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|  |  | **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 |  |
| 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 months prior to or = admdt and  < = dcdt | | **Arrival date is the EARLIEST recorded date on which the patient arrived in the hospital’s acute care setting.** Acute care setting includes:   * **Emergency Department** * **Direct admission to cath lab, endoscopy or surgery** * **Direct admission to observation** * **Direct admission to a nursing floor**   **ONLY ACCEPTABLE SOURCES:** \*Emergency Department record; nursing unit admission assessment/admitting note; observation record; procedure notes (such as cardiac cath, endoscopies, surgical procedures)   * **Review the ONLY ACCEPTABLE SOURCES to determine the earliest date the patient arrived in the acute care setting.**   Suggested Priority sources for patients who arrive in the ED:   1. ED Registration Date (found in Past Clinic Visits/CVP) 2. ED Progress Note - Triage Date, Arrival Date 3. ED Vital Signs, ECG date, Physician orders   Suggested Priority sources for Non-ED Arrivals such as Direct Admit to inpatient unit or observation:   1. Nurse’s Admission Note/admission assessment 2. EADT Date   Other Arrivals (transfers from other ED or hospital inpatient/ outpatient OR Direct Admit for procedure, e.g. cath lab)   1. If transferred from an ED or hospital within your hospital’s system and there is one medical record for the care provided at both facilities, use the arrival date at the first facility.   Cont’d next page |
|  |  |  |  | Arrival Date cont’d   1. Use EARLIEST arrival date for procedure, e.g., cath lab, endoscopy, surgery   **Additional Guidelines for Abstraction**   * Arrival date may differ from admission date. 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 as a direct admit * 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.   * \*The ED Record may include ED Face/Cover Sheet, Registration/sign-in forms, triage record, Consent/Authorization for treatment forms, vital sign record, physician orders, ECG reports, telemetry/rhythm strips, laboratory reports, x-ray reports, head CT scan, CTA, MRI, MRA reports * **If arrival date is unable to be determined from any of the ONLY ACCEPTABLE SOURCES, 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 months prior to or = admdt and  < dcdt | | Warning if > 72 hours prior to admdt | | **Arrival time is the EARLIEST recorded time the patient arrived in this hospital’s acute care setting. Acute care setting includes:**   * **Emergency Department** * **Direct admission to cath lab, endoscopy or surgery** * **Direct admission to observation** * **Direct admission to a nursing floor**   **ONLY ACCEPTABLE SOURCES:** \*Emergency Department record nursing unit admission assessment/admitting note; observation record; procedure notes (such as cardiac cath, endoscopies, surgical procedures)  **Review the ONLY ACCEPTABLE SOURCES to determine the EARLIEST time the patient arrived in the acute care setting..**  Suggested Priority sources for patients who arrive in the ED:   1. ED Registration Time (found in Past Clinic Visits/CVP) 2. ED Progress Note - Triage Time, Arrival Time 3. ED Vital Signs, ECG time, Physician orders   Suggested Priority sources for Non-ED Arrivals such as Direct Admit to inpatient unit or observation:   1. Nurse’s Admission Note/admission assessment 2. EADT Time   Other Arrivals (transfers from other ED or hospital inpatient/ outpatient OR Direct Admit for procedure, e.g. cath lab)   1. If transferred from an ED or hospital within your hospital’s system and there is one medical record for care at both facilities use EARLIEST arrival time at the first facility.   **Cont’d next page** |
|  |  |  |  | Arrival Time cont’d   1. Use EARLIEST arrival time for procedure, e.g. cath lab, endoscopy, surgery   **Additional Guidelines for abstraction:**   * Arrival time may differ from admission time. 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 as a direct admit. * 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.   * \*The ED Record may include ED Face/Cover Sheet, Registration/sign-in forms, triage record, Consent/Authorization for treatment forms, vital sign record, , physician orders, ECG reports, telemetry/rhythm strips, laboratory reports, x-ray reports, head CT scan, CTA, MRI, MRA reports * **If arrival time is unable to be determined from any of the ONLY ACCEPTABLE SOURCES, enter 99:99.** |
| 3 | admdt | Admission date: | mm/dd/yyyy **Auto-filled: can be modified**   |  | | --- | | >= arrvdate and < = dcdt | | **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.   **ONLY ALLOWABLE SOURCES:** Physician orders (priority data source), face sheet  **Exclusion:** admit to observation, arrival date |
| 4 | dcdt | Discharge date: | mm/dd/yyyy  **Auto-filled: cannot be modified** | **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. |
| 5 | princode | Enter the ICD-10-CM principal diagnosis code. | \_\_ \_\_ \_\_. \_\_ \_\_ \_\_ \_\_  (3 alpha-numeric characters/decimal point/four alpha-numeric characters  **Auto-filled: can be modified**   |  | | --- | | **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 record is not the code displayed in the software.** |
| 6 | othrcode1  othrcode2  othrcode3  othrcode4  othrcode5  othrcode6  othrcode7  othrcode8  othrcode9  othrcode10  othrcode11  othrcode12  othrcode13  othrcode14  othrcode15  othrcode16  othrcode17  othrcode18  othrcode19  othrcode20  othrcode21  othrcode22  othrcode23  othrcode24 | 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.** |
| 7 | prinpx  (code)  prinpxdt  (date) | Enter the ICD-10-CM principal procedure code and date the procedure was performed.Code Date  |  |  | | --- | --- | | \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ | \_\_/\_\_/\_\_\_\_ | | \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_  (Must be 7 alpha-numeric characters)  Abstractor can enter xxxxxxx in code field and 99/99/9999 in date field if there is no principal procedure   |  | | --- | | **Cannot enter 0000000** |   mm/dd/yyyy  Abstractor can enter 99/99/9999  If no principal procedure, auto-fill othrpx and othrpxdt with xxxxxxx and 99/99/9999   |  | | --- | | > = admdt and  < = dcdt | | **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 if the procedure date documented in the record is obviously in error (e.g. 02/42/20xx) and no other documentation is found that provides this information, enter 99/99/9999. |
| 8 | othrpx1  othrpx2  othrpx3  othrpx4  othrpx5  (codes)  othrpxdt1  othrpxdt2  othrpxdt3  othrpxdt4  othrpxdt5  (dates) | Enter the ICD-10-CM other procedure codes and dates the procedures were performed.Code Date  |  |  | | --- | --- | | \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ | \_\_/\_\_/\_\_\_\_ | | \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ | \_\_/\_\_/\_\_\_\_ | | \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ (Must be 7 alpha-numeric characters)  Abstractor can enter xxxxxxx in code field and 99/99/9999 in date field if no other procedure was performed  mm/dd/yyyy  Abstractor can enter 99/99/9999   |  | | --- | | > = admdt and  < = dcdt |   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 procedure was performed, it is only necessary to complete the xxxxxxx and 99/99/9999 default entries for the first code and date. It is not necessary to complete the default entry five times. * If the date of a procedure is unable to be determined from the medical record documentation, or if the procedure date documented in the record is obviously in error (e.g. 02/42/20xx) and no other documentation is found that provides this information, enter 99/99/9999. |

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| 9 | dcdispo | What was the patient’s discharge disposition on the day of discharge?  1. Home   * Assisted Living Facilities (ALFs) – includes assisted living care at nursing home/facility * Court/Law Enforcement – includes detention facilities, jails, and prison * Home – includes board and care, domiciliary, foster or residential care, group or personal care homes, retirement communities, and homeless shelters * Home with Home Health Services * Outpatient Services including outpatient procedures at another hospital, outpatient Chemical Dependency Programs and Partial Hospitalization   2. Hospice – Home (or other home setting as listed in #1 above)  3. Hospice – Health Care Facility   * General Inpatient and Respite, Residential and Skilled Facilities, and Other Health Care Facilities   4. Acute Care Facility   * Acute Short Term General and Critical Access Hospitals * Cancer and Children’s Hospitals * Department of Defense and Veteran’s Administration Hospitals   5. Other Health Care Facility   * Extended or Immediate Care Facility (ECF/ICF) * Long Term Acute Care Hospital (LTACH) * Nursing Home or Facility including Veteran’s Administration Nursing Facility * Psychiatric Hospital or Psychiatric Unit of a Hospital * Rehabilitation Facility including Inpatient Rehabilitation Facility/Hospital or Rehabilitation Unit of a Hospital * Skilled Nursing Facility (SNF), Sub-Acute Care or Swing Bed * Transitional Care Unit (TCU) * Veteran’s Home   6. 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 the 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 include discharges with hospice referrals and evaluations.   **Cont’d next page** |
|  |  |  |  | **Discharge disposition cont’d**   * 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 states the patient is being discharged to 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 of 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 |
|  |  | **ADMITTING SERVICE** |  |  |
| 10 |  | **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. |

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|  |  | **Emergency Department** |  |  |
| 11 | edpt  ALL ED | Did the patient receive care/services in the Emergency Department of this VAMC?1. Yes2. No | 1,2  If 2, auto-fill decdt as 99/99/9999, dectm as 99:99, edcdt as 99/99/9999, edctm as 99:99, and go to flustat as applicable | **For the purposes of this data element an Emergency Department (ED) patient is defined as any patient receiving care or services in the ED of this VAMC.**   * If the patient presents to the ED for outpatient services such as lab work and the patient receives the service in the ED, enter “1”. * Patients seen in an Urgent Care, ER Fast Track, etc. are NOT considered an ED patient unless the patient received services in the Emergency Department at this VAMC (e.g., patient treated at an urgent care and transferred to the main campus ED is considered an ED patient, but a patient seen at the urgent care and transferred to the hospital as a direct admit would not be considered an ED patient). * Patients presenting to the ED who do NOT receive care or services in the ED, enter “2” (e.g., patient is sent to hospital from physician office and presents to ED triage and is instructed to proceed straight to floor). * If a patient is transferred in from any emergency department (ED) or observation unit OUTSIDE of the VAMC under review, select “2”. This applies even if the emergency department or observation unit is part of this hospital’s system (e.g., your hospital’s free-standing or satellite emergency department), has a shared medical record or provider number, or is in close proximity. Select “2”, even if the transferred patient is seen in this facility’s ED. * If the patient is transferred to your hospital from an outside hospital where he was an inpatient or outpatient, select “2”. This applies even if the two hospitals are close in proximity, part of the same hospital system, have the same provider number, and/or there is one medical record. Select “2”, even if the transferred patient is seen in this facility’s ED.   **Exclude: Fast track ED, terms synonymous with Urgent Care, Urgent Care**  **Suggested data sources: ED record, face sheet** |
| 12 | decdt  ED5  ED6  ED7 | Enter the earliest documented date of the decision to admit the patient by the physician/APN/PA. | mm/dd/yyyy  Will be auto-filled as 99/99/9999 if  edpt = 2  Abstractor can enter 99/99/9999  If arrvdate = admdt, computer will auto-fill = arrvdate   |  | | --- | | > =arrvdate and < = admdt | | **For purposes of this data element, Decision to Admit Date is the date on which the physician/APN/PA makes the decision to admit the patient from the Emergency Department to the hospital for continued care in the facility. This will not necessarily coincide with the date the patient is officially admitted to inpatient status.**  **ONLY ACCEPTABLE SOURCE: ED record (for purposes of this data element, ED record includes any documentation from time of ED arrival to the time the patient physically departed from the ED).**   * **Do not include any documentation from external sources (e.g., ambulance record, clinic note, lab reports) obtained prior to arrival.** * Use the date from the first documentation of decision to admit for either observation or inpatient. If there are multiple dates documented for the decision to admit, abstract the earliest date. * If the decision to admit the patient is made, but the actual request for a bed is delayed until an inpatient bed is available, record the date the physician/APN/PA made the decision to admit. * Decision to Admit Date includes physician/APN/PA documentation of a decision to send the patient to cath lab or surgery. * Disregard physician/APN/PA narrative documentation of a consult or orders for consult, transfer to another physician’s service, or discussion with another physician since this does not reflect a decision was made. * **If the admission date is the same date as arrival, Decision to Admit date will be auto-filled by the computer software.** * If the decision to admit date is dated prior to the date of patient arrival or after the date of departure or is unable to be determined, enter 99/99/9999. * The medical record must be abstracted as documented (i.e., face value). When the date documented is obviously in error (e.g. 11/42/20xx) or outside the parameters of care (e.g., after discharge date) and no other documentation is found that provides this information, enter 99/99/9999.   **Cont’d next page** |
|  |  |  |  | Decision to Admit Date cont’d  **Includes, but is not limited to: Admit Order Date, Disposition Date**  **Excludes, but is not limited to: Bed Assignment Date, Direct admit patients seen in the ED** |
| 13 | dectm  ED5  ED6  ED7 | Enter the earliest documented time of the decision to admit the patient by the physician/APN/PA. | **\_\_\_\_**  **UMT**  **Will be auto-filled as 99:99 if**  **edpt = 2**  **Abstractor can enter 99:99**   |  | | --- | | **>arrvdate/arrvtime**  **and < = admdt** | | **Warning if decdt/dectm - arrvdate/arrvtime <= 10 minutes or >= 720 minutes** | | **The “decision to admit time” is the time the physician/APN/PA communicates the decision to admit the patient from the ED to the hospital for continued care. This time will not necessarily be the same as the time the patient is officially admitted to inpatient status.**  **ONLY ACCEPTABLE SOURCE: \*ED record, Admission Orders**   * Use the time from the first documentation of the decision to admit to observation/ inpatient status. If there are multiple times documented, abstract the EARLIEST time. * For narrative documentation that clearly refers to the decision to admit to observation/inpatient status or that patient will be going to cath lab or surgery, take the initial note time unless there is a later time specified within that note.   **EXAMPLE:** If the time of the decision to admit is available in the provider’s note, compare it with the admission order time and take the **earliest** time. If there is not a decision time in the provider’s note, but it does document a plan to admit the patient, use the start time of that note and compare it to the admission order time and use the **earliest** time.  **Other Guidelines for Abstraction**   * If the decision to admit the patient is made, but the actual request for a bed is delayed until an inpatient bed is available, record the time the physician/APN/PA communicated the decision to admit. * Disregard physician/APN/PA narrative documentation of a consult or orders for consult, transfer to another physician’s service, or discussion with another physician.   Examples that reflect a decision to admit **WAS** made:   * ED physician note states “Discussed case with hospitalist on call, plan to admit.” The note references a discussion with another physician with “plan to admit” documented, indicating a decision to admit has been made.   **Cont’d next page** |
|  |  |  |  | **Decision to Admit Time cont’d**   * ED physician note states “Discussed case with Dr. Brown who will admit patient to ICU.” The note references a discussion with another physician with “who will admit patient” documented, indicating a decision to admit has been made.   Examples that reflect a decision to admit was **NOT** made:   * ED physician note states “Discussed case with hospitalist.”   This is only documentation that a discussion occurred, there is no documentation regarding a decision to admit.   * ED physician note states “Discussed patient with Dr. Jones who recommends admission.” This reflects a discussion occurred and a recommendation was made to admit, but does not indicate a decision was made to admit. * ED physician note states “Contacted Dr. Smith for admission consult.” This reflects a consult has been requested for admission, but does not indicate a decision to admit has been made. * ED physician note states “Possible admission pending cardiology consult.” This reflects a consult was ordered and admission is possible, but does not indicate a decision to admit has been made. * If documentation of the decision to admit time is prior to arrival or after departure from the ED or unable to be determined enter 99:99. * The medical record must be abstracted as documented (i.e., at face value). When the time documented is obviously in error (e.g. 33:00), and no other documentation is found that provides this information, enter 99:99.   **Includes, but is not limited to: Admit Order Time, Disposition Time**  **Excludes, but is not limited to: Bed Assignment Time, Direct admit patients seen in the ED, Report Called Time** |
| 14 | edcdt  ED1  ED2  ED4 | Enter the date the patient departed from the emergency department. | mm/dd/yyyy  Will be auto-filled as 99/99/9999 if  edpt = 2  Abstractor can enter 99/99/9999   |  | | --- | | > =arrvdate or = admdt and <= dcdt | | If decdt <> 99/99/9999, must be >= decdt |  |  | | --- | | Warning if >= 2 days after arrvdate | | **ONLY ACCEPTABLE SOURCE: ED record**   * If the date of departure from the ED is not documented, but the date of departure can be determined from other documentation, (e.g., you are able to identify from documentation the patient arrived and was transferred to medical unit on the same day), enter this date. * Data fields representing ED Departure Date in electronic documentation for this specific episode of care are acceptable to use as long as the fields are easily understood to mean departure. Information found in an electronically interfaced event log or Admit/Decision/Transfer (ADT) is acceptable provided this information is part of the submitted medical record covering the arrival to discharge date being abstracted. Examples: * Patient departed * Patient transferred off the floor (OTF) * Check out time * Transported to * For patients who are placed into observation under the services of the Emergency Department, abstract the date of departure from the observation services (e.g., patient is seen in the ED and admitted to an observation unit of the ED on 05/01/20xx then is discharged from the observation unit on 5/02/20xx abstract 5/02/20xx as the departure date). * For patients who are placed into observation outside the services of the Emergency Department, abstract the date of departure from the ED. * A departure date listed within a disposition heading from the ED may be used. * If the date the patient departed from the ED is unable to be determined from medical record documentation, enter 99/99/9999. * The medical record must be abstracted as documented (i.e., face value). When the date documented is obviously in error (e.g. 11/42/20xx) or outside the parameters of care (e.g., after discharge date) and no other documentation is found that provides this information, enter 99/99/9999.   **Cont’d next page** |
|  |  |  |  | **ED Departure Date cont’d**  **Includes, but is not limited to:** EDCheckout Date, ED Departure Date, ED Discharge Date, ED Leave Date, ED Transport Date  **Exclude:** Admission Date |
| 15 | edctm  ED1  ED2  ED4 | Enter the time the patient departed from the emergency department. | \_\_\_\_\_  UMT  Will be auto-filled as 99:99 if  edpt = 2  Abstractor can enter 99:99   |  | | --- | | >=arrvdate/arrvtime and < = dcdt | | If dectm <> 99:99, must be >= decdt/dectm |  |  | | --- | | Warning if = 99:99 | | Warning if edcdt/edctm - arrvdate/arrvtime <= 10 minutes or >= 720 minutes | | **ED Departure Time is the time the patient physically left the ED. The intent is to capture the latest time at which the patient was receiving care in the ED.**  **ONLY ACCEPTABLE SOURCE: ED record**   * When more than one ED departure/discharge time is documented, abstract the **latest** time.   For example: Two departure times are found in the ED nurse’s notes: 12:03 via wheelchair and 12:20 via wheelchair. Enter the later time of 12:20 as ED departure time.   * Data fields representing ED Departure Time in electronic documentation for this specific episode of care are acceptable to use as long as the fields are easily understood to mean departure. Information found in an electronically interfaced event log or Admit/Decision/Transfer (ADT) is acceptable provided this information is part of the submitted medical record covering the arrival to discharge time being abstracted. Examples: * Patient departed * Patient transferred off the floor (OTF) * Check out time * Transported to   **For Patients admitted to Observation**   * If the Observation Unit is under the services of the ED, abstract the time of departure from the ED observation services. If the Observation Unit is outside the services of the ED abstract the time of departure from the ED.   **Cont’d next page** |
|  |  |  |  | **ED Departure Time cont’d**  A departure time listed within a Disposition heading in the ED record may be used. If the actual time of departure is not documented within this note, the signature time of the note may be entered.  **Do Not Use the Time:**   * of vital signs or medications documented later than the ED departure time. * the discharge order was written   **Other Guidelines for Abstraction**   * If the time the patient departed from the ED is unable to be determined from medical record documentation, enter 99:99. * If the documented ED Departure Time is prior to arrival, enter 99:99 * If the patient expired in the ED, use the time of death as the departure time. * The medical record must be abstracted as documented (i.e., at face value). When the time documented is obviously in error (e.g. 33:00), and no other documentation is found that provides this information, enter 99:99.   **Includes, but is not limited to:** ED Check Out Time, ED Departure Time, ED Discharge Time, ED Leave Time, ED Transport Time  **Excludes, but is not limited to:** Report Called Time, Admission Time |

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| **If (prinpx or othrpx is on JC Table 12.10) OR dcdispo = 4, 6 or 7, go to comfort as applicable; else go to flustat** | | | | |
|  |  | Immunizations |  |  |
| 16 | flustat  (IMM-4) | What is the patient’s influenza vaccination status?  1. Influenza vaccine was given during this hospitalization  2. Influenza vaccine was received prior to admission during the current flu season, not during this hospitalization  4. There is documentation of :   * + - Allergy/sensitivity to influenza vaccine, anaphylactic latex allergy, or anaphylactic allergy to eggs, OR     - is not likely to be effective because of bone marrow transplant (or autologous stem cell transplant, ASCT) within the past 6 months, OR     - prior history of Guillain-Barre syndrome within 6 weeks after a previous influenza vaccination   6. Only select this option if there is documentation vaccine has been ordered but has not yet been received by the hospital due to problems with vaccine production or distribution AND none of the other options apply  98. Documentation of patient’s refusal or caregiver’s refusal of influenza vaccine during this hospitalization  99. None of the above/not documented/ unable to determine from medical record documentation | 1,2,4,6,98,99 | Each year, flu vaccines start to become available usually in September and most influenza vaccine is administered in October – December, but the vaccine is recommended to be administered throughout the influenza season which can last until May in some years.   * **For the purposes of this project, hospitals are only responsible for discharges October through March.**   Discharges from April – September are excluded from scoring.  **Include:**  Acceptable terms for influenza vaccines include those listed below or refer to CDC list of Influenza vaccines at <http://www.cdc.gov/flu/protect/vaccine/vaccines.htm>  Afluria, FluMist, FluLaval, flu shot, flu vaccine, Fluarix, Fluvirin, Fluzone, Fluzone High Dose, influenza virus vaccine, live attenuated influenza vaccine, quadrivalent influenza vaccine, trivalent influenza vaccine.  **Exclude:** Pandemic monovalent vaccine, e.g. H1N1   * **Selecting value 1:** There must be documentation that the vaccine was given including a date and signature. * If there is conflicting documentation regarding administration of the vaccine in the hospital, use documentation reflecting the vaccine was given during the admission.   Example: There is documentation in the medical record indicating the vaccine was given (dated and signed as administered) during the hospital stay, but the discharge summary states order for vaccine was cancelled and patient did not receive vaccine during the hospital stay, select Value “1.”   * **Selecting value 2:** If there is documentation the patient received the vaccine, and only the current year is documented, select “2.”   **Example:** There is documentation the patient received the vaccine in 2017 and it is October 2017, select value “2.”   * If the discharge is in January, February or March 2017 AND there is documentation the patient received the vaccine in 2016, select “2.” |
|  |  |  |  | * **Selecting value 4:** If there is documentation of allergy/sensitivity to influenza vaccine, anaphylactic latex allergy, or anaphylactic allergy to eggs; OR is not likely to be effective because of bone marrow transplant [or autologous stem cell transplant, (ASCT)] within the past 6 months; OR prior history of Guillain-Barre syndrome within 6 weeks after a previous influenza vaccination, select “4”. The allergy/sensitivity must be accompanied by the exact complication. Must be a specific allergy/sensitivity, not just physician/APN/PA preference. * **Selecting value 6:** Only answer “6,” if the vaccine has been ordered but has not yet been received by the hospital due to problems with vaccine production or distribution AND none of the other options apply. To enter option #6, the abstractor must see the pharmacy record stating the date the vaccine arrived on station (shipping slip, inventory record, etc.) and date must be after the discharge date. * Documentation of unavailability due to problems with vaccine production or distribution from an admission or encounter that is prior to arrival cannot be used for selecting Value “6.” Information for selecting Value “6” must be assessed and documented within the current admission. * **Selecting value 98:** Documentation must indicate the patient/caregiver refused the influenza vaccine during this hospitalization. * The caregiver is defined as the surrogate decision-maker, or healthcare surrogate and may be a patient’s family member or any other person (e.g., home health, VNA provider, prison official or other law enforcement personnel) who is responsible for the healthcare decision-making and care of the patient when the patient is unable to make this decision on his/her own. * Documentation of influenza vaccine refusal from an admission or encounter that is prior to arrival **cannot** be used for selecting Value “98.” Information for selecting Value “98” must be assessed and documented within the current admission. |

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|  |  |  |  | * **Selecting value 99:** * If there is conflicting documentation regarding influenza vaccine refusal, select Value “99.” Example: There is documentation of refusal in the influenza immunization screening for the current admission and the patient did not receive the vaccine, but a subsequent narrative note states the patient wants to receive the vaccine, select Value “99.” * If there is documentation the patient received the vaccine the year prior to the current year and the discharge is NOT January, February, or March, select “99.” For example, the record documents the patient received the vaccine in 2016 and the discharge date for this hospital stay is October 2017, select “99.” * If there is conflicting documentation that supports more than one of the allowable values (1, 2, 4, 98), select the smallest number. For example, nursing note documents patient refused flu vaccine and MAR notes flu vaccine was administered, select “1.”   **EXCEPTION:** If documentation supports patient refusal (option “98”) and option “4,” select “98.  **Unacceptable documentation**:   * Patient is told to return post-discharge for flu vaccine. * Flu vaccine not available * Documented assumption “patient gets annual flu shot or vaccination”   **Suggested Data Sources:** Consultation notes, Discharge summary, ED record, Immunization assessment forms, Medication administration record, Nursing admission assessment/notes, Physician orders/progress notes, Social service notes, Transfer forms, Vaccine order sheet |

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| **If DCDT – ADMDT < = 1 day, go to nformcon as applicable.** | | | | |
|  |  | **Tobacco Treatment** |  |  |
| 17 | comfort  (ALL TOB and SUB) | 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 1,2, or 3, go to nformcon as applicable**     |  | | --- | | 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   **(Cont’d next page)** |
|  |  |  |  | * **CMO cont’d 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)** |

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|  |  |  |  | **CMO 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 |
| 18 | tobstatus2  (All TOB) | What is the patient’s tobacco use status documented within the first day of admission **(by the end of Day1)**?  1. The patient has smoked cigarettes daily on average in a volume of five or more cigarettes (>= ¼ pack) per day AND/OR cigars daily AND/OR pipes daily during the past 30 days  2. The patient has smoked cigarettes daily on average in a volume of four or less cigarettes (< ¼ pack) per day AND/OR used smokeless tobacco AND/OR smoked cigarettes but not daily AND/OR cigars but not daily AND/OR pipes but not daily during the past 30 days  3. The patient has not used any forms of tobacco in the past 30 days  97. The patient was not screened for tobacco use during the first day of admission **(by the end of Day1)** because of cognitive impairment  98. The patient refused the tobacco use screen  99. The patient was not screened for tobacco use within the first day of admission **(by the end of Day1)** or unable to determine the patient’s tobacco use status from medical record documentation | 1,2,3,97,98,99  If 3, 97, 98, or 99, go to auditc as applicable | **The tobacco use status screening timeframe must have occurred within the first day of admission (by the end of Day1). This includes the day of admission which is defined as day zero (Day 0) and the day after admission which is defined as Day 1.**  **EXCEPTION:**  If the screening was performed within 3 days prior to admission, i.e., at the transferring facility, in another inpatient hospital unit, emergency department or observation unit, the screening documentation must be present in the current medical record.   * If there is **any** **conflicting** documentation about the patient’s tobacco use status, e.g., RN assessment states patient has not used any tobacco products in the past 30 days prior to admission, but there is also physician documentation in the H&P that the patient is a “smoker,” select Value “99” since tobacco use status is unable to be determined. * Documentation of cognitive impairment overrides documentation of a tobacco screen and therefore would not be considered “conflicting documentation.” Even if the family or others tell staff the patient uses tobacco, the patient could not be counseled due to cognitive impairment. Select Value “97.” * Documentation of “nicotine” use is not acceptable to determine tobacco use status. The documentation of “nicotine” use needs to be supported by language showing it was in the form of cigarettes, cigars, pipes and/or smokeless tobacco. * If there is documentation that the patient has used smokeless tobacco **AND** has **also** smoked cigarettes daily on average in a volume of five or more cigarettes (=> ¼ pack) per day and/or cigars daily and/or pipes daily during the past 30 days, select Value “1.” * There is no requirement to capture volume and frequency of use for patients using **only** smokeless tobacco.   Cont’d next page |
|  |  |  |  | **Tobacco status cont’d**   * For the History and Physical (H&P) source, use only the H&P report for the current admission. The H&P may be a dictated report, a handwritten report on an H&P form, or a separate entry labeled as the H&P in the progress notes. * If there is documentation of tobacco screening in a pre-admission H&P (for the current admission) completed within 30 days prior to this admission, and the licensed independent practitioner (LIP) makes reference to it within the first day of admission either by indicating there were no changes, or adding any updates to it; that H&P is considered valid documentation for the tobacco screening. * Classify a form as a nursing admission assessment if the content is typical of nursing admission assessment (e.g., med/surg/social history, current meds, allergies, physical assessment) AND the form is completed/reviewed by a nurse or labeled as a “nursing form.” * Disregard documentation of tobacco use history if the current tobacco use status or timeframe that patient quit is not defined (e.g., “20 pk/yr smoking history”, “History of tobacco abuse”). * Do not include documentation of smoking history referenced as a “risk factor” (e.g., “risk factor: tobacco”, “risk factor: smoking”, “risk factor: smoker”), where current tobacco use status is indeterminable. * When there is conflicting information in the record with regard to volume, for instance, one document indicates patient is a light smoker and another indicates patient is a volume greater than light smoking, assume smoking at the heaviest level and select value 1. * If the medical record indicates the patient smokes cigarettes and the volume is not documented or is unknown, assume smoking at the heaviest level and select value 1.   **Include:** Smokeless tobacco, Chewing (spit) tobacco,  Twist, Redman, Moist snuff, Dry snuff, Plug tobacco, snus  **Exclude:** Marijuana use only, E-cigarettes, hookah pipe, Nicotine delivery system, Vaping or nicotine vaporizer use  Cont’d next page |
|  |  |  |  | **Tobacco status cont’d**  **Cognition refers to mental activities associated with thinking, learning, and memory. Cognitive impairment for the purposes of this measure set, is related to documentation that the patient cannot be screened for tobacco use due to the impairment (e.g., comatose, obtunded, confused, memory loss) within the first day of admission (by end of Day 1).**  **Examples of cognitive impairment include: Altered level of consciousness (LOC), altered mental status, cognitive impairment, cognitively impaired, confused, dementia, memory loss, mentally retarded, obtunded, psychotic/psychosis**   * If there is documentation within the first day of admission **(by end of Day 1)** that the patient was psychotic with documented symptoms, e.g., hallucinating, non-communicative, catatonic, etc., which prevented them from answering questions reliably, they would be considered cognitively impaired. * If there is documentation that the patient has temporary cognitive impairment due to acute substance use (e.g., overdose or acute intoxication) value “97” **cannot** be selected. * If there is documentation that the patient was intubated on the day of admission (Day 0) and remains intubated the entire first day of admission (by the end of Day 1), select Value “97” as the patient is unable to answer. * If there is documentation of any of the examples of cognitive impairment above within the first day of admission (by the end of Day 1), select Value “97” regardless of conflicting documentation.   **Suggested Data Sources:** ED record, History and physical, Nursing admission assessment/notes, Physician progress notes, Respiratory therapy notes |
| 19 | tobtxcoun  (TOB-2) | Did the patient receive practical counseling that included all of the following components during the hospital stay?   * Recognizing danger situations * Developing coping skills * Providing basic information about quitting   1. Yes  2. No  98. Patient refused/declined practical counseling during the hospital stay | 1,2,98 | **Practical counseling** requires a one-on-one interaction with the patient to address at a minimum the following three components: recognizing danger situations, developing coping skills, and providing basic information about quitting. Practical counseling may occur at any time during the hospital stay.  If there is documentation of practical counseling in a pre-admission H&P (for the current admission) completed within 30 days prior to this admission and the licensed independent practitioner (LIP) makes reference to it within the first day of admission either by indicating there were no changes, or adding any updates to it; that H&P is considered valid documentation for the practical counseling.   * **A referral to the VA Quitline, 1-855-QUIT-VET, may be considered a component of practical counseling (providing basic information about quitting); however, handing the patient a phone number to call for the Quitline will not meet the intent of practical counseling. There must be interaction between the patient and the caregiver.** * A pamphlet with basic information about quitting, recognizing danger situations and how to develop coping skills may be given to the patient; however, the caregiver must still document what was discussed with the patient from the pamphlet. Giving the patient a pamphlet alone does not constitute practical counseling which requires a one-on-one interaction with the patient. * Danger situations covered in practical counseling might include alcohol use during the first month after quitting, being around smoke and/or other smokers, or times/situations when the patient routinely smoked (in the car, on break at work, with coffee, after a meal, upon waking up, social events, etc.). Triggers and/or roadblocks are the same as danger situations. * Coping skills covered in practical counseling might include learning new ways to manage stress, exercising, relaxation breathing, changing routines and distraction techniques to prevent tobacco use.   Cont’d next page |
|  |  |  |  | * Basic information on quitting covered in practical counseling might include the benefits of quitting tobacco, how to quit techniques and available resources to support quitting. * If there is no documentation that practical counseling was given to the patient, select value 2. * Select value 2 if the documentation provided is not explicit enough to determine if the counseling provided contained all components or if the counseling meets the intent of the measure.   **Suggested data sources:** Respiratory therapy notes, nursing notes, physician progress notes, Medication Administration Record (MAR) |
| **IF TOBSTATUS2 = 1, go to TOBTXMED; else go to REFOPTOB** | | | | |
| 20 | tobtxmed  (TOB-2) | Did the patient receive one of the FDA-approved tobacco cessation medications during the hospital stay?  1. Yes  2. No  98. Patient refused FDA-approved tobacco cessation medications during the hospital stay | 1,2,98  If 1 or 98, go to refoptob | * **In order to select value 1, FDA-approved tobacco cessation medications must have been administered during the hospital stay**. * If nicotine replacement therapy (NRT) is ordered PRN and the patient does not receive any doses during the hospital stay, select value 98 (the patient refused the FDA-approved tobacco cessation medications during the hospital stay). It is not necessary to see documentation that the patient refused the PRN medication to select value 98. NRT may include, but is not limited to: Nicorelief, Nicorette gum, Nicoderm CQ. * Use BCMA for verification that tobacco cessation medications were given during the applicable time frame.  If the letter R is in front of the administration time, this indicates a refusal and value 98 should be selected.   **Inclusion Guidelines for Abstraction:**  Refer to Appendix C, Table 9.1 for the list of FDA-approved tobacco cessation medications (include, but are not limited to: bupropion [Wellbutrin], varenicline [Chantix]).  **Suggested Data Sources:** Physician orders, Medication administration record (MAR); BCMA |
| 21 | notobmed  (TOB-2) | Is there documentation of a reason for not administering one of the FDA-approved tobacco cessation medications during the hospital stay?   * Allergy to all of the FDA-approved tobacco cessation medications. * Drug interaction (for all of the FDA-approved medications) with other drugs the patient is currently taking. * Other reasons documented by physician/APN/PA or pharmacist.   1. Yes  2. No | 1,2 | Documenting a reason for not administering FDA-approved tobacco cessation medications must have occurred during the hospital stay.   * Reasons for not administering FDA-approved tobacco cessation medications must be documented by a physician/APN/PA or pharmacist. * An allergy or adverse reaction to one of the FDA-approved cessation medications would not be a reason for not administering another of the cessation medications. * In determining whether there is a reason documented by physician/APN/PA or pharmacist for not administering tobacco cessation medications, the reason must be **explicitly documented** (e.g., “No tobacco cessation medication as patient is post-operative and nicotine may place them at risk for impaired wound healing”) **or clearly implied** (e.g., “Patient becomes anxious when they take tobacco cessation medication”). * When conflicting information is documented in the medical record, select value “2” for the indicated reasons present for not administering the tobacco cessation medications. * Documentation by the physician, APN, PA, or pharmacist that the patient refused tobacco cessation medication is not considered a valid reason for no tobacco cessation medication during the hospitalization. If refusal is documented as the reason, select Value “2”.   **Exclude:** Medication allergy using a negative modifier or qualifier (questionable, risk of, suspect, etc.)  **Suggested data sources:** ED record, history and physical, progress notes, physician orders, discharge summary, medication administration record |
| 22 | refoptob  (TOB-3) | Did the patient receive a referral for Outpatient Tobacco Cessation Counseling?  1. The referral to outpatient tobacco cessation counseling treatment was made by the healthcare provider/facility staff at any time prior to discharge.  2. Referral information was given to the patient at discharge but the appointment was not made by the provider/facility staff at any time prior to discharge.  4. The patient’s residence is not in the USA.  98. Patient refused the referral for outpatient tobacco cessation counseling treatment and the referral was not made.  99. The referral for outpatient tobacco cessation counseling treatment was not offered at discharge or unable to determine from the medical record documentation. | 1,2,4,98,99  If 4 and tobstatus2 = 1 or 2, auto-fill tobmedc as 3   |  | | --- | | Warning if 4 | | **For the purposes of this data element, documentation must indicate that a referral was made for ongoing evidence-based counseling with clinicians (physician or non-physician such as nurse, psychologist, or counselor)**. Outpatient counseling may include proactive telephone counseling, group counseling and/or individual counseling.  **Guidelines for Selecting “1”**   * **A Counseling referral is defined as an appointment made by the healthcare provider or facility staff either through telephone contact, fax, the EHR or e-mail.** * A Quitline is defined as telephone counseling in which at least some of the contact is initiated by the Quitline counselor to deliver tobacco use interventions. * If a Quitline referral is made, there must be documentation an actual referral was made. Providing a Quitline phone number is NOT sufficient to answer “1”. This includes the VA Quitline, 1-855-QUIT-VET. * For Quitline referrals, the healthcare provider or hospital can either fax or e-mail a Quitline referral or assist the patient in directly calling the Quitline prior to discharge. If the patient directly calls the Quitline during the hospitalization, documentation must reflect that staff was present during the call to verify that an appointment was set. * If only a Quitline number is provided to the patient with no formal referral/consult placed, select “2”.   **Guideline for Selecting “2”**   * If the patient is provided with contact information for e-health or internet smoking cessation programs which tailor program content to the tobacco user’s needs (by collecting information from the tobacco user and using algorithms to tailor feedback or recommendations, permitting the user to select from various features including extensive information on quitting, tobacco dependence, and related topics) select “2”. Note that if Value “2” is selected, the case will not pass the measure. Value “2” can be used as part of an internal performance improvement activity in order to determine if any type of referral was made rather than no referral.   Cont’d next page |
|  |  |  |  | **Guideline for Selecting “4”**   * If the patient does not have a residence in the USA, value “4” must be selected.   **Guideline for Selecting “98”**   * If there is conflicting documentation regarding patient refusal, use the latest documentation. For example, during Admission screening patient refused referral; then in discharge documentation the patient accepted the referral, select the appropriate value. * **Documentation of patient’s refusal of offer of outpatient tobacco cessation counseling referral during the hospitalization is acceptable to select value 98.** * If outpatient tobacco cessation counseling was offered during the hospitalization and the patient refused, select “98”. It does not need to be offered again at discharge.   **Guidelines for Selecting “99”**   * If the patient is provided with self-help materials that are not tailored to the patient’s needs and do not provide a structured program, select value 99. * Select value 99 if: * it cannot be determined that a referral for outpatient cessation counseling was made or; * it is unclear that the absence of the referral was due to a patient refusal or; * a referral was not offered. * If the patient refused *practical counseling* (tobtxcoun = 98) during the hospitalization, a referral for outpatient tobacco cessation counseling must still be offered at the time of discharge. Select “99” if a referral for outpatient counseling was not offered at the time of discharge.   **Include:** group counseling, individual counseling, VA Smoking Cessation Quitline (1-855-QUIT-VET), facility smoking cessation clinic  **Exclude:** E-health, Internet structured programs, Self-help interventions (brochures, videotapes, audiotapes)  **Suggested data sources:** Discharge summary, transfer sheet, discharge instruction sheet, nursing discharge notes, physician order sheet |
| 23 | tobmedc  (TOB-3) | Was an FDA-approved tobacco cessation medication prescribed at discharge?  1. A prescription for an FDA-approved tobacco cessation medication was given to the patient at discharge.  3. The patient’s residence is not in the USA.  98. A prescription for an FDA-approved tobacco cessation medication was offered at discharge and the patient refused.  99. A prescription for an FDA-approved tobacco cessation medication was not offered at discharge or unable to determine from medical record documentation. | 1,3,98,99  Will be auto-filled as 3 if refoptob = 4  If 1, 3, or 98, go to auditc as applicable; else go to notobrxdc   |  | | --- | | If 3, refoptob must = 4 | | * **All discharge medication documentation available in the medical record should be reviewed and taken into account by the abstractor.** In determining whether a tobacco cessation medication was prescribed at discharge, it is not uncommon to see conflicting documentation among different medical record sources. For example, the discharge summary may list Varenicline and this is not included in any of the other discharge medication sources (e.g., discharge orders). Select value 1 unless documentation elsewhere in the medical record suggests that it (tobacco cessation medication) was not prescribed at discharge. * If the physician wants the patient to continue on medication that does not legally require a prescription, for example over the counter (OTC) nicotine replacement therapy (NRT) or medication that will be provided by the outpatient counseling such as the VA Quitline, inclusion of the medication on the discharge medication list is sufficient to select value “1”. **Note:** VHA requires a prescription for OTC nicotine replacement therapy. * If documentation is contradictory (physician noted “d/c Varenicline” or “hold Varenicline” in the discharge orders, but Varenicline is listed in the discharge summary’s discharge medication list), or after careful examination of circumstance, context, timing, etc., the documentation remains unclear, the case should be deemed unable to determine, select value 99. * If the patient does not have a residence in the USA, value “3” must be selected. * If the patient refused tobacco cessation medication during the hospitalization, a prescription must be offered again at the time of discharge. Select Value “99” if documentation reflects that a prescription for cessation medication was not offered at the time of discharge. |
|  |  |  |  | **Refer to TJC Appendix C, Table 9.1 for a comprehensive list of FDA-approved tobacco cessation medications.** FDA-Approved Tobacco Cessation Medications may include, but are not limited to: Nicotine Replacement Therapy (NRT) such as Nicorelief, Nicorette gum; bupropion (Wellbutrin); varenicline (Chantix).  **Suggested data sources:** Discharge summary, transfer sheet, discharge instruction sheet, medication reconciliation form, nursing discharge notes, physician order sheet, transfer sheet |
| 24 | notobrxdc  (TOB-3) | Is there documentation of a reason for not prescribing one of the FDA-approved tobacco cessation medications at discharge?   * Allergy to all of the FDA-approved tobacco cessation medications. * Drug interaction (for all of the FDA-approved medications) with other drugs the patient is currently taking. * Other reasons documented by physician/APN/PA or pharmacist.   1. Yes  2. No | 1,2 | * Reasons for not prescribing FDA-approved tobacco cessation medications must be documented by a physician/APN/PA or pharmacist. * An allergy or adverse reaction to one of the FDA-approved cessation medications would not be a reason for not prescribing another of the cessation medications. * In determining whether there is a reason documented by physician/APN/PA or pharmacist for not prescribing tobacco cessation medications, the reason must be **explicitly documented** (e.g., “No tobacco cessation medication as patient is post-operative and nicotine may place them at risk for impaired wound healing”) **or clearly implied** (e.g., “Patient becomes anxious when they take tobacco cessation medication”). * When conflicting information is documented in the medical record, select value “2”. * If the reason for not prescribing FDA-approved cessation medication is documented at any time during the hospitalization, additional documentation of the reason at the time of discharge is not required. * Documentation by the physician/APN/PA or pharmacist that the patient refused tobacco cessation medication is not considered a valid reason for no tobacco cessation medication at discharge. if refusal is documented as the reason, select “2”.   **Exclude:** Medication allergy using a negative modifier or qualifier (questionable, risk of, suspect, etc.)  **Suggested data sources:** ED record, history and physical, progress notes, physician orders, discharge summary, medication administration record |
| **If DCDT – ADMDT < = 1 day, go to nformcon as applicable.** | | | | |
|  |  | **Substance Use** |  |  |
| 25 | auditc  (SUB-1,SUB-2) | Was the patient screened for alcohol misuse with the AUDIT-C within the first day of admission (by end of Day 1)?  1. Yes  2. No  97. The patient was not screened for alcohol use within the first day of admission (by end of Day 1) because of cognitive impairment  98. Patient refused screening for alcohol misuse within the first day of admission (by end of Day 1) | 1,2,97,98  **If 2 or 98, go to addtxref as applicable**  **If 97, go to nformcon as applicable** | **The alcohol use status screening must have occurred within the first day of admission (by end of Day 1). This includes the day of admission which is defined as day zero (Day 0) and the day after admission which is defined as Day 1.**  **Exception:** If the screening was performed within 3 days prior to admission, i.e., at the transferring facility, in another inpatient hospital unit, emergency department or observation unit, the screening documentation must be present in the current medical record.  **Alcohol screen completed after acute care arrival (e.g., in the ED) is acceptable.**  If there is documentation of an Audit-C alcohol misuse screening in a pre-admission H&P (for the current admission) completed within 30 days prior to this admission, and the licensed independent practitioner (LIP) makes reference to it within the first day of admission either by indicating there were no changes, or adding any updates to it, that H&P is considered valid documentation for the Audit-C alcohol misuse screening.  **Screening for alcohol misuse = the patient was screened using AUDIT-C questions OR AUDIT-C question # 1 alone if answer was “never” (audc1=0).**  AUDIT-C:  Question #1 = “How often did you have a drink containing alcohol in the past year?”  Question #2 = “How many drinks containing alcohol did you have on a typical day when you were drinking in the past year?”  Question #3 = “How often did you have six or more drinks on one occasion in the past year?”  If AUDIT-C question #1 is answered “never”, AUDIT-C questions 2 and 3 are not applicable.  **Cognition refers to mental activities associated with thinking, learning, and memory. Cognitive impairment for the purposes of this measure set is related to documentation that the patient cannot be screened for alcohol use due to the impairment (e.g., comatose, obtunded, confused, memory loss) within the first day of admission (by end of Day 1).**  **Examples of cognitive impairment include:** Altered level of consciousness (LOC), altered mental status, cognitive impairment, cognitively impaired, confused, dementia, memory loss, mentally retarded, obtunded, psychotic/psychosis  Cont’d next page |
|  |  |  |  | AUDIT-C cont’d   * If there is documentation that the patient has temporary cognitive impairment due to acute substance use (e.g., overdose or acute intoxication) value “97” cannot be selected. * If there is documentation within the first day of admission (by end of Day 1) that the patient was psychotic with documented symptoms e.g., hallucinating, non-communicative, catatonic, etc. which prevented them from answering questions reliably, they would be considered cognitively impaired. * If there is documentation that the patient was intubated on the day of admission (Day 0) and remains intubated through the entire first day (Day 1), select value “97” as the patient is unable to answer. * Documentation of cognitive impairment overrides documentation of an alcohol use screen and therefore would not be considered “conflicting documentation.” Even if the family or others tell staff the patient uses alcohol, the patient could not be counseled due to cognitive impairment. Select Value “97.” * If there is documentation within the first day of admission (by end of Day 1) of any of the examples of cognitive impairment above, select value “97” regardless of conflicting documentation.   **Suggested Data Sources:** Consultation notes,ED record, History and physical, Nursing admission assessment/notes, Physician progress notes |
| 26 | dtalscrn  (SUB-1,SUB-2) | Enter the date of screening for alcohol misuse with the AUDIT-C within the first day of admission. | mm/dd/yyyy   |  | | --- | | >= arrvdate and <= 1 day after admdt | | **If the patient is screened for alcohol misuse with the AUDIT-C multiple times within the first day of admission and any AUDIT-C total score is 5 or greater, enter the date of the earliest AUDIT-C screen with total score of 5 or greater within the first day of admission.**  Enter the exact date. The use of 01 to indicate missing month or day is not acceptable. |
| 27 | audc1  (SUB-1,SUB-2) | Enter the score documented for AUDIT–C Question #1 within the first day of admission.  “How often did you have a drink containing alcohol in the past year?   1. Never 2. Monthly or less 3. Two to four times a month 4. Two to three times a week 5. Four or more times a week   99. Not documented | 0,1,2,3,4,99  If 0, auto-fill audc2 and audc3 as 95, and go to alcscor | AUDIT-C Question #1 = “How often did you have a drink containing alcohol in the past year?” Each answer is associated with the following scores:  Never 🡪 0  Monthly or less🡪 1  Two to four times a month 🡪 2  Two to three times a week 🡪 3  Four or more times a week 🡪 4  Not documented 🡪 99  Answers to Question #1 of the AUDIT-C are scored as indicated. If the patient’s answers are documented in the record, the abstractor may assign the score in accordance with the patient’s response. If the score of Question #1 is documented without the question, the abstractor may enter that score. If neither the question response nor the score of the individual question is documented, enter 99. |
| 28 | audc2  (SUB-1,SUB-2) | Enter the score documented for AUDIT-C Question #2 within the first day of admission.  “How many drinks containing alcohol did you have on a typical day when you were drinking in the past year?”   1. 0, 1 or 2 drinks 2. 3 or 4 3. 5 or 6 4. 7 to 9 5. 10 or more   95. Not applicable  99. Not documented | 0,1,2,3,4,95,99  Will be auto-filled as 95 if audc1 = 0 | AUDIT-C Question #2 = “How many drinks containing alcohol did you have on a typical day when you were drinking in the past year?” Each answer is associated with the following scores:  0 drinks 🡪 0  1 or 2 drinks 🡪 0  3 or 4 drinks 🡪 1  5 or 6 drinks 🡪 2  7 to 9 drinks 🡪 3  10 or more drinks 🡪 4  Not documented 🡪 99  Answers to Question #2 of the AUDIT-C are scored as indicated. If the patient’s answers are documented in the record, the abstractor may assign the score in accordance with the patient’s response. If the score of Question #2 is documented without the question, the abstractor may enter that score. If neither the question response nor the score of the individual question is documented, enter 99. |
| 29 | audc3  (SUB-1,SUB-2) | Enter the score documented for AUDIT-C Question #3 within the first day of admission.  “How often did you have six or more drinks on one occasion in the past year?”   1. Never 2. Less than monthly 3. Monthly 4. Weekly 5. Daily or almost daily   95. Not applicable  99. Not documented | 0,1,2,3,4,95,99  Will be auto-filled as 95 if audc1 = 0 | AUDIT-C Question #3 = “How often did you have six or more drinks on one occasion in the past year?” Each answer is associated with the following scores:  Never 🡪 0  Less than monthly 🡪 1  Monthly 🡪 2  Weekly 🡪 3  Daily or almost daily 🡪 4  Not documented 🡪 99  Answers to Question #3 of the AUDIT-C are scored as indicated. If the patient’s answers are documented in the record, the abstractor may assign the score in accordance with the patient’s response. If the score of Question #3 is documented without the question, the abstractor may enter that score. If neither the question response nor the score of the individual question is documented, enter 99. |
| 30 | alcscor  (SUB-1,SUB-2) | Enter the total AUDIT-C score documented within the first day of admission. | \_\_ \_\_  Abstractor may enter default zz if the total score of the AUDIT-C is not documented in the record  **If alcscor >=5, go to briefintv; else go to addtxref as applicable**   |  | | --- | | Whole numbers 0 - 12 | | The abstractor may not enter the total AUDIT-C score calculated from the questions if it is NOT documented in the record.  If the total score is not documented in the record, enter default zz. |

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| 31 | briefintv  (SUB-2) | Following the positive screening result for alcohol use, did the patient receive a brief intervention prior to discharge?   1. The patient received a brief intervention including all of the following components: 2. Concern that the patient is drinking at unhealthy levels known to increase his/her risk of alcohol-related health problems 3. Feedback linking alcohol use and health, including:   - Personalized feedback (i.e., explaining how alcohol use can interact with patient’s medical concerns [hypertension, depression/anxiety, insomnia, injury, congestive heart failure (CHF), diabetes mellitus (DM), breast cancer risk, interactions with medications])  **OR**  - General feedback on health risks associated with drinking.   1. Advice to abstain (if there are contraindications to drinking)   **OR**  Advice to drink below recommended limits (specified for patient).  98. Patient refused/declined brief intervention  99. Brief intervention was not offered to the patient during the hospital stay or unable to determine if a brief intervention was provided from medical record documentation | 1,98,99 | **A brief intervention is a single session or multiple sessions conducted by a qualified healthcare professional following a positive screen for unhealthy alcohol use.**   * A qualified healthcare professional may be defined as a physician, nurse, addictions counselor, psychologist, social worker, or health educator with training in brief intervention. * A brief intervention focuses on increasing the patient’s understanding of the impact of substance use on his or her health and motivating the patient to change risky behaviors. The qualified health care professional engages the patient in a joint decision-making process regarding alcohol use and plans for follow-up are discussed and agreed to. * In order to select value 1, the brief intervention must include the following three components:  1. Concern that the patient is drinking at unhealthy levels known to increase his/her risk of alcohol-related health problems 2. Feedback linking alcohol use and health, including:   - Personalized feedback (i.e., explaining how alcohol use can interact with patient’s medical concerns [hypertension, depression/anxiety, insomnia, injury, congestive heart failure (CHF), diabetes mellitus (DM), breast cancer risk, interactions with medications])  **OR**  - General feedback on health risks associated with drinking.  c. Advice to abstain (if there are contraindications to drinking)  **OR**  Advice to drink below recommended limits (specified for patient).   * If there is documentation of brief intervention in a pre-admission H&P (for the current admission) completed within 30 days prior to this admission, and the licensed independent practitioner (LIP) makes reference to it within the first day of admission either by indicating there were no changes, or adding any updates to it; that H&P is considered valid documentation for the brief intervention. * If there is no documentation that a brief intervention was given to the patient, select value 99. * Select value 99 if the documentation provided is not explicit enough to determine if the intervention provided contained the specific components or if it is determined that the intervention does not meet the intent of the measure. |
| **If dcdispo = 1 or 99 AND (ICD-10 princode or othrdx is on TJC Table 13.1 or 13.2) OR (ICD-10 prinpx or othrpx is on TJC Table 13.3), go to addtxref; else go to nformcon as applicable.** | | | | |
| 32 | addtxref  (SUB-3) | Was a referral for addictions treatment made for the patient prior to discharge?  1. The referral to addictions treatment was made by the healthcare provider/facility staff at any time prior to discharge.  2. Referral information was given to the patient at discharge but the appointment was not made by the provider/facility staff at any time prior to discharge.  4. The patient’s residence is not in the USA.  98. The patient refused the referral for addictions treatment and the referral was not made.  99. The referral for addictions treatment was not offered at any time prior to discharge or unable to determine from the medical record documentation. | 1,2,\*4,98,99  \*If 4, auto-fill sudmedc as 3, and go to nformcon as applicable   |  | | --- | | Warning if 4 | | **In order to answer “1” there must be documentation that a referral was made prior to discharge for addictions treatment by a physician or non-physician (such as nurse, psychologist, or counselor).**   * A referral is defined as an appointment made by the provider either through telephone contact, fax or e-mail. * The referral may be to an addictions treatment program, to a mental health program or mental health specialist for follow-up for substance use or addiction treatment, or to a medical or health professional for follow-up for substance use or addiction. * A referral to Alcoholics Anonymous (AA) or similar mutual support groups does not meet the intent of the measure, select value 99 if such a referral is given to the patient. * If the patient does not have a residence in the USA, value “4” must be selected.   **If there is conflicting documentation regarding patient refusal, use the latest documentation. For example, during Admission screening patient refused referral; then in discharge documentation the patient accepted the referral, select the appropriate value.**  **Inclusion Guidelines for Abstraction:** Group counseling,  Individual counseling (Addictions counselor, Personal physician, Psychiatrist, Psychologist, Social worker)  **Exclusion Guidelines for Abstraction:**   * Self-help interventions (brochures, videotapes, audiotapes, reactive hotlines/help lines) * Support groups that are not considered treatment such as Alcoholics Anonymous (AA) |
| 33 | sudmedc  (SUB-3) | Was one of the FDA-approved medications for alcohol or drug disorder prescribed at discharge?  1. A prescription for an FDA-approved medication for alcohol or drug disorder was given to the patient at discharge.  3. The patient’s residence is not in the USA.  98. A prescription for an FDA-approved medication for alcohol or drug disorder was offered at discharge and the patient refused.  99. A prescription for an FDA-approved medication for alcohol or drug disorder was not offered at discharge, or unable to determine from medical record documentation. | 1,3,98,99  Will be auto-filled as 3 if addtxref = 4   |  | | --- | | If 3, addtxref must = 4 | | * In determining whether a medication for alcohol or drug disorder was prescribed at discharge, it is not uncommon to see conflicting documentation among different medical record sources. For example, the discharge summary may list Disulfiram but this is not included in any of the other discharge medications sources, e.g., discharge orders. All discharge medication documentation available in the chart should be reviewed and taken into account by the abstractor. * In cases where there is a medication for alcohol or drug disorder in one source and it is not mentioned on other sources, it should be interpreted as a discharge medication, select value 1 unless documentation elsewhere in the medical record suggests that it was not prescribed at discharge. * If documentation is contradictory (physician noted “d/c Antabuse” or “hold Antabuse” in the discharge orders, but Antabuse 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 value 99. * If the patient does not have a residence in the USA, value “3” must be selected.   **Inclusion Guidelines for Abstraction:**  Refer to Appendix C, Table 9.2 for a comprehensive list of FDA-approved medications for alcohol and drug dependence (includes but not limited to disulfiram [Antabuse], Methadone).  **Suggested data sources:** Discharge instruction sheet, Discharge summary, Medication reconciliation form, Nursing discharge notes, Physician order sheet, Transfer sheet |

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| **If PRINPX is on Table VASC or TJC Table 5.11, 5.17, 5.19, 5.20, 5.21, 5.22, 5.23, or 5.24, go to NFORMCON. Else enable Medication Reconciliation Module; If INPT\_FE flag = 1, enable Delirium Risk.** | | | | |
| 34 | nformcon | Does the medical record contain an informed consent form that is dated 0 – 60 days prior to the procedure?   1. contains form dated 0 - 60 days prior to procedure 2. contains form but dates outside parameters 3. contains form, not dated   99. no informed consent form in medical record | 1,2,3,99  **If 3 or 99, auto-fill formdate as 99/99/9999**  If 99, auto-fill imed  as 95 | 0 days = on the day of the procedure  Informed consent form may be discussed with the patient and signed in the outpatient clinic or other treatment setting within 60 days prior to the date the procedure is performed.  Use response #2 if informed consent form was signed > 60 days prior to the date of the procedure or after the procedure was performed.  Use response #3 if no date appears on the informed consent form.  Use #99 if no evidence of a formal informed consent form is contained in the paper or electronic record. |
| 35 | formdate | Enter the date recorded on the informed consent form. | mm/dd/yyyy  If nformcon = 3 or 99, will be auto-filled as 99/99/9999   |  | | --- | | If 1, < = 60 days prior or = prinpxdt  If 2, > 60 days prior to prinpxdt or > prinpxdt  Warning if days prior to prinpxdt > = 75 days | | Enter the date that is documented on the informed consent form. |
| 36 | imed | Was iMedConsent used to create the consent form? 1. Yes  2. No  95. Not applicable | 1,2,95  Will be auto-filled as 95 if nformcon = 99 | The iMed consent form is contained in the medical record as a VistA document. There is no common naming convention for the informed consent VistA image as the VistA ID number varies by facility.  **In order to answer “1”, the informed consent form in the medical record must be created using iMedConsent. Informed consent forms generated by iMed are identified in the informed consent note as being “electronically filed by: iMed user”.** Examples of acceptable wording include, but may not be limited to:   * USER IMED * IMEDCONSENT DOCUMENT * iMedConsent document * user IMEDCONSENT * vendor IMED * SERVICE IMED * IMED SERVICE * BGP PSEUDOUSER * USER BGP   Non iMed Consent informed consent forms may also be contained in the medical record as a VistA document, but do not meet the intent of this question. |