic was on order at the time of the notation.
* An allergy or adverse reaction to one type of antithrombotic would NOT be a reason for not administering all antithrombotic agents. Another medication can be ordered.
* For patients on warfarin therapy prior to hospital arrival, but placed on hold the day of or after arrival due to “high INR,” select “2”.

**(Cont’d next page)****Examples of reasons for not administering antithrombotic therapy by the end of hospital day 2 include, but are not limited to:*** Allergy to all antithrombotic medications
* Aortic dissection
* Bleeding disorder
* Brain/CNS cancer
* CVA, hemorrhagic
* Extensive/metastatic CA
* Hemorrhage, any type
* Intracranial surgery/biopsy
* Patient/family refusal
* Peptic ulcer
* Planned surgery within 7 days following discharge
* Risk of bleeding
* Unrepaired intracranial aneurysm

**Exclude:** Delay in stroke diagnosis**Suggested data sources:** Consultation, emergency department record, history & physical, medication reconciliation form, progress notes**Suggested Data Sources for patient/family refusal:** Medication administration Record, Nurses notes**Excluded data sources:** Any documentation dated/timed prior to hospital arrival or after hospital day 2. |

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|  |  |  | **VTE Prophylaxis for Stroke** |  |  |
| 29 | STK1 | vtepro1vtepro2vtepro3vtepro4vtepro5vtepro6vtepro7vtepro8vtepro9vteproA | What type of VTE prophylaxis was administered the day of or day after hospital admission?**Indicate all that apply:**1. Low dose unfractionated heparin (LDUH) (**subcutaneous route only)**2. Low molecular weight heparin (LMWH) (**such as enoxaparin)**3. Intermittent pneumatic compression devices **(such as SCDs)**4. Graduated compression stockings **(such as TED hose)**5. **Parenteral** Factor Xa Inhibitor (fondaparinux)6. Warfarin7. Venous foot pumps (VFP)8. **Oral** Factor Xa Inhibitor (such as rivaroxaban)9. AspirinA None of the above or unable to determine from medical record documentation | 1,2,3,4,5,6,7, 8,9,AIf 1,2,3,5,6,7, auto-fill oralxai as 95 and noadmpro as 95Else if 8, go to oralxai; else go to noadmpro If A, auto-fill oralxai as 95, admprodt as 99/99/9999, and go to noadmpro

|  |
| --- |
| Value A cannot be entered with any other number |

 | * **Begin by looking for documentation of administration of VTE prophylaxis on the day of or day after hospital admission. If no VTE prophylaxis was administered during this timeframe, select A.**
* **Selection of allowable values 1-9 includes any VTE prophylaxis that was administered in the allowable time frame.** For example: If a patient was admitted on 12/8/20xx and had bilateral GCS applied at 13:00 on 12/9/20xx and LMWH was administered at 22:00 on 12/8/20xx, select “2” and “4”.
* Only select prophylaxis if there is documentation that it was administered. Documentation in the physician progress notes under assessment/plan: “DVT prophylaxis - IPC” is not enough to select value “3’.
* If one pharmacological medication is ordered and another medication is substituted (such as per pharmacy formulary substitution or protocol), select the medication administered.

**Examples of each VTE prophylaxis category (refer to TJC Appendix H, Table 2.1 for complete list):****Low dose unfractionated heparin** (LDUH) - **only include heparin administered by subcutaneous route** (SC, SQ, SubQ): heparin, heparin sodium **Low molecular weight heparin** (LMWH): dalteparin (Fragmin), enoxaparin (Lovenox), tinzaparin (Innohep) **Intermittent pneumatic compression devices** (IPC): AE pumps (anti-embolic pumps) calf/thigh, DVT boots-calf/thigh, sequential compression device (SCD)**Graduated compression stockings** (GCS) **knee or thigh high:** Anti-embolism stockings, TED hose (TEDS), Jobst stockings**Parenteral Factor Xa Inhibitor such as**: fondaparinux (Arixtra)**Warfarin** such as: Coumadin, Jantoven**Venous foot pumps:** AE pumps – foot only, Kendall boots, Pneumoboots – foot only**Oral Factor Xa Inhibitor such as**: apixaban (Eliquis), rivaroxaban (Xarelto)**Aspirin such as:** acetylsalicyclic acid (ASA), buffered aspirin**Suggested data sources:** Circulator notes, Emergency Department record, graphic/flow sheets, medication administration record, nursing notes, operative notes, preoperative nursing notes, progress notes, |
| 30 | STK1 | oralxai | Is there physician/APN/PA documentation of a reason why Oral Factor Xa Inhibitor was administered for VTE prophylaxis?1. Yes2. No95. Not applicable | 1,2,95Will be auto-filled as 95 if vtepro <> 8 OR if vteproA = -1

|  |
| --- |
| Warning if 2 AND [(princode or othdx = I48.0, I48.1, I48.2, I48.3, I48.4, I48.91or I48.92) or (othrpx on TJC Table 5.22 or 5.23)] |

 | **Oral Factor Xa Inhibitors include:*** **apixaban (Eliquis)**
* **rivaroxaban (Xarelto)**

**The ONLY acceptable reasons include:*** History or current finding of atrial fibrillation/flutter (AF, A-fib, Atrial fib/flutter); persistent atrial fibrillation OR paroxysmal atrial fibrillation (PAF) EXCEPT within 8 weeks following CABG
* ICD-10-CM Other Procedure Code on TJC Table 5.22 or 5.23
* ICD-10-CM Principal/Other Diagnosis Code of I48.0, I48.1, I48.2, I48.3, I48.4, I48.91or I48.92
* History of Partial or Total hip arthroplasty (THA)/replacement (THR)
* History of Total knee arthroplasty (TKA)/replacement (TKR)
* History of / or current treatment for venous thromboembolism

**If there is conflicting documentation in the medical record, select “Yes”.****Refer to TJC Appendix A, Table 5.22 Elective Hip Replacement or 5.23 Elective Total Knee Replacement for examples of ICD-10-PCS procedure codes.****EXCLUDE:*** Hip fracture
* History of atrial fibrillation/flutter that terminated within 8 weeks following CABG
* History of transient and entirely reversible episode of documented atrial fibrillation/flutter due to thyrotoxicosis
* Paroxysmal atrial tachycardia (PAT)
* Paroxysmal supraventricular tachycardia (PST, PSVT)
* Premature atrial contraction (PAC)

**ONLY ACCEPTABLE SOURCES:** Anesthesia record, Consultation notes, ED record, H&P, Operative note, Physician orders, Progress notes, Risk assessment form, Transfer sheet |

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| --- | --- | --- | --- | --- | --- | --- |
| 31 | STK1 | admprodt | Enter the date VTE prophylaxis was administered after hospital admission. | mm/dd/yyyy

|  |
| --- |
| > = admdt and < = 1day after admdt |

Will be auto-filled as 99/99/9999 if vteproA = -1Abstractor can enter 99/99/9999 | **Enter the earliest date after hospital admission associated with the administration of a form of VTE prophylaxis other than graduated compression stockings (GCS) or aspirin.** * The medical record must be abstracted as documented (taken at “face value”). When the date documented is obviously in error (not a valid date/format) **and** no other documentation is found that provides this information, the abstractor should enter 99/99/9999.

**Example:** Documentation indicates the ICU VTE prophylaxis was administered 03/**42**/20xx. No other documentation in the medical record provides a valid date. This is not a valid date and the abstractor should enter 99/99/9999.* If unable to determine the date the initial VTE prophylaxis was administered during this hospitalization, enter 99/99/9999.
 |
| 32 | STK1 | noadmpro | Is there physician/APN/PA or pharmacist documentation of a reason why VTE prophylaxis was not administered the day of or day after hospital admission?1. Yes 2. No95. Not applicable | 1,2,95Will be auto-filled as 95 if vteproA <> -1 | **Documentation of the reason for not administering mechanical AND pharmacological VTE prophylaxis must be written from arrival to the day after hospital admission.****In order to answer “Yes” to this data element:**There must be explicit documentation indicating the patient is at low risk for VTE; **OR**There is explicit documentation of a contraindication to mechanical prophylaxis AND documentation of a contraindication to pharmacological prophylaxis* **Exceptions to physician/APN/PA or pharmacist documentation of reason for not administering VTE prophylaxis:**
* If Comfort Measures Only was documented after arrival date but by the day after hospital admission or Surgery End Date for surgeries that start the day of or the day after hospital admission, select “Yes.”
* Patient/family refusal of any form of prophylaxis may be documented by a nurse, but should be documented within the same timeframe as the reason for no VTE prophylaxis
* **If reasons are not mentioned in the context of VTE prophylaxis, do not make inferences** (e.g., do not assume that VTE prophylaxis was not administered because of a bleeding disorder unless documentation explicitly states so).
* Documentation that the patient is ambulating without mention of VTE prophylaxis is insufficient. Do not infer that VTE prophylaxis is not needed unless explicitly documented.
* If two physicians/APN/PA or pharmacists document conflicting or questionable needs for prophylaxis, select “**No**.”
* **For ONLY those patients determined to be AT LOW RISK for VTE:**
	+ If documentation of “No VTE Prophylaxis needed” is written, then it will be inferred that both mechanical and pharmacological options were not indicated for the patient. Select “Yes.”
	+ A completed risk assessment within this timeframe determining the patient is low risk is acceptable for this data element. Assessment forms may be initiated and completed by a nurse.
* Any completed VTE risk assessment or physician/APN/PA or pharmacist documentation indicating “low risk” is acceptable.
* If a risk assessment is used and notes anything other than low risk (e.g., intermediate, moderate or high risk), additional documentation must be present to answer “Yes.” **Explicit documentation** of a contraindication to mechanical **AND** pharmacological prophylaxis must be addressed.
* If there is physician documentation of “bleeding, no pharmacologic prophylaxis”, there must also be documentation about mechanical prophylaxis such as “no mechanical prophylaxis” to select “Yes”.
* **For Patients on Anticoagulants:** For patients on continuous IV heparin therapy the day of or day after hospital admission, select “Yes.”
* If warfarin is listed as a home or current medication, select “Yes.”
* For patients receiving anticoagulant therapy for atrial fibrillation or other conditions (e.g. angioplasty), with anticoagulation administered on the day of or the day after hospital admission, select “Yes”.
* Documentation that the patient is adequately anticoagulated or already anticoagulated, select “Yes.”
* Documentation synonymous with “abruptly reversed anticoagulation for major bleeding,” select “Yes.”
* Stroke patients require a documented reason for not administering another form of prophylaxis when graduated compression stockings (GCS) or aspirin are the ONLY form of VTE prophylaxis administered.

**Refer to Appendix H, Table 2.7 Anticoagulation Therapy for Atrial Fibrillation and Other Conditions.** **Suggested Data Sources:** Anesthesia record, Consultation notes,ED record, History and physical, Medication administration record, Nurses notes, Physician orders/progress notes, Risk assessment form, Transfer form |

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| **IF DCDISPO = 2,3,4,6, or 7, go to end** |
|  |  |  | **Atrial Fib/flutter**  |  |  |
| 33 | STK3 | afib | Was there physician/APN/PA documentation of a diagnosis, signed ECG tracing, or a history of ANY atrial fibrillation/flutter in the medical record?1. Yes2. No | 1,2Will be auto-filled as 1 if othdx = I48.0, I48.1, I48.2, I48.3, I48.4, I48.91, or I48.92 Nosory of atrial fibrillation/flutter or current finding or atrial fibrillation/flutter documented in the medical record? | **Atrial fibrillation/Flutter: Documentation that the patient has a history of ANY atrial fibrillation (e.g., remote, persistent, or paroxysmal) or atrial flutter OR a diagnosis or signed ECG tracing of ANY atrial fibrillation or flutter.****This question will be auto-filled if othdx = I48.0, I48.1, I48.2, I48.3, I48.4, I48.91, or I48.92** **Select “Yes” if there is:*** a documented history or diagnosis of ANY condition described above.
* documentation of atrial fibrillation or flutter on a signed ECG..
* a diagnosis OR documentation of a past history of atrial fibrillation or flutter anywhere in the medical record.

EXCEPTION: If there is conflicting documentation of atrial fibrillation or flutter during the hospitalization, the most current cardiologist documentation should be used. If cardiology documentation is unavailable, the most current documentation by other physician/APN/PA should be used.* documentation of a history of an ablation procedure for atrial fibrillation/flutter.

**Select “No” if there is:** * documentation of “suspected/suspicion of/rule out/questionable/possible atrial fibrillation/flutter” and no other documentation of a confirmed diagnosis is found.
* documented history of atrial fibrillation or flutter that terminated within 8 weeks following CABG.
* documented history of transient and entirely reversible episode of atrial fibrillation or flutter due to thyrotoxicosis.
* documentation to monitor the patient for atrial fibrillation/flutter after discharge and no other documentation of a confirmed diagnosis or history of atrial fibrillation/flutter in the medical record. Example: possible cardioembolic origin. Telemetry monitoring for 30 days to exclude PAF.

**Cardiac (atrial) ablation:** a procedure used to destroy small areas in the heart that may be causing cardiac rhythm problems, such as atrial fibrillation/flutter.**Include:** AF, A-fib, atrial fibrillation, atrial flutter, persistent or paroxysmal atrial fibrillation, PAF**Exclude:** Premature atrial contraction (PAC), paroxysmal atrial tachycardia (PAT), paroxysmal supraventricular tachycardia (PST/PSVT)**Suggested data sources:** Consultation notes, Discharge summary, ECG report, History and physical, Holter monitor report, Operative reports, Problem list, Procedure notes, Progress notes, Transfer sheet |

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|  |  |  | **Discharge Medications** |  |  |
| 34 | STK6 | statindc | Was a statin medication prescribed at discharge?**Examples include, but are not limited to:*** atorvastatin calcium (Lipitor)
* fluvastatin sodium (Lescol)
* lovastatin (Mevacor) (Altocor)
* pitavastatin (Livalo)
* pravastatin sodium (Pravacol)
* rosuvastatin calcium (Crestor)
* simvastatin (Zocor)
* ezetimibe/simvastatin (Vytorin)

1. Yes2. No | 1,2If 1, auto-fill nostatin as 95, and go to dcanthrm  | **Review all discharge medication documentation to determine if a statin medication was prescribed at discharge.** In determining whether a statin medication was prescribed at discharge, it is not uncommon to see conflicting documentation amongst different medical record sources. For example, the discharge summary may list a statin medication that is not included in any of the other discharge medication sources (e.g., discharge orders).* In cases where there is a statin medication in one source that is not mentioned in other sources, it should be interpreted as a discharge medication (select "Yes") unless documentation elsewhere in the medical record suggests that it was NOT prescribed at discharge - **Consider the statin a discharge medication in the absence of contradictory documentation.**
* If documentation is contradictory (e.g., physician noted “d/c statin” or “hold statin” in the discharge orders, but a statin is listed in the discharge summary’s discharge medication list), or after careful examination of circumstances, context, timing, etc., documentation raises enough questions, the case should be deemed "unable to determine" (select "2").
* Consider documentation of a hold on a statin after discharge in one location and a listing of that statin as a discharge medication in another location as contradictory ONLY if the timeframe on the hold is not defined (e.g., “Hold statin”). Examples of a hold with a defined timeframe include “Hold statin x2 days” and “Hold statin until after stress test.”
* If a statin is NOT listed as a discharge medication, and there is only documentation of a hold or plan to delay initiation/restarting of a statin after discharge (e.g., “Hold statin x2 days,” “Start statin as outpatient,” “Hold statin”), select “No.”
* If two discharge summaries are included in the medical record, use the one with the latest date/time. If one or both are not dated or timed, and you cannot determine which was done last, use both. This also applies to discharge medication reconciliation forms. Use the dictated date/time over transcribed date/time, file date/time, etc.
* Disregard a statin documented only as a recommended medication for discharge (e.g., “Recommend sending patient home on a statin. Documentation must be clearer that a statin was actually prescribed at discharge.
* Disregard documentation of a statin prescribed at discharge when noted only by medication class (e.g., “Statin Prescribed at Discharge: Yes” on a core measures form). The statin must be listed by name.

**Refer to TJC Appendix C, Table 8.1 for a comprehensive list of Statin Medications.****Suggested data sources:** Consultation, Discharge summary, Medication reconciliation form, Physician orders, Progress notes |

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| --- | --- | --- | --- | --- | --- |
| 35 | STK6 | nostatin | Is there physician/APN/PA or pharmacist documentation of a reason for not prescribing a statin medication at discharge?1. Allergy to statin medication2. Physician/APN/PA or pharmacist documentation of a reason for not prescribing a statin medication at discharge95. Not applicable98. Patient/family refusal99. No documented reason | 1,2,95,98,99Will be auto-filled as 95 if statindc = 1 | * **With exception of allergy and patient/family refusal, reasons for not prescribing a statin medication at discharge must be documented by a physician/APN/PA or pharmacist.**
* **Statin medication allergy:** a statin medication “allergy” or “sensitivity”,\ documented at any time 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 statin medication is acceptable to take as an allergy to the entire class of statin medications (e.g., “allergic to atorvastatin”).
* Documentation of a LDL-c less than 70 mg/dL anytime during the hospital stay is an acceptable stand-alone reason for not prescribing statin medication at discharge - linkage with statin is not needed. Direct or calculated fasting or non-fasting values are both acceptable. LDL values obtained within 30 days prior to hospital arrival are acceptable.

**Other reasons:*** **If reasons are not mentioned in the context of statin medications, do not make inferences** (e.g., do not assume that a statin medicationwas not prescribed because of the patient’s history of alcoholism or severe liver disease alone).
* Reasons must be explicitly documented (e.g., “Chronic liver failure – statins contraindicated”, “Hx muscle soreness with statins in past”) OR clearly implied (“No evidence of atherosclerosis - no statin therapy,” “No statin medications” [no reason given]).
* Physician/APN/PA or pharmacist documentation of a hold or discontinuation of statin medications that occurs during the hospital stay constitutes a “clearly implied” reason for not prescribing a statin medication at discharge. A hold/discontinuation of all p.o. medications counts if statin medication p.o. was on order at the time of the notation.

 **EXCEPTIONS:**  - Documentation of a **conditional** hold/discontinuation of a statin medication (e.g., “hold simvastatin if diarrhea persists.”) does not count as a reason for not prescribing a statin medication at discharge.- Discontinuation of a particular statin medication documented in combination with the start of a different statin medication (i.e., switch in type of statin medication) does not count as a reason for not prescribing a statin medication at discharge.  - Discontinuation of a statin medication at a particular dose documented in combination with the start of a different dose of that statin (i.e., change in dosage) does not count as a reason for not prescribing a statin medication at discharge. - Deferral of statin medication from one physician/APN/PA or pharmacist to another does NOT count as a reason for not prescribing a statin at discharge UNLESS the problem underlying the deferral is also noted. * If there is documentation of a plan to initiate/restart a statin medication and the reason/problem underlying the delay is also noted, this constitutes a “clearly implied” reason for not proscribing a statin medication at discharge.
* Reasons do NOT need to be documented at the time of discharge or otherwise associated specifically with discharge prescription. Documentation of reasons anytime during the stay is acceptable.
* Reason documentation which refers to a more general medication class is not acceptable (e.g., “No cholesterol-reducers”, “Hold all lipid-lowering medications”).
* If there is conflicting documentation in the record regarding a reason for not prescribing a statin med at discharge, accept as a “yes” for the applicable reason.
* When the current record includes documentation of a pre-arrival reason for no statin medication, the following counts regardless of whether this documentation is included in a pre-arrival record made part of the current record or whether it is noted by hospital staff during the current hospital stay:
* Pre-arrival statin medication allergy
* Pre-arrival hold/discontinuation or notation such as “No statin medications” IF the underlying reason/problem is also noted (e.g., “Lipitor discontinued in transferring hospital secondary to severe diarrhea”).
* Pre-arrival “other reason” as noted above.
* Physician/APN/PA or pharmacist documentation of a pre-arrival hold, discontinuation of a statin medication, or “other reason” counts as a reason for not prescribing a statin medication at discharge ONLY if the underlying reason is noted.

**Examples of reasons for not prescribing a statin medication at discharge include, but are not limited to:** hepatic failure, hepatitis, myalgias, patient/family refusal, rhabdomyolysis**Suggested data sources:** Consultation notes, Discharge summary, Emergency department record, History & physical, Medication administration record, Medication reconciliation form, Nursing notes, Pharmacy notes, Physician orders, Progress notes**Excluded Data Sources:** Any documentation dated/timed after discharge, except discharge summary. |

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| --- | --- | --- | --- | --- | --- |
| 36 | STK2 | dcanthrm | Was antithrombotic therapy prescribed at discharge?**Examples of antithrombotic therapy include, but are not limited to: Aspirin, clopidogrel (Plavix), warfarin (Coumadin), dabigatran, enoxaparin, fondaparinux, heparin IV, ticlopidine, Zorprin**1. Yes2. No | 1,2If 1, autofill ynoanthrm as 95 and go to anticoag | **Review all discharge medication documentation to determine if antithrombotic therapy was prescribed at discharge**. In determining whether anticoagulation therapy was prescribed at discharge, it is not uncommon to see conflicting documentation amongst different medical record sources. For example, the discharge summary may list an anticoagulant that is not included in any of the other discharge medication sources (e.g., discharge orders). * In cases where there is an antithromboticin one source that is not mentioned in other sources, it should be interpreted as a discharge medication (select "Yes") unless documentation elsewhere in the medical record suggests that it was NOT prescribed at discharge - **Consider the antithrombotic a discharge medication in the absence of contradictory documentation.**
* If documentation is contradictory (e.g., physician noted “d/c Plavix” in the discharge orders, but Plavix is listed in the discharge summary’s discharge medication list), or after careful examination of circumstances, context, timing, etc., documentation raises enough questions, the case should be deemed "unable to determine" (select "No").
* Consider documentation of a hold on an antithrombotic after discharge in one location and a listing of that antithrombotic as a discharge medication in another location as contradictory ONLY if the timeframe on the hold is not defined (e.g., “Hold Plavix”). Examples of a hold with a defined timeframe include “Hold Plavix x2 days” and “Hold ASA until after stress test.”
* If an antithrombotic is NOT listed as a discharge medication, and there is only documentation of a hold or plan to delay initiation/restarting of antithrombotic therapy after discharge (e.g., “Hold Plavix x2 days,” “Start Plavix as outpatient,” “Hold Plavix”), select “No.”
* If two discharge summaries are included in the medical record, use the one with the latest date/time. If one or both are not dated or timed, and you cannot determine which was done last, use both. This also applies to discharge medication reconciliation forms. Use the dictated date/time over transcribed date/time, file date/time, etc.
* Disregard an antithrombotic medication documented only as a recommended medication for discharge (e.g., “Recommend sending patient home on aspirin”). Documentation must be clearer that an antithrombotic was actually prescribed at discharge.
* Disregard documentation of an antithrombotic prescribed at discharge when noted only by medication class (e.g., “Antithrombotic Prescribed at Discharge: Yes” on a core measures form). The antithrombotic must be listed by name.

**Refer to TJC Appendix C, Table 8.2 for a list of antithrombotic medications.****Exclude:** Heparin Flush, Heparin SQ, Hep-Lock**Suggested data sources:** consultation notes, discharge summary, medication reconciliation form, physician orders, progress notes |
| 45 | STK2 | ynoanthrm | Is there documentation by a physician/APN/PA or pharmacist in the medical record of a reason for not prescribing antithrombotic therapy at discharge1. Allergy to ALL antithrombotic medications2. Physician/APN/PA or pharmacist documentation of a reason for not prescribing antithrombotic therapy at discharge95. Not applicable98. Patient/family refusal99. No documented reason | 1,2,95,98,99Will be auto-filled as 95 if dcanthrm = 1 | * **With exception of allergy and patient/family refusal, reason for not administering antithrombotic therapy must be documented by a physician/APN/PA or pharmacist.**
* **If reasons are not mentioned in the context of antithrombotics, do not make inferences** (e.g., do not assume that antithrombotic therapy was not administered because of a bleeding disorder unless documentation explicitly states so).
* Reasons must be explicitly documented (e.g., “Active GI bleed - antithrombotic therapy contraindicated,” “No ASA” [no reason given]).
* Physician/APN/PA or pharmacist documentation of a hold or discontinuation of an antithrombotic medication that occurs during the hospital stay constitutes a “clearly implied” reason for not prescribing antithrombotic therapy at discharge. A hold/discontinuation of all p.o. medications counts if an oral antithrombotic (e.g. Plavix) was on order at the time of the notation.

**EXCEPTIONS -The following do NOT count as a reason for not prescribing an antithrombotic at discharge:**- Documentation of a conditional hold or discontinuation of an antithrombotic (e.g., “Hold ASA if guaiac positive”, Stop Plavix if rash persists”).- Discontinuation of a particular antithrombotic documented in combination with the start of a different antithrombotic (e.g., “Change Plavix to aspirin” in progress note.- Discontinuation of an antithrombotic at a particular dose documented in combination with the start of a different dose (e.g., “Increase Ecotrin 81 mg to 325 mg daily”).Deferral of antithrombotic therapy from one physician/APN/PA or pharmacist to another UNLESS the problem underlying the deferral is also noted. Examples:  “Consulting neurologist to evaluate pt for warfarin therapy” -  select “99”. “Rule out GI bleed. Start ASA if OK with gastroenterology.”  - select “2”.* If there is documentation of a plan to initiate/restart antithrombotic therapy, and the reason/problem underlying the delay in starting/restarting antithrombotic therapy is also noted, this constitutes a “clearly implied” reason for not prescribing antithrombotic therapy at discharge.
* Reasons do NOT need to be documented at discharge or otherwise linked to the discharge timeframe: Documentation of reasons anytime during the hospital stay is acceptable.
* An allergy or adverse reaction to one type of antithrombotic would NOT be a reason for not administering all

antithrombotic agents. Another medication can be ordered. * When conflicting information is documented in a medical record, select “2”.
* When the current record includes documentation of a pre-arrival reason for no antithrombotic, the following counts as a reason regardless of whether this documentation if included in a pre-arrival record made part of the current record or whether it is noted by hospital staff during the current hospital stay:
* Pre-arrival hold/discontinuation or notation such as “No Coumadin” IF the underlying reason /problem is also noted (e.g., “Coumadin held in transferring hospital due to possible GI bleed”).
* Pre-arrival “other reason” (other than hold/discontinuation or notation of “No ASA”) (e.g., “Hx GI bleeding with ASA” in transferring ED record)>

**Examples of reasons for not administering antithrombotic** **therapy at discharge include, but are not limited to:*** Allergy to all antithrombotic medications
* Aortic dissection
* Bleeding disorder
* Brain/CNS cancer
* CVA, hemorrhagic
* Extensive/metastatic CA
* Hemorrhage, any type
* Intracranial surgery/biopsy
* Patient/family refusal
* Peptic ulcer
* Planned surgery within 7 days following discharge
* Risk of bleeding
* Unrepaired intracranial aneurysm

**Refer to Appendix C, Table 8.2 for a comprehensive list of Antithrombotic Medications****Suggested data sources:** Consultation notes, Discharge summary, Emergency department record, History & physical, Medication administration record, Medication reconciliation form, Physician orders, Progress notes**Excluded Data Sources:** Any documentation dated/timed after discharge, except discharge summary. |

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| 37 | STK3 | anticoag | Was anticoagulation therapy prescribed at discharge?**Examples include, but are not limited to:*** argatroban
* dabigatran (Pradaxa)
* dalteparin (Fragmin)
* enoxaparin (Lovenox)
* fondaparinux (Arixtra)
* heparin **IV only**
* rivaroxaban (Xarelto)
* tinzaparin (Innohep)
* warfarin (Coumadin)

1. Yes2. No | 1,2If 1, auto-fill noantcoag as 95 and go to rehab | **Review all discharge medication documentation to determine if anticoagulation therapy was prescribed at discharge**. In determining whether anticoagulation therapy was prescribed at discharge, it is not uncommon to see conflicting documentation amongst different medical record sources. For example, the discharge summary may list an anticoagulant that is not included in any of the other discharge medication sources (e.g., discharge orders). * In cases where there is an anticoagulant medication in one source that is not mentioned in other sources, it should be interpreted as a discharge medication (select "Yes") unless documentation elsewhere in the medical record suggests that it was NOT prescribed at discharge - **Consider the anticoagulant a discharge medication in the absence of contradictory documentation.**
* If documentation is contradictory (e.g., physician noted “d/c Coumadin” in the discharge orders, but Coumadin is listed in the discharge summary’s discharge medication list), or after careful examination of circumstances, context, timing, etc., documentation raises enough questions, the case should be deemed "unable to determine" (select "2").
* Consider documentation of a “hold” on an anticoagulantafter discharge as contradictory ONLY if the timeframe on the hold is **not defined** (e.g., “Hold warfarin” does not have a timeframe). Examples of a hold with a defined timeframe include “Hold Coumadin x2 days” and “Hold warfarin until after stress test.”
* If an anticoagulant is NOT listed as a discharge medication, and there is only documentation of a hold or plan to delay initiation/restarting of anticoagulation therapy after discharge (e.g., “Hold Coumadin x2 days,” “Start Coumadin as outpatient,” “Hold Coumadin”), select “2.”
* If two discharge summaries are included in the medical record, use the one with the latest date/time. If one or both are not dated or timed, and you cannot determine which was done last, use both. This also applies to discharge medication reconciliation forms. Use the dictated date/time over transcribed date/time, file date/time, etc.
* Disregard an anticoagulant medication documented only as a recommended medication for discharge (e.g., “Recommend sending patient home on dabigatran”). Documentation must be clearer that an anticoagulant was actually prescribed at discharge.
* Disregard documentation of anticoagulant prescribed at discharge when noted only by medication class (e.g., “Anticoagulant Prescribed at Discharge: Yes” on a core measures form). The anticoagulant must be listed by name.

**Refer to TJC Appendix C, Table 8.3 for a list of medications used for anticoagulation therapy.****Exclude:** Heparin SQ, Heparin flush, Hep-lock **Suggested data sources:** Consultation notes, Discharge summary, Medication reconciliation form, Physician orders, Progress notes |

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| 38 | STK3 | noantcoag | Is there documentation by a physician/APN/PA or pharmacist in the medical record of a reason for not prescribing anticoagulation therapy at hospital discharge?1. Allergy to ALL anticoagulation medications2. Physician/APN/PA or pharmacist documentation of a reason for not prescribing anticoagulation therapy at discharge95. Not applicable98. Patient/family refusal99. No documented reason | 1,2,95,98,99Will be auto-filled as 95 if anticoag = 1 | * **With exception of allergy and patient/family refusal, reason for not prescribing anticoagulation therapy at hospital discharge must be documented by a physician/APN/PA or pharmacist.**
* **If reasons are not mentioned in the context of anticoagulation therapy, do not make inferences** (e.g., do not assume that anticoagulation therapy was not prescribed because of a bleeding disorder unless documentation explicitly states so).
* Reasons must be explicitly documented (e.g., “Active GI bleed – anticoagulation therapy contraindicated”, “No warfarin” [no reason given]).
* Documentation of a hold or discontinuation of an anticoagulant medication that occurs during the hospital stay constitutes a “clearly implied” reason for not prescribing anticoagulation therapy at discharge. A hold/discontinuation of all p.o. medications counts if an oral anticoagulant medication (e.g., warfarin) was ordered at the time of the notation.

**EXCEPTIONS:** - Documentation of a conditional hold/discontinuation of an anticoagulant medication does not count as a reason for not prescribing an anticoagulant medication at discharge (e.g., “Hold Coumadin if guaiac positive”, “Stop warfarin if rash persists”).- Discontinuation of a particular anticoagulant medication documented in combination with the start of a different anticoagulant medication (i.e., switch type of anticoagulant medication) does not count as a reason for not prescribing an anticoagulant medication at discharge. - Discontinuation of an anticoagulant medication at a particular dose documented in combination with the start of a different dose of that anticoagulant (i.e., change in dosage) does not count as a reason for not prescribing an anticoagulant medication at discharge. * Deferral of an anticoagulant from one physician/APN/PA or pharmacist to another does NOT count as a reason for not prescribing an anticoagulant at discharge UNLESS the problem underlying the deferral is also noted.
* If there is documentation of a plan to initiate/restart an anticoagulation and the reason/problem underlying the delay is also noted, this constitutes a “clearly implied” reason for not proscribing an anticoagulant at discharge.
* Reasons do NOT need to be documented at discharge or otherwise linked to the discharge timeframe. Documentation of reasons anytime during the stay is acceptable.
* An allergy or adverse reaction to one type of anticoagulant would NOT be a reason for not administering all anticoagulants. Another medication can be ordered.
* When conflicting information is documented in a medical record, select “Yes.”
* When the current record includes documentation of a pre-arrival reason for no anticoagulation therapy, the following counts regardless of whether this documentation is included in a pre-arrival record made part of the current record or whether it is noted by hospital staff during the current hospital stay:
* Pre-arrival hold/discontinuation or notation such as "No Coumadin" IF the underlying reason/problem is also noted (e.g., “Coumadin held in transferring hospital due to possible GI bleed”).
* Pre-arrival "other reason" (other than hold/discontinuation or notation of "No warfarin") (e.g., "Hx GI bleeding with warfarin" in transferring ED record).

**Examples of reasons for not prescribing anticoagulation therapy at discharge include, but are not limited to:*** Allergy to all anticoagulant medications
* Aortic dissection
* Bleeding disorder
* Brain/CNS cancer
* CVA, hemorrhagic
* Extensive/metastatic CA
* Hemorrhage, any type
* Intracranial surgery/biopsy
* Patient/family refusal
* Peptic ulcer
* Planned surgery within 7 days following discharge
* Risk of bleeding
* Unrepaired intracranial aneurysm

**Refer to TJC Appendix C, Table 8.3 for a list of medications used for anticoagulation therapy.****Suggested data sources:** Consultation notes, Discharge summary, Emergency department record, History & physical, Medication administration record, Medication reconciliation form, Physician orders, Progress notes**Excluded Data Sources:** Any documentation dated/timed after discharge, except discharge summary. |
| 39 | STK10 | rehab | Is there documentation that the patient was assessed for and/or received rehabilitation services during this hospitalization?1. Yes2. No | 1,2 | **The assessment for rehabilitation services must be completed by a qualified provider. See Inclusion Guidelines.*** **If a documented reason exists for NOT completing a rehabilitation assessment, select “Yes.” Examples:**
* “Patient returned to prior level of function, rehabilitation not indicated at this time.”
* “Patient unable to tolerate rehabilitation therapeutic regimen.”
* **Patient/family refusal**
* Do not infer that documentation of symptoms resolved means that a rehabilitation assessment was completed, unless mentioned in the context of rehabilitation services. **Example:** “Symptoms resolved - no rehab needed.”
* When an assessment is not found in the medical record, but documentation indicates that rehabilitation services were initiated (i.e., Physical Therapy [PT], Occupational Therapy [OT], Speech Language Therapy [SLT], Neuropsychology) during the hospital stay, select “Yes.” Examples:
* PT x 2 for range of motion (ROM) exercises at bedside.”
* Patient aphasic - evaluated by speech pathology”
* When patient is transferred to a rehabilitation facility or referred to rehabilitation services following discharge, select “Yes.”

**Inclusion Guidelines:*** Assessment/consult done by member of the rehabilitation team.
* Patient received rehabilitation services from a member(s) of the rehabilitation team.
* Members of the rehabilitation team:
* Advanced Practice Nurse (APN)
* Kinesiotherapist (KT)
* Neuro-psychologist (PsychD)
* Occupational therapist (OT)
* Physical therapist (PT)
* Physician
* Physician Assistant (PA)Speech and language pathologist (SLT)

**Exclude:** Request/order for inpatient rehabilitation consult that was not performed**Suggested Data Sources:** Consultation notes, Discharge summary, History and physical, Progress notes, Referral forms, Rehabilitation records, Therapy notes (e.g., KT/PT/OT/SLT)**Excluded Data Sources:** any documentation other than Physician/APN/PA/KT/PT/OT/SLT/Neuropsychologist |

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| **IF DCDISPO = 5, go to end.**  |
|  |  |  | **Discharge Instructions** |  |  |
| 40 | STK8 | ptedems | Did the WRITTEN discharge instructions or other educational material given to the patient/caregiver address **activation of the emergency medical system (EMS**) **if signs or symptoms of stroke occur?**1. Yes2. No | 1,2 | **Educational material must address activation of the emergency medical system if signs or symptoms of stroke occur.****Example:** “Call 911 immediately if sudden numbness or weakness of an extremity is noted.”**Inclusion Guidelines for Emergency Medical System*** EMS
* 911

If the patient refused written discharge instructions/material which addressed activation of EMS, select “1.”**Guidelines for Discharge Instructions (applies to all 5 discharge instruction questions):**1) Use only 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. 2) Written instructions given anytime during the hospital stay are acceptable. 3) 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. 4) If documentation indicates that written instructions/material on each topic were not given because the patient is cognitively impaired (e.g., comatose, obtunded, confused, short-term memory loss) and has no caregiver available, select “Yes.”5) The caregiver is defined as the patient’s family or any other person (e.g., home health, VNA provider, prison official or other law enforcement personnel) who will be responsible for care of the patient after discharge. **Acceptable educational materials include discharge instruction sheets, brochures, booklets, teaching sheets, videos, CDs, and DVDs.****Suggested Data Sources for All Discharge Instructions:** Discharge instruction sheet, Discharge summary, Education record, Home health referral form, Nursing discharge notes, Nursing notes, Progress notes, Teaching sheet**Inclusion Guidelines - Warning Signs and Symptoms of Stroke**Sudden:* numbness or weakness of the face, arm or leg, especially on one side of the body
* confusion, trouble speaking or understanding
* trouble seeing in one or both eyes
* trouble walking, dizziness, loss of balance or coordination
* severe headache with no known cause
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| 41 | STK8 | ptedfolup | Did the WRITTEN discharge instructions or other educational material given to the patient/caregiver address **follow-up with a physician/APN/PA after discharge**?1. Yes2. No | 1,2 | **In the absence of explicit documentation that follow-up involves contact with a physician/APN/PA, the abstractor may infer contact with a physician/APN/PA, unless documentation suggests otherwise (e.g., BP check, laboratory work only).**If the patient refused written discharge instructions/material which addressed follow-up with a physician/APN/PA after discharge, select “1.” |
| 42 | STK8 | ptedmed | Did the WRITTEN discharge instructions or other educational material given to the patient/caregiver address **all discharge medications**?1. Yes2. No | 1,2 | **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.** * 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 best source of a patient’s discharge medications is the pharmacy discharge medication list.** **1. Determine all of the medications being prescribed at discharge, based on available 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 “d/c ASA” in the discharge orders, but it is listed in the discharge summary’s discharge medication list), or, after careful examination of circumstances, context, timing, etc., documentation raises enough questions about what medications are being prescribed at discharge, the case should be deemed "unable to determine” (select "No”).
* If there is documentation of a plan to start/restart a medication after discharge or a hold on a medication for a defined timeframe after discharge (e.g., “Start Plavix as outpatient,” “Hold Lasix x 2 days,” “Hold ASA until after endoscopy”):
	+ - If it is NOT listed as a discharge medication elsewhere (e.g., “Lasix,” “Plavix”), it is not required in the discharge instructions (but if it is listed on the instructions, this is acceptable).
		- If it IS listed as a discharge medication elsewhere (e.g., “Lasix,” “Plavix”), do not regard this as contradictory documentation, and require the medication in the discharge instructions.
* Disregard a medication documented only as a recommended medication for discharge. E.g., “Recommend sending patient home on Vasotec” – Vasotec is not required in the discharge instructions (but if it is listed on the instructions, this is acceptable). Documentation must be clearer that such a medication was actually prescribed at discharge.
* Discharge medication information included in a discharge summary dated after discharge should be used as long as it was added within 30 days after discharge.
* If two discharge summaries are included in the medical record, use the one with the latest date/time. If one or both are not dated or timed, and you cannot determine which was done last, use both. This also applies to discharge medication reconciliation forms. Use the dictated date/time over transcribed date/time, file date/time, etc.

If the patient refused written discharge instructions/material which addressed discharge medications, select “Yes.”  |

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| 43 | STK8 | ptedrsk | Did the WRITTEN discharge instructions or other educational material given to the patient/caregiver address **risk factors for stroke**?1. Yes2. No | 1,2 | **Educational material must specifically address risk factors for stroke - Example:**Stroke Risk Factors:o Overweighto Smokingo Sedentary lifestyle* See the inclusion list for acceptable risk factors for stroke. The list is not all-inclusive.
* **Individual risk factors that are not mentioned in the context of education provided on the risk factors for stroke, do not count** (e.g., discharge instruction to limit alcohol without explicit documentation that excessive alcohol consumption is a risk factor for stroke).

**Inclusion Guidelines for Risk Factors for Stroke*** Age
* Atrial fibrillation
* Carotid artery stenosis
* Carotid/peripheral or other artery disease
* Cigarette smoking
* Diabetes mellitus
* Excessive alcohol consumption
* Heredity (family history)
* High blood pressure
* Other heart disease (e.g., coronary heart disease, heart failure, dilated cardiomyopathy)
* Overweight (BMI greater than or equal to 25)
* Physical inactivity
* Poor diet (e.g., high in saturated fat, trans fat, cholesterol or sodium)
* Prior stroke, TIA or heart attack
* Race
* Sex (gender)
* Sickle cell disease / sickle cell anemia

If the patient refused written discharge instructions/material which addressed risk factors for stroke, select “Yes.” |

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| 44 | STK8 | ptedwarn | Did the WRITTEN discharge instructions or other educational material given to the patient/caregiver address **warning signs and symptoms of stroke**?1. Yes2. No | 1,2 | **Discharge instructions must address what to do if warning signs or symptoms of stroke are noted.** Example: “Call 911 immediately if sudden numbness or weakness of an extremity is noted.”**Inclusion Guidelines for Warning Signs and Symptoms of Stroke - include term “Sudden:”*** numbness or weakness of the face, arm or leg, especially on one side of the body
* confusion, trouble speaking or understanding
* trouble seeing in one or both eyes
* trouble walking, dizziness, loss of balance or coordination
* severe headache with no known cause

If the patient refused written instructions/material which addressed warning signs and symptoms of stroke, select “Yes.”  |