|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | |  | | | **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   |  | | --- | | < = 6 mos prior to or = vteadmdt and  < = vtedcdt |  |  | | --- | | Warning if > 3 days prior to vteadmdt | | | | **Arrival date is the earliest recorded date on which the patient arrived in the hospital’s acute care setting.**  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, or 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.  **(Cont’d Next Page)** | |
|  | |  | | |  | |  | | | **(Arrival Date cont’d)**   * 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. | |
| 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**   |  | | --- | | < = 6 mos prior to  or = vteadmdt/vteadmtm and < = vtedcdt/vtedctm |  |  | | --- | | Warning if > 72 hours prior to vteadmdt/vteadmtm | | | | **Arrival time is the earliest recorded time the patient arrived in this hospital’s acute care setting. 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  **Cont’d next page** | |
|  | |  | | |  | |  | | | **(Arrival Time cont’d)**   * 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 obviously in error (e.g. 33:00) and no other documentation is found that provides this information, enter 99:99. | |
| 3 | | vteadmdt  ALL | | | Date of admission to acute inpatient care: | | mm/dd/yyyy  **Auto-filled: can be modified**   |  | | --- | | > = arrvdate and < = vtedcdt | | | | **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 | |
| 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.  **Admission time = time when the patient was formally admitted to inpatient status.**  **Exclusion:** Admit to observation time, Arrival time  If correction is necessary, enter time in Universal Military Time. | |
| 5 | | vtedcdt  ALL | | | Discharge date: | | mm/dd/yyyy  **Auto-filled. Cannot be modified**  > = vteadmdt | | | **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 | | vtedctm | | | Time of discharge: | | \_\_\_\_\_\_ UMT  **Auto-filled; can be modified**   |  | | --- | | > vteadmdt/vteadmtm | | | | **Auto-filled; can be modified.**  Abstractor to verify discharge time is correct.  **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  \*ALL | | | 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. Do NOT change the principal diagnosis code unless the principal diagnosis code documented in the medical record is not the code displayed in the software.** | |
| 8 | | vteothdx1  vteothdx2  vteothdx3  vteothdx4  vteothdx5  vteothdx6  vteothdx7  vteothdx8  vteothdx9  vteothdx10  vteothdx11  vteothdx12  vteothdx13  vteothdx14  vteothdx15  vteothdx16  vteothdx17  vteothdx18  vteothdx19  vteothdx20  vteothdx21  vteothdx22  vteothdx23  vteothdx24  \*ALL | | Enter the ICD-9-CM other diagnosis codes: | | | \_\_ \_\_ \_\_. \_\_ \_\_  (3 digits/decimal point/two digits)  Auto-filled: cannot be modified  **If enabled, can enter up to 24 codes**  **If enabled, abstractor can enter xxx.xx in code field if no other diagnosis codes found** | | | **Will be auto-filled from PTF with up to 24 ICD-9-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.xx.** | |
| 9 | | vtepxcd  (code)  ALL  VTE1,2  vtepxdt  (date)  ALL | | 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. The principal procedure is related to the principal diagnosis and needs to be accurately identified.**   * VA records do not identify the principal procedure; use the above definition of principal procedure to determine the correct code to enter if there are multiple procedures during the episode of care. Ask for assistance from your RM or WVMI if you are uncertain.   **If no procedure was performed during the episode of care, fill ICD-9-CM code field with default code xx.xx. Do not enter 99.99 or 00.00 to indicate no procedure was performed.**  **Date of the principal procedure is to be filled with 99/99/9999 if no procedure was performed.**  If the principal procedure date is unable to be determined from the medical record documentation, or the date documented in the record is obviously in error (e.g. 11/42/20xx) and no other documentation is found that provides this information, enter 99/99/9999. | |
| 10 | | othrpx1  othrpx2  othrpx3  othrpx4  othrpx5  (codes)  ALL  othpxdts1  othpxdts2  othpxdts3  othpxdts4  othpxdts5  (dates)  ALL | | 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**   |  | | --- | | **Cannot enter 00.00** | | > = 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. * If no other procedures were performed, it is only necessary to complete the xx.xx and 99/99/9999 default entries for the first code and date. It is not necessary to complete the default entry five times. * If the date of a procedure is unable to be determined from the medical record documentation, or if the procedure date documented in the record is obviously in error (e.g. 11/42/20xx) and no other documentation is found that provides this information, enter 99/99/9999. | |
| **If vtepxcd is on TJC Table 5.17, 5.19, 5.20, 5.21, 5.22, 5.23, or 5.24, go to anebegdt; else go to dcdispo as applicable** | | | | | | | | | | | |
| 11 | | anebegdt  VTE2 | | Enter the anesthesia start date for the principal procedure. | | | mm/dd/yyyy  Abstractor can enter 99/99/9999   |  | | --- | | >= vteadmdt and <=vtedcdt | | Warning if anebegdt <> vtepxdt | | | | **The Anesthesia Start Dateis the date associated with the start of anesthesia for the principal procedure.** If a patient enters the operating room, but the surgery is canceled before incision and the principal procedure is performed on a later date, the Anesthesia Start Dateis the date the principal procedure was actually performed.  **NOTE: The anesthesia record is the priority data source for this element.**   * **If a valid Anesthesia Start Date is found on the anesthesia record, enter that date.** * **If a valid Anesthesia Start Date is not documented on the anesthesia record, use other suggested data sources (e.g., intraoperative record, circulator record, post-anesthesia evaluation record, operating room notes) to determine the Anesthesia Start Date.** * 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, Anesthesia Start Time is 23:30 and Anesthesia End Time is 00:45. Abstract Anesthesia Start Date as 10/01/20xx because the date would change if the anesthesia ended after midnight and the start time was prior to midnight. * When the date documented is obviously invalid (not a valid format/range such as 11-39-20xx or after the Discharge Date or Anesthesia End Date) **and** no other documentation can be found that provides the correct information, enter 99/99/9999. * If the Anesthesia Start Datecannot be determined from the medical record documentation, enter 99/99/9999. * If the Anesthesia Start Dateis incorrect but it is a valid date and the correct date can be supported with other documentation in the medical record, the correct date may be entered*.* If supporting documentation of the correct date cannot be found, the medical record must be abstracted as documented or at “face value.” | |
| 12 | dcdispo  ALL  VTE3,4,5 | | 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. Expired  7. Left Against Medical Advice/AMA  99. Not documented or unable to determine | | | | | 1,2,3,4,5,6,7,99 | | **Discharge disposition: The final place or setting to which the patient was discharged on the day of discharge.**   * **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 back to skilled care. Enter “5”. * **Discharge disposition documentation in the discharge summary, a 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.   o Acute Care Facility  o Hospice – Health Care Facility  o Hospice – Home  o Other Health Care Facility  o 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”.   **Cont’d next page** |
|  |  | |  | | | | |  | | **Discharge dispo cont’d**   * **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 |
| **If VTEOTHDX is on TJC Table 7.03 or 7.04 and VTEPRIN is not on TJC Table 7.03 or 7.04 , go to ARRVTEDX; else go to COMFORT** | | | | | | | | | | |
| 13 | arrvtedx  VTE6 | | Is there documentation by the physician/APN/PA that venous thromboembolism (VTE) was diagnosed or suspected from arrival to the day after admission?  1. Yes  2. No | | | | 1,2 | | | * + The time frame for this data element includes any documentation of VTE confirmed or suspected from arrival to the day after admission. Documentation of a VTE Diagnostic Test, diagnosis or suspicion of VTE is acceptable.   **Example:** A patient arrived on 10/1/20xx with shortness of breath. On 10/2/20xx, there is documentation that a PE was suspected, select “1.”   * + If documentation is questionable regarding whether VTE was present or suspected at admission, select “1”.   + For patients with only a history of VTE documented, select “2.”   + If the patient was admitted and has surgery on day of or day after hospital admission or ICU admission, and there was no documentation of diagnosed/suspected VTE prior to surgery, VTE is not considered present on admission and “2” would be selected.   **Suggested Data Sources:** Consultation notes, Emergency Department record, History and physical, Radiology report, Observation notes, Outpatient surgery notes, Physician notes |
| 14 | | comfort  VTE1,2,3,46 | | 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 TJC VTE Hospital Quality Measures; else, go to clntrial**   |  | | --- | | 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.**   |  |  | | --- | --- | | **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).   **(Cont’d next page)** |
|  | |  | |  | | |  | | |  |
|  | |  | |  | | |  | | | **(Comfort cont’d)**   * **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  **Exclusion Statement: Clinician documentation of “comfort measures only (CMO)” excludes the case from The Joint Commission designated VTE Hospital Quality measures. Abstraction of required data elements for VHA measures remains applicable.** |
| 15 | clntrial  ALL | | During this hospital stay, was the patient enrolled in a clinical trial in which patients with venous thromboembolism (VTE) were being studied?  1. Yes  2. No | | | \*1,2  **\*If 1, the record is excluded from TJC VTE Hospital Quality Measures review; go to end.**  **\*If 2 AND comfort = 1 AND dcdispo = 1, 2, or 99; go to vtetest; else, if 2, go to icuvte as applicable** | | | **Only capture patients enrolled in clinical trials studying patients with VTE (prevention or treatment interventions).**  **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.** | |
| 16 | icuvte  VTE1,2 | | Was the patient admitted or transferred to the intensive care unit (ICU) anytime during this hospitalization?  1. Yes  2. No  99. Unable to determine | | | 1,2,99  **If 2 or 99, go to vtesurg as applicable** | | | The definition of an ICU for the purpose of this review is that used by the CDC in the NHSN Patient Safety Project. An intensive care unit can be defined as a nursing care area that provides intensive observation, diagnosis, and therapeutic procedures for adults and/or children who are critically ill. An ICU excludes nursing areas that provide step-down, intermediate care or telemetry only and specialty care areas.  **ONLY ACCEPTABLE DATA SOURCE: Physician/APN/PA orders. Other data sources may be used to support admission or transfer to ICU only.**   * **If there is documentation that the order was written for the patient to be directly admitted or transferred (from a lower level of care) to the intensive care unit (ICU) anytime during this hospitalization, 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 was not moved to an ICU because the patient’s condition changed and did not require an ICU level of care, select “2”. However, if the patient is not moved to an ICU unit due to a lack of a bed, select “1”.   **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) * Specialty care units (e.g., bone marrow transplant, solid organ transplant, inpatient acute dialysis, hematology/oncology, long term acute care) | |
| 17 | icuadmdt  VTE1,2 | | Enter the earliest date that the order was written for the ICU admission or transfer during this hospitalization. | | | mm/dd/yyyy  Abstractor can enter 99/99/9999   |  | | --- | | >= vteadmdt and <=vtedcdt | | | | **The intent of the question is to determine the date that the patient was actually admitted to ICU.**   * **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.** * For patients who are admitted to Observation status and subsequently admitted to ICU, enter the date that the determination was made and the order written to admit to ICU. Do not use the date that the patient was admitted to Observation. * 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 a patient is admitted to ICU on 10/19/20xx and discharged to a medical floor on 10/20/20xx, that is equal to one day, regardless of the number of hours. More than one day in ICU is when a patient is admitted to ICU on 10/19/20xx and discharged on 10/21/20xx, regardless of the number of hours. * Enter the date the admission/transfer was ordered regardless of whether the patient is physically admitted to the ICU on the same date.   If unable to determine the ICU admission/transfer date after reviewing the medical record documentation, enter 99/99/9999.  **ONLY ALLOWABLE DATA SOURCE: Physician/APN/PA orders** | |
| 18 | icudcdt  VTE1,2 | | Enter the date that the order was written for the patient to be discharged from the ICU. | | | mm/dd/yyyy  Abstractor can enter 99/99/9999  If icuadmdt – vteadmdt >= 2 days OR icudcdt – icuadmdt = 0 days, go to vtesurg as applicable; else go to icusurg   |  | | --- | | > = 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).**   * Enter the date that the order to discharge was written regardless of whether the patient was physically discharged from ICU. * If the patient had more than one ICU discharge within the same 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.   **Suggested data source:** Physician/APN/PA orders | |
| **If VTEDCDT – VTEADMDT < 2 days OR (VTEPRIN or VTEOTHDX is on TJC Table 7.03 or 7.04)** **, go to VTETEST; else go to VTESURG** | | | | | | | | | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  | **Surgery** |  |  |
| 19 | vtesurg  VTE1 | Was a surgical procedure performed using general or neuraxial anesthesia the day of or the day after hospital admission?  1. Yes  2. No | 1,2  If 2 and (vteprin is on TJC Table 7.01, 8.1 or 8.2, OR vtepxcd is on TJC Table 5.17, 5.19, 5.20, 5.21, 5.22, 5.23, or 5.24) and icuvte=1,  go to icusurg; 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: Endotracheal, Inhaled gases, Intravenous, Laryngeal mask airway or anesthesia (LMA), Total Intravenous Anesthesia (TIVA)  Neuraxial Anesthesia: Epidural block, Spinal anesthesia, Spinal block, , Subarachnoid blocks  **Exclusion Guidelines for Abstraction:** Conscious sedation, Deep sedation, Local with sedation , Local with stand-by, Monitored anesthesia care (MAC), Peripheral nerve blocks, Saddle block  **Suggested Data Sources:** Anesthesia record, Intraoperative record, Operating room notes, Operative report, PACU/recovery room record, Preop checklist, Procedure note |
| 20 | vtesurdt  VTE1 | 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 | | **Enter the surgery end date associated with the surgical procedure performed the day of or the day after hospital admission.**   * 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. * When the date documented is obviously invalid (not a valid format/range), e.g., a date after the *Discharge Date*, before the *Surgery End Date*, 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 Datewas 03-12-20xx. Other documentation in the medical record supports the date of death as being accurate. Since the Surgery End Date is outside of the parameter for care (after the Discharge Date[death]), enter “99/99/9999”. * If the Surgery End Dateis 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 10-10-2013 and other documentation in the medical record supports that the correct date was 10-10-2014; 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.   If unable to determine the surgery end date after reviewing the medical record documentation, enter 99/99/9999.  **Suggested data sources:** Anesthesia record, operating room notes, operative report |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  | **Hospital VTE Prophylaxis** |  |  |
| 21 | vtepro1  vtepro2  vtepro3  vtepro4  vtepro5  vtepro6  vtepro7  vtepro8  vtepro9  vteproA  VTE1 | What type of VTE prophylaxis was administered during this hospitalization?  **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. Warfarin  7. Venous foot pumps (VFP)  8. Oral Factor Xa Inhibitor (such as rivaroxaban)  9. Aspirin  A None of the above or unable to determine from medical record documentation | 1,2,3,4,5,6,7, 8,9,A  If 1,2,3,4,5,6,7, or 8, auto-fill noadmpro as 95  If A or only 9, auto-fill oralxai as 95, admprodt as 99/99/9999, and go to noadmpro  If only 8, **OR** 8 and 9, go to oralxai; else auto-fill oralxai as 95   |  | | --- | | 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 (non-ICU setting) or the day of or the day after Surgery End Date for surgeries that start the day of or the day after hospital admission (non-ICU setting). 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)  **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  **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, |
| 22 | oralxai  VTE1 | Is there physician/APN/PA documentation of a reason why Oral Factor Xa Inhibitor was administered for VTE prophylaxis?  1. Yes  2. No  95. Not applicable | 1,2,95  Will be auto-filled as 95 if vtepro <> 8; if vteproA = -1; **OR** if only vtepro9 = -1   |  | | --- | | Warning if 2 AND [(vteprin or vteothdx = 427.31 or 427.32) or (othrpx = 81.51, 81.52, 81.53, 81.54 or 81.55)] | | **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-9-CM Other Procedure Code of 81.51, 81.52, 81.53, 81.54 or 81.55 * ICD-9-CM Principal/Other Diagnosis Code of 427.31 or 427.32 * 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”.**  **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 |
| 23 | admprodt  VTE1 | Enter the date VTE prophylaxis was administered after hospital admission. | mm/dd/yyyy  Will be auto-filled as 99/99/9999 if  vteproA = -1 or if only vtepro9 = -1  If icuvte = 1, go to icusurg; else go to vtetest as applicable  Abstractor can enter 99/99/9999   |  | | --- | | > = vteadmdt and  < = vtedcdt | | **Enter the earliest date after hospital admission associated with the administration of a form of VTE prophylaxis other than aspirin.**  Example: The patient was admitted on 12/08/20xx and aspirin was administered at 13:00 on 12/08/20xx and LMWH was administered at 02:00 on 12/09/20xx, enter the 12/09/20xx date.  If unable to determine the date VTE prophylaxis other than aspirin was administered during this hospitalization, enter 99/99/9999. |
| 24 | noadmpro  VTE1 | 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 (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 vtepro <> A or if vtepro <> 9 only  If icuvte = 1, go to icusurg; else go to vtetest as applicable | **Documentation of the reason for not administering mechanical AND pharmacological VTE prophylaxis must be written from arrival to the day after hospital admission or the day after Surgery End Date.**  **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.   (Cont’d next page) |
|  |  |  |  | Reason for no prophylaxis cont’d   * 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.” * **VTE patients require a documented reason for not administering another form of prophylaxis when aspirin is the ONLY form of VTE prophylaxis administered.**   **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 |
|  |  |  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | |  | **ICU VTE Prophylaxis** |  |  |
| 25 | | icusurg  VTE2 | Was a surgical procedure performed using general or neuraxial anesthesia the day of or the day after ICU admission?  1. Yes  2. No | 1,2  If 2 auto-fill 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: Endotracheal, Inhaled gases, Intravenous, Laryngeal mask airway or anesthesia (LMA), Total Intravenous Anesthesia (TIVA)  Neuraxial Anesthesia; Epidural block, Spinal anesthesia, Spinal block, Subarachnoid blocks  **Exclusion Guidelines for Abstraction:** Conscious sedation, Deep sedation, Local with sedation, Local with stand-by, Monitored anesthesia care (MAC), Peripheral nerve blocks, Saddle block  **Suggested Data Sources:** Anesthesia record, Intraoperative record, Operating room notes, Operative report, PACU/recovery room record, Preop checklist, Procedure note |
| 26 | | icusurdt  VTE2 | 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   |  | | --- | | <= 1 day after or = icuadmdt and <=vtedcdt | | **Enter the surgery end date associated with the 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* of the initial procedure performed on the day of or the day after ICU admission or transfer. 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), e.g., a date after the *Discharge Date*, before the *Surgery End Date*, 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* 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 10-10-2013 and other documentation in the medical record supports that the correct date was 10-10-2014; 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.   **Suggested data sources:** Anesthesia record, operating room notes, operative report |
| 27 | icupro1  icupro2  icupro3  icupro4  icupro5  icupro6  icupro7  icupro8  icuproA  VTE2 | | What type of VTE prophylaxis was administered in the ICU?  **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. Warfarin  7. Venous foot pumps (VFP)  8. Oral Factor Xa Inhibitor (such as rivaroxaban)  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  If only 8, go to oralxai2, otherwise auto-fill oralxai2 as 95   |  | | --- | | Value A cannot be entered with any number | | * **Begin by looking for documentation of administration of VTE prophylaxis on the day of or day after ICU admission/transfer (or the day of or the day after Surgery End Date for surgeries that start the day of or the day after ICU admission). If no ICU VTE prophylaxis was administered during this timeframe, select value “A.”** * **Selection of allowable values 1-8 includes any VTE prophylaxis that was administered in the ICU in the allowable time frame.** For example: If a patient was admitted to ICU on 12/8/20xx and had bilateral GCS applied at 13:00 on 12/8/20xx and LMWH was administered at 22:00 on 12/9/20xx, 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 administered in the ICU during the specified time frame. For example: if the patient received warfarin for atrial fibrillation on the day of ICU admission, select “6”. * Only select prophylaxis if there is documentation that it was administered. Documentation in the progress notes under Assessment/Plan: “DVT prophylaxis - SCD” is not enough to select “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)  **Cont’d next page** |
|  |  | |  |  | **ICU 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  **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)  **Suggested data sources:** Circulator notes, Emergency Department record, graphic/flow sheets, medication administration record, nursing notes, operative notes, physician notes, preoperative nursing notes, progress notes |
| 28 | oralxai2  VTE2 | | Is there physician/APN/PA documentation of a reason why Oral Factor Xa Inhibitor was administered for ICU VTE prophylaxis?  1. Yes  2. No  95. Not applicable | 1,2,95  Will be auto-filled as 95 if icupro <> 8   |  | | --- | | Warning if 2 AND [(vteprin or vteothdx = 427.31 or 427.32) or (othrpx = 81.51, 81.52, 81.53, 81.54 or 81.55)] | | **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-9-CM Other Procedure Code of 81.51, 81.52, 81.53, 81.54 or 81.55 * ICD-9-CM Principal/Other Diagnosis Code of 427.31 or 427.32 * 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”.**  **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, ICU flow sheet, Operative note, Physician orders, Progress notes, Risk assessment form, Transfer sheet |
| 29 | icuprodt  VTE2 | | Enter the date VTE prophylaxis was administered in the ICU. | mm/dd/yyyy  Will be auto-filled as 99/99/9999 if  icuproA = -1  Go to vtetest as applicable  Abstractor can enter 99/99/9999   |  | | --- | | >= icuadmdt and <=icudcdt | | **Enter the earliest date associated with the VTE prophylaxis administered in the ICU.**   * 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 VTE prophylaxis was administered in the ICU, enter 99/99/9999. |
| 30 | noicupro  VTE2 | | Is there physician/APN/PA documentation of a reason why 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 icuproA <> -1 | **Documentation of the reason for not administering mechanical AND pharmacological VTE prophylaxis must be written from the day of ICU arrival to the day after ICU admission/transfer or the day after Surgery End Date for surgeries that start the day of or the day after ICU admission/transfer.**.   * **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 ICU 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 a patient did not receive VTE prophylaxis on the medical unit due to physician documentation and is transferred to the ICU, another reason (even if it is the same reason) must be documented if no VTE prophylaxis was administered upon ICU admission/transfer.** * **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 alone 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**.”   **Cont’d next page** |
|  |  | |  |  | **Reason for No VTE prophylaxis cont’d**   * **For ONLY those patients determined to be AT LOW RISK for VTE:** * If documentation of “No VTE Prophylaxis needed” is written, 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. Select “Yes.” 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 ICU admission, select “Yes.” * If warfarin is listed as a home med, previous medication prior to admission/transfer to ICU, 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 ICU admission/transfer, 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.” * **VTE patients require a documented reason for not administering another form of prophylaxis when aspirin is the ONLY form of VTE prophylaxis administered.**   **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 |
| **If COMFORT = 99 OR if (COMFORT = 2 or 3 AND DCDISPO = 1, 2, or 99), go to VTETEST, else if COMFORT = 2 or 3, go to end** | | | | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  | **VTE Diagnosis** |  |  |
| 31 | vtetest  VTE3,4,5,6 | Is there documentation that a diagnostic test for VTE was performed within four days prior to arrival or anytime during the hospitalization?  1. Yes  2. No | 1,\*2  **\*If 2, go to end** | * + This data element includes patients who had one of the acceptable diagnostic tests performed within four days prior to arrival, or anytime during hospitalization. Examples: * Patient arrives on 1/1/20xx and documentation indicates a CT of chest with contrast was performed on arrival, earlier that same day. * Patient arrived on 1/1/20xx and documentation indicates the patient was admitted on 1/2/20xx. A VQ scan was performed on 1/2/20xx. * Patient transferred on 1/5/20xx with documentation from a transferring hospital indicating vascular ultrasound was performed on 1/2/20xx.   + Physician/APN/PA documentation must reflect the time frame within four calendar days prior to arrival or anytime during hospitalization.   + Documentation other than radiology reports must confirm one of the acceptable tests was performed.   Examples:   * Physician Notes: “Venous Doppler positive for DVT left popliteal,” select “Yes.”. * Emergency Notes: Patient to CT without contrast, select “No.”   + If a diagnostic test was performed that is not on the inclusion list, select “No”. Example: Physician notes indicate a 2D Echo was done that confirmed a PE (pulmonary emboli), select “No”. |
|  |  |  |  | **VTE Diagnostic testing includes the following (ALL Inclusive):**   * Compression Ultrasound/Vascular Ultrasound/Duplex ultrasound (DUS)/Venous Doppler of lower extremities * Computed tomography (CT) of thorax (chest), abdomen/pelvis, or lower extremity leg veins with contrast * Magnetic resonance imaging (MRI or MRV) of the thorax(chest), abdomen/pelvis, or lower extremity leg veins * Nuclear Medicine Pulmonary Scan/ventilation/perfusion (V/Q) lung scan * Pulmonary arteriography/angiography/angiogram * Venography/Venogram of pelvic, femoral or other lower extremity veins using contrast material   **Exclude:**   * VTE confirmation by only D-dimer tests * VTE diagnosed by tests not listed * Patients with a diagnostic test performed greater than four days prior to arrival |
| 32 | 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 diagnostic test related to this hospitalization was performed within four days prior to arrival, enter the date of admission as VTE test ordered date.  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. |
| 33 | posvte  VTE3,4,5,6 | Is there physician/APN/PA documentation that the patient had a diagnosis of VTE confirmed in one of the defined locations within four calendar days prior to arrival, or anytime during hospitalization?  **VTE Confirmed: Deep Vein Thrombosis (DVT) located in the proximal leg veins, including superficial femoral vein; the inferior vena cava (IVC); iliac, femoral or popliteal veins; or 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.**  **All physician/APN/PA documentation must reflect the time frame within four calendar days prior to arrival or anytime during hospitalization.**   * This data element includes patients who had an acceptable VTE diagnostic test and are confirmed to have an acute VTE by a physician/APN/PA within four days prior to arrival or anytime during hospitalization. Examples: * Physician/APN/PA documentation states that PE was confirmed with a VQ scan on arrival in the ED, select “Yes.” * Physician/APN/PA documentation states that the patient may have arrived without prior DVT confirmation, but after arrival, there is documentation based on a venous Doppler that the patient developed an acute DVT. * Physician/APN/PA documentation states that the patient had an acceptable VTE diagnostic test which confirmed the development of the VTE anytime during the hospital stay. * If a patient had a new or acute VTE confirmed in one of the defined locations by an acceptable VTE diagnostic test within four calendar days prior to arrival or anytime during the hospitalization, select “Yes.”   Examples:   * Patient arrives as a direct admission on 1/3/20xx with documentation of a PE confirmed in the right upper lobe by VQ scan, dated 1/1/20xx from an outside facility, select “Yes.” * Patient arrives to the ED on 2/1/20xx and past medical history reveals a DVT confirmed in the right superficial distal vein from 1/1/20xx, **greater than four calendar days prior to arrival**, select “No.” * If the patient was transferred from another acute care hospital, and there is no documentation indicating the VTE location, select “No.” * If VTE is diagnosed in any veins within the defined locations, select “Yes”. For example, documentation of a “non-occlusive thrombus to the right popliteal”, select “Yes.”   **Cont’d next page** |
|  |  |  |  | **VTE confirmed cont’d**   * Recurrent, chronic, sub-acute, or history of VTE is acceptable ONLY if there is documentation of an acute or new VTE. For example: If a patient had a history of lower extremity VTE, but diagnostic testing found a new VTE in the proximal vein of the lower extremity, select “Yes”. * If more than one acceptable VTE diagnostic test was performed, review the record for the earliest test that confirmed the VTE in one of the defined locations. * If the VTE diagnostic test results are noted as “low probability” or “inconclusive test results”, select “No”. * If a nuclear medicine VQ scan to rule-out PE was performed and the result was documented as “high probability”, select “Yes”. For all other impressions (e.g., “low probability”, “intermediate”, “intermediate to high probability” or “inconclusive test results”), select “No” * If there is questionable physician/APN/PA documentation regarding whether the patient had VTE, select “1”. For example, if the radiologist interpretation of the exam did not confirm VTE, but there is documentation of a DVT in the physician’s progress notes, select “1”.   **Exclude VTE located in the following areas:**   * Confirmed sites of VTE without a proximal leg DVT or PE also involved * History of VTE greater than four days prior to arrival, without documentation of a new/acute event * Hepatic/portal/splenic/mesenteric thrombosis * Not in the defined locations * Ovarian vein thrombosis * Renal vein thrombosis * Upper extremity thrombosis |
| 34 | posvtedt | Enter the earliest date the diagnosis of VTE in one of the defined locations was confirmed. | mm/dd/yyyy   |  | | --- | | >= 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 within four days prior to arrival, 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 = 2, go to VTEPROADM; else go to ADMIVHEP** | | | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  | **Prophylaxis Prior to Secondary VTE** |  |  |
| 35 | vteproadm  VTE6 | Was mechanical and/or pharmacological VTE prophylaxis administered anytime from hospital admission date and the day before the VTE diagnostic test order date?  1. Yes  2. No | 1,2  If 1, auto-fill nomecpro and norxpro as 95, and go to admivhep | * **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 4/11/20xx a CT of the thorax is ordered, but not completed until 4/12/20xx. Use 4/11/20xx 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 11/1/20xx to rule out DVT, and another test was ordered on 11/5/20xx to rule out PE. Determine if any prophylaxis was administered anytime between the hospital admission date and before 11/1/20xx. If VTE prophylaxis was not given during that timeframe, select “2.” * If the record contains questionable information regarding the administration of VTE prophylaxis prior to the VTE diagnostic test order date, select “2." * Application of mechanical prophylaxis may be documented by any personnel. * Only select prophylaxis if there is documentation it was administered. * If one pharmacological medication is ordered and another medication is substituted (such as per pharmacy formulary substitution or protocol), select “1” if the substitution medication was administered. * Aspirin is not an approved medication for prophylaxis in the VTE population. If aspirin is the only form of prophylaxis documented in the record, select “2.” |
|  |  |  |  | **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, aspirin  **Suggested data sources:** Consultation notes, discharge summary, Emergency Department record, medication administration record, nursing notes, progress notes |
| 36 | nomecpro  VTE6 | 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. Yes  2. No  95. Not applicable | 1,2,95  Will be auto-filled as 95 if vteproadm = 1 | **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.” * If the patient was on IV heparin between the hospital arrival date and the day before the VTE diagnostic test order date, select “1” * **Patient/family 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 include but are not limited to:** bilateral amputee, patient/family refusal, bilateral lower extremity trauma, massive leg edema, pulmonary edema, severe peripheral artery disease, severe peripheral neuropathy, major leg deformity, dermatitis, patients on IV heparin therapy  **Mechanical prophylaxis** = compression devices or stockings such as anti-embolism hose used to prevent VTE. (See TJC, Appendix H, Table 2.1 for examples) |
| 37 | norxpro  VTE6 | Did the physician/APN/PA or pharmacist document a reason for not administering pharmacological VTE prophylaxis anytime from admission date 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 vteproadm = 1 | **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 select “1.” * Patient/family 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 include but are not limited to:** active bleeding (gastrointestinal or GI bleeding, cerebral hemorrhage, retroperitoneal bleeding), bleeding risk, hemorrhage, patient/family refusal, thrombocytopenia, patients on IV heparin therapy  **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.” * Patient received IV heparin bolus or IV push heparin   **Pharmacological prophylaxis** = medications used to prevent VTE such as subQ low dose heparin, warfarin (Coumadin), or enoxaparin (Lovenox) |
| 38 | admivhep  VTE4 | Is there documentation that **intravenous (IV) unfractionated heparin** was administered?  1. Yes  2. No | 1,2  If 2, auto-fill mgtheptx as 95, and go to warfadm | If there is documentation that unfractionated heparin IV was administered during this hospitalization, 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.”  **Exclude:** Intravenous push, IV push, IVP, one time dose |
| 39 | mgtheptx  VTE4 | Was there physician/APN/PA or Pharmacist documentation that the IV unfractionated heparin (UFH) AND platelet counts were managed by defined parameters using a nomogram or protocol?  1. Yes  2. No  95. Not applicable | 1,2,95  Will be auto-filled as 95 if admivhep = 2 | **Physician/APN/PA or pharmacist documentation is required with the exception of nursing documentation on a UFH pathway used to manage UFH therapy.**   * Pathways, orders or documentation that state that a nomogram or protocol was used to calculate the UFH therapy dosages and platelet count monitoring are acceptable. * “Defined parameters” for managing UFH therapy may include documents labeled a nomogram or protocol. * For orders that state that UFH therapy is ordered per pharmacy dosing or per pharmacy protocol select “1” if there is documentation that platelet counts were also monitored. * If IV UFH was managed by a nomogram, but was discontinued prior to monitoring the platelet counts, select “Yes”. * If there is physician/APN/PA or pharmacist documentation of an explicit reason for not using documentation such as a nomogram or protocol, linked to the heparin order, select “Yes.”   Example: Do not use heparin protocol, MD to manage heparin drip. Select “Yes.”  **Suggested data sources:** Nomogram or Protocol for UFH management, Physician/APN/PA or Pharmacist orders/notes, , UFH pathway |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  | **Anticoagulant Medications** |  |  |
| 40 | warfadm  VTE3 | Is there documentation that warfarin was administered any time after the VTE diagnostic test?  1. Yes  2. No | 1,2  If 2, go to warfrxdc | To determine the value for this data element, locate the acceptable VTE diagnostic test completed and review the chart to determine if warfarin was administered any time after the test.   * If there is documentation that warfarin (Coumadin) was administered during the acceptable time frame, enter “1.” * If warfarin was ordered, but not administered, select “2”. * If VTE was diagnosed prior to admission and warfarin was administered on arrival, select “1”. * If the VTE diagnostic test and warfarin administration are on the same day, or anytime thereafter, select “1.”   Refer to TJC Appendix C, Table 1.4 Warfarin Therapy.  **Exclude:** Warfarin administered prior to day of arrival.  **Suggested data sources:** ED record, medication administration record, nursing notes |
| 41 | ovrlap  VTE3 | Is there documentation that parenteral (IV or subcutaneous) anticoagulation therapy AND warfarin were both administered on the same day during the hospitalization?  1. Yes  2. No or unable to determine | 1,2,  If 1, auto-fill ynovrlap as 95  If 2, auto-fill anti2dt as 99/99/9999 and go to ynovrlap | **Overlap therapy: administration of both parenteral (IV or subcutaneous) anticoagulation medication and the oral anticoagulant warfarin (Coumadin) on the same day.**   * To select “1”, both parenteral anticoagulation therapy and warfarin must be administered and documented on the same calendar day at least one time. * If conflicting documentation is present whether or not both warfarin and parenteral anticoagulation therapy were administered on the same day, select “2”.   Refer to TJC Appendix H, Table 2.3 VTE Parenteral Therapy Table and Appendix C, Table 1.4 Warfarin Therapy.  **Unfractionated heparin** (LDUH) - subcutaneous route(SC, SQ, SubQ) or intravenous (IV): heparin, heparin sodium  **Low molecular weight heparin** (LMWH): dalteparin (Fragmin), enoxaparin (Lovenox), tinzaparin (Innohep)  **Parenteral Factor Xa Inhibitor such as**: fondaparinux (Arixtra)  **Direct Thrombin Inhibitors:** argatroban (Acova), bivalirudin (Angiomax), lepirudin (Refludan)  **Suggested Data Sources:** ED record, medication administration record, nursing notes |
| 42 | anti2dt  VTE3 | Enter the first date that a parenteral (IV or subcutaneous) anticoagulant medication **AND** warfarin were both administered. | mm/dd/yyyy  Will be auto-filled as 99/99/9999 if ovrlap = 2  Abstractor can enter 99/99/9999   |  | | --- | | >= arrvdate and <=vtedcdt | | Enter the exact date. The use of 01 to indicate missing month or day is not acceptable.   * For patients admitted for VTE who were on warfarin at home and took a dose the day of admission, select the day of admission as the Overlap Therapy Start Date if the parenteral anticoagulant was started the day of admission. * For patients diagnosed with VTE while in the ED that had overlap therapy started prior to admission, enter the date that both medications were administered prior to the admission date. * 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. |
| 43 | ynovrlap  VTE3 | Is there physician/APN/PA or pharmacist documentation on the day of or the day after the VTE diagnostic test of a reason why overlap therapy (parenteral anticoagulation therapy and warfarin) was not administered?  1. Yes  2. No  95. Not applicable | 1,2.95  Will be auto-filled as 95 if ovrlap = 1 | **Overlap therapy: administration of both parenteral (IV or subcutaneous) anticoagulation medication and the oral anticoagulant warfarin (Coumadin) on the same day.**   * **The explicit reason for no overlap therapy must be documented by the physician/APN/PA or pharmacist on the day of or the day after the VTE diagnostic test.** * **If rivaroxaban (Xarelto) or apixaban (Eliquis) is ordered or administered during hospitalization or prescribed at discharge, select “1”.** * **Reasons for not administering overlap therapy must be explicitly documented.** Examples: * “No overlap therapy, patient bleeding” * “No bridge therapy, GI bleed” * “Intolerance to parenteral anticoagulation therapies” * “Patient is not a candidate for anticoagulant therapy” * Patient/family refusal of any or all forms of overlap therapy (e.g., “patient refused heparin”) is acceptable to select “1”. Patient/family refusal and/or patient allergy/intolerance to ALL parenteral anticoagulants may be documented by a nurse, but should be documented within the same timeframe as the reason for no overlap therapy. * Documentation that the patient is allergic or intolerant to **ALL** parenteral anticoagulation therapy is acceptable. Allergy or adverse reaction to ONE type of anticoagulant is NOT a reason for not administering all anticoagulants. Another medication can be ordered. * For VTE diagnostic tests performed prior to arrival, documentation must be present the day of or the day after arrival.   **Suggested Data Sources:** Anesthesia record, Consultation notes, Discharge summary, ED record, H&P, Physician orders, Progress notes  **Excluded Data Sources:** Any documentation dated/timed after discharge. |
| 44 | anticodt  VTE3 | 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 rxantidc   |  | | --- | | >= anti2dt and <=vtedcdt | | Enter the exact date. The use of 01 to indicate missing month or day is not acceptable.   * Parenteral Anticoagulant End Date is the last date that the anticoagulant medication was administered during hospitalization. This may be the same day as the discharge day. * For patients with non-consecutive medication administration, use the last day the parenteral medication was given. For example, if LMWH was given from 4/9 to 4/11, resumed from 4/13 to 4/15, use 4/15 as the end date. * If the parenteral medications are changed during overlap therapy, the end date is when the last dose of the parenteral medication is given during hospitalization. For example, if the patient receives 2 days of LMWH on 11/1 and 11/2 and is changed to Arixta on 11/3, 11/4 and 11/5, the parenteral end date would be 11/5.   If the last date that a parenteral anticoagulant was administered is unable to be determined from medical record documentation, enter 99/99/9999.  **Suggested data sources:** medication administration record, nursing notes |
| 45 | preinr  VTE3 | Is there documentation of an international normalized ratio (INR) result greater than or equal to 2 (INR > 2) on the day of or the day after the last dose 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 or the day after the last dose of the parenteral anticoagulation therapy. If any INR result is ≥ 2, select “1”.  Examples:   * On 1/1/20xx, after four days of overlap therapy, the INR is 1.8. On 1/2/20xx, the patient received enoxaparin, the INR is 2.0. Select “Yes” because the INR was equal to 2.0 on the day of or the day after the last dose of the parenteral anticoagulation therapy. * On 1/1/20xx, after five days of overlap therapy, the last dose of heparin is administered, the INR is 1.8. The patient is discharged without parenteral anticoagulation therapy Select “No” because the INR was not greater than or equal to 2.0 on the day of or the day after the last dose of parenteral anticoagulation therapy.   **Suggested Data Sources**:Lab reports |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  | **Discharge Anticoagulants** |  |  |
| 46 | rxantidc  VTE3 | Is there documentation that a parenteral (IV or subcutaneous) anticoagulant medication was prescribed at discharge?  1. Yes  2. No | 1,2  If 1, auto-fill dcantico as 95, and go to warfrxdc | **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.” * If two discharge summaries are included in the medical record, use the one with the latest date/time. This also applies to discharge medication reconciliation forms.   **Cont’d next page** |
|  |  |  |  | **Parenteral Anticoagulant cont’d**  **Examples of parenteral anticoagulant medications (refer to TJC Appendix H, Table 2.3 VTE Parenteral Therapy):**  **Unfractionated heparin** (LDUH) - subcutaneous route(SC, SQ, SubQ) or intravenous (IV): heparin, heparin sodium  **Low molecular weight heparin** (LMWH): dalteparin (Fragmin), enoxaparin (Lovenox), tinzaparin (Innohep)  **Parenteral Factor Xa Inhibitor** such as: fondaparinux (Arixtra)  **Direct Thrombin Inhibitors:** argatroban (Acova), bivalirudin (Angiomax), lepirudin (Refludan)  **Excluded Data Sources:** Any documentation dated/timed after discharge, except discharge summary and operative/procedure/diagnostic test reports (from procedure done during hospital stay). |
| 47 | dcantico  VTE3 | Is there a reason documented by a physician/APN/PA or pharmacist for discontinuation of the parenteral anticoagulant therapy on the **same day or the day before** the order for the discontinuation?  1. Yes  2. No  95. Not applicable | 1,2,95  Will be auto-filled as 95 if rxantidc = 1 | * Reasons for discontinuation of parenteral anticoagulant therapy must be explicitly documented by a Physician/APN/PA or pharmacist on the **same day or the day before** the order for discontinuation. * Reasons for discontinuation of parenteral therapy must be explicitly documented (e.g., “GI Bleed - Discontinue Lovenox”) OR clearly implied (e.g., “Severe anemia - discontinue heparin”). * If reasons are not mentioned in the context of the discontinuation of the parenteral therapy, do not make inferences (e.g., Do not assume that Lovenox is not prescribed at discharge because of the patient’s history of anemia). * Patient refusal of parenteral anticoagulant medication during hospitalization or at discharge is a reason for discontinuation and may be documented by a nurse. * Substitution of one parenteral drug for another parenteral drug is not considered discontinuation of parenteral therapy. For example, if patient was on sq heparin and was changed to Arixtra on day 3, the patient is still on a parenteral anticoagulant. * Do not infer reasons based on laboratory values alone, ONLY Physician/APN/PA or pharmacist documentation of the specified reason is acceptable. * If rivaroxaban (Xarelto) or apixaban (Eliquis) is ordered or administered during hospitalization or prescribed at discharge, select “Yes”. * Documentation that the patient is allergic or intolerant to **ALL** parenteral anticoagulation therapy is acceptable. An allergy or adverse reaction to ONE type of parenteral anticoagulant is NOT a reason for not administering all parenteral anticoagulants. Another medication can be ordered.   Cont’d next page |
|  |  |  |  | **Reason for dc parenteral cont’d**  **Examples of reasons for discontinuing parenteral therapy include, but are not limited to:** bleeding risk; “high” INR value/ supratherapeutic INR value; severe anemia; actively bleeding; not a candidate for long-term anticoagulation; previously on warfarin; received blood during this timeframe; scheduled for surgery; patient/caregiver refusal; thrombocytopenia; use of oral anticoagulants other than warfarin (such as rivaroxaban [Xarelto] or apixaban [Eliquis])  **Exclude:** discontinuation of parenteral medication without additional documentation  **Excluded Data Sources:** Any documentation dated/timed after discharge. |
| 48 | warfrxdc  VTE5 | Is there documentation that warfarin was prescribed at discharge?  1. Yes  2. No | 1,2  If 1 AND dcdispo = 1,2, or 99, go to ptedcom; else go to end | **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 two discharge summaries are included in the medical record, use the one with the latest date/time. This also applies to discharge medication reconciliation forms. * 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.”   **Refer to TJC Appendix C, Table 1.4 Warfarin Therapy.**  **Excluded Data Sources:** Any documentation dated/timed after discharge, except discharge summary and operative/procedure/diagnostic test reports (from procedure done during hospital stay). |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  | **Discharge Instructions** |  |  |
| 49 | ptedcom  VTE5 | 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. Yes  2. No | 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) 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) 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.  If the patient refused written discharge instructions/material which addressed compliance issues, select “1.”  **Acceptable educational materials include discharge instruction sheets, brochures, booklets, teaching sheets, videos, CDs, and DVDs.** |
| 50 | ptediet  VTE5 | 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. Yes  2. No | 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.   If the patient refused written discharge instructions/material which addressed dietary advice related to warfarin therapy, select “1.” |
| 51 | ptedfolo  VTE5 | 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. Yes  2. No | 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 the following:**   * Information about plans to monitor warfarin post-discharge. For example, if “follow-up with Coumadin clinic in one week” is documented, select “Yes”.   **If home health will be monitoring the warfarin, select “Yes”.**  If the patient refused written discharge instructions/material which addressed follow-up monitoring related to warfarin therapy, select “1.” |
| 52 | ptedadr  VTE5 | 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. Yes  2. No | 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.   If the patient refused written discharge instructions/material which addressed potential for adverse drug reactions and interaction related to warfarin therapy, select “1.” |