|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | | | **Organizational Identifiers** | |  | |  | |
|  | VAMC  CONTROL  QIC  BEGDTE  REVDTE | | | Facility ID Control Number  Abstractor ID  Abstraction Begin Date  Abstraction End Date | | Auto-fill  Auto-fill  Auto-fill  Auto-fill  Auto-fill | |  | |
|  |  | | | Patient Identifiers | |  | |  | |
|  | SSN  PTNAMEF  PTNAMEL  BIRTHDT  SEX  MARISTAT  RACE | | | Patient SSN First Name  Last Name  Birth Date  Sex  Marital Status  Race | | Auto-fill: no change  Auto-fill: no change  Auto-fill: no change  Auto-fill: no change  Auto-fill: **can change**  Auto-fill: no change  Auto-fill: no change | |  | |
|  |  | | | **Administrative Data** | |  | |  | |
| 1 | arrvdate | | | Enter the **earliest** documented date the patient arrived at acute care at this VAMC. | | mm/dd/yyyy  Abstractor may enter 99/99/9999 if arrival date is unable to be determined   |  | | --- | | < = vteadmdt and  < = vtedcdt | | | **Arrival date is the earliest recorded date on which the patient arrived in the hospital’s acute care setting.** The intent of the arrival data elements is to capture the earliest date and time the patient was in this VAMC. Arrival date may differ from admission date.   * Do not include documentation from external sources (e.g., ambulance records, clinic records, physician office record, or lab reports) obtained prior to arrival to determine arrival date. The intent is to utilize documentation that reflects processes that occurred in the ED or hospital. * For patients in observation status and subsequently admitted to hospital:   + If the patient was admitted to observation from the ED of the hospital, use the date the patient presented to ED.   + If the patient was admitted to observation from an outpatient setting of the hospital, use the date the patient presented to ED or arrived on the floor for observation care.   + If the patient was a direct admit to observation, use the earliest date the patient arrived at the hospital. * If the patient is in an outpatient setting of the hospital (e.g., undergoing dialysis, chemotherapy) and is subsequently admitted to acute inpatient, use the date the patient presents to the ED or arrives on the floor for acute inpatient care as the arrival date. * For “Direct Admits” to acute inpatient, use the earliest date the patient arrived at the hospital.   **ONLY ACCEPTABLE SOURCES:** Any ED documentation (includes ED vital sign record, ED Outpatient Registration form, triage record, ECG, lab or x-ray reports, etc., if these services were rendered while the patient was an ED patient), nursing admission assessment /admitting note, observation record, procedure notes (such as bronchoscopy, endoscopy), vital signs graphic record  Only enter 99/99/9999 if the arrival date is unable to be determined from the medical record documentation. If the arrival date documented in the record is obviously in error (e.g. 02/42/2007) and no other documentation is found that provides this information, enter 99/99/9999. | |
| 2 | arrvtime | | | Enter the **earliest** documented time the patient arrived at acute care at this VAMC. | | \_\_\_\_\_  UMT **If unable to find the time of arrival, the abstractor can enter 99:99**   |  | | --- | | < =vteadmdt/vteadmtm and < = vtedcdt/vtedctm | | | **Arrival time is the earliest recorded time the patient arrived in the hospital’s acute care setting. Determine the earliest time the patient arrived at this VHA hospital, such as in the ED or observation unit**.   * Do not include documentation from external sources (e.g., ambulance records, clinic records, physician office record, or lab reports) obtained prior to arrival to determine arrival time. The intent is to utilize documentation that reflects processes that occurred in the ED or hospital. * For patients in observation status and subsequently admitted to hospital:   + If the patient was admitted to observation from the ED of the hospital, use the time the patient presented to ED.   + If the patient was admitted to observation from an outpatient setting of the hospital, use the time the patient presented to ED or arrived on the floor for observation care.   + If the patient was a direct admit to observation, use the earliest time the patient arrived at the hospital. * If the patient is in an outpatient setting of the hospital (e.g., undergoing dialysis, chemotherapy) and is subsequently admitted to acute inpatient, use the time the patient presents to the ED or arrives on the floor for acute inpatient care as the arrival time. If the time the patient arrived on the floor is not documented by the nurse, enter the admission time recorded in EADT. * For “Direct Admits” to acute inpatient, use the earliest time the patient arrived at the hospital.   **ONLY ACCEPTABLE SOURCES:** Any ED documentation (includes ED vital sign record, ED Outpatient Registration form, triage record, ECG, lab or x-ray reports, etc., if these services were rendered while the patient was an ED patient), nursing admission assessment /admitting note, observation record, procedure notes (such as bronchoscopy, endoscopy), vital signs graphic record  **If unable to determine the time of arrival, enter default time 99:99.** If the arrival time documented in the record is obviously in error (e.g. 33:00) and no other documentation is found that provides this information, enter 99:99. | |
| 3 | vteadmdt | | | Date of admission to acute inpatient care: | | mm/dd/yyyy  **Auto-filled: can be modified**   |  | | --- | | > = arrvdate and < = vtedcdt | | | **Auto-filled; can be modified**  Admission date is the date the patient was formally admitted to acute inpatient care. A patient of a hospital is considered an inpatient upon issuance of written physician orders to that effect.  Exclusion: admit to observation, arrival date | |
| 4 | vteadmtm | | | Time of admission to acute inpatient care: | | \_\_\_\_\_ UMT **Auto-filled: can be modified**   |  | | --- | | > = arrvdate/arrvtime and < vtedcdt/vtedctm | | | **Auto-filled; can be modified**  Abstractor to verify admission time is correct. DO NOT use ED discharge time or patient transfer time. | |
| 5 | vtedcdt | | | Discharge date: | | mm/dd/yyyy  **Auto-filled. Cannot be modified**  > = vteadmdt | | The computer will auto-fill the discharge date from the OQP pull list. This date cannot be modified in order to ensure the selected episode of care is reviewed. | |
| 6 | vtedctm | | | Time of discharge: | | \_\_\_\_\_\_ UMT   |  | | --- | | > vteadmdt/vteadmtm | | | **Does not auto-fill. Discharge time must be entered.**  **Includes the time the patient was discharged from acute care, left against medical advice (AMA), or expired during this stay.**  If the patient expired, use the time of death as the discharge time.  **Suggested sources for patient who expire:**  Death record, resuscitation record, physician progress notes, physician orders, nurses notes  **For other patients:**  If the time of discharge is NOT documented in the nurses notes, discharge/transfer form, or progress notes, enter the discharge time documented in EADT under the “Reports Tab.”  Enter time in Universal Military Time: a 24-hour period from midnight to midnight using a 4-digit number of which the first two digits indicate the hour and the last two digits indicate the minute.  Converting time to military time:  If time is in the a.m., no conversion is required.  If time is the p.m., add 12 to the clock hour time. | |
| 7 | vteprin | | | Enter the ICD-9-CM principal diagnosis code: | | \_\_ \_\_ \_\_. \_\_ \_\_  (3 digits/decimal point/two digits)   |  | | --- | | **Cannot enter 000.00, 123.45, or 999.99** | | | **Will auto-fill from PTF with ability to change. If the principal diagnosis code is incorrect, enter the principal diagnosis code as documented in the medical record.**  Do not change the principal diagnosis code unless a different principal diagnosis code is documented in the medical record. | |
| 8 | vteothdx1  vteothdx2  vteothdx3  vteothdx4  vteothdx5  vteothdx6  vteothdx7  vteothdx8  vteothdx9  vteothdx10  vteothdx11  vteothdx12  vteothdx13  vteothdx14  vteothdx15  vteothdx16  vteothdx17 | | Enter the ICD-9-CM other diagnosis codes: | | | \_\_ \_\_ \_\_. \_\_ \_\_  (3 digits/decimal point/two digits)  Can enter 17 codes   |  | | --- | | **Cannot enter 000.00, 123.45, or 999.99** | | **Abstractor can enter xxx.xx in code field if no other dx found** | | | **Can enter 17 ICD-9-CM other diagnosis codes.** **Will auto-fill from PTF with ability to change. If the “other diagnoses” codes are incorrect, enter the codes as documented in the medical record.** If entered manually, use the codes listed in the discharge summary for this inpatient episode of care.  **Any order in which VTE is noted in the listing of discharge diagnoses is acceptable**. | |
| 9 | vtepxcd  (code)  vtepxdt  (date) | | Enter the ICD-9-CM principal procedure code and date.  Code Date   |  |  | | --- | --- | | \_\_ \_\_. \_\_ \_\_ | \_\_/\_\_/\_\_\_\_ | | | | \_\_ \_\_. \_\_ \_\_  **If there is no principal procedure, the abstractor can enter xx.xx in code field and**  **99/99/9999 in date field**   |  | | --- | | **Cannot enter 00.00** |   mm/dd/yyyy  **Abstractor can enter 99/99/9999**  **If there is no principal procedure, auto-fill othrpx and otherpxdt with xx.xx and 99/99/9999**   |  | | --- | | > = vteadmdt and < = vtedcdt | | **Hard Edit:** If anebegdt <> 99/99/9999, vtepxdt cannot = 99/99/9999 | | | Principal procedure= that procedure performed for definitive treatment, rather than for diagnostic or exploratory reasons, or was necessary to treat a complication. Related to the principal diagnosis.  Enter the ICD-9-CM code principal procedure code assigned by the VAMC, even if it does not meet the strict definition noted above.  **If there is no principal procedure, enter default code xx.xx in code field and default date 99/99/9999 in date field.**  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. 02/42/2009) and no other documentation is found that provides this information, enter 99/99/9999. | |
| 10 | othrpx1  othrpx2  othrpx3  othrpx4  othrpx5  (codes)  othpxdts1  othpxdts2  othpxdts3  othpxdts4  othpxdts5  (dates) | | Enter the ICD-9-CM other procedure codes and dates.  Code Date   |  |  | | --- | --- | | \_\_ \_\_. \_\_ \_\_ | \_\_/\_\_/\_\_\_\_ | | \_\_ \_\_. \_\_ \_\_ | \_\_/\_\_/\_\_\_\_ | | | | \_\_ \_\_. \_\_ \_\_ **If no other procedure was performed, the abstractor can enter xx.xx in code field and 99/99/9999 in date field**  mm/dd/yyyy  **Abstractor can enter 99/99/9999**   |  | | --- | | > = vteadmdt and < = vtedcdt |   **Can enter 5 codes and dates** | | **Can enter 5 procedure codes, other than the principal procedure code.** Enter the ICD-9-CM codes and dates corresponding to each of the procedures performed, beginning with the procedure performed most immediately following the admission.  **If no other procedures were performed, enter default code xx.xx in the code field and default date 99/99/9999 in the date field.**  It is only necessary to complete the xx.xx and 99/99/9999 default entries for the first code and date. It is not necessary to complete the default entry five times.  If the date of a procedure is unable to be determined from the medical record documentation, or if the procedure date documented in the record is obviously in error (e.g. 02/42/2009) and no other documentation is found that provides this information, enter 99/99/9999. | |
|  |  | | **ED Services** | | |  | |  | |
| 11 | vtedpt | | Did the patient receive care/services in the Emergency Department of this VAMC?  1. Yes  2. No | | | 1,2  If 2, auto-fill vteobsv as 95, vtedecdt as 99/99/9999, vtedectm as 99:99, edcvtedt as 99/99/9999, edcvtetm as 99:99, and go to vteptdc | | **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 | |
| 12 | vteobsv | Was there documentation the patient was placed in observation services in the Emergency Department of this VAMC?  1. Yes  2. No  95. Not applicable | | | 1,2  Will be auto-filled as 95 if vtedpt = 2 | | **The intent is to capture emergency department patients placed into observation services in this Emergency Department prior to admission to the facility as an inpatient.**  If there is documentation the patient was placed into observation services and received care in observation provided by the Emergency Department or in an observation unit of the ED, select “1.”  If there is documentation the patient is being admitted for observation outside the Emergency Department, select “2.”  If there is no documentation the patient received observation services in the ED of this VAMC, select “2.”  **ONLY ALLOWABLE SOURCE: ED record** | |
| 13 | vtedecdt | Enter the earliest documented date of the decision to admit the patient. | | | mm/dd/yyyy  Will be auto-filled as 99/99/9999 if  vtedpt = 2  Abstractor can enter 99/99/9999  **If arrvdate = vteadmdt, computer will auto-fill = arrvdate**   |  | | --- | | > =arrvdate and < = vteadmdt | | | **For purposes of this data element, Decision to Admit Date is the date on which the physician/APN/PA makes the decision to admit the patient from the Emergency Department to the hospital as an inpatient.** This will not necessarily coincide with the date the patient is officially admitted to inpatient status.  **ONLY ACCEPTABLE SOURCE: ED record. Do not include any documentation from external sources (e.g., ambulance record, clinic note) obtained prior to arrival.**   * If there are multiple dates documented for the decision to admit abstract the earliest date. * If it can be determined that the patient arrived on the same date and departed on the same date, the arrival date can be used as the decision to admit date. * If the decision to admit the patient is made, but the actual request for a bed is delayed until an inpatient bed is available, record the date the physician/APN/PA made the decision to admit. * If the decision to admit date is dated prior to the date of patient arrival or after the date of departure, enter 99/99/9999. * If the date of the decision to admit is unable to be determined from medical record documentation, enter 99/99/9999.   If the admission date is the same date as arrival, Decision to Admit date will be auto-filled by the computer software.  The medical record must be abstracted as documented (i.e., face value). When the date documented is obviously in error (e.g. 11/42/20XX) or outside the parameters of care (e.g., after discharge date) and no other documentation is found that provides this information, enter 99/99/9999.  **Excludes, but is not limited to:** Bed assignment date, Admit Orders date, Admit to Observation date | |
| 14 | vtedectm | Enter the **earliest** documented time of the decision to admit the patient. | | | \_\_\_\_  UMT  Will be auto-filled as 99:99 if  vtedpt = 2  Abstractor can enter 99:99   |  | | --- | | > =arrvdate/arrvtime and < = vteadmdt/vteadmtm | | | **For purposes of this data element “decision to admit time” is the time the physician/APN/PA communicates the decision to admit the patient from the Emergency Department to the hospital as an inpatient.** The decision to admit time will not necessarily coincide with the time the patient is officially admitted to inpatient status.  **ONLY ACCEPTABLE SOURCE: ED record. Do not include any documentation from external sources (e.g., ambulance record, clinic note) obtained prior to arrival.**   * If there are multiple times documented for the decision to admit abstract the earliest time. * If the decision to admit the patient is made, but the actual request for a bed is delayed until an inpatient bed is available, record the time the physician/APN/PA communicated the decision to admit. * Do not use admit order time for the Decision to Admit Time unless documentation clearly indicates this is the time the provider communicated the decision. If the documentation does not clearly indicate this was the time of the decision, enter 99:99 * If documentation of the decision to admit time is prior to arrival or after departure from the ED, enter 99:99. * If the time of the decision to admit is unable to be determined from medical record documentation, enter 99:99.   The medical record must be abstracted as documented (i.e., at face value). When the time documented is obviously in error (e.g. 33:00), and no other documentation is found that provides this information, enter 99:99.  **Excludes, but is not limited to:** Bed assignment time, Admit Orders time, Admit to Observation time | |
| 15 | edcvtedt | Enter the date the patient departed from the emergency department. | | | mm/dd/yyyy  Will be auto-filled as 99/99/9999 if  vtedpt = 2  Abstractor can enter 99/99/9999   |  | | --- | | > =arrvdate or = vteadmdt and <= 3 days after vteadmdt | | | **ONLY ACCEPTABLE SOURCE: ED record**   * If the date of departure from the ED is not documented, but the date of departure can be determined from other documentation, (e.g., you are able to identify from documentation the patient arrived and was transferred to medical unit on the same day), enter this date. * For patients who are placed into observation under the services of the Emergency Department, abstract the date of departure from the observation services (e.g., patient is seen in the ED and admitted to an observation unit of the ED on 05/01/2009 then is discharged from the observation unit on 5/02/2009, abstract 5/02/2009 as the departure date). * For patients who are placed into observation outside the services of the Emergency Department, abstract the date of departure from the ED. * If there is documentation the patient left against medical advice and it cannot be determined what date the patient left against medical advice, enter 99/99/9999. * If the date the patient departed from the ED is unable to be determined from medical record documentation, enter 99/99/9999.   The medical record must be abstracted as documented (i.e., face value). When the date documented is obviously in error (e.g. 11/42/20XX) or outside the parameters of care (e.g., after discharge date) and no other documentation is found that provides this information, enter 99/99/9999.  **Includes, but is not limited to:** ED departure date, ED discharge date, ED leave date | |
| 16 | edcvtetm | Enter the time the patient departed from the emergency department. | | | \_\_\_\_  UMT  Will be auto-filled as 99:99 if  vtedpt = 2  Abstractor can enter 99:99   |  | | --- | | > =arrvdate/arrvtime and < = 72 hours after vteadmdt/vteadmtm | | | **ED Departure Time is the time the patient physically left the Emergency Department.** **The intention is to capture the latest time at which the patient was receiving care in the ED, under the care of Emergency Department services, or awaiting transport to another service/unit.**   * When more than one acceptable ED departure/discharge time is documented, abstract the **latest time**.   For example: Two departure times are found in the ED nurse’s notes: 12:03 via wheelchair and 12:20 via wheelchair. Enter the later time of 12:20 as ED departure time.   * If patient expired in the ED, use the time of death as the departure time. * For patients who are placed into observation under the services of the emergency department, abstract the time of departure from the ED observation services. For example, the patient is seen in the ED and admitted to an observation unit of the ED, then discharged from the observation unit. Enter the time the patient departed from the ED observation unit. * For patients who are placed into observation outside the services of the emergency department, abstract the time of departure from the emergency department. * Do not use the time the discharge order was written because it may not represent the actual time of departure. * If the time the patient departed from the ED is unable to be determined from medical record documentation, enter 99:99.   The medical record must be abstracted as documented (i.e., at face value). When the time documented is obviously in error (e.g. 33:00), and no other documentation is found that provides this information, enter 99:99.  **Includes, but is not limited to:** ED Leave time, ED Discharge time, ED Departure time, ED Check Out time  **Excludes, but is not limited to**: Report Called time  **ONLY ACCEPTABLE SOURCE:** ED record | |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| 17 | vteptdc | Enter the patient’s discharge disposition:  1. Discharged to home care or self care (routine discharge)  2. Discharged/transferred to a short term general hospital for inpatient care  3. Discharged/transferred to a skilled nursing facility (SNF) with Medicare certification in anticipation of skilled care  4. Discharged/transferred to a facility that provides custodial or supportive care  5. Discharged/transferred to a Designated Cancer Center or Children’s Hospital  6. Discharged/transferred to home under care of organized home health service organization in anticipation of covered skilled care. Report this code when the patient is discharged/transferred to home with a written plan of care (tailored to the patient’s medical needs) for home care services  7. Left against medical advice or discontinued care  20.Expired  21.Discharged/transferred to court/law enforcement (includes transfers to incarceration facilities such as jail, prison, or other detention facilities)  43. Discharged/transferred to a federal health care facility  50. Hospice – home  51. Hospice – medical facility (certified) providing hospice level of care  61. Discharged/transferred to hospital-based Medicare approved swing bed  62. Discharged/transferred to inpatient rehabilitation facility (IRF) including rehabilitation distinct parts of a hospital  63. Discharged/transferred to a Medicare certified long-term care hospital  64. Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare  65. Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital  66. Discharged/transferred to a Critical Access Hospital (CAH)  70. Discharged/transferred to another Type of Health Care Institution not Defined Elsewhere in this Code List | | 1,2,3,4,5,6,7,20,21,  43,50,51,61,62, 63,64,65,66,70 | | **Inclusion: Refer to Joint Commission Table 2.5 (Appendix H), Discharge Status Disposition**  1 = Discharged to home care or self care includes discharge to home; home on oxygen if DME only; any other DME only; group home, foster care, independent living and other residential care arrangements; outpatient programs, such as partial hospitalization or outpatient chemical dependency programs; domiciliary.  2 = To respond “2,” it must be known the “other” hospital is a **non-VHA** acute-care facility.  3 = Includes skilled nursing facility, skilled nursing facility with hospice referral only (has not accepted hospice care by a hospice organization), SNF rehabilitation unit (a unit within the SNF), Sub-Acute Care, Transitional Care Unit (TCU)  4 = Includes intermediate care facilities (ICFs) if specifically designated at the state level and Assisted Living Facilities. Also used to designate patients discharged/transferred to a nursing facility with neither Medicare nor Medicaid certification.  5 = For transfers to non-designated cancer hospitals, use  option 2.  7 = To respond “7,” a signed AMA document, or progress note by a physician, APN, or PA must appear in the record.  43 = Use option #43 for discharges and transfers to a government operated health care facility such as a Department of Defense hospital, a Veteran’s Administration hospital or a Veteran’s Administration nursing facility. To be used whenever the destination at discharge is a federal health care facility, whether the patient resides there or not. |
| **If VTEPRIN is not on Joint Commission Table 7.03 or 7.04 AND VTEOTHDX is on Table 7.03 or 7.04, go to ARRVTEDX, else go to COMFORT** | | | | | | |
| 18 | arrvtedx | Is there documentation by the physician/APN/PA that venous thromboembolism (VTE) was diagnosed or suspected on admission? | 1,2 | | * + VTE Present at Admission includes hospital or ICU admission depending on the earliest documentation of admission.   + For patients diagnosed with VTE prior to admission and already on treatment at admission, select “1”.   + Physician/APN/PA documentation of suspected or possible DVT (deep vein thrombosis), PE (pulmonary emboli), or VTE is acceptable, but must be written the day of or the day after hospital admission date for non-surgical patients. For example: If a patient was admitted on 04/10/09 with documentation that a PE was suspected and test was ordered to rule out PE, select “1”.   + If the patient was admitted for a surgical procedure and there was no documentation of diagnosed/suspected VTE prior to surgery, VTE is not considered present on admission and “2” would be selected.   + If the physician/APN/PA documentation is insufficient to determine if VTE was present or suspected at admission, select “2”.   **Possible VTE Diagnoses Include:**   * **Pulmonary Embolism and Infarction** * **Phlebitis and Thrombophlebitis of deep vessels of lower extremities - Femoral vein (deep)** * **Phlebitis and Thrombophlebitis of iliac vein** * **Venous embolism and thrombosis of deep vessels of proximal lower extremity** | |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 19 | comfort | When is the earliest physician, APN, or PA documentation of comfort measures only?  1. Day of arrival (day 0) or day after arrival (day 1)  2. Two or more days after arrival (day 2 or greater)  3. Comfort measures only documented during hospital stay, but timing unclear  99. Comfort measures only was not documented by the physician/APN/PA or unable to determine | \*1,2,3,99  **\*If 1 AND vteprin or vteothdx is not on Table 7.03 or 7.04, the record is excluded from the JC VTE Hospital Quality Measures; else, go to clntrial**   |  | | --- | | Warning if comfort = 2 | | **Only accept terms identified in the list of inclusions. No other terminology will be accepted. Day of arrival is day 0.**   |  |  | | --- | --- | | **Inclusion (Only acceptable terms)** | | | Brain death /dead | Hospice | | Comfort care | Hospice Care | | Comfort measures | Organ harvest | | Comfort measures only (CMO) | Palliative care | | Comfort only | Palliative measures | | End of life care | Terminal care |  * **Determine the earliest day the physician/APN/PA DOCUMENTED comfort measures only.** Do not factor in when comfort measures only was actually instituted. E.g., “Discussed comfort care with family on arrival” noted in day 2 progress note – Select “2.” * **Consider comfort measures only documentation in the discharge summary as documentation on the last day of the hospitalization, regardless of when the summary is dictated.** * **Physician/APN/PA documentation of comfort measures only mentioned in the following context is acceptable:** comfort measures only recommendation, order for consultation/evaluation by hospice/palliative care, patient/family request for comfort measures only, referral to hospice/palliative care service. * If any of the inclusions are documented, select option “1,” “2,” or “3” accordingly, unless otherwise specified.   Disregard documentation of comfort measures only when clearly described as negative (e.g. “No comfort care,” “Not appropriate for hospice care,” “Declines palliative care”).  A negative comfort measures only notation associated with a day/date may be acceptable (e.g. On Day 0, the physician documents, “The patient is not a hospice candidate.” On Day 3, the physician orders a hospice consult. Select “2.”)  **Exclusion: DNR-Comfort Care Arrest, DNR-CCA, DNRCC-A, DNRCC-Arrest, DNRCCA**  **Cont’d next page** |
|  |  |  |  | **Comfort Care cont’d**  **If DNR-CC is documented, enter “99” unless there is documented clarification that CC stands for “comfort care.”**  Do not use documentation that is dated prior to arrival or documentation which refers to the pre-arrival time period (e.g., comfort measures only order in previous hospitalization record, “Pt. on hospice at home” in H&P).  **EXCEPTION:** State-authorized portable orders (SAPOs). SAPOs are specialized forms, Out-of-Hospital DNR (OOH DNR) or Do Not Attempt Resuscitation (DNAR) orders, or identifiers authorized by state law, that translate a patient’s preferences about specific-end- of-life treatment decisions into portable medical orders. **Examples:** DNR-Comfort Care form, MOLST (Medical Orders for Life Sustaining Treatment), POLST (Physician Orders for Life-Sustaining Treatment)  **Excluded Data Source:** Restraint order sheet  **Exclusion Statement: Clinician documentation of “comfort measures only” excludes the case from Joint Commission designated VTE Hospital Quality measures. Abstraction of required data elements for VHA measures remains applicable.** |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 20 | clntrial | During this hospital stay, was the patient enrolled in a clinical trial in which patients with venous thromboembolism (VTE) were being studied? | \*1,2  **\*If 1, the record is excluded from the JC VTE Hospital Quality Measures review; go to end.**  **\*If 2 AND comfort = 1 and AND vteptdc = 01, 06, 21, or 50 (Partial Abstraction only); go to vtetest; else, if 2, go to vtesurg as applicable** | **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 VTE 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 VTE excludes the case from the Joint Commission VTE Hospital Quality Measures.** |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **If VTEDCDT – VTEADMDT < 2 days OR (VTEPRIN or VTEOTHDX is on Joint Commission Table 7.03 or 7.04)** **, go to VTETEST; else go to VTESURG** | | | | |
|  |  | **Surgery** |  |  |
| 21 | vtesurg | Was a surgical procedure performed using general or neuraxial anesthesia the day of or the day after hospital admission? | 1,2  If 2 and vteprin is on Joint Commission Table 7.01, 8.1 or 8.2, go to icuvte; else if 2, auto-fill vtesurdt as 99/99/9999, and go to vtepro | If unable to determine if the patient had a surgical procedure and/or whether general or neuraxial anesthesia was used from the medical record documentation, select “2.”  **Inclusion Guidelines for Abstraction:**  General Anesthesia: Inhaled gases, Intravenous, Endotracheal, Laryngeal mask airway, or anesthesia (LMA)  Neuraxial Anesthesia; Spinal block, Epidural block, Spinal anesthesia, Subarachnoid blocks  **Exclusion Guidelines for Abstraction:** Conscious sedation, Monitored anesthesia care (MAC), Local with sedation , Local with stand-by, Peripheral nerve blocks, Saddle block, Deep sedation |
| 22 | vtesurdt | Enter the surgery end date. | mm/dd/yyyy  Will be auto-filled as 99/99/9999 if  vtesurg = 2  Abstractor can enter 99/99/9999   |  | | --- | | < = 1 day after or  = vteadmdt and  < =vtedcdt | | If a patient leaves the operating room with an open incision (for closure at a later date/time), use the Surgery End Date of the initial procedure. Do NOT use the date the patient returns to the OR for closure.  If unable to determine the surgery end date after reviewing the medical record documentation, enter 99/99/9999. |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  | **VTE Prophylaxis** |  |  |
| 23 | vtepro1  vtepro2  vtepro3  vtepro4  vtepro5  vtepro6  vtepro7  vtepro8  vteproA | What type of VTE prophylaxis was administered during this hospitalization?  **Indicate all that apply:**  1. Low dose unfractionated heparin (LDUH)  2. Low molecular weight heparin (LMWH)  3. Intermittent pneumatic compression devices  4. Graduated compression stockings (GCS)  5. Factor Xa Inhibitor  6. Warfarin  7. Venous foot pumps (VFP)  8. Oral Factor Xa Inhibitor  A None of the above or unable to determine from medical record documentation | 1,2,3,4,5,6,7,8,A  If A, auto-fill admprodt as 99/99/9999, and go to noadmpro  If <> A, auto-fill noadmpro as 95  Option 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. Selection of allowable values 1-7 includes any VTE prophylaxis that was initially administered on the same date.** For example: If a patient was admitted on 10/05/2010 and had bilateral GCS applied at 13:00 on 10/05/2010 and LMWH was administered at 22:00 on 10/05/2010, select “2” and “4”.  Include VTE prophylaxis administered in the emergency department prior to admission.  If the patient received one of the pharmacologic anticoagulation medications for other reasons, select the anticoagulation medication that was administered during the specified timeframe.  **Examples of each VTE prophylaxis category such as:**  **Low dose unfractionated heparin** (LDUH) - **only include heparin administered by subcutaneous route** (SC, SQ, SubQ): heparin, calcilean, calciparine  **Low molecular weight heparin** (LMWH): enoxaparin (Lovenox), fragmin, 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  **Factor Xa Inhibitor**: Arixtra, Fondaparinux sodium  **Warfarin** such as: Coumadin, Jantoven, Panwarfin, Warfilone  **Venous foot pumps:** AE pumps – foot only, Kendall boots, Pneumoboots – foot only  **Oral Factor Xa Inhibitor**: Rivaroxaban  Refer to Appendix H, Table 2.1 VTE Prophylaxis Inclusion Table.  **Suggested data sources:** graphic/flow sheets, medication administration record, nursing notes, operative notes, progress notes |
| 24 | admprodt | Enter the date the initial VTE prophylaxis was administered after hospital admission. | mm/dd/yyyy  Will be auto-filled as 99/99/9999 if  vteproA = -1  Abstractor can enter 99/99/9999   |  | | --- | | > = vteadmdt and  < = vtedcdt | | **Enter the date the initial VTE prophylaxis was administered after hospital admission.**  If VTE prophylaxis was administered the day of and the day after hospital admission, enter the date that the initial VTE prophylaxis was administered. For example: The patient was admitted on 10/08/2010 and bilateral GCS was applied at 13:00 on 10/08/2010 and LMWH was administered at 02:00 on 10/09/2010, enter the 10/08/2010 date.  If unable to determine the date the initial VTE prophylaxis was administered during this hospitalization, enter 99/99/9999. |
| 25 | noadmpro | Is there documentation of a reason VTE prophylaxis was not administered the day of or day after hospital admission (or day of surgery or day after surgery end date)?  1. Yes  2. No  95. Not applicable | 1,2,95  Will be auto-filled as 95 if vteproA <> -1 | **Documentation of the reason for not administering VTE prophylaxis must be located within the timeframe of the day of or the day after hospital admission or the day of or the day after Surgery End Datefor surgeries that start the day of or the day after hospital admission.** It is not necessary to review documentation outside of this timeframe to answer this data element. **Physician/APN/PA or pharmacist documentation of reason for not administering VTE prophylaxis is required with the EXCEPTION of nursing documentation of patient refusal or completion of a VTE risk assessment form by a nurse.**  A completed VTE risk assessment within this timeframe is an acceptable source for this data element.   * For patients on continuous IV heparin therapy the day of or day after hospital admission, select “Yes.”   + For patients on warfarin therapy prior to admission, but placed on hold due to “high INR”, select “Yes.”   • Both the pharmacological and mechanical approaches must be assessed to answer “Yes” to this data element. For example, if there is physician documentation of “bleeding, no pharmacologic prophylaxis needed”, there must also be documentation of a reason why no mechanical prophylaxis was administered to select “Yes.” If either type of prophylaxis was administered, then no reason is required.   * + Patient refusal may be documented by a nurse, but must be documented on the day of day after hospital admission.   + For the purposes of this data element, physician/APN/PA, or pharmacist documentation that the patient is at low risk for VTE or explicit documentation that the patient does not need VTE prophylaxis is acceptable. |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  | **ICU Admission** |  |  |
| 26 | icuvte | Was the patient admitted or transferred to the intensive care unit (ICU) for more than one day during this hospitalization?  1. Yes  2. No  99. Unable to determine | 1,\*2,\*99  **\*If 2 or 99, go to vtetest** | **If there is documentation the patient was admitted or transferred (from a lower level of care) to the intensive care unit (ICU) during this hospitalization for more than one day, select “1.”**  Direct admits, admissions via the emergency department, or transfers from lower levels of inpatient care to ICU are included.  Do not use clinical judgment based on the type of care administered to the patient. The level of intensive care MUST be documented.  PCU is not an inclusion for ICU, unless it is identified as a Pulmonary Care Unit, which can be considered synonymous with Respiratory Care Unit.  If there is an order for ICU, but the patient is not moved to an ICU unit due to a lack of a bed, select “2”.  **Exclude:**   * ED, OR, or procedure units as inpatient units * **Intermediate care unit (IMCU)** Step down unit: * A post critical care unit for patients that are hemodynamically stable who can benefit from close supervision and monitoring such as frequent pulmonary toilet, vital signs, and/or neurological and neurovascular checks. * Inpatient units with telemetry monitoring that are not intensive care units * Post coronary care unit (PCCU) |
| 27 | icuadmdt | Enter the earliest date the patient was admitted or transferred to ICU for more than one day during this hospitalization. | mm/dd/yyyy  Abstractor can enter 99/99/9999   |  | | --- | | >= vteadmdt and <=vtedcdt | | **If the patient had more than one ICU admission/transfer for greater than one day during this hospitalization, enter the ICU admission date that was closest to the hospital admission date.**  If there are discrepancies in the ICU admission/transfer date refer to the ICU admission/transfer vital signs, nurse’s notes or progress notes to determine the date.  If unable to determine the ICU admission/transfer date after reviewing the medical record documentation, enter 99/99/9999. |
| 28 | icudcdt | Enter the date the patient was discharged from the ICU. | mm/dd/yyyy  Abstractor can enter 99/99/9999   |  | | --- | | > = 1 day after icuadmdt and <=vtedcdt | | **ICU discharge does not include a temporary transfer from an intensive care unit (e.g., for surgery, radiology or to the recovery room) or transfers between different ICUs (e.g. transfer from CCU to SICU).**  If the patient had more than one ICU admission/transfer for greater than one day during this hospitalization, enter the ICU discharge date that corresponds to the ICU admission/transfer date entered in ICUADMDT.  If unable to determine the ICU discharge date after reviewing the medical record documentation, enter 99/99/9999. |
| 29 | icusurg | Was a surgical procedure performed using general or neuraxial anesthesia the day of or the day after ICU admission? | 1,2  If 2, auto-fill anebegdt as 99/99/9999, icusurdt as 99/99/9999, and go to icupro1 | If unable to determine if the patient had a surgical procedure and/or whether general or neuraxial anesthesia was used from the medical record documentation, select “2.”  **Inclusion Guidelines for Abstraction:**  General Anesthesia: Inhaled gases, Intravenous, Endotracheal, Laryngeal mask airway, or anesthesia (LMA)  Neuraxial Anesthesia; Spinal block, Epidural block, Spinal anesthesia, Subarachnoid blocks  **Exclusion Guidelines for Abstraction:** Conscious sedation, Monitored anesthesia care (MAC), Local with sedation , Local with stand-by, Peripheral nerve blocks, Saddle block, Deep sedation |
| 30 | anebegdt | Enter the anesthesia start date. | mm/dd/yyyy  Will be auto-filled as 99/99/9999 if  icusurg = 2  Abstractor can enter 99/99/9999   |  | | --- | | >= vteadmdt and <=vtedcdt | | Warning if anebegdt <> vtepxdt | | The *Anesthesia Start Date* is the date associated with the start of anesthesia for the surgical procedure that was performed the day of or the day after hospital admission OR the day of or the day after ICU admission/transfer.   * If the patient had a surgical procedure the day of AND the day after hospital admission OR the day of or day after ICU admission/transfer, enter the date of the last procedure that was performed using general or neuraxial anesthesia.   + If an anesthesia start date is not documented use surrounding documentation to determine the date anesthesia started.   Example: The anesthesia end date is 10-02-20XX, the anesthesia start time is 2330 and the anesthesia end time is 0045. The anesthesia start date should be abstracted as 10-01-20XX because it is obvious that the date would change if the anesthesia ended after midnight.  If unable to determine the anesthesia start date after reviewing the medical record documentation, enter 99/99/9999. |
| 31 | icusurdt | Enter the surgery end date. | mm/dd/yyyy  Will be auto-filled as 99/99/9999 if  icusurg = 2  Abstractor can enter 99/99/9999   |  | | --- | | >= anebegdt and <=vtedcdt | | **Select the surgery end date with the associated surgical procedure performed the day of or the day after ICU admission or transfer.**   * If a patient leaves the operating room with an open incision (for closure at a later date/time), use the *Surgery End Date - ICU Admission* of the initial procedure. Do NOT use the date the patient returns to the OR for closure. * When the date documented is obviously invalid (not a valid format/range), ex: a date after the *Discharge Date*, before the *Surgery End Date – ICU Admission*, or in an invalid format (12-**39**-20XX) **and if** no other documentation is found that provides the correct information, the abstractor should enter “99/99/9999.”   + **Example:** Patient expires on 02-12-20XX and documentation indicates the *Surgery End Date* was 03-12-20XX. Other documentation in the medical record supports the date of death as being accurate. Since the *Surgery End Date – ICU Admission* is outside of the parameter for care (after the *Discharge Date* [death]), enter “99/99/9999”. * If the *Surgery End Date* is incorrect (in error) but it is a valid date and the correct date can be found and supported with other documentation in the medical record, use the correct date for *Surgery End Date.* If supporting documentation of the correct date cannot be found, the medical record must be abstracted as documented (at “face value”). **Examples**:   + The anesthesia form is dated 12-10-2007 and other documentation in the medical record supports that the correct date was 12-10-2009; use the correct date as the *Surgery End Date.*   + A *Surgery End Date* of 11-20-20XX and the *Anesthesia Start Date* was 11-10-20XX and no other documentation can be found to support the correct date for the *Surgery End Date*, then it must be abstracted as 11-20-20XX, at face value. |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  | **ICU VTE Prophylaxis** |  |  |
| 32 | icupro1  icupro2  icupro3  icupro4  icupro5  icupro6  icupro7  icupro8  icuproA | What type of VTE prophylaxis was initially administered in the ICU?  **Indicate all that apply:**  1. Low dose unfractionated heparin (LDUH)  2. Low molecular weight heparin (LMWH)  3. Intermittent pneumatic compression devices  4. Graduated compression stockings (GCS)  5. Factor Xa Inhibitor  6. Warfarin  7. Venous foot pumps (VFP)  8. Oral Factor Xa Inhibitor  A None of the above or unable to determine from medical record documentation | 1,2,3,4,5,6,7,8,A  If A, auto-fill icuprodt as 99/99/9999, and go to noicupro  If <> A, auto-fill noicupro as 95  Option 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 ICU admission/transfer. Selection of allowable values 1-7 includes any VTE prophylaxis that was initially administered in the ICU on the same date.** For example: If a patient was admitted to ICU on 10/05/2010and had bilateral GCS applied at 13:00 on 10/05/2010 and LMWH was administered at 22:00 on 10/05/2010, select “2” and “4”.  If the patient received one of the pharmacologic anticoagulation medications for reasons other than VTE prophylaxis, select the anticoagulation medication(s) that was initially administered in the ICU.  **Examples of each VTE prophylaxis category such as:**  **Low dose unfractionated heparin** (LDUH) – **only include heparin administered by subcutaneous route** (SC, SQ, SubQ): heparin, calcilean, calciparine  **Low molecular weight heparin** (LMWH): enoxaparin (Lovenox), fragmin, 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  **Factor Xa Inhibitor**: Arixtra, Fondaparinux sodium  **Warfarin** such as: Coumadin, Jantoven, Panwarfin, Warfilone  **Venous foot pumps:** AE pumps – foot only, Kendall boots, Pneumoboots – foot only  **Oral Factor Xa Inhibitor**: Rivaroxaban  **Suggested data sources:** graphic/flow sheets, medication administration record, nursing notes, operative notes, progress notes |
| 33 | icuprodt | Enter the date the initial VTE prophylaxis was administered in the ICU. | mm/dd/yyyy  Will be auto-filled as 99/99/9999 if  vteproA = -1  Abstractor can enter 99/99/9999   |  | | --- | | >= icuadmdt and <=icudcdt | | Enter the date the initial VTE prophylaxis was administered in the ICU.  If VTE prophylaxis was administered the day of and the day after ICU admission/transfer, select the date that the initial VTE prophylaxis was administered. For example: If the patient was admitted to ICU on 10/08/2010 and bilateral GCS was applied at 13:00 on 10/08/2010 and LMWH was administered at 02:00 on 10/09/2010, enter the 10/08/2010 date.  If unable to determine the date the initial VTE prophylaxis was administered in the ICU, enter 99/99/9999. |
| 34 | noicupro | Is there documentation of a reason VTE prophylaxis was not administered the day of or day after ICU admission/transfer?  1. Yes  2. No  95. Not applicable | 1,2,95  Will be auto-filled as 95 if vteproA <> -1 | * **Documentation of the reason for not administering VTE prophylaxis must be located within the timeframe of the day of or the day after ICU admission/transfer.** * **Patients who have procedures with general or neuraxial anesthesia the day of or the day after ICU admission, have until the day after the *Surgery End Date* to document the reason for no prophylaxis**.   **NOTE: It is not necessary to review documentation outside of this timeframe to answer this data element.**  **A completed VTE risk assessment within this timeframe is an acceptable source for this data element, if it is clear that the patient is at low risk for VTE and does not need VTE prophylaxis.**  **Physician/APN/PA or pharmacist documentation of reason for not administering VTE prophylaxis is required with the EXCEPTION of nursing documentation of patient refusal or completion of a VTE risk assessment form by a nurse.**   * For patients on continuous IV heparin therapy the day of or day after ICU admission, select “Yes.”   + For patients on warfarin therapy prior to admission, but placed on hold due to “high INR”, select “Yes.”   • Both the pharmacological and mechanical approaches must be assessed to answer “Yes” to this data element. For example, if there is physician documentation of “bleeding, no pharmacologic prophylaxis needed”, there must also be documentation of a reason why no mechanical prophylaxis was administered to select “Yes.” If either type of prophylaxis was administered, then no reason is required.   * + For the purposes of this data element, physician/APN/PA, or pharmacist documentation that the patient is at low risk for VTE or explicit documentation that the patient does not need VTE prophylaxis is acceptable. |
| **If COMFORT = 99 OR if (COMFORT = 2 or 3 AND VTEPTDC = 01, 06, 21, or 50), go to VTETEST, else if COMFORT = 2 or 3, go to end** | | | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  | **VTE Diagnosis** |  |  |
| 35 | vtetest | Is there documentation that a diagnostic test for VTE was performed?  1. Yes  2. No | 1,\*2  **\*If 2, go to end** | * + Select “yes” only if the diagnostic test for VTE was performed on the day of admission/transfer or anytime during hospitalization. If the patient was transferred from another acute care hospital, and there is no documentation about which test was performed to diagnose VTE, select “2”.   + If a diagnostic test for VTE that is not on the included list was performed, select “2”. For example: If an echo was done that confirmed a PE (pulmonary emboli), select “2”.   **VTE Diagnostic testing includes the following:**   * Compression Ultrasound/Vascular Ultrasound/Duplex ultrasound (DUS)/Venous Doppler * Venography/Venogram of femoral and other lower extremity veins using contrast material * Computed tomography (CT) of thorax with contrast * Magnetic resonance imaging (MRI or MRV) of the thorax or lower extremity leg veins * Pulmonary arteriography/angiography * Nuclear Medicine Pulmonary Scan/ventilation/perfusion (V/Q) lung scan   **Exclude:**   * VTE confirmation by only D-dimer tests * VTE diagnosed by tests not listed |
| 36 | vtesordt | Enter the date the first diagnostic test for VTE was ordered during this hospitalization. | mm/dd/yyyy  Abstractor can enter 99/99/9999   |  | | --- | | >= vteadmdt and <=vtedcdt | | Enter the exact date. The use of 01 to indicate missing month or day is not acceptable.  If the date the first diagnostic test for VTE was ordered is unable to be determined from the medical record documentation, enter 99/99/9999. |
| 37 | vtetstdt | Enter the date the first diagnostic test for VTE was performed during this hospitalization. | mm/dd/yyyy  Abstractor can enter 99/99/9999   |  | | --- | | >= vteadmdt and <=vtedcdt | | Enter the exact date. The use of 01 to indicate missing month or day is not acceptable.  If a diagnostic test for VTE was performed prior to admission and is the reason for admission, but the test date is unknown, enter 99/99/9999. |
| 38 | posvte | Is there physician/APN/PA documentation that the patient had a diagnosis of VTE confirmed in one of the defined locations?  **VTE Location: DVT located in the proximal leg veins, including the inferior vena cava (IVC), iliac, femoral or popliteal veins, or to pulmonary emboli (PE).**  1.Yes  2. No or unable to determine from medical record documentation | 1,\*2  **\*If 2, go to end** | **The data element does not apply to other sites of venous thrombosis unless a proximal leg DVT or pulmonary emboli (PE) are also involved.**  This data element includes patients who are diagnosed with VTE on arrival or during hospitalization. For example: A patient may have documentation that VTE was confirmed on arrival or the patient may have been admitted without VTE, but there is documentation that the patient developed VTE after admission.   * If a patient had confirmed VTE in one of the defined locations, prior to hospitalization but VTE was the reason for the admission, select “1”. * If the patient was transferred from another acute care hospital, and there is no documentation related to the VTE location, select “2”. * Recurrent VTE may be considered a VTE diagnosis if the patient has documentation of an “acute VTE”. For example: If a patient had a history of VTE, but diagnostic testing found a new VTE in the proximal vein of the lower extremity, select “1”. * For tests that confirm a diagnosis of only “chronic” or “a history of VTE”, select “2”. * If the VTE diagnostic test results are noted as “low probability” or “inconclusive test results”, select “2”. * If a nuclear medicine VQ scan to rule-out PE was performed and the result was documented as “high probability”, select “1”.   **Exclude VTE located in the following areas:**   * Isolated calf vein thrombosis * Upper extremity thrombosis * Intracranial venous thrombosis * Hepatic/portal/splenic/mesenteric thrombosis * Renal vein thrombosis * Ovarian vein thrombosis * Not in the defined locations |
| 40 | posvtedt | Enter the earliest date the diagnosis of VTE in one of the defined locations was confirmed. | mm/dd/yyyy   |  | | --- | | If vtetstdt valid, >= vtetstdt and <=vtedcdt, else >= vteadmdt and < = vtedcdt | | **VTE Location: DVT located in the proximal leg veins, including the inferior vena cava (IVC), iliac, femoral or popliteal veins, or to pulmonary emboli (PE).**  If the patient had a confirmed VTE prior to hospitalization, but VTE was the reason for admission, enter the date of admission.  If more than one diagnostic test was performed that confirmed VTE in one of the defined locations, enter the date of the earliest test.  Enter the exact date. The use of 01 to indicate missing month or day is not acceptable. |
| **If ARRVTEDX = 1, go to WARFADM; else if ARRVTEDX = 2, go to NOMECPRO** | | | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  | **Prophylaxis Prior to VTE** |  |  |
| 41 | nomecpro | Did the physician/APN/PA or pharmacist document a reason for not administering mechanical VTE prophylaxis anytime from admission date and the day before the VTE diagnostic test order date? | 1,2 | **Physician, APN, PA, or pharmacist documentation of a reason for not administering mechanical venous thromboembolism prophylaxis must be found within the timeframe from admission and the day before the VTE diagnostic test order date.**  If there is documentation that the patient had surgery within the timeframe from admission and up to the day before the VTE diagnostic test order date AND there is documentation the patient was on continuous IV heparin therapy within 24 hours before or after the surgery, select “1.”  **Patient refusal of mechanical VTE prophylaxis may be documented by a nurse, but refusal must be documented in the timeframe from admission and the day before the VTE diagnostic test order date.**  An order to hold mechanical VTE prophylaxis without a documented reason for not administering mechanical VTE prophylaxis by the physician/APN/PA or pharmacist is not acceptable.  Documentation that the patient is at low risk for VTE or VTE prophylaxis is not needed is not acceptable as a reason for not administering mechanical prophylaxis.  **Examples of reasons for not administering VTE mechanical prophylaxis such as:** bilateral amputee, patient refusal, bilateral lower extremity trauma, massive leg edema, pulmonary edema, severe peripheral artery disease, severe peripheral neuropathy, major leg deformity, or dermatitis  **Mechanical prophylaxis** = compression devices or stockings such as anti-embolism hose used to prevent VTE |
| 42 | norxpro | Did the physician/APN/PA or pharmacist document a reason for not administering pharmacological VTE prophylaxis anytime from admission day and the day before the VTE diagnostic test order date? | 1,2  If 1 and nomecpro = 1, auto-fill vteproadm as 95, and go to warfadm | **Physician, APN, PA, or pharmacist documentation of a reason for not administering pharmacological venous thromboembolism prophylaxis must be found within the timeframe from admission and the day before the VTE diagnostic test order date.**   * If the physician orders a transfusion and the blood products are administered within the timeframe from admission and the day before the VTE diagnostic test order date, select “1.” * Blood or blood products administered during surgery and documented on the anesthesia record or in the operative report should be considered an order for transfusion, select “1.” * If there is documentation that the patient is on continuous IV heparin therapy within 24 hours before or after surgery, select “1.” * Patient refusal of pharmacological VTE prophylaxis may be documented by a nurse, but must be documented within the timeframe from admission and the day before the VTE diagnostic test order.   **Examples of reasons for not administering VTE pharmacological prophylaxis such as:** active bleeding (gastrointestinal or GI bleeding, cerebral hemorrhage, retroperitoneal bleeding), bleeding risk, hemorrhage, patient refusal, risk of bleeding, thrombocytopenia  **Unacceptable documentation of a reason for not administering VTE prophylaxis:**   * An order to hold VTE prophylaxis without a documented reason by the physician/APN/PA or pharmacist * Documentation the patient is at low risk for VTE or VTE prophylaxis is not needed * Documentation of “history of bleeding” without mention of active bleeding or bleeding risk * Re-infusion of blood products (blood salvage) collected with blood recovery systems * Documentation of an allergy or adverse reaction to ONE type of pharmacological prophylaxis. For example, “patient allergic to Coumadin” would not be acceptable.   Cont’d next page |
|  |  |  |  | **Reason for no VTE prophylaxis cont’d**   * Physician documentation of bleeding risk associated with surgery is not considered a reason for not administering pharmacological VTE prophylaxis. For example, physician documents, “Discussed risks and benefits of surgery. Included risk of infection and bleeding.”   **Pharmacological prophylaxis** = medications used to prevent VTE such as subQ low dose heparin, warfarin (Coumadin), or enoxaparin (Lovenox) |
| 43 | vteproadm | Was mechanical and/or pharmacological VTE prophylaxis administered anytime from admission day and the day before the VTE diagnostic test order date?  1. Yes  2. No  95. Not applicable | 1,2,95  Will be auto-filled as 95 if nomecpro = 1 and norxpro = 1 | **In order to answer this question, locate the diagnostic test order date (date entered in VTESORDT) and then review the chart to determine if VTE prophylaxis was administered within the timeframe from admission and the day before the test order date. If any VTE prophylaxis was given within the specified timeframe, select “1”.**  The VTE diagnostic test order date is the date the order was written to determine whether the patient developed VTE during hospitalization, not the date the test was completed. For example: On 4/11/2010 a CT of the thorax is ordered, but not completed until 4/12/2010. Use 4/11/2009 as the diagnostic test order date to determine if any prophylaxis was administered before that date.  If more than one diagnostic test was ordered to rule out VTE, and both confirmed VTE, select the first diagnostic test that confirmed VTE to determine if the patient received VTE prophylaxis. For example, a doppler was ordered on 4/20/2010 to rule out DVT, and another test was ordered on 4/23/2010 to rule out PE. Determine if any prophylaxis was administered anytime between the hospital admission date and before 4/20/2010. If VTE prophylaxis was not given during that timeframe, select “2.”  **Examples of each VTE prophylaxis category such as:**  **Low dose unfractionated heparin** (LDUH) - **only include heparin administered by subcutaneous route** (SC, SQ, SubQ): heparin, calcilean, calciparine  **Low molecular weight heparin** (LMWH): enoxaparin (Lovenox), fragmin, innohep  Cont’d next page |
|  |  |  |  | **VTE Prophylaxis cont’d**  **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  **Factor Xa Inhibitor**: Arixtra, Fondaparinux sodium  **Warfarin** such as: Coumadin, Jantoven, Panwarfin, Warfilone  **Oral Factor Xa Inhibitor**: Rivaroxaban  **Venous foot pumps:** AE pumps – foot only, Kendall boots, Pneumoboots – foot only |
|  |  | **Anticoagulant Medications** |  |  |
| 44 | warfadm | Is there documentation that warfarin was administered within the timeframe of 2 days prior to 2 days after the date the VTE was confirmed? | 1,2 | If there is documentation that warfarin was administered during the timeframe within 2 days prior to 2 days after the date the VTE was confirmed (date entered in POSVTEDT), enter “1.”  If warfarin was ordered, but not administered, select “2”.  If warfarin was not administered within the specified timeframe, enter “2.” |
| 45 | ivantico | Is there documentation a parenteral (IV or subcutaneous) anticoagulant medication was administered within the timeframe of 2 days prior to 2 days after the date the VTE was confirmed? | 1,2 | If there is documentation that a parenteral anticoagulant was administered during the timeframe within 2 days prior to 2 days after the date the VTE was confirmed (date entered in POSVTEDT), enter “1.”  If a parenteral anticoagulation was ordered, but not administered, select “2”.  If a parenteral anticoagulation was not administered within the specified timeframe, enter “2.”  **Unfractionated heparin** (LDUH) - subcutaneous route(SC, SQ, SubQ) or intravenous (IV): heparin, calcilean, calciparine  **Low molecular weight heparin** (LMWH): enoxaparin (Lovenox), fragmin, innohep  **Factor Xa Inhibitor**: Arixtra, Fondaparinux sodium  **Direct Thrombin Inhibitors:** argatroban, bivalirudin, lepirudin |
| 46 | admivhep | Is there documentation that **intravenous (IV) unfractionated heparin** was administered within the timeframe of 2 days prior to 2 days after the date the VTE was confirmed?  1. Yes  2. No | 1,\*2  \*If 2 AND ivantico = 2, go to warfrxdc, else if 2 auto-fill mgtheptx as 95, and go to anti2dt   |  | | --- | | Warning if 2 and ivantico = 1 | | If there is documentation that unfractionated heparin IV was administered during the timeframe within 2 days prior to 2 days after the date the VTE was confirmed (date entered in POSVTEDT), enter “1.”  If unfractionated heparin IV was ordered, but not administered, select “2”.  If unable to determine that route of administration was intravenous (IV), select “2.” |
| 47 | anti2dt | Enter the first date that a parenteral (IV or subcutaneous) anticoagulant medication **AND** warfarin were both administered. | mm/dd/yyyy  Abstractor can enter 99/99/9999   |  | | --- | | < = 2 days prior to or = posvtedt and <= 2 days after posvtedt and <= vtedcdt | | Enter the exact date. The use of 01 to indicate missing month or day is not acceptable.  If the first date that both a parenteral anticoagulant AND warfarin were administered is unable to be determined from medical record documentation, enter 99/99/9999. |
| 48 | anticodt | Enter the last date that a parenteral (IV or subcutaneous) anticoagulant medication was administered. | mm/dd/yyyy  Abstractor can enter 99/99/9999  If anticodt – anti2dt < 4 days, auto-fill preinr as 95 and go to mgtheptx   |  | | --- | | >= anti2dt and <=vtedcdt | | Enter the exact date. The use of 01 to indicate missing month or day is not acceptable.  If the last date that a parenteral anticoagulant was administered is unable to be determined from medical record documentation, enter 99/99/9999. |
| 49 | preinr | Is there documentation of an INR result greater than or equal to 2 (INR > 2) the day of or the day prior to the discontinuation of the parenteral anticoagulation medication?  1. Yes  2. No  95. Not applicable | 1,2,95  Will be auto-filled as 95 if anticodt – anti2dt < 4 | To determine the value for this data element, review the INR values the day of and the day prior to the discontinuation of the parenteral anticoagulation therapy. If any INR result is ≥ 2, select “1”. |
| 50 | mgtheptx | Is there documentation that the IV unfractionated heparin AND platelet counts were managed by defined parameters using a protocol (or nomogram)?  1. Yes  2. No  95. Not applicable | 1,2,95  Will be auto-filled as 95 if admivhep = 2 | **With the exception of nursing documentation of use of a UFH pathway to manage UFH therapy, physician/APN/PA or pharmacist documentation is required.**  Pathways or orders that state that a nomogram or protocol was used to calculate the UFH therapy dosages are acceptable. The pathways or orders must specify that the platelet counts were being monitoring within the defined specifications.  “Defined parameters” for managing UFH therapy may include documents labeled a nomogram or protocol.  Platelet count monitoring must be within the defined specifications of the inclusion guidelines in order to select “1”.  For orders that state that UFH therapy is ordered per pharmacy dosing or per pharmacy protocol select “1” if the platelet counts were also monitored within the defined specifications.  **The defined platelet count monitoring specifications are as follows:**   * Baseline platelet count the day of (must be drawn before initiation of UFH) or the day before initiation of UFH. * Repeat platelet count the day following the initiation of UFH. * Platelet count at least three non-consecutive days within the first seven days (this includes the repeat platelet count day following the initiation of UFH therapy) and on at least three non-consecutive days between days 7 and 14 or until UFH is discontinued (whichever is first). |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  | **Discharge Anticoagulants** |  |  |
| 51 | warfrxdc | Is there documentation that warfarin was prescribed at discharge? | 1,2 | **Review all discharge medication documentation to determine if warfarin was prescribed at discharge.** In determining whether warfarin was prescribed at discharge, it is not uncommon to see conflicting documentation in different medical record sources. For example, the discharge summary may list warfarin that is not included in any of the other discharge medication sources (e.g., discharge orders).   * If documentation is contradictory (e.g., physician noted “d/c warfarin” or “hold warfarin” in the discharge orders, but warfarin 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 warfarinafter discharge as contradictory ONLY if the timeframe on the hold is **not defined** (e.g., “Hold warfarin” does not have a timeframe). * If warfarin is listed as a discharge medication, select "1" unless contradictory documentation exists (see above). * If Coumadin/warfarin is on hold at discharge but there is documentation of a plan to restart it after discharge (e.g., “Resume Coumadin after INR normalizes”), select “1.” * If there are instructions to follow-up with the Coumadin clinic, or have a PT/INR drawn, select “1.”   **Excluded Data Sources:** Any documentation dated/timed after discharge, except discharge summary and operative/procedure/diagnostic test reports (from procedure done during hospital stay). |
| 52 | rxantidc | Is there documentation that a parenteral anticoagulant medication was prescribed at discharge? | 1,2  If 1, auto-fill dcovrlap as 95 and if VTEPTDC = 01, 06, 21, or 50 AND warfrxdx = 1, go to PTEDCOM; else go to end | **Review all discharge medication documentation to determine if a parenteral anticoagulant (e.g. LMWH) was prescribed at discharge.** In determining whether a parenteral anticoagulant medication was prescribed at discharge, it is not uncommon to see conflicting documentation in different medical record sources. For example, the discharge summary may list LMWH that is not included in any of the other discharge medication sources (e.g., discharge orders).   * If documentation is contradictory (e.g., physician noted “d/c LMWH” or “hold LMWH” in the discharge orders, but LMWH 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 parenteral anticoagulant (e.g. LMWH)after discharge as contradictory ONLY if the timeframe on the hold is **not defined** (e.g., “Hold LMWH” does not have a timeframe). * If a parenteral anticoagulant medication is listed as a discharge medication, select "1" unless contradictory documentation exists (see above). * If a parenteral anticoagulant medication is NOT listed as a discharge medication and there is only documentation of a hold or plan to delay initiation/restarting of the parenteral anticoagulant for a time period after discharge (e.g., “Hold LMWH X 2 days,” “Start LMWH as outpatient”after INR normalizes”), select “2.”   **Examples of parenteral anticoagulant medications:**  **Unfractionated heparin** (LDUH) - subcutaneous route(SC, SQ, SubQ) or intravenous (IV): heparin, calcilean, calciparine  **Low molecular weight heparin** (LMWH): enoxaparin (Lovenox), fragmin, innohep  **Factor Xa Inhibitor**: Arixtra, Fondaparinux sodium  **Direct Thrombin Inhibitors:** argatroban, bivalirudin, lepirudin  **Excluded Data Sources:** Any documentation dated/timed after discharge, except discharge summary and operative/procedure/diagnostic test reports (from procedure done during hospital stay). |
| 53 | dcovrlap | Is there a reason documented by a physician/APN/PA or pharmacist for discontinuation of the overlap therapy? | 1,2,95  Will be auto-filled as 95 if rxantidc = 1 | **Patient refusal may be documented by a nurse.**  **Examples of reasons for discontinuing overlap therapy include, but are not limited to:** active bleeding (gastrointestinal or GI bleeding, cerebral hemorrhage, retroperitoneal bleeding), bleeding risk, hemorrhage, risk of bleeding, thrombocytopenia  **Excluded Data Sources:** Any documentation dated/timed after discharge, except discharge summary. |
| **IF VTEPTDC = 01, 06, 21, or 50 and WARFRXDX = 1, go to PTEDCOM; else go to end.** | | | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  | **Discharge Instructions** |  |  |
| 54 | ptedcom | Did the WRITTEN discharge instructions or other educational material given to the patient/caregiver address **compliance issues** **related to warfarin therapy** prescribed after discharge? | 1,2 | **Written discharge instructions or documentation of educational material given to the patient/caregiver that addresses compliance issues related to warfarin therapy must include BOTH of the following:**   * The importance of taking warfarin as instructed. * The importance of monitoring warfarin with scheduled PT/INR blood draws.   **Guidelines for Discharge Instructions (applies to all 4 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) If the patient refused written discharge instructions/material which addressed compliance issues, select “1.”  4) 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.  5) The caregiver is defined as the patient’s family or any other person (e.g., home health, 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.** |
| 55 | ptediet | Did the WRITTEN discharge instructions or other educational material given to the patient/caregiver address **dietary advice related to warfarin therapy** prescribed after discharge? | 1,2 | **Written discharge instructions or documentation of educational material given to the patient/caregiver that addresses dietary advice related to warfarin therapy must include BOTH of the following:**   * A “consistent amount” of foods with Vitamin K rather than avoidance should be advised. * Avoid major changes in dietary habits, or notify health professional before changing habits. |
| 56 | ptedfolo | Did the WRITTEN discharge instructions or other educational material given to the patient/caregiver address **follow-up monitoring** **related to warfarin therapy** prescribed after discharge? | 1,2 | **Written discharge instructions or documentation of educational material given to the patient/caregiver that addresses follow-up monitoring related to warfarin therapy must include BOTH of the following:**   * Name and phone number of health professional/clinic or office, monitoring the anticoagulation therapy. * Next date for PT/INR laboratory blood draw.   **Select “Yes”, if the next date for PT/INR is documented as “follow-up with Coumadin clinic in one week.”** |
| 57 | ptedadr | Did the WRITTEN discharge instructions or other educational material given to the patient/caregiver address **potential for adverse drug reactions and interactions related to warfarin therapy** prescribed after discharge? | 1,2 | **Written discharge instructions or documentation of educational material given to the patient/caregiver that addresses potential for adverse drug reactions and interactions related to warfarin therapy must include ALL of the following:**   * Diet and medications can affect the PT/INR level. * Do not take or discontinue any medication or over-the-counter medication except on the advice of the physician or pharmacist. * Warfarin increases the risk of bleeding. |
| **Enable Fall Assessment** | | | | |