|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | |  | | | **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 | 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 | | vteadmdt  ALL | | | Date of admission to acute inpatient care: | mm/dd/yyyy  **Auto-filled: can be modified**   |  | | --- | | < = 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 |
| 2 | | 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. |
| 3 | | vteprin  \*ALL | | | Enter the ICD-10-CM principal diagnosis code: | \_\_ \_\_ \_\_. \_\_ \_\_ \_\_ \_\_  (3 alpha-numeric characters/decimal point/four alpha-numeric characters)   |  | | --- | | **Cannot enter 000.0000, 123.4567, or 999.9999** | | | **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.** |
| 4 | | 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-10-CM other diagnosis codes: | | \_\_ \_\_ \_\_. \_\_ \_\_ \_\_ \_\_  (3 alpha-numeric characters /decimal point/four alpha-numeric characters)  Auto-filled: cannot be modified  **If enabled, can enter up to 24 codes**  **If enabled, abstractor can enter xxx.xxxx in code field if no other diagnosis codes found** | | **Will be auto-filled from PTF with up to 24 ICD-10-CM other diagnosis codes. Cannot be modified.**  **If no other diagnosis codes are received from PTF, abstractor is to verify codes documented in the record and enter. If no other diagnosis codes are found in the record, enter xxx.xxxx.** |
| 5 | | vtepxcd  (code)  ALL  VTE1,2  vtepxdt  (date)  ALL | | Enter the ICD-10-CM principal procedure code and date.  Code Date   |  |  | | --- | --- | | \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ | \_\_/\_\_/\_\_\_\_ | | | \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_  **(Must be 7 alpha-numeric characters)**  **If there is no principal procedure, the abstractor can enter xxxxxxx in code field and**  **99/99/9999 in date field**   |  | | --- | | **Cannot enter 0000000** |   mm/dd/yyyy  **Abstractor can enter 99/99/9999**  **If there is no principal procedure, auto-fill othrpx and otherpxdt with xxxxxxx and 99/99/9999**   |  | | --- | | > = vteadmdt and < = vtedcdt | | | **Principal procedure= that procedure performed for definitive treatment, rather than for diagnostic or exploratory reasons, or was necessary to treat a complication. The principal procedure is related to the principal diagnosis and needs to be accurately identified.**   * VA records do not identify the principal procedure; use the above definition of principal procedure to determine the correct code to enter if there are multiple procedures during the episode of care. Ask for assistance from your RM or WVMI if you are uncertain.   **If no procedure was performed during the episode of care, fill ICD-10-CM code field with default code xxxxxxx. Do not enter 9999999 or 0000000 to indicate no procedure was performed.**  **Date of the principal procedure is to be filled with 99/99/9999 if no procedure was performed.**  If the principal procedure date is unable to be determined from the medical record documentation, or the date documented in the record is obviously in error (e.g. 11/42/20xx) and no other documentation is found that provides this information, enter 99/99/9999. |
| 6 | | othrpx1  othrpx2  othrpx3  othrpx4  othrpx5  (codes)  ALL  othpxdts1  othpxdts2  othpxdts3  othpxdts4  othpxdts5  (dates)  ALL | | Enter the ICD-10-CM other procedure codes and dates.  Code Date   |  |  | | --- | --- | | \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ | \_\_/\_\_/\_\_\_\_ | | \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ | \_\_/\_\_/\_\_\_\_ | | | \_\_ \_\_ \_\_. \_\_ \_\_ \_\_ \_\_ **(Must be 7 alpha-numeric characters)**  **If no other procedure was performed, the abstractor can enter xxxxxxx in code field and 99/99/9999 in date field**  mm/dd/yyyy  **Abstractor can enter 99/99/9999**   |  | | --- | | **Cannot enter 0000000** | | > = vteadmdt and < = vtedcdt |   **Can enter 5 codes and dates** | | **Can enter 5 procedure codes, other than the principal procedure code.** Enter the ICD-10-CM codes and dates corresponding to each of the procedures performed, beginning with the procedure performed most immediately following the admission.   * If no other procedures were performed, enter default code xxxxxxx in the code field and default date 99/99/9999 in the date field. * If no other procedures were performed, it is only necessary to complete the xxxxxxx and 99/99/9999 default entries for the first code and date. It is not necessary to complete the default entry five times. * If the date of a procedure is unable to be determined from the medical record documentation, or if the procedure date documented in the record is obviously in error (e.g. 11/42/20xx) and no other documentation is found that provides this information, enter 99/99/9999. |
| 7 | dcdispo  VTE3, 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 the medical record states the patient is being discharged to assisted living care or an assisted living facility (ALF) and the documentation also includes nursing home, intermediate care or skilled nursing facility, select Value “1” (“Home”). * 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”. * 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”.   Cont’d next page |
|  |  | |  | | | |  | **Discharge dispo cont’d**   * If the medical record states the patient is being discharged to a nursing home, intermediate care or skilled nursing facility without mention of assisted living care or assisted living facility (ALF), select Value “5” (“Other Health Care Facility”). * 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”. * **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 |

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|  |  | | **ADMITTING SERVICE** | |  | | |  |
| 8 |  | | **Admitting Service** | | Text  (Limit to 30 characters)   |  | | --- | | **Warning if left blank** | | | | **Free text entry. In determining the Service (e.g. Surgery, Cardiology, Medicine, etc.) or facility unit (ICU, CCU, etc.) to which the patient was admitted, the abstractor should be guided by Admission Orders, Progress Notes, Discharge Summary, etc.**  If unable to make a definitive decision, consult with the facility Liaison for help in determining the Admitting Service. |
| **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** | | | | | | | | |
| 9 | 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 | | | * + Please read all relevant data sources in order to answer this question accurately.   + **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 and was admitted to the hospital. 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 had 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 |
| 10 | | comfort  VTE 3, 6 | | 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.** |
| 11 | 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.** | **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.** | |

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| **If COMFORT = 99 OR if (COMFORT = 1, 2 or 3 AND DCDISPO = 1, 2, or 99), go to VTETEST, else if COMFORT = 1, 2 or 3, go to end** |

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|  |  | **VTE Diagnosis** |  |  |
| 12 | vtetest  VTE3,5,6 | Is there documentation that a diagnostic test for VTE was performed within four days prior to arrival or anytime during the hospitalization?  **VTE Diagnostic testing includes the following (ALL Inclusive):**   * Compression Ultrasound/Vascular Ultrasound/Duplex ultrasound (DUS)/Venous Doppler of lower extremities * Computed tomography (CT) Angiogram/Pulmonary Angiogram of Chest * Computed tomography (CT) of thorax (chest), abdomen/pelvis, or lower extremity leg veins with IV 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 IV contrast material   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”.   **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   **Suggested Data Sources:** Admission notes, Consult notes, ED record, H&P, Physician notes, Radiology report |
| 13 | 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. |
| 14 | posvte  VTE3,5,6 | Is there physician/APN/PA documentation that the VTE Diagnostic Test confirmed a diagnosis of VTE in one of the defined locations within four calendar days prior to arrival, or anytime during hospitalization?  **VTE Confirmed in Defined Locations:**   * **Pulmonary Emboli (PE)** * **Deep Vein Thrombosis (DVT) located in Common femoral vein; Common iliac; External iliac vein; Femoral/superficial femoral vein; Inferior vena cava (IVC); Internal iliac, Popliteal vein; Profunda/deep femoral vein.**   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 01/03/20xx with outside documentation of a DVT in the right femoral vein and **no date is noted**, select “No.” * 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.”   **Cont’d next page** |
|  |  |  |  | **VTE confirmed cont’d**   * If there is physician/APN/PA documentation that the patient had a VTE, select “Yes”. * 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 conflicting documentation between providers is present, select “Yes.” * For patients with radiology reports that state “low probability” or “inconclusive test results” on any of the acceptable VTE Diagnostic Tests, select “No”. * For patients with a nuclear medicine VQ scan to rule-out PE, if 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 “Yes”. 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 “Yes”.   + If the record indicates ONLY a radiology report, and that report is questionable regarding whether the patient had a VTE, select “No”.   Examples:   * If the radiology report of a CTA indicates, “possible” or “suggestive of” common femoral clot, select “No”. * If the radiology report of an angiogram indicates, distal vein clot that may extend into the greater saphenous vein, select “No”. |
|  |  |  |  | **Documentation in sources other than radiology reports:**   * + The physician/APN/PA documentation must reflect the time frame within four calendar days prior to arrival or anytime during hospitalization.   + The physician/APN/PA documentation must indicate the clinician’s confirmation of an acute VTE.   Example:  Physician notes “Venous Doppler on day of admission positive for DVT left popliteal vein clot”, select “Yes.”  **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 * One subsegmental pulmonary embolus with Doppler performed which was negative |
| 15 | posvtedt | Enter the earliest date the diagnosis of VTE in one of the defined locations was confirmed. | mm/dd/yyyy   |  | | --- | | >= vteadmdt and < = vtedcdt | | **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.  **VTE Location includes:**   * **Pulmonary Emboli (PE)** * **Deep Vein Thrombosis (DVT) located in Common femoral vein; Common iliac; External iliac vein; Femoral/superficial femoral vein; Inferior vena cava (IVC); Internal iliac, Popliteal vein; Profunda/deep femoral vein.** |
| **If ARRVTEDX = 2, go to VTEPROADM; else if ARRVTEDX = 1 or null, go to WARFADM.** | | | | |
|  |  | **Prophylaxis Prior to Secondary VTE** |  |  |
| 16 | vteproadm  VTE6 | Was mechanical and/or pharmacological VTE prophylaxis administered between the 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 warfadm | * To determine the value for this data element, the abstractor must determine the admission date and then review the chart to determine if VTE prophylaxis was administered the day before the VTE diagnostic 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 acceptable VTE diagnostic test was ordered to rule out VTE, and both confirmed VTE, select the earliest diagnostic test that confirmed VTE to determine if the patient received VTE prophylaxis. Example, Patient was admitted 11/1/20xx. A Doppler was ordered 11/4/20xx and confirmed a DVT of the right lower extremity. In addition, a CT scan with contrast was ordered on 11/5/20xx and confirmed a PE. Determine if any prophylaxis was administered anytime between the hospital admission date of 11/1/20xx and 11/4/20xx. If VTE prophylaxis was not given during that timeframe, select “No.” * If the VTE diagnostic test was ordered the day of or the day after the admission date, select “Yes.” * When the VTE is diagnosed within four days prior to arrival you may select “Yes”. Use calendar days to determine this timeframe. * If the record contains questionable information regarding the administration of VTE prophylaxis the day before the VTE diagnostic test order date, select “No." * 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 “Yes” if the substitution medication was administered.   Cont’d next page |
|  |  |  |  | VTE Prophylaxis cont’d   * **Aspirin is only acceptable as VTE prophylaxis in total hip replacement and total knee replacement surgery.**   **Examples of each VTE prophylaxis category (refer to TJC Appendix H, Table 2.1 VTE Prophylaxis Inclusion Table 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), edoxaban (Savaysa)  **Suggested data sources:** Circulator notes, Emergency Department record, Graphic/flow sheets, Medication administration record, Nursing notes, Preoperative/operative notes, Progress notes, Radiology reports |
| 17 | nomecpro  VTE6 | Is there physician/APN/PA or pharmacist documentation why mechanical VTE prophylaxis was not administered on the days between arrival and the date the VTE diagnostic test was performed?  1. Yes  2. No  95. Not applicable | 1,2,95  Will be auto-filled as 95 if vteproadm = 1 | * **There must be explicit physician, APN, PA, or pharmacist documentation of a reason for not administering mechanical VTE prophylaxis. Documentation must be dated between arrival and the date the VTE diagnostic test was performed.**   Example of documentation:   * Active GI bleeding, no mechanical VTE prophylaxis needed. Select “Yes.” * Reasons for not prescribing VTE prophylaxis must be documented by a physician/APN/PA or pharmacist.   **EXCEPTIONS:**   * Patient/family refusal of mechanical VTE prophylaxis may be documented by a nurse, but refusal must be documented in the timeframe between arrival and the day the VTE diagnostic test was performed. * For patients receiving anticoagulant therapy, including IV heparin, the day before the VTE diagnostic test order date, select “Yes.” * 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). * If the VTE diagnostic test was performed the day of or the day after arrival or admission, select “Yes.” * Documentation that a formal risk assessment was administered AND the results indicated that there was no risk or low risk for VTE is acceptable as a reason for not administering VTE prophylaxis. A copy of the validated risk assessment must be included in the medical record along with the results to select “Yes.”   Cont’d next page |
|  |  |  |  | * If two physicians/APN/PA or pharmacists document conflicting or questionable needs for mechanical prophylaxis, select “No.” * If Comfort Measures Only (CMO) was documented prior to the VTE diagnostic test, select “Yes.”   **Suggested Data Sources** (for physician/APN/PA or pharmacist documentation)**:** Anesthesia record, Consultation notes, ED record, H&P, Physician orders/Progress notes, Risk assessment form, Transfer form  **Suggested Data Sources** (for patient refusal)**:** Medication administration record, Nurses notes  **Mechanical prophylaxis** = compression devices or stockings such as anti-embolism hose used to prevent VTE. (See TJC, Appendix H, Table 2.1 for examples)  **Inclusion Guidelines for Abstraction**  Explicit documentation that the patient does not need VTE prophylaxis  **ALL INCLUSIVE VALIDATED RISK ASSESSMENTS:**   * Caprini DVT Risk Assessment * Padua Prediction Score * International Medical Prevention Registry on Venous Thromboembolism (IMPROVE) |

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| 18 | norxpro  VTE6 | Is there physician/APN/PA or pharmacist documentation why pharmacological VTE prophylaxis was not administered on the days between arrival and the date the VTE diagnostic test was performed?  1. Yes  2. No  95. Not applicable | 1,2,95  Will be auto-filled as 95 if vteproadm = 1 | * **There must be explicit physician, APN, PA, or pharmacist documentation of a reason for not administering pharmacological VTE prophylaxis. Documentation must be dated between arrival and the date the VTE diagnostic test was performed.**   Example of documentation:   * Active GI bleeding, no pharmacological VTE prophylaxis needed. Select “Yes.” * Reasons for not prescribing VTE prophylaxis must be documented by a physician/APN/PA or pharmacist.   **EXCEPTIONS:**   * Patient/family refusal of pharmacological VTE prophylaxis may be documented by a nurse, but refusal must be documented within the timeframe from arrival and the date the VTE diagnostic test was performed. * For patients receiving anticoagulant therapy, including IV heparin, the day before the VTE diagnostic test order date, , select “Yes.” * 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). * **If the VTE diagnostic test was performed the day of or the day after arrival or admission, select “Yes.”**   Cont’d next page |
|  |  |  |  | **Reason for no VTE prophylaxis cont’d**   * Documentation that a formal risk assessment was administered AND the results indicated that there was no risk or low risk for VTE is acceptable as a reason for not administering VTE prophylaxis. A copy of the validated risk assessment must be included in the medical record along with the results to select “Yes.” * If two physicians/APN/PA or pharmacists document conflicting or questionable needs for pharmacological prophylaxis, select “No.” * If Comfort Measures Only (CMO) was documented prior to the VTE diagnostic test, select “Yes.”   **Suggested Data Sources** (for physician/APN/PA or pharmacist documentation)**:** Anesthesia record, Consultation notes, ED record, H&P, Physician orders/Progress notes, Risk assessment form, Transfer form  **Suggested Data Sources** (for patient refusal)**:** Medication administration record, Nurses notes  **Pharmacological prophylaxis** = medications used to prevent VTE such as subQ low dose heparin, warfarin (Coumadin), or enoxaparin (Lovenox)  Refer to Appendix H Table 2.7 Anticoagulation Therapy  **Inclusion Guidelines for Abstraction**  Explicit documentation that the patient does not need VTE prophylaxis  **ALL INCLUSIVE VALIDATED RISK ASSESSMENTS:**   * Caprini DVT Risk Assessment * Padua Prediction Score * International Medical Prevention Registry on Venous Thromboembolism (IMPROVE) |

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|  |  | **Anticoagulant Medications** |  |  |
| 19 | 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 as applicable | 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:** Medication administration record, nursing notes, physician notes |
| 20 | 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 (includes but not limited to heparin, enoxaparin) 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 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 |
| 21 | 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   |  | | --- | | <=vtedcdt |  |  | | --- | | Warning if > 60 days prior to vteadmdt | | 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. |
| 22 | 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. * Reasons (other than those listed in the inclusion guidelines) not mentioned in the context of NO overlap therapy are not acceptable. * Documentation by the physician/APN/PA or pharmacist must state the reason for no overlap therapy.   Examples:   * “No overlap therapy, patient bleeding” * “No bridge therapy, GI bleed” * “Intolerance to parenteral anticoagulation therapies” * If there is questionable documentation regarding the reason for no overlap therapy, select “No.” * 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.   **Exceptions** to physician/APN/PA or pharmacist documentation only:   * Patient/family refusal of any or all forms of overlap therapy does not have to be documented by a physician/APN/PA or pharmacist. Refusal 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 to ALL parenteral anticoagulation therapy may be documented by a nurse. |
|  |  |  |  | **Suggested Data Sources** (for physician/APN/PA or pharmacist documentation)**:** Anesthesia record, Consultation notes, Discharge summary, ED record, H&P, Physician orders, Progress notes  **Suggested Data Sources** (for patient refusal, allergy or administration of oral factor Xa inhibitor)**:** Medication administration record, Nursing notes  **Excluded Data Sources:** Any documentation dated/timed after discharge.  **Inclusion Guidelines** (Documentation must be present on the day of or the day after the VTE diagnostic test):   * Administration of Oral Factor Xa Inhibitors * Xarelto or rivaroxaban * Eliquis or apixaban * Savaysa or edoxaban * Administration of Direct Thrombin Inhibitor * Pradaxa or dabigatran * Documentation of: * active bleeding * a plan for surgery * a plan for blood transfusion * patient is not a candidate for anticoagulation therapy   Refer to Appendix C, Table 1.4 Warfarin Therapy. |
| 23 | 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 |
| 24 | 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  If 1, go to warfrxdc as applicable | 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 |

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|  |  | **Discharge Anticoagulants** |  |  |
| 25 | 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 as applicable | **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:**  **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). |
| 26 | 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 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), apixaban (Eliquis) or edoxaban (Savaysa) 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:**   * Administration of Oral Factor Xa Inhibitors * Xarelto or rivaroxaban * Eliquis or apixaban * edoxaban (Savaysa) * Administration of Direct Thrombin Inhibitor * Pradaxa or dabigatran * Documentation of: * active bleeding * a plan for surgery * a plan for blood transfusion * patient is not a candidate for anticoagulation therapy * thrombocytopenia   **Suggested Data Sources** (for Physician/APN/PA or pharmacist documentation)**:** Consultation notes, Discharge summary, ED record, H&P, Operative notes, Physician orders/progress notes, Procedure notes.  **Exclude:** discontinuation of parenteral medication without additional documentation. IVC filter is not an acceptable reason for discontinuing parenteral therapy prior to five days of treatment unless physician/APN/PA indicates a reason.  **Excluded Data Sources:** Any documentation dated/timed after discharge. |
| **If DCDISPO = 3, 4, 5, 6 or 7, go to end.** | | | | |
| 27 | warfrxdc  VTE5 | Is there documentation that warfarin was prescribed at discharge?  1. Yes  2. No | 1,2  If 2, 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).   * In cases where there is warfarin in one source that is not mentioned in other sources, it should be interpreted as a discharge medication (select “Yes”) unless documentation elsewhere in the medical record suggests that it was NOT prescribed at discharge. **Consider it a discharge medication in the absence of contradictory documentation.** * If documentation is contradictory (e.g., physician noted “d/c 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). |

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|  |  | **Discharge Instructions** |  |  |
| 28 | ptedvte | **Written VTE discharge instructions or other educational material given to the patient/caregiver must address ALL of the following components related to warfarin therapy prescribed after discharge:**   * **Compliance issues** * **Dietary advice** * **Follow-up monitoring** * **Potential for adverse drug reactions and interactions related to warfarin therapy** | Note: Each element of written discharge instructions is counted individually, but ALL four elements must be addressed to meet the measure | **Guidelines for VTE Discharge Instructions related to warfarin therapy prescribed after discharge (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.  **Acceptable educational materials include discharge instruction sheets, brochures, booklets, teaching sheets, videos, CDs, and DVDs.** |
| 29 | 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?  **Must include BOTH of the following:**   * The importance of taking warfarin as instructed; and * The importance of monitoring warfarin with scheduled PT/INR blood draws.   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.   If the patient refused written discharge instructions/material which addressed compliance issues, select “1.” |
| 30 | 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?  **Must include BOTH of the following:**   * A “consistent amount” of foods with Vitamin K rather than avoidance should be advised; and * Avoid major changes in dietary habits, or notify health professional before changing habits.   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.” |
| 31 | 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.” |
| 32 | 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?  **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; and * Warfarin increases the risk of bleeding.   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.” |