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|   |  | **Organizational Identifiers** |  |  |
|  | VAMCCONTROLQICBEGDTEREVDTE | Facility IDControl NumberAbstractor IDAbstraction Begin DateAbstraction End Date | Pre-fillQI pre-fillAuto-fillAuto-fillAuto-fill |  |
|  |  | Patient Identifiers |  |  |
|  | SSNFINPTNAMEFPTNAMELBIRTHDTSEXRACEETHNICITYCOHORTAGE | Patient SSNFINFirst NameLast NameBirth DateSex RaceEthnicityCohortAge | Pre-fill: no changePre-fill: no changePre-fill: no changePre-fill: no changePre -fill: no changePre -fill: **can change**Pre-fill: no changePre-fill: no changePre-fill: no change**Calculate age at ADMDT** |  |
| 1 | arrvdate | Enter the **earliest** documented date the patient arrived at acute care at this VAMC. | mm/dd/yyyyAbstractor may enter 99/99/9999 if arrival date is unable to be determined

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| <= 6 months prior to or = admdt and < = dcdt |

 | **Arrival date is the EARLIEST recorded date on which the patient arrived in the hospital’s acute care setting.** Acute care setting includes:* **Emergency Department**
* **Direct admission to cath lab, endoscopy or surgery**
* **Direct admission to observation**
* **Direct admission to a nursing floor**

**ONLY ACCEPTABLE SOURCES:** \*Emergency Department record; nursing unit admission assessment/admitting note; observation record; procedure notes (such as cardiac cath, endoscopies, surgical procedures) * **Review the ONLY ACCEPTABLE SOURCES to determine the earliest date the patient arrived in the acute care setting.**
* **Exclude: Pre-Arrival Orders**

Suggested Priority sources for patients who arrive in the ED:1. ED Registration Date (found in Past Clinic Visits/CVP)
2. ED Progress Note - Triage Date, Arrival Date
3. ED Vital Signs, ECG date, Physician orders

**Cont’d next page****Arrival Date cont’d****Suggested Priority sources for Non-ED Arrivals such as Direct Admit to inpatient unit or observation:**1. Nurse’s Admission Note/admission assessment
2. EADT Date

Other Arrivals (transfers from other ED or hospital inpatient/ outpatient OR Direct Admit for procedure, e.g. cath lab)1. If transferred from an ED or hospital within your hospital’s system and there is one medical record for the care provided at both facilities, use the arrival date at the first facility.
2. Use EARLIEST arrival date for procedure, e.g., cath lab, endoscopy, surgery

**Additional Guidelines for Abstraction*** Arrival date may differ from admission date. The intent is to utilize any documentation which reflects processes that occurred after arrival at the ED or after arrival to the nursing floor/observation/cath lab as a direct admit
* If the earliest date documented appears to be an obvious error, this date should not be abstracted.

Example: ED MAR has a med documented as 1430 on 11-03-20xx. All other dates in ED record are 12-03-20xx. The 11-03-20xx would not be used because it appears to be an obvious error.* \*The ED Record may include ED Face/Cover Sheet, Registration/sign-in forms, triage record, Consent/Authorization for treatment forms, vital sign record, physician orders, ECG reports, telemetry/rhythm strips, laboratory reports, x-ray reports, head CT scan, CTA, MRI, MRA reports

**If arrival date is unable to be determined from any of the ONLY ACCEPTABLE SOURCES, enter 99/99/9999.** |

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| 2 | arrvtime | Enter the **earliest** documented time the patient arrived at acute care at this VAMC. | \_\_\_\_\_UMT**If unable to find the time of arrival, the abstractor can enter 99:99**

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| < = 6 months prior to or = admdt and < dcdt |
| Warning if > 72 hours prior to admdt |

 | **Arrival time is the EARLIEST recorded time the patient arrived in this hospital’s acute care setting. Acute care setting includes:*** **Emergency Department**
* **Direct admission to cath lab, endoscopy or surgery**
* **Direct admission to observation**
* **Direct admission to a nursing floor**

**ONLY ACCEPTABLE SOURCES:** \*Emergency Department record; nursing unit admission assessment/admitting note; observation record; procedure notes (such as cardiac cath, endoscopies, surgical procedures) **Review the ONLY ACCEPTABLE SOURCES to determine the EARLIEST time the patient arrived in the acute care setting.** * **Exclude: Pre-Arrival Orders**

Suggested Priority sources for patients who arrive in the ED:1. ED Registration Time (found in Past Clinic Visits/CVP)
2. ED Progress Note - Triage Time, Arrival Time
3. ED Vital Signs, ECG time, Physician orders

Suggested Priority sources for Non-ED Arrivals such as Direct Admit to inpatient unit or observation:1. Nurse’s Admission Note/admission assessment
2. EADT Time

Other Arrivals (transfers from other ED or hospital inpatient/ outpatient OR Direct Admit for procedure, e.g. cath lab)1. If transferred from an ED or hospital within your hospital’s system and there is one medical record for care at both facilities use EARLIEST arrival time at the first facility.
2. Use EARLIEST arrival time for procedure, e.g. cath lab, endoscopy, surgery

**Additional Guidelines for abstraction:*** Arrival time may differ from admission time. The intent is to utilize any documentation which reflects processes that occurred after arrival at the ED or after arrival to the nursing floor/observation/cath lab as a direct admit.

**Cont’d next page** |
|  |  |  |  | **Arrival Time cont’d*** If the earliest time documented appears to be an obvious error, this time should not be abstracted.

Example: ED face sheet lists arrival time 1320. ED registration 1325. ED triage 1330. ED consent to treat form has 1:17 with “AM” circled. ED record documentation suggests the 1:17 AM is an obvious error. Enter 1320 for Arrival Time. * \*The ED Record may include ED Face/Cover Sheet, Registration/sign-in forms, triage record, Consent/Authorization for treatment forms, vital sign record, , physician orders, ECG reports, telemetry/rhythm strips, laboratory reports, x-ray reports, head CT scan, CTA, MRI, MRA reports
* **If arrival time is unable to be determined from any of the ONLY ACCEPTABLE SOURCES, enter 99:99.**
 |
| 3 | admdt | Admission date:  | mm/dd/yyyy**Pre-filled: can be modified**

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| >= arrvdate and < = dcdt |

 | **Pre-filled; can be modified if abstractor determines that the date is incorrect.*** Admission date is the date the patient was actually admitted to acute inpatient care.
* For patients who are admitted to Observation status and subsequently admitted to acute inpatient care, abstract the date that the determination was made to admit to acute inpatient care and the order was written. Do not abstract the date that the patient was admitted to Observation.
* If there are multiple inpatient orders, use the order that most accurately reflects the date that the patient was admitted.
* The admission date should not be abstracted from the earliest admission order without regards to substantiating documentation. If documentation suggests that the earliest admission order does not reflect the date the patient was admitted to inpatient care, this date should not be used.

**ONLY ALLOWABLE SOURCES:** Physician orders (priority data source), face sheet**Exclusion:** admit to observation, arrival date |
| 4 | dcdt | Discharge date: | mm/dd/yyyy**Pre-filled: cannot be modified** | **Pre-filled; cannot be modified**The computer auto-fills the discharge date from the API-PM pull list. This date cannot be modified in order to ensure the selected episode of care is reviewed.  |
| 5 | princode | Enter the ICD-10-CM principal diagnosis code. | \_\_ \_\_ \_\_. \_\_ \_\_ \_\_ \_\_(3 alpha-numeric characters/decimal point/four alpha-numeric characters**Pre-filled: can be modified**

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| --- |
| **Cannot enter 000.0000, 123.4567, or 999.9999** |

 | **Will pre-fill from PTF with ability to change. Do NOT change the principal diagnosis code unless the principal diagnosis code documented in the record is not the code displayed in the software.** |
| 6 | othrcode1othrcode2othrcode3othrcode4othrcode5othrcode6othrcode7othrcode8othrcode9othrcode10othrcode11othrcode12othrcode13othrcode14othrcode15othrcode16othrcode17othrcode18othrcode19othrcode20othrcode21othrcode22othrcode23othrcode24 | Enter the ICD-10-CM other diagnosis codes:  | \_\_ \_\_ \_\_. \_\_ \_\_ \_\_ \_\_(3 alpha-numeric characters/decimal point/four alpha-numeric characters)**Pre-filled: cannot be modified****If enabled, can enter up to 24 codes****If enabled, abstractor can enter xxx.xxxx in code field if no other diagnosis codes found.** | **Will be pre-filled from PTF with up to 24 ICD-10-CM other diagnosis codes. Cannot be modified.** **If no other diagnosis codes are received from PTF, abstractor is to verify codes documented in the record and enter. If no other diagnosis codes are found in the record, enter xxx.xxxx.**  |

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| 7 | prinpx(code)prinpxdt(date) | Enter the ICD-10-PCS principal procedure code and date the procedure was performed. Code Date

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| \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ | \_\_/\_\_/\_\_\_\_ |

 | \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_(Must be 7 alpha-numeric characters)Abstractor can enter xxxxxxx in code field and 99/99/9999 in date field if there is no principal procedure

|  |
| --- |
| **Cannot enter 0000000** |

mm/dd/yyyyAbstractor can enter 99/99/9999If no principal procedure, auto-fill othrpx and othrpxdt with xxxxxxx and 99/99/9999

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| > = admdt and< = dcdt |

 | **Principal procedure= that procedure performed for definitive treatment, rather than for diagnostic or exploratory reasons, or was necessary to treat a complication. The principal procedure is related to the principal diagnosis and needs to be accurately identified.*** VA records do not identify the principal procedure; use the above definition of principal procedure to determine the correct code to enter if there are multiple procedures during the episode of care. Ask for assistance from your RM or Quality Insights if you are uncertain.

**If no procedure was performed during the episode of care, enter ICD-10-PCS code field with default code xxxxxxx. Do not enter 9999999 or 0000000 to indicate no procedure was performed.** **Enter 99/99/9999 for the date of the principal procedure if no procedure was performed.**If the principal procedure date is unable to be determined from the medical record documentation, or if the procedure date documented in the record is obviously in error (e.g. 02/42/20xx) and no other documentation is found that provides this information, enter 99/99/9999. |
| 8 | othrpx1othrpx2othrpx3othrpx4othrpx5(codes)othrpxdt1othrpxdt2othrpxdt3othrpxdt4othrpxdt5(dates) | Enter the ICD-10-PCS other procedure codes and dates the procedures were performed. Code Date

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| \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ | \_\_/\_\_/\_\_\_\_ |
| \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ | \_\_/\_\_/\_\_\_\_ |

 | \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_(Must be 7 alpha-numeric characters)Abstractor can enter xxxxxxx in code field and 99/99/9999 in date field if no other procedure was performedmm/dd/yyyyAbstractor can enter 99/99/9999

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| --- |
| > = admdt and< = dcdt |

Can enter 5 codes and dates | **Can enter 5 procedure codes, other than the principal procedure code.** Enter the ICD-10-PCS codes and dates corresponding to each of the procedures performed, beginning with the procedure performed most immediately following the admission. * If no other procedures were performed, enter default code xxxxxxx in the code field and default date 99/99/9999 in the date field.
* If no other procedure was performed, it is only necessary to complete the xxxxxxx and 99/99/9999 default entries for the first code and date. It is not necessary to complete the default entry five times.
* If the date of a procedure is unable to be determined from the medical record documentation, or if the procedure date documented in the record is obviously in error (e.g. 02/42/20xx) and no other documentation is found that provides this information, enter 99/99/9999.
 |
| 9 | dcdispo | What was the patient’s discharge disposition on the day of discharge?1. Home* Assisted Living Facilities (ALFs) – includes assisted living care at nursing home/facility
* Court/Law Enforcement – includes detention facilities, jails, and prison
* Home – includes board and care, domiciliary, foster or residential care, group or personal care homes, retirement communities, and homeless shelters
* Home with Home Health Services
* Outpatient Services including outpatient procedures at another hospital, outpatient Chemical Dependency Programs and Partial Hospitalization

2. Hospice – Home (or other home setting as listed in #1 above)3. Hospice – Health Care Facility* General Inpatient and Respite, Residential and Skilled Facilities, and Other Health Care Facilities

4. Acute Care Facility* Acute Short Term General and Critical Access Hospitals
* Cancer and Children’s Hospitals
* Department of Defense and Veteran’s Administration Hospitals

5. Other Health Care Facility* Extended or Immediate Care Facility (ECF/ICF)
* Long Term Acute Care Hospital (LTACH)
* Nursing Home or Facility including Veteran’s Administration Nursing Facility
* Psychiatric Hospital or Psychiatric Unit of a Hospital
* Rehabilitation Facility including, but not limited to: Inpatient Rehabilitation Facility/Hospital, Rehabilitation Unit of a Hospital, Chemical Dependency/Alcohol Rehabilitation Facility
* Skilled Nursing Facility (SNF), Sub-Acute Care or Swing Bed
* Transitional Care Unit (TCU)
* Veteran’s Home

6. Expired7. Left Against Medical Advice/AMA99. Not documented or unable to determine  | 1,2,3,4,5,6,7,99 | **Discharge disposition: The final place or setting to which the patient was discharged on the day of discharge.*** **Only use documentation written on the day prior to discharge or the day of discharge when abstracting this data element.** For example: Discharge planning notes on 04-01-20xx document the patient will be discharged back home. On 04-06-20xx, the nursing discharge notes on the day of discharge indicate the patient was being transferred back to skilled care. Enter “5”.
* **Discharge disposition documentation in the discharge summary, a post-discharge addendum, or a late entry, may be considered if written within 30 days after discharge date and prior to the pull list date**
* **If there is documentation that further clarifies the level of care, that documentation should be used to determine the correct value to abstract.** If documentation is contradictory, use the latest documentation. For example: Discharge planner note from day before discharge states “XYZ Nursing Home”. Nursing discharge note on day of discharge states “Discharged: Home.” Select “1”.
* If the patient is being discharged to assisted living care or an assisted living facility (ALF) that is located within a skilled nursing facility and the documentation in the medical record also includes nursing home, intermediate care or skilled nursing facility, select Value “1” (“Home”).
* If documentation is contradictory, and you are unable to determine the latest documentation, select the disposition ranked highest (top to bottom) in the following list.

o Acute Care Facility o Hospice – Health Care Facility o Hospice – Home o Other Health Care Facility o Home * Values “2” and “3” hospice include discharges with hospice referrals and evaluations.

**Cont’d next page****Discharge disposition cont’d*** If the medical record states only that the patient is being discharged to another hospital and does not reflect the level of care that the patient will be receiving, select “4”.
* If the medical record states the patient is being discharged to nursing home, intermediate care or skilled nursing facility without mention of assisted living care or assisted living facility (ALF), select Value “5” (“Other Health Care Facility”).
* If the medical record identifies the facility the patient is being discharged to by name only (e.g., Park Meadows) and does not reflect the type of facility of level of care, select “5”.
* Selection of option “7” (left AMA):
	+ Explicit “left against medical advice” documentation is not required (e.g., “Patient is refusing to stay for continued care”- select “7”). **For the purposes of this data element, a signed AMA form is not required.**
	+ If any source states the patient left against medical advice, select value “7”, regardless of whether the AMA documentation was written last.
	+ Documentation suggesting that the patient left before discharge instructions could be given without “left AMA” documentation does not count.
* Select value “99” or unable to determine 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.

**Excluded Data Sources:** Any documentation prior to the last two days of hospitalization, coding documents**Suggested Data Sources:** Discharge instruction sheet, discharge planning notes, discharge summary, nursing discharge notes, physician orders, progress notes, social service notes, transfer record |

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|  |  | **ADMITTING SERVICE** |  |  |
| 10 |  | **Admitting Service** | Text(Limit to 30 characters)

|  |
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| **Warning if left blank** |

 | **Free text entry. In determining the Service (e.g. Surgery, Cardiology, Medicine, etc.) or facility unit (ICU, CCU, etc.) to which the patient was admitted, the abstractor should be guided by Admission Orders, Progress Notes, Discharge Summary, etc.**If unable to make a definitive decision, consult with the facility Liaison for help in determining the Admitting Service. |
| **If (prinpx or othrpx is on JC Table 12.10) OR dcdispo = 4, 6 or 7, OR dcdt >= 4/01/2024 and <= 9/30/2024, go to comfort as applicable; else go to flustat** |
|  |  |  **Immunizations**  |  |  |

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| 11 | flustat | What is the patient’s influenza vaccination status?1. Influenza vaccine was given during this hospitalization2. Influenza vaccine was received prior to admission during the current flu season, not during this hospitalization4. There is documentation of :* + - Allergy/sensitivity to influenza vaccine, OR
		- is not likely to be effective because of bone marrow transplant (or autologous stem cell transplant, ASCT) within the past 6 months, OR
		- prior history of Guillain-Barre syndrome within 6 weeks after a previous influenza vaccination, OR
		- symptomatic suspected or confirmed COVID-19 during this hospitalization

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 apply98. Documentation of patient’s refusal or caregiver’s refusal of influenza vaccine during this hospitalization99. None of the above/not documented/ unable to determine from medical record documentation | 1,2,4,6,98,99 | The intent of this question is to determine if hospitalized inpatients were screened for seasonal influenza immunization status and were vaccinated if indicated. Flu vaccines usually become available in September and most are administered in October through December. However, it is recommended the vaccine be administered throughout the influenza season which can last until May in some years. * **Only vaccines administered during August through March of the current season (7/01/2024 - 6/30/2025) are acceptable.**
* **For the purposes of this project, hospitals are only responsible for discharges October through March.**

Discharges from April – September are excluded from scoring. **Include:** Acceptable terms for influenza vaccines include those listed below or refer to CDC list of Influenza vaccines at <https://www.cdc.gov/flu/professionals/vaccination/index.htm> Afluria, FluMist, FluLaval, flu shot, flu vaccine, Fluarix, Fluvirin, Fluzone, Fluzone High Dose, influenza virus vaccine, live attenuated influenza vaccine, quadrivalent influenza vaccine, trivalent influenza vaccine. **Exclude:** Pandemic monovalent vaccine, e.g. H1N1* **Selecting value “1”:** There must be documentation that the vaccine was given including a date and signature.
* If there is conflicting documentation regarding administration of the vaccine in the hospital, use documentation reflecting the vaccine was given during the admission.

**Example:** Documentation in the medical record indicates the vaccine was given (dated and signed as administered), but the discharge summary states vaccine order was cancelled and patient did not receive vaccine during the hospital stay, select Value “1”. * **Selecting value “2”:**
	+ - If there is documentation the patient received the vaccine, and only the current year is documented, select “2”. **Example:** There is documentation the patient received the vaccine in 2024 and it is October 2024, select value “2”

**Cont’d next page** |
|  |  |  |  | **Influenza vaccination cont’d*** + - If the discharge is in January, February or March 2025 AND there is documentation the patient received the vaccine in 2024 select “2”.
		- Documentation in the Immunization Health Summary (under the Reports tab in CPRS) or in Joint Longitudinal Viewer (JLV) that the vaccine information was provided by the IZ Gateway IIS is acceptable. IZ Gateway immunization information must include:
			* Name of vaccine (e.g., Influenza)
			* Date administered: MM/DD/YYYY (e.g., 01/31/2025)
			* Location will include IZG, state abbreviation (e.g., FL) and IIS. For example, Location: IZG: AZ IIS.
* **Selecting value “4”:** If there is documentation of
	+ allergy/sensitivity to influenza vaccine: The allergy/sensitivity must be accompanied by the exact complication. Must be a specific allergy/sensitivity to influenza vaccine, not just physician/APN/PA preference;
	+ vaccine not likely to be effective because of bone marrow transplant [or autologous stem cell transplant, (ASCT)] within the past 6 months;
	+ prior history of Guillain-Barre syndrome within 6 weeks after a previous influenza vaccination;
	+ symptomatic suspected or confirmed COVID-19 during this hospitalization
* **Selecting value “6”:** Only answer “6”, if the vaccine has been ordered but has not yet been received by the hospital due to problems with vaccine production or distribution AND none of the other options apply. 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.

**Cont’d next page****Influenza vaccination cont’d*** + Documentation of unavailability due to problems with vaccine production or distribution from an admission or encounter that is prior to arrival cannot be used for selecting Value “6”. Information must be documented within the current admission.
* **Selecting value “98”:** Documentation must indicate the patient/caregiver refused the influenza vaccine during this hospitalization.
	+ The caregiver is defined as the surrogate decision-maker, or healthcare surrogate and may be a patient’s family member or any other person (e.g., home health, VNA provider, prison official or other law enforcement personnel) who is responsible for the healthcare decision-making and care of the patient when the patient is unable to make this decision on his/her own.
* Documentation of influenza vaccine refusal from an admission or encounter prior to arrival **cannot** be used for selecting Value “98”. Information must be documented within the current admission.
* **Selecting value “99”:**
* If there is conflicting documentation regarding influenza vaccine refusal, select Value “99”.

**Example:** There is documentation of refusal in the influenza immunization screening for the current admission and the patient did not receive the vaccine, but a subsequent narrative note states the patient wants to receive the vaccine, select Value “99”. * If there is documentation the patient received the vaccine the year prior to the current year and the discharge is NOT January, February, or March, select “99”. For example, the record documents the patient received the vaccine in **2023** and the discharge date for this hospital stay is October **2024**, select “99”.

 **Cont’d next page*** If there is conflicting documentation that supports more than one of the allowable values (1, 2, 4, 98), select the smallest number. For example, nursing note documents patient refused flu vaccine and MAR notes flu vaccine was administered, select “1”.

**EXCEPTION:** If documentation supports patient refusal (option “98”) and option “4”, select “98”. **Unacceptable documentation**: * Patient is told to return post-discharge for flu vaccine.
* Flu vaccine not available
* Documented assumption “patient gets annual flu shot or vaccination”

**Suggested Data Sources**: BCMA, Consultation notes, Discharge summary, ED record, Immunization assessment forms, Medication administration record, Nursing admission assessment/notes, Physician orders/progress notes, Social service notes, Transfer forms, Vaccine order sheet |
| **If DCDT – ADMDT < = 1 day, go to end.** |
|  |  | **Tobacco Treatment** |  |  |

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| 12 | comfort | When is the earliest physician, APN, or PA documentation of comfort measures only?1. Day of arrival (day 0) or day after arrival (day 1)2. Two or more days after arrival (day 2 or greater) 3. Comfort measures only documented during hospital stay, but timing unclear99. Comfort measures only was not documented by the physician/APN/PA or unable to determine | \*1,\*2,\*3,99**\*If 1,2, or 3, go to end**

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| Warning if comfort = 2 |

 | **Comfort Measures Only (CMO):** refers to medical treatment of a dying person where the natural dying process is permitted to occur while assuring maximum comfort; includes attention to psychological and spiritual needs of patient and support for patient and family; commonly referred to as “comfort care” by general public. It is not equivalent to physician order to withhold emergency resuscitative measures such as Do Not Resuscitate (DNR). **ONLY accept terms identified in the list of inclusions. No other terminology will be accepted.**

|  |
| --- |
| **Inclusion (Only acceptable terms)** |
| Brain death/dead | Donation after Cardiac Death (DCD) |
| Comfort care | Donation after Circulatory Death (DCD) |
| Comfort focused treatment | End of life care |
| Comfort measures | Hospice |
| Comfort measures only (CMO) | Hospice care |
| Comfort only | Organ harvest |
| Compassionate extubation | Terminal care |
| Do Not Resuscitate Comfort Care (DNR-CC) | Terminal extubation |

* **Determine the earliest day the physician/APN/PA documented CMO. If any of the inclusion terms are documented by the physician/APN/PA, select option “1,” “2,” or “3,” accordingly.** Example: “Discussed comfort care with family on arrival” noted in day 2 progress note – Select “2.”
* **Physician/APN/PA documentation of CMO mentioned in the following context is acceptable:**
	+ Comfort measures only recommendation
	+ Order for consultation/evaluation by hospice care
	+ Patient/family request for comfort measures only
	+ Plan for comfort measures only
	+ Referral to hospice care service
	+ Discussion of comfort measures

**Cont’d next page** |
|  |  |   |  | **CMO cont’d** * **State-authorized portable orders (SAPOs):**
* SAPOs = specialized forms/identifiers authorized by state law; translate patient’s preferences about specific end-of-life treatment decisions into portable medical orders.
* **Examples:** DNR-Comfort Care form; MOLST (Medical Orders for Life-Sustaining Treatment); POLST (Physician Orders for Life-Sustaining Treatment); Out-of-Hospital DNR (OOH DNR)
* SAPO in the record, dated and signed prior to arrival with any inclusion term checked, select value “1.”
* SAPO listing any CMO option, select value “1,” “2,” or “3” as applicable
* Use only the most recently dated/signed SAPO if more than one in record. Disregard undated SAPOs.
* If a SAPO is dated prior to arrival and there is documentation on day of arrival or day after arrival that patient does not want CMO, and no other documentation regarding CMO is found in the record, disregard the SAPO.
* **Disregard documentation of an Inclusion term in the following situations:**
* Documentation (other than SAPOs) that is dated prior to arrival or documentation which refers to the pre-arrival time period (e.g., comfort measures only order in previous hospitalization record, “Pt. on hospice at home” in physician ED note).
* Inclusion term clearly described as negative or conditional (**Examples:** “No comfort care,” “Not appropriate for hospice care,” “Family requests CMO should the patient arrest”).
* If documentation makes clear it is not being used as an acronym for Comfort Measures Only (e.g., “hx dilated CMO” - Cardiomyopathy context).

**Cont’d next page****CMO cont’d*** **If there is physician/APN/PA documentation of an inclusion term in one source that indicates the patient is CMO, AND there is physician/APN/PA documentation of an inclusion term in another source that indicates the patient is NOT CMO, the source that indicates the patient is CMO would be used to select value “1,” “2,” or “3” for this data element.**

**Examples:*** Physician documents in progress note on day 1 “The patient has refused Comfort Measures” AND then on day 2 the physician writes an order for a Hospice referral. Select value “2.”
* ED physician documents in a note on day of arrival “Patient states they want to be enrolled in Hospice” AND then on day 2 there is a physician progress note with documentation of “Patient is not a Hospice candidate.” Select value “1.”

**Suggested Data Sources:** Consultation notes, Discharge summary, DNR/MOLST/POLST forms, Emergency Department record, History and physical, Physician orders, Progress notes**Excluded data source:** Restraint order sheet |

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| 13 | tobstatus3 | What is the patient’s tobacco use status documented within the first day of admission **(by the end of Day1)**?1. Current everyday tobacco user2. Current some day tobacco user3. Former tobacco user4. Never tobacco user97. The patient was not screened for tobacco use within the first day of admission (by end of Day 1) because of cognitive impairment98. The patient refused the tobacco use screen99. Tobacco use status unknown | 1,2,3,4,97,98,99If 1 or 2, go to refoptob If 3, 4, 98, or 99, go to auditc as applicableIf 97, auto-fill auditc as 97 and go to cogimp2

|  |
| --- |
| **Hard edi**t: If 97, AUDITC must = 97  |

 | **Tobacco use includes all forms of tobacco including cigarettes, smokeless tobacco products, pipe, and cigars.****Include:** Smokeless tobacco, Chewing (spit) tobacco, Twist, Redman, Moist snuff, Dry snuff, Plug tobacco, snus **Exclude:** Marijuana use only, E-cigarettes, hookah pipe, Nicotine delivery system, Vaping or nicotine vaporizer use**The tobacco use status screening timeframe must have occurred within the first day of admission (by the end of Day1). This includes the day of admission which is defined as day zero (Day 0) and the day after admission which is defined as Day 1. EXCEPTION:** If the screening was performed within 3 days prior to admission, i.e., at the transferring facility, in another inpatient hospital unit, emergency department or observation unit, the screening documentation must be present in the current medical record.**Tobacco Use Status guidelines:*** There is no requirement to capture volume of use.
* Documentation of “nicotine” use needs to be supported by language showing it was in the form of cigarettes, smokeless tobacco products, pipe, and cigars.
* **Value “1” Current everyday tobacco user:** Documentation that the patient uses any amount or any type of tobacco product on a daily basis or is a current everyday smoker. When both daily and sporadic (“some day”) tobacco use are documented, select value “1”.
* **Value “2” Current some day tobacco user**: Defined as tobacco use that is infrequent, sporadic, use that is not on a daily basis. This is regardless of volume or occurrence of tobacco use.
* **Value “3” Former tobacco user:** Documentation that the patient is not a current tobacco user but used tobacco at any time in the past, regardless of date of last tobacco use.
* **Value “4” Never tobacco user**: If screening documentation states "denies tobacco use" and there is no conflicting information documented on the patient’s history of smoking, select value “'4”.

**Cont’d next page****Tobacco use cont’d*** **Value “99” Tobacco use status unknown:** If the patient was not screened for tobacco use within the first day of admission (by the end of Day 1) OR if unable to determine the patient’s tobacco use status from medical record documentation, select value “99”.
	+ **For example, if there is any conflicting documentation about the patient’s tobacco use status where there is documentation of both tobacco use and no tobacco use**, e.g., RN assessment states patient does not use any tobacco products, but there is also physician documentation in the H&P that the patient is a “smoker,” select value “99”.
	+ **Data would also be considered conflicting if there is documentation of former tobacco user and never used. Enter “99” for conflicting documentation in this scenario.**

**Value “97” Not screened for tobacco use due to cognitive impairment**: Documentation of cognitive impairment overrides documentation of a tobacco screen and therefore would not be considered “conflicting documentation.” Even if the family or others tell staff the patient uses tobacco, the patient could not be appropriately screened and counseled due to cognitive impairment. Select value “97”. Any documentation within the first day of admission from the admitting provider or nurse stating that the patient was unabled to be screened or assessment was unable to be completed due to cognitive impairment, select value “97”.* **Cognition refers to mental activities associated with thinking, learning, and memory. Cognitive impairment for the purposes of this measure set is related to documentation that the patient cannot be screened for tobacco use due to the impairment (e.g., comatose, obtunded, confused, memory loss) within the first day of admission (by end of Day 1).**

**Cont’d next page****Tobacco use cont’d*** **Examples of cognitive impairment include:** Altered level of consciousness (LOC); altered mental status; cognitive impairment; cognitively impaired; cognitive impairment due to acute substance use; overdose; acute intoxication; confused; dementia; intubation and patient is intubated through the end of Day 1; memory loss; mentally handicapped; obtunded; psychotic/psychosis with documented symptoms; sedation.
* **If there is documentation of any of the examples of cognitive impairment above within the first day of admission (by the end of Day 1), select value “97” regardless of conflicting documentation.**
* If there is documentation within the first day of admission (by end of Day 1) that the patient was psychotic, symptoms of psychosis, e.g., hallucinating, non-communicative, catatonic, etc., must also be documented for the patient to be considered cognitively impaired.
* If there is documentation to “rule out” a condition/diagnosis related to cognitive impairment, value “97” cannot be selected unless there is documentation of symptoms.

Examples:* Patient actively hallucinating, rule out psychosis (Select value “97”).
* Rule out psychosis (**Cannot** select value “97”).

**Additional Guidelines:*** For the 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.
* 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.”

**Suggested Data Sources:** ED record, History and physical, Nursing admission assessment/notes, Physician progress notes, Respiratory therapy notes |
| **IF TOBSTATUS3 = 1 or 2 and dcdispo = 1 or 99, go to REFOPTOB, else go to auditc as applicable** |

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| 14 | refoptob | Did the patient receive a referral (i.e. an appointment with date and time) for Outpatient Tobacco Cessation Counseling?1. The referral (i.e. an appointment with date and time) to outpatient tobacco cessation counseling treatment was made by the healthcare provider/facility staff at any time prior to discharge. 2. Referral information was given to the patient at discharge but the appointment was not made by the provider/facility staff at any time prior to discharge. 4. The patient is:- being discharged to a residence outside the USA - released to a court hearing and does not return - being discharged to jail/law enforcement98. Patient refused the referral for outpatient tobacco cessation counseling treatment and the referral was not made. 99. The referral for outpatient tobacco cessation counseling treatment was not offered at discharge or unable to determine from the medical record documentation. | 1,2,4,98,99If 4 and tobstatus3 = 1 or 2, auto-fill tobmedc as 3

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| Warning if 4 |

 | **For the purposes of this data element, documentation must indicate that a referral** (i.e. an appointment with date and time) **was made for ongoing evidence-based counseling with clinicians (physician or non-physician such as nurse, psychologist, or counselor)**. Outpatient counseling may include proactive telephone counseling, group counseling and/or individual counseling. **Guidelines for Selecting “1”*** **A Counseling referral is defined as an appointment made by the healthcare provider or facility staff either through telephone contact, fax, the EHR or e-mail.**
* If a patient is referred to an outpatient tobacco cessation counseling provider that does not schedule appointments and the patient was given a specific date and time to present for counseling, select Value “1.” **Example:** Discharge Instructions, “Please attend tobacco cessation clinic next Wed. 7/24/2020 at 10:00 am.”
* A Quitline is defined as telephone counseling in which at least some of the contact is initiated by the Quitline counselor to deliver tobacco use interventions.
* If a Quitline referral is made, there must be documentation an actual referral was made. Providing a Quitline phone number is NOT sufficient to answer “1”. This includes the VA Quitline, 1-855-QUIT-VET.
* For Quitline referrals, the healthcare provider or hospital can either fax or e-mail a Quitline referral or assist the patient in directly calling the Quitline prior to discharge. If the patient directly calls the Quitline during the hospitalization, documentation must reflect that staff was present during the call to verify that an appointment was set.
* If only a Quitline number is provided to the patient with no formal referral/consult placed, select “2”.

**Cont’d next page****Outpatient tobacco referral cont’d****Guideline for Selecting “2”*** If the patient is provided with contact information for e-health or internet smoking cessation programs which tailor program content to the tobacco user’s needs (by collecting information from the tobacco user and using algorithms to tailor feedback or recommendations, permitting the user to select from various features including extensive information on quitting, tobacco dependence, and related topics) select “2”.
* Note that if Value “2” is selected, the case will not pass the measure.
* Value “2” can be used as part of an internal performance improvement activity in order to determine if any type of referral was made rather than no referral.

**Guideline for Selecting “4”*** Select value “4” if the patient is:

- being discharged to a residence outside the USA - released to a court hearing and does not return - being discharged to jail/law enforcement**Guideline for Selecting “98”*** If there is conflicting documentation regarding patient refusal, use the latest documentation. For example, during Admission screening patient refused referral; then in discharge documentation the patient accepted the referral, select the appropriate value.
* **Documentation of patient’s refusal of offer of outpatient tobacco cessation counseling referral during the hospitalization, or at discharge, is acceptable to select value 98.**

**Guidelines for Selecting “99”*** If the patient is provided with self-help materials that are not tailored to the patient’s needs and do not provide a structured program, select value 99.
* Select value 99 if:
* it cannot be determined that a referral for outpatient cessation counseling was made or;

**Cont’d next page****Outpatient tobacco referral cont’d*** it is unclear that the absence of the referral was due to a patient refusal or because the referral was not offered.
* Select “99” if a referral for outpatient counseling was not offered during the hospitalization or at the time of discharge.

**Include:** group counseling, individual counseling, VA Smoking Cessation Quitline (1-855-QUIT-VET), facility smoking cessation clinic**Exclude:** E-health, Internet structured programs, Self-help interventions in the form of printed/electronic/digital media**Suggested data sources:** Discharge summary, transfer sheet, discharge instruction sheet, nursing discharge notes, physician orders |

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| 15 | tobmedc | Was an FDA-approved tobacco cessation medication prescribed at discharge?

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| **FDA-Approved Tobacco Cessation Medications** |
| Bupropion (Wellbutrin, Zyban) |
| Nicotine Replacement Therapy (NRT)(e.g., nicotine gum, lozenge, nasal spray, patch/transdermal) |
| Varenicline (Chantix) |

1. A prescription for an FDA-approved tobacco cessation medication was given to the patient at discharge. 3. The patient is:- being discharged to a residence outside the USA - released to a court hearing and does not return - being discharged to jail/law enforcement 98. A prescription for an FDA-approved tobacco cessation medication was offered at discharge and the patient refused. 99. A prescription for an FDA-approved tobacco cessation medication was not offered at discharge or unable to determine from medical record documentation. | 1,3,98,99Will be auto-filled as 3 if refoptob = 4If 1, 3, or 98, go to auditc as applicable; else go to notobrxdc  | * **All discharge medication documentation available in the medical record should be reviewed and taken into account by the abstractor.** In determining whether a tobacco cessation medication was prescribed at discharge, it is not uncommon to see conflicting documentation among different medical record sources. For example, the discharge summary may list Varenicline and this is not included in any of the other discharge medication sources (e.g., discharge orders). Select value 1 unless documentation elsewhere in the medical record suggests that it (tobacco cessation medication) was not prescribed at discharge.
* If the physician wants the patient to continue on medication that does not legally require a prescription, for example over the counter (OTC) nicotine replacement therapy (NRT) or medication that will be provided by the outpatient counseling such as the VA Quitline, inclusion of the medication on the discharge medication list is sufficient to select value “1”. **Note:** VHA requires a prescription for OTC nicotine replacement therapy.
* If documentation is contradictory (physician noted “d/c Varenicline” or “hold Varenicline” in the discharge orders, but Varenicline is listed in the discharge summary’s discharge medication list), or after careful examination of circumstance, context, timing, etc., the documentation remains unclear, the case should be deemed unable to determine, select value 99.
* Select value “3” if the patient is:

- being discharged to a residence outside the USA- released to a court hearing and does not return - being discharged to jail/law enforcement* If the patient refused tobacco cessation medication during the hospitalization, a prescription must be offered again at the time of discharge. Select Value “99” if documentation reflects that a prescription for cessation medication was not offered at the time of discharge.

**Cont’d next page****FDA-approved medication cont’d**If NRT or a prescribed FDA-approved tobacco cessation medication is listed as a discharge medication but there is also documentation of refusal by the patient at discharge, select Value “98.”**Refer to TJC Appendix C, Table 9.1 for a comprehensive list of FDA-approved tobacco cessation medications.** FDA-Approved Tobacco Cessation Medications may include, but are not limited to: Nicotine Replacement Therapy (NRT) such as Nicorelief, Nicorette gum; bupropion (Wellbutrin); varenicline (Chantix).* **Suggested data sources:** Discharge summary, transfer sheet, discharge instruction sheet, medication reconciliation form, nursing discharge notes, physician order sheet, transfer sheet
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| 16 | notobrxdc | Is there documentation of a reason for not prescribing one of the FDA-approved tobacco cessation medications at discharge?* Allergy to all of the FDA-approved tobacco cessation medications.
* Drug interaction (for all of the FDA-approved medications) with other drugs the patient is currently taking.
* Patient is pregnant
* Other reasons documented by physician/APN/PA or pharmacist.

1. Yes2. No | 1,2 | * Reasons (other than pregnancy) for not prescribing FDA-approved tobacco cessation medications must be documented by a physician/APN/PA or pharmacist.
* If there is any documentation in the medical record indicating the patient is pregnant, select “Yes”.
* An allergy or adverse reaction to one of the FDA-approved cessation medications would not be a reason for not prescribing another of the cessation medications.
* In determining whether there is a reason documented by physician/APN/PA or pharmacist for not prescribing tobacco cessation medications, the reason must be **explicitly documented** (e.g., “No tobacco cessation medication as patient is post-operative and nicotine may place them at risk for impaired wound healing”) **or clearly implied** (e.g., “Patient becomes anxious when they take tobacco cessation medication”).
* When conflicting information is documented in the medical record, select value “2”.
* If the reason for not prescribing FDA-approved cessation medication is documented at any time during the hospitalization, additional documentation of the reason at the time of discharge is not required.
* Documentation by the physician/APN/PA or pharmacist that the patient refused tobacco cessation medication is not considered a valid reason for no tobacco cessation medication at discharge. if refusal is documented as the reason, select “2”.

**Exclude:** Medication allergy using a negative modifier or qualifier (questionable, risk of, suspect, etc.)**Suggested data sources:** ED record, history and physical, progress notes, physician orders, discharge summary, medication administration record |
| **If DCDT – ADMDT < = 1 day, go to end.** |

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|  |  | **Substance Use** |  |  |
| 17 | auditc | Was the patient screened for alcohol misuse with the AUDIT-C within the first day of admission (by end of Day 1)? 1. Yes2. No97. The patient was not screened for alcohol use within the first day of admission (by end of Day 1) because of cognitive impairment98. Patient refused screening for alcohol misuse within the first day of admission (by end of Day 1) | 1,2,97,98**If 1, go to dtalscrn****If 2 or 98, go to addtxref as applicable****If 97, go to cogimp2**

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| **Hard edi**t: If 97, tobstatus3 must = 97 |

 | **The alcohol use status screening must have occurred within the first day of admission (by end of Day 1). This includes the day of admission which is defined as day zero (Day 0), and the day after admission which is defined as Day 1.****Exception:** If the screening was performed within 3 days prior to admission, i.e., at the transferring facility, in another inpatient hospital unit, emergency department or observation unit, the screening documentation must be present in the current medical record.**Alcohol screen completed after acute care arrival (e.g., in the ED) is acceptable.****Screening for alcohol misuse = the patient was screened using AUDIT-C questions OR AUDIT-C question # 1 alone if answer was “never” (audc1=0).** AUDIT-C:Question #1 = “How often did you have a drink containing alcohol in the past year?” Question #2 = “How many drinks containing alcohol did you have on a typical day when you were drinking in the past year?”Question #3 = “How often did you have six or more drinks on one occasion in the past year?”If AUDIT-C question #1 is answered “never”, AUDIT-C questions 2 and 3 are not applicable.**Value “97” Not screened for alcohol use due to cognitive impairment: Documentation of cognitive impairment overrides documentation of an alcohol use screen and therefore would not be considered “conflicting documentation.”** Even if the family or others tell staff the patient uses alcohol, the patient could not be appropriately screened and counseled due to cognitive impairment. Select Value “97.” Any documentation within the first day of admission from the admitting provider or nurse stating that the patient was unabled to be screened or assessment was unable to be completed due to cognitive impairment, select value “97”.**Cont’d next page****Audit-C cont’d*** **Cognition refers to mental activities associated with thinking, learning, and memory. Cognitive impairment for the purposes of this measure set is related to documentation that the patient cannot be screened for alcohol use due to the impairment (e.g., comatose, obtunded, confused, memory loss) within the first day of admission (by end of Day 1).**
* **Examples of cognitive impairment include:** Altered level of consciousness (LOC); altered mental status;cognitive impairment; cognitively impaired; cognitive impairment due to acute substance use; overdose; acute intoxication; confused; dementia; intubation and patient is intubated through the end of Day 1; memory loss; mentally handicapped; obtunded; psychotic/psychosis with documented symptoms; sedation
* **If there is documentation within the first day of admission (by end of Day 1) of any of the examples of cognitive impairment above, select value “97” regardless of conflicting documentation.**
* If there is documentation within the first day of admission (by end of Day 1) that the patient was psychotic, symptoms of psychosis, e.g., hallucinating, non-communicative, catatonic, etc. must also be documented for the patient to be considered cognitively impaired.
* If there is documentation to “rule out” a condition/diagnosis related to cognitive impairment, Value “97” cannot be selected unless there is documentation of symptoms.

Examples:* Patient actively hallucinating, rule out psychosis (Select Value “97”).
* Rule out psychosis (**Cannot** select Value “97”).

**Additional Guidelines:*** For the 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.

**Cont’d next page****Audit-C cont’d*** 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.”

**Suggested Data Sources:** Consultation notes,ED record, History and physical, Nursing admission assessment/notes, Physician progress notes |
| 18 | cogimp2 | Did a **physician/APN/PA** document cognitive impairment within the first day of admission (by end of Day 1)?1. Yes
2. No
 | 1, 2 If 2, go to end | **The day of acute care admission is defined as Day 0 and the day after admission is Day 1.*** **Examples of cognitive impairment include:** Altered level of consciousness (LOC), altered mental status,cognitive impairment, cognitively impaired, cognitive impairment due to acute substance use, overdose, acute intoxication, confused; dementia, intubation and patient is intubated through the end of Day 1, memory loss, mentally handicapped, obtunded, psychotic/psychosis with documented symptoms, sedation
* **If there is physician/APN/PA documentation within the first day of admission (by end of Day 1) of any of the examples of cognitive impairment above, select value “1” regardless of conflicting documentation.**
* If there is physician/APN/PA documentation within the first day of admission (by end of Day 1) that the patient was psychotic, symptoms of psychosis (e.g., hallucinating, non-communicative, catatonic, etc.) must also be documented for the patient to be considered cognitively impaired.
* **Suggested Data Sources:** Consultation notes,ED record, History and physical, Physician/APN/PA progress notes.
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| 19 | careplan | Is there **physician/APN/PA** documentation of a plan of care related to cognitive impairment within the first day of admission (by end of Day 1)?1. Yes
2. No
 | 1, 2If 1or 2, go to end | Read the assessment (impression) and plan section of the physician/APN/PA and other progress notes or consults for documentation of a plan of care related to cognitive impairment. * For example, if the physician documents in the admission note (day of admission) “Cognitive impairment—will consult neurology for further evaluation,” select value “1”.
* If there is no documentation of a plan of care related to cognitive impairment within the first day of admission (by end of Day 1), select value “2”.

**Suggested Data Sources:** Consultation notes,ED record, History and physical, Physician/APN/PA progress notes. |
| 20 | dtalscrn | Enter the date of screening for alcohol misuse with the AUDIT-C within the first day of admission or 3 days prior to admission. | mm/dd/yyyy

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| <= 3 days prior to admdt and <= 1 day after admdt |

 | **The alcohol use status screening must have occurred within the first day of admission (by end of Day 1). This includes the day of admission which is defined as day zero (Day 0), and the day after admission which is defined as Day 1.****If the patient is screened for alcohol misuse with the AUDIT-C multiple times within the first day of admission or within 3 days prior to admission meeting the exception rule below, and any AUDIT-C total score is 5 or greater, enter the date of the earliest AUDIT-C screen with total score of 5 or greater within the first day of admission.** **Exception:** If the screening was performed within 3 days prior to admission, i.e., at the transferring facility, in another inpatient hospital unit, emergency department or observation unit, the screening documentation must be present in the current medical record.Use the signature date of the note that contains the AUDIT-C screening.The use of 01 to indicate missing month or day is not acceptable. |

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| 21 | audc1 | Enter the score documented for AUDIT–C Question #1 within the first day of admission. “How often did you have a drink containing alcohol in the past year?1. Never
2. Monthly or less
3. Two to four times a month
4. Two to three times a week
5. Four or more times a week

99. Not documented | 0,1,2,3,4,99If 0, auto-fill audc2 and audc3 as 95, and go to alcscor | AUDIT-C Question #1 = “How often did you have a drink containing alcohol in the past year?” Each answer is associated with the following scores:Never 🡪 0Monthly or less🡪 1Two to four times a month 🡪 2Two to three times a week 🡪 3Four or more times a week 🡪 4Not documented 🡪 99Answers 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. |

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| 22 | audc2 | Enter the score documented for AUDIT-C Question #2 within the first day of admission.“How many drinks containing alcohol did you have on a typical day when you were drinking in the past year?”1. 0, 1 or 2 drinks
2. 3 or 4
3. 5 or 6
4. 7 to 9
5. 10 or more

95. Not applicable99. Not documented | 0,1,2,3,4,95,99Will be auto-filled as 95 if audc1 = 0 | AUDIT-C Question #2 = “How many drinks containing alcohol did you have on a typical day when you were drinking in the past year?” Each answer is associated with the following scores:0 drinks 🡪 01 or 2 drinks 🡪 03 or 4 drinks 🡪 15 or 6 drinks 🡪 27 to 9 drinks 🡪 310 or more drinks 🡪 4Not documented 🡪 99Answers 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. |

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| 23 | audc3 | Enter the score documented for AUDIT-C Question #3 within the first day of admission.  “How often did you have six or more drinks on one occasion in the past year?” 1. Never
2. Less than monthly
3. Monthly
4. Weekly
5. Daily or almost daily

95. Not applicable 99. Not documented | 0,1,2,3,4,95,99Will be auto-filled as 95 if audc1 = 0 | AUDIT-C Question #3 = “How often did you have six or more drinks on one occasion in the past year?” Each answer is associated with the following scores:Never 🡪 0Less than monthly 🡪 1Monthly 🡪 2Weekly 🡪 3Daily or almost daily 🡪 4 Not documented 🡪 99Answers 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. |
| 24 | alcscor | Enter the total AUDIT-C score documented within the first day of admission.  | \_\_ \_\_Abstractor may enter default zz if the total score of the AUDIT-C is not documented in the record**If alcscor >=5, go to briefintv; else go to addtxref as applicable**

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| Whole numbers 0 - 12 |

 | The abstractor may not enter the total AUDIT-C score calculated from the questions if it is NOT documented in the record. If the total score is not documented in the record, enter default zz. |

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| 25 | briefintv | Following the positive screening result for alcohol use, did the patient receive a brief intervention prior to discharge?1. The patient received a brief intervention including all of the following components:
2. Concern that the patient is drinking at unhealthy levels known to increase his/her risk of alcohol-related health problems
3. Feedback linking alcohol use and health, including:

- Personalized feedback (i.e., explaining how alcohol use can interact with patient’s medical concerns [hypertension, depression/anxiety, insomnia, injury, congestive heart failure (CHF), diabetes mellitus (DM), breast cancer risk, interactions with medications])**OR** - General feedback on health risks associated with drinking. 1. Advice to abstain (if there are contraindications to drinking)

**OR** Advice to drink below recommended limits (specified for patient).98. Patient refused/declined brief intervention99. Brief intervention was not offered to the patient during the hospital stay or unable to determine if a brief intervention was provided from medical record documentation | 1,98,99 | **A brief intervention is a single session or multiple sessions conducted by a qualified healthcare professional following a positive screen for unhealthy alcohol use.** * A qualified healthcare professional may be defined as a physician, nurse, addictions counselor, psychologist, social worker, or health educator with training in brief intervention.
* A brief intervention focuses on increasing the patient’s understanding of the impact of substance use on his or her health and motivating the patient to change risky behaviors. The qualified health care professional engages the patient in a joint decision-making process regarding alcohol use and plans for follow-up are discussed and agreed to.
* In order to select value 1, the brief intervention must include the following three components:
1. Concern that the patient is drinking at unhealthy levels known to increase his/her risk of alcohol-related health problems
2. Feedback linking alcohol use and health, including:

- Personalized feedback (i.e., explaining how alcohol use can interact with patient’s medical concerns [hypertension, depression/anxiety, insomnia, injury, congestive heart failure (CHF), diabetes mellitus (DM), breast cancer risk, interactions with medications])**OR** - General feedback on health risks associated with drinking. 1. Advice to abstain (if there are contraindications to drinking)

**OR** Advice to drink below recommended limits (specified for patient).* If there is documentation of brief intervention in a pre-admission H&P (for the current admission) completed within 30 days prior to this admission, and the licensed independent practitioner (LIP) makes reference to it within the first day of admission either by indicating there were no changes, or adding any updates to it; that H&P is considered valid documentation for the brief intervention.

**Cont’d next page****Brief intervention cont’d*** If there is no documentation that a brief intervention was given to the patient, select value 99.
* Select value 99 if the documentation provided is not explicit enough to determine if the intervention provided contained the specific components or if it is determined that the intervention does not meet the intent of the measure.
 |
| **If dcdispo = 1 or 99 AND (ICD-10 princode or othrdx is on TJC Table 13.1 or 13.2) OR (ICD-10 prinpx or othrpx is on TJC Table 13.3), go to addtxref; else go to end.** |

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| 26 | addtxref | Was a referral (i.e. an appointment with date and time) for addictions treatment made for the patient prior to discharge?1. The appointment for addictions treatment with date and time was made by the healthcare provider/facility staff at any time prior to discharge2. Referral information for addictions treatment was given to the patient, but an appointment was NOT made by the provider/facility staff at any time prior to discharge 4. The patient is:- being discharged to a residence outside the USA - released to a court hearing and does not return - being discharged to jail/law enforcement98. The patient refused the referral for addictions treatment and an appointment was not made. 99. The referral for addictions treatment was not offered at any time prior to discharge or unable to determine from the medical record documentation. | 1,2,\*4,98,99\*If 4, auto-fill sudmedc as 3, and go to end

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| Warning if 4 |

 | **For the purposes of this data element, documentation must indicate that a referral (i.e., an appointment with date and time) was made for ongoing evidence-based addictions treatment by a physician or non-physician (such as nurse, psychologist, or counselor)**. Outpatient counseling may include proactive telephone counseling, group counseling and/or individual counseling. **Guidelines for Selecting “1”*** **A referral is defined as an appointment made by the provider, either through telephone contact, fax or e-mail.**
* **In order to answer “1” there must be documentation that an appointment with date and time** **for addictions treatment by a physician or non-physician (such as nurse, psychologist, or counselor)** **was made prior to discharge.**
* The appointment 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.

Examples of substance use treatment programs include but are not limited to:* **SATP:** Substance Abuse Treatment Program
* **STAR:** Substance Treatment and Recovery
* **SUD Clinic:** Substance Use Disorder Clinic
* **IOP:** Intensive Outpatient Program
* **SARRTP:** Substance Abuse Residential Rehabilitation Treatment Program

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| Inclusions | Exclusions |
| * Group counseling
* Individual counseling
* Addictions counselor
* Personal physician
* Psychiatrist
* Psychologist
* Social Worker
 | * Self-help interventions in the form of printed/electronic/digital media
* Support groups that are not considered treatment such as Alcoholics Anonymous (AA)
 |

**Cont’d next page*** If a patient is referred to an addictions treatment provider that does not schedule appointments electronically via CPRS/VistA scheduling package and there is documentation the patient was given a specific date and time to present for addictions treatment, select Value “1.”A referral to Alcoholics Anonymous (AA) or similar mutual support groups **does** **NOT** meet the intent of the measure, select value “99” if such a referral is given to the patient.
* Select value “4” if the patient is:

- being discharged to a residence outside the USA - released to a court hearing and does not return - being discharged to jail/law enforcement* Select value “99” if
	+ it cannot be determined that referral information or an appointment for addictions treatment was made or;
	+ it is unclear that the absence of an appointment was due to a patient refusal or because referral information or an appointment was not offered.

**If there is conflicting documentation regarding patient refusal, use the latest documentation. For example, during Admission screening patient refused an appointment; then in discharge documentation the patient accepted the appointment, select value “1”.**  |
| 27 | sudmedc | Was one of the FDA-approved medications for alcohol or drug disorder prescribed at discharge?1. A prescription for an FDA-approved medication for alcohol or drug disorder was given to the patient at discharge. 3. The patient is: - being discharged to a residence outside the USA - released to a court hearing and does not return - being discharged to jail/law enforcement98. A prescription for an FDA-approved medication for alcohol or drug disorder was offered at discharge and the patient refused. 99. A prescription for an FDA-approved medication for alcohol or drug disorder was not offered at discharge, or unable to determine from medical record documentation.tob | 1,3,98,99Will be auto-filled as 3 if addtxref = 4

|  |
| --- |
| If 3, addtxref must = 4 |

 | **Inclusion Guidelines for Abstraction:** TJC Table 9.2 FDA-Approved Medications for Alcohol and Drug Dependence

|  |  |
| --- | --- |
| acamprosate (Campral) | buprenorphine/naloxone (Suboxone) |
| disulfiram (Antabuse) | methadone (Dolophine) |
| buprenorphine (Subutex) | Naltrexone (ReVia, Vivitrol) |

All discharge medication documentation available in the chart should be reviewed and taken into account by the abstractor.* 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.
* In cases where there is a medication for alcohol or drug disorder in one source and it is not mentioned on other sources, it should be interpreted as a discharge medication, select value 1 unless documentation elsewhere in the medical record suggests that it was not prescribed at discharge.
* If documentation is contradictory (physician noted “d/c Antabuse” or “hold Antabuse” in the discharge orders, but Antabuse is listed in the discharge summary’s discharge medication list), or after careful examination of circumstances, context, timing, etc., documentation raises enough questions, the case should be deemed unable to determine, select value 99.
* Select value “3” if the patient is:

- being discharged to a residence outside the USA - released to a court hearing and does not return - being discharged to jail/law enforcement**Suggested data sources:** Discharge instruction sheet, Discharge summary, Medication reconciliation form, Nursing discharge notes, Physician order sheet, Transfer sheet |
| **Enable Medication Reconciliation Module; if INPT\_FE flag = 1, enable Delirium Risk.** |