| # | Name | QUESTION | Field Format | DEFINITION/DECISION RULES |
|---|---|---|---|---|
| | | **Computer to pre-fill question responses prior to EDPT** | | |
| | | **Organizational Identifiers** | | |
| | VAMC<br>CONTROL<br>QIC<br>BEGDTE<br>REVDTE | Facility ID<br>Control Number<br>Abstractor ID<br>Abstraction Begin Date<br>Abstraction End Date | Auto-fill<br>Auto-fill<br>Auto-fill<br>Auto-fill<br>Auto-fill | |
| | | **Patient Identifiers** | | |
| | SSN<br>PTNAMEF<br>PTNAMEL<br>BIRTHDT<br>SEX<br>MARISTAT<br>RACE | Patient SSN<br>First Name<br>Last Name<br>Birth Date<br>Sex<br>Marital Status<br>Race | Auto-fill: no change<br>Auto-fill: no change<br>Auto-fill: no change<br>Auto-fill: no change<br>Auto-fill: **can change**<br>Auto-fill: no change<br>Auto-fill: no change | |
| 1 | arrvdate | Enter the **earliest** documented date the patient arrived at acute care at this VAMC. | mm/dd/yyyy<br><br>Abstractor may enter 99/99/9999 if arrival date is unable to be determined<br><br>< = 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.** Arrival date may differ from admission date.**ONLY ACCEPTABLE SOURCES:** Emergency Department record (includes ED Face Sheet, Consent/Authorization for treatment forms, Registration/sign-in forms, vital sign record, triage record, physician orders, ECG reports, telemetry/rhythm strips, laboratory reports, x-ray reports); nursing admission assessment/admitting note; observation record; procedure notes (such as cardiac cath, endoscopies, surgical procedures); vital signs graphic record<br><br>• **Review the ONLY ACCEPTABLE SOURCES to determine the earliest date the patient arrived at the ED, nursing floor, observation, or as a direct admit to the cath lab. The intent is to utilize any documentation which reflects processes that occurred after arrival at the ED or after arrival to the nursing floor/observation/cath lab for a direct admit.** |

| # | Name | QUESTION | Field Format | DEFINITION/DECISION RULES |
|---|------|----------|--------------|---------------------------|
| | | | | • If the patient was transferred from your hospital's satellite/free-standing ED or from another hospital within your hospital's system (as an inpatient or ED patient), and there is one medical record for the care provided at both facilities, use the arrival date at the first facility. <br> • Documentation outside of the ONLY ACCEPTABLE SOURCES list should NOT be referenced (e.g., ambulance record, physician office record, H&P). <br> • Arrival date should NOT be abstracted simply as the earliest date in one of the ONLY ACCEPTABLE SOURCES, without regard to other substantiating documentation. When looking at the ONLY ACCEPTABLE SOURCES, if the earliest date documented appears to be an obvious error, this date should not be abstracted. Example: ED MAR has a med documented as 1430 on 11-03-20xx. All other dates in ED record are 12-03-20xx. The 11-03-20xx would not be used because it appears to be an obvious error. <br> • If the patient is in an outpatient setting of the hospital (e.g., undergoing dialysis, chemotherapy) or a SNF unit of the hospital, and is subsequently admitted to acute inpatient, use the date the patient presents to the ED or arrives on the floor for acute inpatient care as the arrival date. <br> • For Observation Status: <br>   ○ If the patient was admitted to observation from the ED of the hospital, use the date the patient arrived at the ED. <br>   ○ If the patient was admitted to observation from an outpatient setting of the hospital, use the date the patient arrived at the ED or on the floor for observation care. <br> • For Direct Admits: <br>   ○ If the patient is a "Direct Admit" to the cath lab, use the earliest date the patient arrived at the cath lab (or cath lab staging/holding area) as the arrival date. <br>   ○ For "Direct Admits" to acute inpatient or observation, use the earliest date the patient arrived at the nursing floor or in observation (as documented in the ONLY ACCEPTABLE SOURCES) as the arrival date. <br> • **If arrival date is unable to be determined from any of the ONLY** |

| # | Name | QUESTION | Field Format | DEFINITION/DECISION RULES |
|---|------|----------|--------------|---------------------------|
| | | | | ACCEPTABLE SOURCES, enter 99/99/9999. |
| 2 | arrvtime | Enter the **earliest** documented time the patient arrived at acute care at this VAMC. | ____ <br> UMT <br> **If unable to find the time of arrival, the abstractor can enter 99:99** <br><br> < = 6 months prior to or = admdt/admtm and < dcdt/dctime <br><br> Warning if > 72 hours prior to admdt/admtm | **Arrival time is the earliest recorded time the patient arrived in this hospital's acute care setting. Arrival time may differ from admission time.ONLY ACCEPTABLE SOURCES:** Emergency Department record (includes ED Face Sheet, Consent/Authorization for treatment forms, Registration/sign-in forms, vital sign record, triage record, physician orders, ECG reports, telemetry/rhythm strips, laboratory reports, x-ray reports); nursing admission assessment/admitting note; observation record; procedure notes (such as cardiac cath, endoscopies, surgical procedures); vital signs graphic record <br><br> • **Review the ONLY ACCEPTABLE SOURCES to determine the earliest time the patient arrived at the ED, nursing floor, observation, or as a direct admit to the cath lab. The intent is to utilize any documentation which reflects processes that occurred after arrival at the ED or after arrival to the nursing floor/observation/cath lab as a direct admit.** <br> • If the patient was transferred from your hospital's satellite/free-standing ED or from another hospital within your hospital's system (as an inpatient or ED patient), and there is one medical record for the care provided at both facilities, use the arrival time at the first facility. <br> • Documentation outside of the ONLY ACCEPTABLE SOURCES list should NOT be referenced (e.g., ambulance record, physician office record, H&P). <br> • Arrival time should NOT be abstracted simply as the earliest time in one of the ONLY ACCEPTABLE SOURCES, without regard to other substantiating documentation. When looking at the ONLY ACCEPTABLE SOURCES, if the earliest time documented appears to be an obvious error, this time should not be abstracted. Example: ED face sheet lists arrival time 1320. ED registration 1325. ED triage 1330. ED consent to treat form has 1:17 with "AM" circled. ED record documentation suggests the 1:17 AM is an obvious error. Enter 1320 for Arrival Time. <br> • If the patient is in an outpatient setting of the hospital (e.g., undergoing dialysis, chemotherapy) or a SNF unit of the hospital, and is subsequently |

| # | Name | QUESTION | Field Format | DEFINITION/DECISION RULES |
|---|------|----------|--------------|---------------------------|
| | | | | admitted to acute inpatient, use the time the patient presents to the ED or arrives on the floor for acute inpatient care as the arrival time.<br><ul><li>If the time the patient arrived on the floor is not documented by the nurse, enter the admission time recorded in EADT.</li></ul><ul><li>For Observation Status:<ul><li>If the patient was admitted to observation from the ED of the hospital, use the time the patient arrived at the ED.</li><li>If the patient was admitted to observation from an outpatient setting of the hospital, use the time the patient arrived at the ED or on the floor for observation care.</li></ul></li><li>For Direct Admits:<ul><li>If the patient is a "Direct Admit" to the cath lab, use the earliest time the patient arrived at the cath lab (or cath lab staging/holding area) as the arrival time.</li><li>For "Direct Admits" to acute inpatient or observation, use the earliest time the patient arrived at the nursing floor or in observation (as documented in the ONLY ACCEPTABLE SOURCES) as the arrival time.</li></ul></li><li>**If arrival time is unable to be determined from any of the ONLY ACCEPTABLE SOURCES, enter 99:99.**</li></ul> |

| # | Name | QUESTION | Field Format | DEFINITION/DECISION RULES |
|---|------|----------|--------------|---------------------------|
| 3 | admdt | Admission date: | mm/dd/yyyy **Auto-filled: can be modified** $<= dcdt$ | **Auto-filled; can be modified if abstractor determines that the date is incorrect.** <br><br> • Admission date is the date the patient was actually admitted to acute inpatient care. <br> • 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. <br> • If there are multiple inpatient orders, use the order that most accurately reflects the date that the patient was admitted. <br> • 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. <br><br> **ONLY ALLOWABLE SOURCES:** Physician orders (priority data source), face sheet <br> **Exclusion:** admit to observation, arrival date |
| 4 | admtm | Admission time: | ____ UMT **Auto-filled: can be modified** $< dcdt/dctime$ | **Auto-filled: can be modified.** <br> Abstractor to verify admission time is correct. If correction is necessary, enter time in Universal Military Time. <br> **Admission time = time when the patient was formally admitted to inpatient status.** <br> **Exclusion: Admit to observation time, Arrival time** |
| 5 | dcdt | Discharge date: | mm/dd/yyyy **Auto-filled: cannot be modified** | **Auto-filled; cannot be modified** <br> 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. |

| # | Name | QUESTION | Field Format | DEFINITION/DECISION RULES |
|---|------|----------|--------------|---------------------------|
| 6 | dctime | Discharge time: | _____<br>UMT<br><br>> admdt/admtm | **Does not auto-fill.  Discharge time must be entered.**<br>**Includes the time the patient was discharged from acute care, left against medical advice (AMA), or expired during this stay.**<br>If the patient expired, use the time of death as the discharge time.<br>**Suggested sources for patient who expire:**<br>Death record, resuscitation record, physician progress notes, physician orders, nurses notes<br>**For other patients:**<br>If the time of discharge is NOT documented in the nurses notes, discharge/transfer form, or progress notes, enter the discharge time documented in EADT under the "Reports Tab."<br>Enter time in Universal Military Time: a 24-hour period from midnight to midnight using a 4-digit number of which the first two digits indicate the hour and the last two digits indicate the minute.<br>Converting time to military time:<br>If time is in the a.m., no conversion is required.<br>If time is the p.m., add 12 to the clock hour time. |
| 7 | princode | Enter the ICD-9-CM principal diagnosis code. | __ __ __. __ __<br>(3 digits/decimal point/two digits<br>**Auto-filled: can be modified**<br><br>**Cannot enter 000.00, 123.45, or 999.99** | **Will auto-fill from PTF with ability to change.  Do NOT change the principal diagnosis code unless the principal diagnosis code documented in the record is not the code displayed in the software.** |

| # | Name | QUESTION | Field Format | DEFINITION/DECISION RULES |
|---|------|----------|--------------|---------------------------|
| 8 | othrcode1 othrcode2 othrcode3 othrcode4 othrcode5 othrcode6 othrcode7 othrcode8 othrcode9 othrcode10 othrcode11 othrcode12 | Enter the ICD-9-CM other diagnosis codes: | __ __ __. __ __ (3 digits/decimal point/two digits) **Auto-filled: can be modified** Can enter 12 codes Abstractor can enter xxx.xx in code field if no other dx found | **Can enter 12 ICD-9-CM other diagnosis codes. Will auto-fill from the PTF with ability to change. If the "other diagnoses" codes are incorrect, enter the codes as documented in the medical record.** If entered manually, use the codes listed in discharge diagnosis (DD) under the reports tab. Enter xxx.xx in code field if no other diagnoses codes exist for this record. |
| 9 | prinpxdt prinpx | Enter the ICD-9-CM principal procedure code and date the procedure was performed. Code  Date __ __. __ __   __/__/____ | __ __. __ __ Abstractor can enter xx.xx in code field and 99/99/9999 in date field if there is no principal procedure **Cannot enter 00.00** mm/dd/yyyy Abstractor can enter 99/99/9999 If no principal procedure, auto-fill othrpx and othrpxdt with xx.xx 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.** <br><br> • 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. <br><br> **If no procedure was performed during the episode of care, fill ICD-9-CM code field with default code xx.xx. Do not enter 99.99 or 00.00 to indicate no procedure was performed.** **Date of the principal procedure is to be filled with 99/99/9999 if no procedure was performed.** If the principal procedure date is unable to be determined from the medical record documentation, or 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. |

| # | Name | QUESTION | Field Format | DEFINITION/DECISION RULES |
|---|------|----------|--------------|---------------------------|
| 10 | othrpx1 othrpxdt1 othrpxdt2 othrpxdt3 othrpx5 othrpxdt5 othrpx2 othrpx3 othrpx4 othrpxdt4 | Enter the ICD-9-CM other procedure codes and dates the procedures were performed.<br><br>Code Date<br><br>__ __. __ __    __/__/____<br><br>__ __. __ __    __/__/____ | __ __. __ __<br>Abstractor can enter xx.xx in code field and 99/99/9999 in date field if no other procedure was performed<br><br>mm/dd/yyyy<br>Abstractor can enter 99/99/9999<br><br>> = admdt and < = dcdt<br><br>Can enter 5 codes and dates | **Can enter 5 procedure codes, other than the principal procedure code.** Enter the ICD-9-CM codes and dates corresponding to each of the procedures performed, beginning with the procedure performed most immediately following the admission.<br><br>• If no other procedures were performed, enter default code xx.xx in the code field and default date 99/99/9999 in the date field.<br>• If no other procedure was performed, it is only necessary to complete the xx.xx and 99/99/9999 default entries for the first code and date. It is not necessary to complete the default entry five times.<br>• 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. |
| 11 | dcdispo | What was the patient's discharge disposition on the day of discharge?<br>1. Home<br><br>• Assisted Living Facilities (ALFs) - includes assisted living care at nursing home/facility<br>• Court/Law Enforcement - includes detention facilities, jails, and prison<br>• Home - includes board and care, domiciliary, foster or residential care, group or personal care homes, retirement communities, and homeless shelters<br>• Home with Home Health Services<br>• Outpatient Services including outpatient procedures at another hospital, outpatient Chemical Dependency Programs and Partial Hospitalization | 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.**<br><br>• **Only use documentation written <u>on the day prior to discharge or the day of discharge</u> 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".<br>• **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.**<br>• **If there is documentation that further clarifies the level of care that documentation should be used to determine the correct value to** |

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|---|------|----------|--------------|---------------------------|
| | | 2. Hospice - Home (or other home setting as listed in #1 above)<br>3. Hospice - Health Care Facility<br><br>• General Inpatient and Respite, Residential and Skilled Facilities, and Other Health Care Facilities<br><br>4. Acute Care Facility<br><br>• Acute Short Term General and Critical Access Hospitals<br>• Cancer and Children's Hospitals<br>• Department of Defense and Veteran's Administration Hospitals<br><br>5. Other Health Care Facility<br><br>• Extended or Immediate Care Facility (ECF/ICF)<br>• Long Term Acute Care Hospital (LTACH)<br>• Nursing Home or Facility including Veteran's Administration Nursing Facility<br>• Psychiatric Hospital or Psychiatric Unit of a Hospital<br>• Rehabilitation Facility including Inpatient Rehabilitation Facility/Hospital or Rehabilitation Unit of a Hospital<br>• Skilled Nursing Facility (SNF), Sub-Acute Care or Swing Bed<br>• Transitional Care Unit (TCU)<br>Veteran's Home<br><br>6. Expired<br>7. Left Against Medical Advice/AMA<br>99. Not documented or unable to determine | | **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".<br>• 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.<br>    ◦ Acute Care Facility<br>    ◦ Hospice - Health Care Facility<br>    ◦ Hospice - Home<br>    ◦ Other Health Care Facility<br>    ◦ Home<br>• Values "2" and "3" hospice includes discharges with hospice referrals and evaluations<br>• 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".<br>• 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".<br>• 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".<br>• Selection of option "7" (left AMA):<br>    ◦ 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.**<br>    ◦ If any source states the patient left against medical advice, select value "7", regardless of whether the AMA documentation was written last.<br>    ◦ Documentation suggesting that the patient left before discharge instructions could be given without "left AMA" documentation does not count. |

| # | Name | QUESTION | Field Format | DEFINITION/DECISION RULES |
|---|------|----------|--------------|---------------------------|
| | | | | **Excluded Data Sources:** Any documentation prior to the last two days of hospitalization, coding documents <br> **Suggested Data Sources:** Discharge instruction sheet, discharge planning notes, discharge summary,  nursing discharge notes, physician orders, progress notes, social service notes, transfer record |
| | | **Emergency Department** | | |

| # | Name | QUESTION | Field Format | DEFINITION/DECISION RULES |
|---|------|----------|--------------|---------------------------|
| 12 | edpt | Did the patient receive care/services in the Emergency Department of this VAMC?<br>1. Yes<br>2. No | 1, 2<br><br>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 vaxstat 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.**<br><br>• 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".<br>• 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).<br>• 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).<br>• 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.<br>• 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.<br><br>**Exclude:Fast track ED, terms synonymous with Urgent Care, Urgent Care**<br>**Suggested data sources: ED record, face sheet** |

| # | Name | QUESTION | Field Format | DEFINITION/DECISION RULES |
|---|------|----------|--------------|---------------------------|
| 13 | decdt | Enter the earliest documented date of the decision to admit the patient by the physician/APN/PA. | mm/dd/yyyy<br><br>Will be auto-filled as 99/99/9999 if edpt = 2<br><br>Abstractor can enter 99/99/9999<br><br>If arrvdate = admdt, computer will auto-fill = arrvdate<br><br>>= 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.**<br>**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).**<br><br>• **Do not include any documentation from external sources (e.g., ambulance record, clinic note, lab reports) obtained prior to arrival.**<br>• 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.<br>• 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.<br>• Decision to Admit Date includes physician/APN/PA documentation of a decision to send the patient to cath lab or surgery.<br>• 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.<br>• **If the admission date is the same date as arrival, Decision to Admit date will be auto-filled by the computer software.**<br>• 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.<br>• 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.<br><br>**Includes, but is not limited to: Admit Order Date, Disposition Order Date**<br>**Excludes, but is not limited to: Bed Assignment Date, Direct admit patients seen in the ED** |

| # | Name | QUESTION | Field Format | DEFINITION/DECISION RULES |
|---|------|----------|--------------|---------------------------|
| 14 | dectm | Enter the earliest documented time of the decision to admit the patient by the physician/APN/PA. | ___ UMT<br><br>Will be auto-filled as 99:99 if edpt = 2<br><br>Abstractor can enter 99:99<br><br>>= arrvdate/arrvtime and <= admdt/admtm | **For purposes of this data element "decision to admit time" is the time the physician/APN/PA communicates the decision to admit the patient from the Emergency Department to the hospital for continued care in the facility. The decision to admit time will not necessarily coincide with the time the patient is officially admitted to inpatient status.**<br>**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).**<br><br>• **Do not include any documentation from external sources (e.g., ambulance record, clinic note, lab reports) obtained prior to arrival.**<br>• Use the time from the first documentation of decision to admit for either observation or inpatient. If there are multiple times documented for the decision to admit, abstract the earliest time.<br>• 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.<br>• Decision to Admit Time includes physician/APN/PA documentation of a decision to send the patient to cath lab or surgery.<br>• 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.<br>• 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.<br>• 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.<br>• 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.<br><br>**Includes, but is not limited to: Admit Order Time, Disposition Order Time**<br>**Excludes, but is not limited to: Bed Assignment Time, Direct admit patients seen in the ED, Report Called Time** |

| # | Name | QUESTION | Field Format | DEFINITION/DECISION RULES |
|---|------|----------|--------------|---------------------------|
| 15 | edcdt | Enter the date the patient departed from the emergency department. | mm/dd/yyyy<br><br>Will be auto-filled as 99/99/9999 if edpt = 2<br><br>Abstractor can enter 99/99/9999<br><br>>= arrvdate or = admdt and <= 3 days after admdt<br><br>If decdt <> 99/99/9999, must be >= decdt | **ONLY ACCEPTABLE SOURCE:  ED record**<br><br>• 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.<br>• 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).<br>• For patients who are placed into observation outside the services of the Emergency Department, abstract the date of departure from the ED.<br>• A departure date listed within a disposition heading from the ED may be used.<br>• If there is documentation the patient left against medical advice and it cannot be determined what date the patient left against medical advice, enter 99/99/9999.<br>• If the date the patient departed from the ED is unable to be determined from medical record documentation, enter 99/99/9999.<br>• 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.<br><br>**Includes, but is not limited to:**  ED Checkout Date, ED Departure Date, ED Discharge Date, ED Leave Date, ED Transport Date |

| # | Name | QUESTION | Field Format | DEFINITION/DECISION RULES |
|---|------|----------|--------------|---------------------------|
| 16 | edctm | Enter the time the patient departed from the emergency department. | ____ UMT<br><br>Will be auto-filled as 99:99 if edpt = 2<br><br>Abstractor can enter 99:99<br><br>>= arrvdate/arrvtime and <= 72 hours after admdt/admtm<br><br>If dectm <> 99:99, must be >= decdt/dectm | **ONLY ACCEPTABLE SOURCE: ED record**<br>**ED Departure Time is the time the patient physically left the Emergency Department. The intention is to capture the latest time at which the patient was receiving care in the ED, under the care of ED services.**<br><br>• When more than one acceptable ED departure/discharge time is documented, abstract the **latest** time. For example: Two departure times are found in the ED nurse's notes: 12:03 via wheelchair and 12:20 via wheelchair. Enter the later time of 12:20 as ED departure time.<br>• For patients who are placed into observation under the services of the Emergency Department, abstract the time of departure from the ED observation services. For example, patient is seen in the ED and admitted to an observation unit of the ED, then discharged from the observation unit. Enter the time the patient departed from the ED observation unit.<br>• For patients who are placed into observation outside the services of the Emergency Department, abstract the time of departure from the Emergency Department.<br>• Do not use the time the discharge order was written because it may not represent the actual time of departure.<br>• A departure time listed within a disposition heading from the ED may be used.<br>• If the time the patient departed from the ED is unable to be determined from medical record documentation, enter 99:99.<br>• 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.<br>**Includes, but is not limited to:** ED Check Out Time, ED Departure Time, ED Discharge Time, ED Leave Time, ED Transport Time<br>**Excludes, but is not limited to:** Report Called Time |
|  |  | **If (prinpx or othrpx is on JC Table 12.10) OR dcdispo = 6, go to comfort as applicable**<br>**If princode or othrcode is on JC Table 12.3 AND dcdispo <> 6, go to flustat** |  |  |

| # | Name | QUESTION | Field Format | DEFINITION/DECISION RULES |
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| | | **Immunizations** | | |
| 17 | vaxstat | What is the patient's pneumococcal vaccination status?<br>1. Pneumococcal vaccination was given during this hospitalization<br>2. Pneumococcal vaccination was received in the past, not during this hospitalization<br>4. Documentation of:<br><br>• Allergy/sensitivity to pneumococcal vaccine, OR<br>• Is not likely to be effective because of bone marrow transplant (or autologous stem cell transplant, ASCT) within the past 12 months, OR<br>• Currently receiving a scheduled course of chemotherapy or radiation therapy, or received a chemotherapy or radiation during this hospitalization or less than 2 weeks prior, OR<br>• Received the shingles vaccine (Zostavax) within the last 4 weeks<br><br>98. Documentation of patient's or caregiver's refusal of pneumococcal vaccine<br>99. None of the above/not documented/unable to determine from medical record documentation | 1, 2, 4, 98, 99 | **Include:** Pneumoccocal vaccine, pneumonia shot/vaccine, pneumovax, pneumovax23, pnu-imune 23, polyvalent pneumonia vaccine, PPSV, PPSV 23<br>1 = the patient received pneumococcal vaccination during this episode of care, even if it was also given at any time in the past.<br>In order to answer "1," there must be documentation that the vaccine was given including a date and signature.<br>2 = the patient received pneumococcal vaccination at anytime in the past<br>4 = Patients with specific documented allergy/sensitivity (should be accompanied by the exact complication) to vaccine including any component in the vaccine, including thimerosal. Also, sizeable local reaction at injection site ( > 10.2 cm), or the occurrence of any type of an immediate or delayed hypersensitivity reaction or the occurrence of neurological signs and symptoms following administration. May not be based solely on physician/APN/PA preference. Autologous stem cell transplant and ASCT are other names for a bone marrow transplant.<br>98 = Documentation must indicate the patient/caregiver refused the pneumococcal vaccine during this hospitalization. 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 is responsible for the care of the patient when the patient is unable to make this decision on his/her own.<br>99 = No documentation of pneumococcal vaccination status or unable to determine<br>**If there is 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 pneumococcal vaccine and medication administration record documents pneumococcal vaccine was administered, select "1."**<br>**EXCEPTION: If documentation supports patient refusal (option "98") and option "4," select "98."** |
| 18 | flustat | What is the patient's influenza vaccination status?<br>1. Influenza vaccine was given during this hospitalization<br>2. Influenza vaccine was received prior to admission during the current flu season, not during this hospitalization | 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. |

| # | Name | QUESTION | Field Format | DEFINITION/DECISION RULES |
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| | | 4. There is documentation of:<br><br>• Allergy/sensitivity to influenza vaccine, anaphylactic latex allergy, or anaphylactic allergy to eggs OR<br>• is not likely to be effective because of bone marrow transplant (or autologous stem cell transplant, ASCT) within the past 6 months, OR<br>• prior history of Guillian-Barre syndrome within 6 weeks after a previous influenza vaccination<br><br>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<br>98. Documentation of patient's refusal or caregiver's refusal of influenza vaccine<br>99. None of the above/not documented/ unable to determine from medical record documentation | | **For the purposes of this project, hospitals are only responsible for discharges October through March.**<br>Discharges from April - September are excluded from scoring.<br>**Include documentation of:** Afluria, Flumist, FluLaval, flu shot, flu vaccine, Fluarix, Fluvirin, Fluzone, Fluzone High Dose, influenza virus vaccine, trivalent influenza vaccine<br>**Exclude:** Pandemic monovalent vaccine, e.g. H1N1<br>1 = the patient received influenza vaccination during this episode of care. There must be documentation that the vaccine was given including a date and signature.<br>2 = If there is documentation the patient received the vaccine, and only the current year is documented, select "2."<br><br>• 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 2012 and the discharge date for this hospital stay is October 2013, select "99." If the discharge is in January, February or March 2014 AND there is documentation the patient received the vaccine in 2013, select "2."<br><br>4 = patients with anaphylactic allergy to eggs, anaphylactic latex allergy, or other specific allergy/sensitivity to the vaccine. The allergy/sensitivity must be accompanied by the exact complication. Must be a specific allergy/sensitivity, not just physician/APN/PA preference.<br>6 = vaccine not available to hospital, due to shortage of vaccine. 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.<br>98 = Documentation must indicate the patient/caregiver refused the influenza vaccine during this hospitalization. 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 is responsible for the care of the patient when the patient is unable to make this decision on his/her own. |

| # | Name | QUESTION | Field Format | DEFINITION/DECISION RULES |
|---|------|----------|--------------|---------------------------|
| | | | | 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."<br>**EXCEPTION:**  If documentation supports patient refusal (option "98") and option "4," select "98.<br>**Unacceptable:**<br>• Patient is told to return post-discharge for flu vaccine.<br>• Flu vaccine not available<br>• Documented assumption "patient gets annual flu shot or vaccination" |
| | | **If DCDT - ADMDT < = 3 days, go to end.** | | |
| | | **Tobacco Treatment** | | |
| 19 | comfort | When is the earliest physician, APN, or PA documentation of comfort measures only?<br>1. Day of arrival (day 0) or day after arrival (day 1)<br>2. Two or more days after arrival (day 2 or greater)<br>3. Comfort measures only documented during hospital stay, but timing unclear<br>99. Comfort measures only was not documented by the physician/APN/PA or unable to determine | \*1, \*2, \*3, 99<br>\*If 1, 2, or 3, go to end<br><br>Warning if comfort = 2 | **Comfort Measures Only:** refers to medical treatment of a dying person where the natural dying process is permitted to occur while assuring maximum comfort. It includes attention to the psychological and spiritual needs of the patient and support for both the dying patient and the patient's family. Comfort Measures Only is commonly referred to as "comfort care" by the general public. It is not equivalent to a physician order to withhold emergency resuscitative measures such as Do Not Resuscitate (DNR).<br>**ONLY accept terms identified in the list of inclusions.  No other terminology will be accepted. Day of arrival is day 0.**<br><br>Inclusion (Only acceptable terms)<br><br>Brain death/dead — End of life care<br>Comfort care — Hospice<br>Comfort measures — Hospice care<br>Comfort measures only (CMO) — Organ harvest<br>Comfort only — Terminal care<br>DNR-CC<br><br>• **Determine the earliest day the physician/APN/PA DOCUMENTED** |

| # | Name | QUESTION | Field Format | DEFINITION/DECISION RULES |
|---|------|----------|--------------|---------------------------|
| | | | | **comfort measures only in the ONLY ACCEPTABLE SOURCES.** Do not factor in when comfort measures only was actually instituted. Example: "Discussed comfort care with family on arrival" noted in day 2 progress note - Select "2."<br>• **Consider comfort measures only documentation in the discharge summary as documentation on the last day of the hospitalization, regardless of when the summary is dictated.**<br>• **Physician/APN/PA documentation of comfort measures only mentioned in the following context is acceptable:**<br>  ◦ Comfort measures only recommendation<br>  ◦ Order for consultation/evaluation by hospice care<br>  ◦ Patient/family request for comfort measures only<br>  ◦ Plan for comfort measures only<br>  ◦ Referral to hospice care service<br>• **If any of the inclusions are documented in the ONLY ACCEPTABLE SOURCES, select option "1," "2," or "3" accordingly, unless otherwise specified.**<br>• **Documentation of "CMO should be disregarded if documentation makes clear it is not being used as an acronym for Comfort Measures Only (e.g., "hx dilated CMO" - Cardiomyopathy context).**<br>• **Disregard documentation of an Inclusion term in the following situations:**<br>  ◦ Inclusion term clearly described as negative (Examples: "No comfort care," "Not appropriate for hospice care," "Declines hospice care").<br>  ◦ **NOTE:** If an Inclusion term is clearly described as negative in one source and NOT described as negative in another source, the second source would count for comfort measures only. (e.g., On Day 0, the physician documents, "The patient is not a hospice candidate." On Day 3, the physician orders a hospice consult. Select "2.")<br>  ◦ Comfort measures made conditional upon whether or not the patient arrests. (**Examples:** "DNRCCA" (Do Not Resuscitate-Comfort Care Arrest; "Comfort Care Protocol will be implemented in the event of a cardiac or respiratory arrest"; "Family requests comfort measures only should the patient arrest.") |

| # | Name | QUESTION | Field Format | DEFINITION/DECISION RULES |
|---|------|----------|--------------|---------------------------|
| | | | | ○ Documentation that is dated prior to arrival or documentation which refers to the pre-arrival time period (e.g., comfort measures only order in previous hospitalization record, "Pt. on hospice at home" in physician ED note).<br>**EXCEPTION:** State-authorized portable orders (SAPOs). SAPOs are specialized forms, Out-of-Hospital DNR (OOH DNR) or Do Not Attempt Resuscitation (DNAR) orders, or identifiers authorized by state law, that translate a patient's preferences about specific-end-of-life treatment decisions into portable medical orders<br>**Examples:** DNR-Comfort Care form, MOLST (Medical Orders for Life- Sustaining Treatment), POLST (Physician Orders for Life-Sustaining Treatment)<br>○ Pre-printed order forms signed by physician/APN/PA: Disregard an Inclusion term in a statement that is not part of the order or that is not clearly selected (on a form that offers options to select from).<br>**Examples:**<br>■ Inclusion term used only in the title of the form (e.g., DNR-Comfort Care order form - option "Comfort Care" is not checked.<br>■ Inclusion term used only in the pre-printed instruction for completing the form (e.g., "Copy of form to hospice", "Instructions" section of the form further defines the option "Comfort care")<br><br>**ONLY ACCEPTABLE SOURCES:** Discharge summary, DNR/MOLST/POLST forms, Emergency Department record, physician orders, progress notes<br>**Excluded data source:** Restraint order sheet |

| # | Name | QUESTION | Field Format | DEFINITION/DECISION RULES |
|---|------|----------|--------------|---------------------------|
| 20 | cogimp | Is there documentation in the medical record that indicates the patient was cognitively impaired during the entire hospitalization?<br>1. Yes<br>2. No | *1, 2<br>**\*If 1, go to end** | **Cognition refers to mental activities associated with thinking, learning, and memory.**<br>**Cognitive impairment for the purposes of the tobacco and substance use measures, is related to documentation that the patient cannot be screened for tobacco and alcohol use due to the impairment (e.g., comatose, obtunded, confused, memory loss) during the entire hospitalization.**<br><br>• Cognitive impairment must be documented at all times during the hospitalization in order to answer "Yes".<br>• If there is documentation in the medical record that a patient is cognitively impaired, and there is no additional documentation that the patient's mental status was normal at any other time during the hospitalization, i.e., alert and oriented, the abstractor can select value "Yes".<br><br>**Include:** Altered mental status, altered level of consciousness (LOC), cognitive impairment, cognitively impaired, confused, memory loss, mentally retarded, obtunded<br>**Exclude:** Temporary cognitive impairment due to acute substance use (e.g., overdose or acute intoxication) |
| 21 | tobstatus2 | What is the patient's tobacco use status documented within the first three days of admission? | 1, 2, 3, 98, 99<br>If 3, 98, or 99, go to | The tobacco use status screening timeframe must have occurred within the first three days of admission. The day after admission is defined as the first day. |

| # | Name | QUESTION | Field Format | DEFINITION/DECISION RULES |
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| | | 1. The patient has smoked cigarettes daily on average in a volume of five or more cigarettes (>= 1/4 pack) per day AND/OR cigars daily AND/OR pipes daily during the past 30 days<br>2. The patient has smoked cigarettes daily on average in a volume of four or less cigarettes (< 1/4 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<br>3. The patient has not used any forms of tobacco in the past 30 days<br>98. The patient refused the tobacco use screen<br>99. The patient was not screened for tobacco use within the first three days of admission or unable to determine the patient's tobacco use status from medical record documentation | auditc | • If there is definitive documentation that the patient either currently uses tobacco products or is an ex-user that quit less than 30 days prior to arrival, select the appropriate allowable value for the type of product used, **regardless of whether or not there is conflicting documentation.**<br>• 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.<br>• 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".<br>• 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").<br>• 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.<br>• 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.<br>• 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.<br><br>**Include:** Smokeless tobacco, Chewing (spit) tobacco, Twist, Redman, Moist snuff, Dry snuff, Plug tobacco, snus<br>**Exclude:** Illegal drug use only (e.g., marijuana), E-cigarettes, hookah pipe<br>Suggested data sources: ED record, history and physical, nursing admission assessment, nursing admission notes, physician progress notes, respiratory therapy notes |

| # | Name | QUESTION | Field Format | DEFINITION/DECISION RULES |
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| 22 | tobtxcoun | Did the patient receive practical counseling that included all of the following components within the first three days of hospital admission?<br><br>• Recognizing danger situations<br>• Developing coping skills<br>• Providing basic information about quitting<br><br>1. Yes<br>2. No<br>98. Patient refused/declined practical counseling within the first three days of hospital admission | 1, 2, 98 | **The timeframe for receiving practical counseling must have occurred within the first three days of admission. The day after admission is defined as the first day.**<br><br>• **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.**<br>• Danger situations (potential triggers) 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.).<br>• Developing coping skills may include but is not limited to: advise on identifying triggers for tobacco use and plan or strategies for how to handle.<br>• Providing basic information about quitting may include but is not limited to: setting a quit date, removing all tobacco products from the home, supportive message about how quitting smoking will improve patient's health.<br>• If there is no documentation that practical counseling was given to the patient, select value 2.<br>• 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.<br><br>Suggested data sources: Respiratory therapy notes, nursing notes, progress notes |
| | | **IF TOBSTATUS2 = 1, go to TOBTXMED; else go to REFOPTOB** | | |

| # | Name | QUESTION | Field Format | DEFINITION/DECISION RULES |
|---|------|----------|--------------|---------------------------|
| 23 | tobtxmed | Did the patient receive one of the FDA-approved tobacco cessation medications within the first three days of hospital admission?<br>1. Yes<br>2. No<br>98. Patient refused FDA-approved tobacco cessation medications within the first three days of hospital admission | 1, 2, 98<br>If 1 or 98, go to refoptob | The timeframe for receiving FDA-approved tobacco cessation medications must have occurred within the first three days of admission.  The day after admission is defined as the first day.<br>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).<br>**Inclusion Guidelines for Abstraction:**<br>Refer to Appendix C, Table 9.1 for the list of FDA-approved tobacco cessation medications<br>Suggested Data Sources: Physician orders, Medication administration record (MAR) |
| 24 | notobmed | Is there documentation of a reason for not administering one of the FDA-approved tobacco cessation medications within the first three days of admission?<br><br>• Allergy to all of the FDA-approved tobacco cessation medications.<br>• Drug interaction (for all of the FDA-approved medications) with other drugs the patient is currently taking.<br>• Other reasons documented by physician/APN/PA or pharmacist.<br><br>1. Yes<br>2. No | 1, 2 | The timeframe for documenting a reason for not administering FDA-approved tobacco cessation medications must have occurred within the first three days of admission.  The day after admission is defined as the first day.<br><br>• Reasons for not administering FDA-approved tobacco cessation medications must be documented by a physician/APN/PA or pharmacist.<br>• 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.<br>• 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.<br>• When conflicting information is documented in the medical record, select the appropriate value for the indicated reasons present for not administering the tobacco cessation medications.<br><br>**Exclude:**  Medication allergy using a negative modifier or qualifier (questionable, risk of, suspect, etc.)<br>Suggested data sources:  ED record, history and physical, progress notes, physician orders, discharge summary, medication administration record |

| # | Name | QUESTION | Field Format | DEFINITION/DECISION RULES |
|---|------|----------|--------------|---------------------------|
| 25 | refoptob | Did the patient receive a referral for Outpatient Tobacco Cessation Counseling? <br> 1. The referral to outpatient tobacco cessation counseling treatment was made by the healthcare provider prior to discharge. <br> 2. Referral information was given to the patient at discharge but the appointment was not made by the provider/facility prior to discharge. <br> 4. The referral for outpatient tobacco cessation counseling treatment was not offered because the patient's residence is not in the USA. <br> 98. Patient refused the referral for outpatient tobacco cessation counseling treatment and the referral was not made. <br> 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 <br><br> If 98, or 99 and tobstatus2 = 1, auto-fill tobdcoun as 2 <br><br> If 4 and tobstatus2 = 1, auto-fill tobdcoun as 2 and tobmedc as 3 <br><br> If tobstatus2 = 2, go to auditc | • If a referral is made to a Quitline, defined as a telephone counseling in which at least some of the contact is initiated by the Quitline counselor to deliver tobacco use interventions, select value "1". This includes VA Quitline, 1-855-QUIT-VET. <br> • 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 (collect information from the tobacco user and use 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 value "2". <br> • 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". <br> • Select value "99" if it cannot be determined if a referral for outpatient cessation counseling was made or if it is unclear if the absence of the referral was due to a patient refusal or it simply was not offered. <br><br> **Include:** group counseling, individual counseling, VA Smoking Cessation Quitline (1-855-QUIT-VET), facility smoking cessation clinic, E-health, internet structured programs <br> **Exclude:** Self-help interventions (brochures, videotapes, audiotapes) <br> Suggested data sources: Discharge summary, transfer sheet, discharge instruction sheet, nursing discharge notes, physician order sheet |

| # | Name | QUESTION | Field Format | DEFINITION/DECISION RULES |
|---|------|----------|--------------|---------------------------|
| 26 | tobmedc | Was an FDA-approved tobacco cessation medication prescribed at discharge?<br>1. A prescription for an FDA-approved tobacco cessation medication was given to the patient at discharge.<br>3. A prescription for an FDA-approved tobacco cessation medication was not offered because the patient's residence is not in the USA.<br>98. A prescription for an FDA-approved tobacco cessation medication was offered at discharge and the patient refused.<br>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<br>Will be auto-filled as 3 if refoptob = 4<br>If 1, 3, or 98, go to auditc; else go to notobrxdc<br>If 3, 98, or 99, auto-fill tobdcmed = 2 | • 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). All discharge medication documentation available in the chart should be reviewed and taken into account by the abstractor.<br>• In cases where tobacco cessation medication is in one source that 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 (tobacco cessation medication) was not prescribed at discharge.<br>• 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.<br>• 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, documentation raises enough questions, the case should be deemed unable to determine, select value "99".<br><br>Suggested data sources:  Discharge summary, transfer sheet, discharge instruction sheet, nursing discharge notes, physician order sheet |

| # | Name | QUESTION | Field Format | DEFINITION/DECISION RULES |
|---|------|----------|--------------|---------------------------|
| 27 | notobrxdc | Is there documentation of a reason for not administering one of the FDA-approved tobacco cessation medications at discharge?<br><br>• Allergy to all of the FDA-approved tobacco cessation medications.<br>• Drug interaction (for all of the FDA-approved medications) with other drugs the patient is currently taking.<br>• Other reasons documented by physician/APN/PA or pharmacist.<br><br>1. Yes<br>2. No | 1, 2 | • Reasons for not administering FDA-approved tobacco cessation medications must be documented by a physician/APN/PA or pharmacist.<br>• 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.<br>• 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.<br>• When conflicting information is documented in the medical record, select the appropriate value for the indicated reasons present for not administering the tobacco cessation medications.<br><br>**Exclude:** Medication allergy using a negative modifier or qualifier (questionable, risk of, suspect, etc.)<br>Suggested data sources: ED record, history and physical, progress notes, physician orders, discharge summary, medication administration record |
| | | **Substance Use** | | |
| 28 | auditc | Was the patient screened for alcohol misuse with the AUDIT-C within the first 3 days of admission?<br>1. Yes<br>2. No<br>98. Patient refused screening for alcohol misuse during the first 3 days of admission | 1, 2, 98<br>**If 2 or 98, go to sudisord as applicable** | **The day after admission is defined as the first day.**<br>**Alcohol screen completed after acute care arrival (e.g., in the ED) is acceptable.**<br>**Screening for alcohol misuse = the patient was screened within the first 3 days of admission using AUDIT-C questions OR AUDIT-C question #1 alone if answer was "never" (audc1=0).**<br>AUDIT-C:<br>Question #1 = "How often did you have a drink containing alcohol in the past year?"<br>Question #2 = "How many drinks containing alcohol did you have on a typical day when you were drinking in the past year?"<br>Question #3 = "How often did you have six or more drinks on one occasion in the past year?"<br>If AUDIT-C question #1 is answered "never", AUDIT-C questions 2 and 3 are not applicable. |

| # | Name | QUESTION | Field Format | DEFINITION/DECISION RULES |
|---|------|----------|--------------|---------------------------|
| 29 | dtalscrn | Enter the date of screening for alcohol misuse with the AUDIT-C within the first 3 days of admission. | mm/dd/yyyy<br><br>>= arrvdate and <= 3 days after admdt | Enter the exact date. The use of 01 to indicate missing month or day is not acceptable. |
| 30 | audc1 | Enter the score documented for AUDIT-C Question #1 within the first 3 days of admission.<br> "How often did you have a drink containing alcohol in the past year?<br>0. Never<br>1. Monthly or less<br>2. Two to four times a month<br>3. Two to three times a week<br>4. Four or more times a week<br>99.  Not documented | 0, 1, 2, 3, 4, 99<br>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:<br>Never --> 0<br>Monthly or less -->1<br>Two to four times a month --> 2<br>Two to three times a week --> 3<br>Four or more times a week --> 4<br>Not documented --> 99<br>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. |
| 31 | audc2 | Enter the score documented for AUDIT-C Question #2 within the first 3 days of admission.<br>"How many drinks containing alcohol did you have on a typical day when you were drinking in the past year?"<br>0. 0, 1 or 2 drinks<br>1. 3 or 4<br>2. 5 or 6<br>3. 7 to 9<br>4. 10 or more<br>95.  Not applicable<br>99.  Not documented | 0, 1, 2, 3, 4, 95, 99<br>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:<br>0 drinks --> 0<br>1 or 2 drinks --> 0<br>3 or 4 drinks --> 1<br>5 or 6 drinks --> 2<br>7 to 9 drinks --> 3<br>10 or more drinks --> 4<br>Not documented --> 99<br>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. |

| # | Name | QUESTION | Field Format | DEFINITION/DECISION RULES |
|---|------|----------|--------------|---------------------------|
| 32 | audc3 | Enter the score documented for AUDIT-C Question #3 within the first 3 days of admission.<br> "How often did you have six or more drinks on one occasion in the past year?"<br>0. Never<br>1. Less than monthly<br>2. Monthly<br>3. Weekly<br>4. Daily or almost daily<br>95. Not applicable<br>99. Not documented | 0, 1, 2, 3, 4, 95, 99<br>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:<br>Never --> 0<br>Less than monthly --> 1<br>Monthly --> 2<br>Weekly --> 3<br>Daily or almost daily --> 4<br>Not documented --> 99<br>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. |
| 33 | alcscor | Enter the total AUDIT-C score documented within the first 3 days of admission. | __ __<br>Abstractor may enter default zz if the total score of the AUDIT-C is not documented in the record<br>**If alcscor >= 5, go to briefint; else go to sudisord as applicable**<br>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.<br>If the total score is not documented in the record, enter default zz. |

| # | Name | QUESTION | Field Format | DEFINITION/DECISION RULES |
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| 34 | briefint1 briefint2 briefint3 briefint98 briefint99 | Following the positive screening result for alcohol use, did the patient receive a brief intervention including any of the following components prior to discharge? **Indicate all that apply:** 1. Feedback concerning the quantity and frequency of alcohol consumed by the patient in comparison with national norms 2. A discussion of negative physical, emotional, and occupational consequences 3. A discussion of the overall severity of the problem. 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, 2, 3, 98, 99 Cannot enter 98 or 99 with any other value | **A brief intervention is defined as a single interaction between the qualified healthcare professional and the patient following a positive screening result for unhealthy alcohol use or alcohol use disorder.** <br><br> • A qualified healthcare professional may be defined as a physician, nurse, addictions counselor, psychologist, social worker, or health educator with training in brief intervention. <br> • 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. <br> • The components of the intervention include feedback concerning the quantity and frequency of alcohol consumed by the patient in comparison with national norms; a discussion of negative physical, emotional, and occupational consequences; and a discussion of the overall severity of the problem. <br> • 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. Brief intervention corresponds directly with the 5 A's (Ask, Advise, Assess, Assist, Arrange) recommended for alcohol dependence. <br> • If there is no documentation that a brief intervention was given to the patient, select value 99. <br> • 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 = 2, 3, 4, 5, 6, or 7, go to end.** **If dcdispo = 1 or 99 AND (ICD-9 princode or othrdx is on JC Table 13.1 or 13.2) OR (ICD-9 prinpx or othrpx is on JC Table 13.3), go to addtxref; else go to sudisord** | | |

| # | Name | QUESTION | Field Format | DEFINITION/DECISION RULES |
|---|------|----------|--------------|---------------------------|
| 35 | sudisord | Is there documentation in the medical record that the patient has an alcohol or drug use disorder?<br>1. Yes<br>2. No | 1, 2<br><br>If 1, go to addtxref<br>If 2, go to folosub as applicable | The abstractor should not try to determine if alcohol or drug abuse exists from documentation of symptoms. The health care provider must document explicitly that the patient has an alcohol or drug use disorder.<br>For example, if documentation in the record indicates the patient has drink-seeking or drug seeking behavior or alcohol or drug tolerance, but does not specifically use the terminology "alcohol (or drug) disorder or dependent" or "suspect alcohol dependence", select "2".<br>If the specific terms utilized in the inclusion notes below are used, select "1".<br>If an ICD-9-CM code for alcohol or drug disorder or dependence is documented, select "1".<br>**Inclusion Guidelines for Abstraction:**<br><br>• Alcohol or Drug dependent/dependence (may be described as appears to have, consider, consistent with (C/W), diagnostic of, evidence of , indicative of , likely, most likely, probable , representative of )<br>• Admission for Detoxification<br>• Delirium Tremens (DTs)<br>• Withdrawal syndrome<br><br>See Appendix A code Table 13.1 for ICD-9-CM codes for Alcohol Disorders, and Table 13.2 for ICD-9-CM codes for Drug Use Disorders<br>See Appendix A procedure code table 13.3 for procedures that would be administered to patients with alcohol or drug use disorders<br>**Exclusion Guidelines for Abstraction:**<br><br>• History of dependence<br><br>Refer to Appendix H Table 2.6 for Qualifiers and Modifiers Specifications |

| # | Name | QUESTION | Field Format | DEFINITION/DECISION RULES |
|---|------|----------|--------------|---------------------------|
| 36 | addtxref | Was a referral for addictions treatment made for the patient prior to discharge?<br>1. The referral to addictions treatment was made by the healthcare provider prior to discharge.<br>2. Referral information was given to the patient at discharge but the appointment was not made by the provider prior to discharge.<br>4. The referral for addictions treatment was not offered because the patient's residence is not in the USA.<br>98. The patient refused the referral for addictions treatment and the referral was not made.<br>99. The referral for addictions treatment was not offered at discharge or unable to determine from the medical record documentation. | *1, 2, *4, 98, 99<br>*If 1, go to folosub as applicable<br>If 4, 98, or 99, auto-fill sudcoun as 3<br>*If 4, auto-fill sudmedc as 3, and go to folosub as applicable | **In order to answer "1" there must be documentation that a referral was made at discharge for addictions treatment by a physician or non-physician (such as nurse, psychologist, or counselor).**<br><br>• A referral may be defined as an appointment made by the provider either through telephone contact, fax or e-mail.<br>• 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.<br>• A referral to Alcoholics Anonymous (AA) or similar mutual support groups does not meet the intent of the measure, select value "98" if such a referral is given to the patient.<br><br>**Inclusion Guidelines for Abstraction:** Group counseling, Individual counseling, Personal physician, Psychiatrist Psychologist, Addictions counselor, Social worker<br>**Exclusion Guidelines for Abstraction:**<br><br>• Self-help interventions (brochures, videotapes, audiotapes, reactive hotlines/help lines)<br>• Support groups that are not considered treatment such as Alcoholics Anonymous (AA) |

| # | Name | QUESTION | Field Format | DEFINITION/DECISION RULES |
|---|------|----------|--------------|---------------------------|
| 37 | sudmedc | Was one of the FDA-approved medications for alcohol or drug disorder prescribed at discharge?<br>1. A prescription for an FDA-approved medication for alcohol or drug disorder was given to the patient at discharge.<br>3. A prescription for an FDA-approved medication for alcohol or drug disorder was not offered at discharge because the patient's residence is not in the USA.<br>98. A prescription for an FDA-approved medication for alcohol or drug disorder was offered at discharge and the patient refused.<br>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<br>Will be auto-filled as 3 if addtxref = 4<br>If 3, 98, or 99, auto-fill sudcmed as 3 | • 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.<br>• 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.<br>• 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".<br><br>**Inclusion Guidelines for Abstraction:**<br>Refer to Appendix C, Table 9.2 for a comprehensive list of FDA-approved medications for alcohol and drug dependence<br>Suggested data sources:  Discharge summary, transfer sheet, discharge instruction sheet, nursing discharge notes, physician order sheet |
| | | **If (princode or othrcode = ICD-9 code on JC Appendix A, Tables 13.1 or 13.2) OR (prinpx or othrpx = ICD-9 code on JC Table 13.3) OR (sudisord = 1), go to folosub**<br>**If tobstatus2 = 1 or 2, go to folotob; else go to end.** | | |
| | | **Follow-up** | | |

| # | Name | QUESTION | Field Format | DEFINITION/DECISION RULES |
|---|------|----------|--------------|---------------------------|
| 38 | folosub | Was contact made with the patient relative to their alcohol or other drug use status between 7 and 30 days post discharge? 1. A follow-up contact was made between 7 and within 30 days post discharge relative to the patient's alcohol or other drug use status. 2. A follow-up contact was made, but not between 7 and 30 days post discharge 3. A follow-up contact was not made between 7 and 30 days post discharge because the patient's residence is not in the USA, the patient was incarcerated, contact number was no longer valid, the patient had no phone, or the patient was re-admitted to the hospital within 30 days post discharge, or at least 3 unsuccessful attempts to contact the patient were documented. 99. A follow-up contact relative to the patient's alcohol or other drug use status was not made or unable to determine from medical record documentation. | 1, 2, 3, 99 If 1, go to folosubdt If 2, 3, or 99 and tobstatus2 = 1 or 2, go to folotob; else go to end | • **If follow-up contact is being made for a patient who screened positive for alcohol use or who was found to be alcohol or drug dependent, the contact must be made for the purpose of gaining information about their alcohol or drug use status post discharge. Contact with the patient may be made by a variety of methods including phone calls, discussion at follow-up clinic visits, or mail.** <br>• If information relative to alcohol or other drug use status was obtained in person at the time of a clinic visit between 7 and 30 days post discharge, select value 1. <br>• If follow-up contact was made and contact was made with a family member or other person who answered the questions on the behalf of the patient, select value 1. <br>• If there is documentation at discharge that the patient is homeless, answer 3. <br>• If there is documentation the patient died within 30 days post discharge, select value 3. <br>• If trying to contact the patient by phone or mail and a return is received indicating the contact information is no longer valid, select value 3. <br>• If at least 3 attempts to contact the patient were made but were unsuccessful, select value 3. If less than 3 unsuccessful attempts were made, select value 99. <br>• If the patient is readmitted following the initial hospitalization, select value 3 if the hospitalization continued into the specified time frame for follow-up. <br>• If a follow-up contact was not made during the specified timeframe, select value 99. <br>• If follow-up contact is made by letter or e-mail and no response is received from patient within 30 days post discharge, select value 99. <br><br>Suggested data sources: Medical record documentation dated within the follow-up timeframe |

| # | Name | QUESTION | Field Format | DEFINITION/DECISION RULES |
|---|------|----------|--------------|---------------------------|
| 39 | folosubdt | Enter the date the follow-up contact was made with the patient to assess substance use post discharge. | mm/dd/yyyy<br><br>>= 7 days and <= 30 days after dcdt | • If multiple contacts are made with the patient post discharge, select the date of the latest contact where information is received relative to substance use status.<br>• If contact is made through e-mail or letter, select the date of receipt of the patient's alcohol or drug use post discharge status, not the date the e-mail or letter was sent. |
| 40 | sudcoun | Is the patient with an alcohol or drug disorder or addiction attending the referred addictions counseling post discharge?<br>1. The patient was referred and is attending the referred addictions treatment.<br>2. The patient was referred and patient is not attending addictions treatment.<br>3. The patient was NOT referred to addictions treatment.<br>98. Patient refused to provide information relative to post discharge counseling attendance.<br>99. Not documented or unable to determine from follow-up information collected. | 1, 2, 3, 98, 99<br>Will be auto-filled as 3 if addtxref = 4, 98, or 99<br>Cannot enter 3 if addtxref = 1 or 2 | **This data element is used to determine if the patient with an alcohol or drug disorder or addiction is attending the referred addictions counseling. 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.**<br>Follow-up contact to determine post-discharge status can be made with the patient anytime between the 7 and 30 day time frame specified by the measure.<br>If the first counseling session has not occurred at the time of the post discharge follow-up, and the patient intends to attend, select value 1.<br>The counseling, medication, and use status information must relate to the follow-up contact date selected by the abstractor.<br>If follow-up contact is made with the patient but no post discharge substance use status information is collected, select value 99.<br>Suggested data sources:  Medical record documentation dated within the follow-up timeframe |

| # | Name | QUESTION | Field Format | DEFINITION/DECISION RULES |
|---|------|----------|--------------|---------------------------|
| 41 | sudcmed | Is the patient with an alcohol or drug disorder or addiction taking the prescribed medication post discharge?<br>1. The patient was given a prescription and is taking medication post discharge for an alcohol or drug use disorder as prescribed.<br>2. The patient was given a prescription and is not taking medication post discharge for an alcohol or drug use disorder as prescribed.<br>3. The patient was NOT given a prescription for medication to treat an alcohol or drug use disorder.<br>98. Patient refused to provide information relative to post discharge medication use.<br>99. Not documented or unable to determine from follow-up information collected. | 1, 2, 3, 98, 99<br>Will be auto-filled as 3 if sudmedc = 3, 98, or 99<br><br>Cannot enter 3 if sudmedc = 1 | **This data element is used to determine if the patient with an alcohol or drug disorder or addiction is taking the prescribed medication post discharge.**<br>**Follow-up contact to determine post discharge substance use status can be made anytime between the 7 and 30 day timeframe specified by the measure.**<br>If the patient is contacted more than once during the 7 to 30 day time frame post discharge, select the value that corresponds to the compliance with medication use status obtained at the latest point in time.<br>The counseling, medication, and use status information must relate to the follow-up contact date selected by the abstractor.<br>If follow-up contact is made with the patient but no post discharge substance use status information is collected, select value 99.<br>Suggested data sources: Medical record documentation dated within the follow-up timeframe |

| # | Name | QUESTION | Field Format | DEFINITION/DECISION RULES |
|---|------|----------|--------------|---------------------------|
| 42 | alcdcquit | What is the status of the patient's alcohol use at the time of the post discharge follow-up contact?<br>1. The patient has quit or reduced their alcohol intake.<br>2. The patient has not quit or reduced their alcohol intake.<br>3. Not applicable, the patient does not use or does not have unhealthy alcohol use.<br>98. The patient refused to provide information relative to alcohol use status at the follow up contact.<br>99. Not documented or unable to determine from follow-up information collected. | 1, 2, 3, 98, 99<br><br>Cannot enter 3 if alcscor >= 5 or (princode or othrcode = code on JC table 13.1) or (prinpx or othrpx = 94.61, 94.62, 94.63, 94.67, 94.68, or 94.69 on JC table 13.3) | • **This data element is used to determine the alcohol use status post discharge for patients with unhealthy alcohol use or an alcohol disorder or addiction.**<br>• **Follow-up contact with the patient to determine post discharge status can be made anytime between the 7 and 30 day timeframe specified by the measure.**<br>• **Quit is defined as not using alcohol in the 7 day timeframe prior to the follow-up contact date.**<br>• The counseling, medication, and use status information must relate to the follow-up contact date selected by the abstractor.<br>• If alcohol use is not the substance of interest for follow up (i.e., no documentation that the patient has unhealthy alcohol use, alcohol disorder, or alcohol addiction), select value 3.<br>• If the patient refuses to give alcohol use status information when contacted post discharge, select value 98.<br>• Select value 99 if the patient was contacted post discharge and the patient was not questioned regarding their alcohol use post discharge.<br><br>Suggested data sources: Medical record documentation dated within the follow-up timeframe |

| # | Name | QUESTION | Field Format | DEFINITION/DECISION RULES |
|---|------|----------|--------------|---------------------------|
| 43 | sudcquit | What is the status of the patient's drug use at the time of the post discharge follow-up contact?<br>1. The patient has quit using drugs.<br>2. The patient has not quit using drugs.<br>3. Not applicable, the patient does not use drugs.<br>98. The patient refused to provide information relative to drug use status at the follow up contact.<br>99. Not documented or unable to determine from follow-up information collected. | 1, 2, 3, 98, 99<br>If tobstatus2 = 1 or 2, go to folotob; else go to end<br><br>Cannot enter 3 if alcdcquit = 3 or (princode or othrcode = code on JC table 13.2) or (prinpx or othrpx = 94.64, 94.65, 94.66, 94.67, 94.68, or 94.69 on JC table 13.3) | • **This data element is used to determine the drug use status post discharge for patients identified with a drug disorder or addiction.**<br>• **Follow-up contact with the patient to determine post discharge status can be made anytime between the 7 and 30 day timeframe specified by the measure.**<br>• Quit is defined as not using drugs in the 7 day timeframe prior to the follow-up contact date.<br>• The counseling, medication, and use status information must relate to the follow-up contact date selected by the abstractor.<br>• If the patient was not identified during the hospital stay as having a drug disorder or addiction and drug use is not the substance of interest for follow up, select value 3.<br>• If the patient refuses to give drug use status information when contacted post discharge, select value 98.<br>• Select value 99 if the patient was contacted post discharge and the patient was not questioned regarding their drug use post discharge.<br><br>Suggested data sources: Medical record documentation dated within the follow-up timeframe |

| # | Name | QUESTION | Field Format | DEFINITION/DECISION RULES |
|---|------|----------|--------------|---------------------------|
| 44 | folotob | Was contact made with the patient relative to tobacco use status between 15 and 30 days post discharge?<br>1. A follow-up contact was made between 15 and 30 days post discharge relative to the patient's tobacco use status.<br>2. A follow-up contact relative to the patient's tobacco use status was made, but not between 15 and 30 days post discharge<br>3. A follow-up contact was not made within 30 days post discharge because the patient's residence is not in the USA, the patient was incarcerated, contact number was no longer valid, the patient had no phone, or the patient was re-admitted to the hospital within 30 days post discharge, or at least 3 unsuccessful attempts to contact the patient were documented.<br>99. A follow-up contact relative to the patient's tobacco use status was not made post discharge or unable to determine from medical record documentation. | 1, 2, 3, 99<br>If 2, 3, or 99, go to end | • **Contact is made with the discharged patient within a specified time frame for the purpose of gaining information about the patients post discharge tobacco use status. Contact with the patient may be made using a variety of methods including phone calls, discussion at follow-up clinic visits, or mail.**<br>• If information relative to tobacco use status was obtained in person at the time of a clinic visit between 15 to 30 days post discharge, select value 1.<br>• If follow-up contact was made and contact was made with a family member or other person who answered the questions on the behalf of the patient, select value 1.<br>• If there is documentation at discharge that the patient is homeless, answer 3.<br>• If there is documentation the patient died within 30 days post discharge, select value 3.<br>• If trying to contact the patient by phone or mail and a return is received indicating the contact information is no longer valid, select value 3.<br>• If at least 3 attempts to contact the patient were made but were unsuccessful, select value 3. If less than 3 unsuccessful attempts were made select value 99.<br>• If the patient is readmitted following the initial hospitalization, select value 3 if the hospitalization continued into the specified time frame for follow-up.<br>• If a follow-up contact relative to the patient's tobacco use status was not made and none of the other options apply, select value 99.<br>• If follow-up contact is made by letter or e-mail and no response is received from patient within 30 days post discharge, select value 99.<br><br>Suggested data sources: Medical record documentation dated within the follow-up timeframe |
| 45 | folotobdt | Enter the date the follow-up contact was made with the patient to assess tobacco use post discharge. | mm/dd/yyyy<br><br>>= 15 days and<br><= 30 days after dcdt | • If multiple contacts are made with the patient post discharge, select the date of the latest contact where progress with tobacco use was addressed.<br>• If contact is made through e-mail or letter, select the date of receipt of the patient's tobacco use post discharge status, not the date the e-mail or letter was sent. |

| # | Name | QUESTION | Field Format | DEFINITION/DECISION RULES |
|---|------|----------|--------------|---------------------------|
| 46 | tobdcoun | Is the patient attending (receiving) outpatient tobacco cessation counseling post discharge?<br>1. The patient is attending outpatient tobacco cessation counseling post discharge.<br>2. The patient is not attending outpatient tobacco cessation counseling post discharge.<br>98. Patient refused to provide information relative to post discharge counseling attendance.<br>99. Not documented or unable to determine from follow-up information. | 1, 2, 98, 99<br>Will be auto-filled as 2 if refoptob = 4, 98, or 99 | **Counseling can include any of the following: telephone-based counseling (e.g., VA Quitline), in-person counseling, and/or group counseling.**<br>If the first counseling session has not occurred at the time of the post discharge follow-up contact and the patient intends to attend the scheduled appointment, select value 1.<br>If follow-up contact is made with the patient but no post discharge tobacco use status information is collected, select value 99.<br>The counseling, medication and use status information must relate to the follow up contact date selected by the abstractor.<br>Suggested data sources: Medical Record documentation dated within the follow-up timeframe |
| 47 | tobdcmed | Is the patient taking the recommend tobacco cessation medication post discharge?<br>1. The patient is taking the recommended tobacco cessation medication post discharge.<br>2. The patient is not taking the recommended tobacco cessation medication post discharge.<br>98. Patient refused to provide information relative to tobacco cessation medication use post discharge.<br>99. Not documented or unable to determine from follow-up information. | 1, 2, 98, 99<br><br>Will be auto-filled as 2 if tobmedc = 3, 98, or 99 | If the patient is taking an over the counter tobacco cessation product not requiring a prescription, select value 1.<br>If the patient is not taking tobacco cessation medication because a prescription for the medication was not given to the patient prior to discharge, select value 2.<br>If an over the counter tobacco cessation medication was listed on the discharge medication list and the patient is not taking the medication, select value 2.<br>The counseling, medication and use status information must relate to the follow up contact date selected by the abstractor.<br>Suggested data sources: Medical Record documentation dated within the follow-up timeframe |
| 48 | tobdcquit | Has the patient quit using tobacco products post discharge?<br>1. The patient has quit using tobacco products post discharge<br>2. The patient has not quit using tobacco products post discharge.<br>98. Patient refused to provide information relative to tobacco use status at the follow-up contact.<br>99. Not documented or unable to determine from follow-up information collected. | 1, 2, 98, 99 | If the patient has not used any tobacco products in the past 7 days prior to the time of follow-up contact, select value 1.<br>If the patient has reduced the amount of tobacco products used but has not quit using, select value 2.<br>If the patient has initiated a quit attempt but has been tobacco free for less than 7 days prior to the follow-up contact, select value 2.<br>The counseling, medication and use status information must relate to the follow up contact date selected by the abstractor.<br>Suggested data sources: Medical Record documentation dated within the follow-up timeframe |