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| --- | --- | --- | --- | --- |
|  |  | **Organizational Identifiers** |  |  |
|  | VAMC  CONTROL  QIC  BEGDTE  REVDTE | Facility ID Control Number  Abstractor ID  Abstraction Begin Date  Abstraction End Date | Auto-fill  Auto-fill  Auto-fill  Auto-fill  Auto-fill |  |
|  |  | Patient Identifiers |  |  |
|  | SSN  PTNAMEF  PTNAMEL  BIRTHDT  SEX  MARISTAT  RACE | Patient SSN First Name  Last Name  Birth Date  Sex  Marital Status  Race | Auto-fill: no change  Auto-fill: no change  Auto-fill: no change  Auto-fill: no change  Auto-fill: **can change**  Auto-fill: no change  Auto-fill: no change |  |
|  |  |  |  |  |
| 1 | arrvdate  ALL | Enter the **earliest** documented date the patient arrived in the emergency department at this VAMC. | mm/dd/yyyy  **Auto-filled: Can be modified**   |  | | --- | | >= stdybeg and <= stdyend | | **Auto-filled; can be modified if abstractor determines that the date is incorrect.**  **The intent of this data element is to determine the earliest date the patient arrived in the emergency department at this VAMC.**  **Exclusion:** Preoperative tests or screening  Suggested Data Sources: Emergency Department record |

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| --- | --- | --- | --- | --- |
| 2 | arrvtime  ALL | Enter the **earliest** documented time the patient arrived at the emergency department at this VAMC. | \_\_\_\_\_  UMT **If unable to find the time of arrival, the abstractor can enter 99:99** | **Arrival time is the earliest recorded time the patient arrived at the emergency department. Arrival time may differ from admission time.**  **ONLY ACCEPTABLE SOURCES:** Emergency Department record includes any documentation from the time period that the patient was an ED patient. Documentation may include ED Face Sheet, ED Consent/Authorization for treatment forms, ED Registration/sign-in forms, vital sign graphic record, triage record, physician orders, ED ECG reports, ED telemetry/rhythm strips, ED laboratory reports, ED x-ray reports  **Review the ONLY ACCEPTABLE SOURCES to determine the earliest time the patient arrived at the ED. The intent is to utilize any documentation which reflects processes that occurred after arrival at the ED.**   * 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. * Documentation outside of the ONLY ACCEPTABLE SOURCES list should NOT be referenced (e.g., ambulance record, physician office record, H&P). * 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.   * 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 transferred to the ED, use the time the patient arrives in the ED. * **If arrival time is unable to be determined from any of the ONLY ACCEPTABLE SOURCES, enter 99:99.** |
| 3 | emcode  ALL | Enter the E/M code documented for this emergency department encounter. | **\_\_ \_\_ \_\_ \_\_ \_\_**  **Auto-filled: can be modified** | **Will auto-fill from PTF with ability to change.**  This code is used to report evaluation and management services provided in the emergency department.  **Do NOT change the E/M code unless the E/M code documented in the record is not the code displayed in the software.**  **E/M codes for ED encounters: 99281, 99282, 99283, 99284, 99285, and 99291.** |
| 4 | princode  ALL | Enter the ICD-10-CM principal diagnosis code. | \_\_ \_\_ \_\_. \_\_ \_\_ \_\_ \_\_  (3 alpha-numeric characters/decimal point/four alpha-numeric characters)  **Auto-filled: can be modified**   |  | | --- | | **Cannot enter 000.0000, 123.4567, or 999.9999** | | **Will auto-fill from PTF with ability to change. Do NOT change the principal diagnosis code unless the principal diagnosis code documented in the record is not the code displayed in the software.**  **The principal diagnosis code is the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) code associated with the diagnosis established after study to be chiefly responsible for the emergency department encounter.** |
| 5 | othrcode1  othrcode2  othrcode3  othrcode4  othrcode5  othrcode6  othrcode7  othrcode8  othrcode9  othrcode10  othrcode11  othrcode12  othrcode13  othrcode14  othrcode15  othrcode16  othrcode17  othrcode18  othrcode19  othrcode20  othrcode21  othrcode22  othrcode23  othrcode24  **OP-4, OP-5** | Enter the ICD-10-CM other diagnosis codes: | \_\_ \_\_ \_\_. \_\_ \_\_ \_\_ \_\_  (3 alpha-numeric characters /decimal point/four alpha-numeric characters)  **Auto-filled: cannot be modified**  **If enabled, can enter up to 24 codes**  **If enabled, abstractor can enter xxx.xxxx in code field if no other diagnosis codes found** | **Will be auto-filled from PTF with up to 24 ICD-10-CM other diagnosis codes. Cannot be modified.**  **If no other diagnosis codes are received from PTF, abstractor is to verify codes documented the record and enter. If no other diagnosis codes are found in the record, enter xxx.xxxx.** |

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| --- | --- | --- | --- | --- | --- | --- |
| 6 | dccode  ALL | What was the patient’s discharge disposition from the outpatient setting?  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   4a. Non-VA Acute Care Facility – General Inpatient Care  4b. Acute Care Facility – Critical Access Hospital  4c. Acute Care Facility - Cancer or Children’s Hospitals  4d. Acute Care Facility - Department of Defense or Veteran’s Administration Hospitals  5. Other Health Care Facility   * Extended or Immediate Care Facility (ECF/ICF) * Long Term Acute Care Hospital (LTACH) * Nursing Home or Facility including Veteran’s Administration Nursing Facility * Psychiatric Hospital or Psychiatric Unit of a Hospital * Rehabilitation Facility including Inpatient Rehabilitation Facility/Hospital or Rehabilitation Unit of a Hospital * Skilled Nursing Facility (SNF), Sub-Acute Care or Swing Bed * Transitional Care Unit (TCU) * Veteran’s Home   6. Expired  7. Left Against Medical Advice/AMA  99. Not documented or unable to determine | | | 1,2,3,4a, 4b,4c,4d,5,6,7,99 | **Discharge disposition: The final place or setting to which the patient was discharged from the outpatient setting.**   * **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. Example: Nursing discharge note documentation indicates that the patient was discharged to home. A later Social Services note states “Home with Hospice.” Select “2”. * Values “2” and “3” hospice include discharges with hospice referrals and evaluations * If the medical record states only that the patient is being discharged to a non -VA hospital and does not reflect the level of care that the patient will be receiving, select “4a”. * 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):   + A signed AMA form is not required for this data element, but in the absence of a signed form, the medical record must contain physician or nurse documentation that the patient left against medical advice or AMA.   + Do not consider AMA documentation and other disposition documentation as “contradictory.” If any source states the patient left against medical advice, select “7” regardless of whether the AMA documentation was written last (e.g., AMA form signed and discharge instruction sheet states “Discharged home with belongings” - select “7”.   + Physician order written to discharge to home. Nursing notes reflect that the patient left before discharge instructions could be given; select “1”.     **Suggested Data Sources:** Discharge instruction sheet, Emergency Department record, nursing discharge notes, physician orders, progress notes, transfer record |
|  |  | **Emergency Department** |  | | |  |
| 7 | provcondt  OP-20 | Enter the date the patient first had direct personal exchange with the physician/APN/PA or institutionally credentialed provider to initiate the medical screening examination in the emergency department. | mm/dd/yyyy  Abstractor can enter 99/99/9999   |  | | --- | | > =arrvdate and <= 3 days after arrvdate | | | | **ONLY ACCEPTABLE SOURCE: ED record**   * There must be documentation of direct contact between the ambulatory patient and the physician/APN/PA or institutionally credentialed provider, **excluding the triage nurse**. Advanced Practice Nurse (APN, APRN) titles may vary between state and clinical specialties. Some common titles that represent the advanced practice nurse role are Nurse Practitioner (NP), Certified Registered Nurse Anesthetist (CRNA), Clinical Nurse Specialist (CNS), and Certified Nurse Midwife (CNM). * If the date of provider contact is not documented, but you are able to determine the date from other ED documentation this is acceptable. * If the date the patient first had direct contact with the physician/APN/PA or institutionally credentialed provider is unable to be determined from medical record documentation, enter 99/99/9999. * If there is documentation the patient left against medical advice and it cannot be determined whether the patient had direct contact with the physician/APN/PA or institutionally credentialed provider, enter 99/99/9999. * The medical record must be abstracted as documented (taken at “face value”). When the date documented is obviously in error (not a valid format/range or outside of the parameters of care) **and** no other documentation is found that provides this information, the abstractor should enter 99/99/9999.   Examples:   * Documentation indicates the *Provider Contact Date* was 03-**42**-20xx. No other documentation in the ED record provides a valid date. Since the *Provider Contact Date* is outside of the range listed in the Allowable Values for “Day,” it is not a valid date and the abstractor should enter 99/99/9999.   Cont’d next page |
|  |  |  |  | | | **Provider Contact Date cont’d**   * + Patient expires on 02-12-20xx and all documentation within the ONLY ACCEPTABLE SOURCES indicates the *Provider Contact Date* was 03-12-20xx. Other documentation in the medical record supports the date of death as being accurate. Since the *Provider Contact Date* is after the *Discharge Date* (death), it is outside of the parameter of care and the abstractor should enter 99/99/9999.   **Exclusion: Admission Date, Arrival Date, Presentation Date, Triage Date** |
| 8 | provcontm  OP-20 | Enter the time the patient first had direct personal exchange with the physician/APN/PA or institutionally credentialed provider to initiate the medical screening examination in the emergency department. | \_\_\_\_\_\_  UMT  Abstractor can enter 99:99   |  | | --- | | >= arrvtime and <= 72 hours after arrvtime | | Warning if provcondt/provcontm - arrvdate/arrvtime <= 10 minutes or >= 120 minutes | | | | | **ONLY ACCEPTABLE SOURCE: ED record**   * There must be documentation of direct contact between the ambulatory patient and the physician/APN/PA or institutionally credentialed provider, **excluding the triage nurse**. **The intention is to capture the earliest time at which the patient had direct contact with the physician/APN/PA or institutionally credentialed provider in the emergency department.** Advanced Practice Nurse (APN, APRN) titles may vary between state and clinical specialties. Some common titles that represent the advanced practice nurse role are Nurse Practitioner (NP), Certified Registered Nurse Anesthetist (CRNA), Clinical Nurse Specialist (CNS), and Certified Nurse Midwife (CNM). * If the time the patient first had direct contact with the physician/APN/PA or institutionally credentialed provider is unable to be determined from medical record documentation, enter 99:99. * Documentation of a provider writing an order, beginning the patient note, or making other documentations regarding a patient in the medical record, is not sufficient for the *Provider Contact Time* because there is no evidence that the provider had direct, personal contact with the patient during these actions. * If there is documentation that a provider had direct, personal contact with a patient during an examination and that this was the first direct encounter between the patient and the provider, then the time of the exam may be abstracted for the *Provider Contact Time* data element, even if it is not specifically documented as “provider contact time” in the medical record. |
|  |  |  |  | | | * Documentation of a re-examination or that clearly describes an encounter with the patient that was not the first time of provider contact is not sufficient for the *Provider Contact Time*. If a re-examination is the only encounter time documented, then enter 99:99. * If there is documentation the patient left against medical advice and the patient did not have direct contact with the physician/APN/PA or institutionally credentialed provider, enter 99:99. * If the *Provider Contact Time* is documented prior to arrival or after departure/discharge from the ED, enter 99:99. * The medical record must be abstracted as documented (taken at “face value”). When the time documented is obviously in error (not a valid format/range) **and** no other documentation is found that provides this information, the abstractor should enter 99:99. Example:   + Documentation indicates the *Provider Contact Time* was 3300. No other documentation in the ED record provides a valid time. Since the *Provider Contact Time* is outside of the range in the Allowable Values for “Hour,” it is not a valid time and the abstractor should enter 99:99.   **Exclusion: Admission Time, Arrival Time, Presentation Time, Triage Time, Provider Assigned Time** |
| 9 | edcdt  OP-3,OP-18 | Enter the date the patient departed from the emergency department. | mm/dd/yyyy  Abstractor can enter 99/99/9999   |  | | --- | | > =arrvdate and <= 3 days after arrvdate | | | | **ONLY ACCEPTABLE SOURCE: ED record**   * If the date of departure from the ED is not documented, but the date of departure can be determined from other documentation, (e.g., you are able to identify from documentation the patient arrived and was transferred to medical unit on the same day), enter this date. * For patients who are placed into observation services, enter the date of the physician/APN/PA order for observation services as ED Departure Date. * A discharge date listed on a disposition sheet may be used. * 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. * If the date the patient departed from the ED is unable to be determined from medical record documentation, enter 99/99/9999. * The medical record must be abstracted as documented (i.e., face value). When the date documented is obviously in error (e.g. 11/42/20xx) or outside the parameters of care (e.g., after discharge date) and no other documentation is found that provides this information, enter 99/99/9999.   **Includes, but is not limited to:** ED Departure Date, ED Discharge Date, ED Leave Date  **Exclude:** Disposition Date |
| 10 | edctm  OP-3,OP-18 | Enter the time the patient departed from the emergency department. | \_\_\_\_\_  UMT  Abstractor can enter 99:99   |  | | --- | | >=arrvdate/arrvtime and < = 72 hours after arrvdate/arrvtime |  |  | | --- | | Warning if edcdt/edctm - arrvdate/arrvtime <= 10 minutes or >= 240 minutes | | | | **ONLY ACCEPTABLE SOURCE: ED record**  ***ED Departure Time* is the documented 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, or awaiting transport to services/care.**   * When more than one acceptable *ED Departure Time* is documented, abstract the **latest** time.   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.   * If the patient expired in the ED, use the time of death as the *ED Departure Time.* * For patients who are placed into observation services, use the time of the physician/APN/PA order for observation services as *ED Departure Time*. * Do not use the time the discharge order was written because it may not represent the actual time of departure. * A departure time listed within a disposition heading from the ED may be used. * If the time the patient departed from the ED is unable to be determined from medical record documentation, enter 99:99. * The medical record must be abstracted as documented (i.e., at face value). When the time documented is obviously in error (e.g. 33:00), and no other documentation is found that provides this information, enter 99:99.   **Includes, but is not limited to:** ED Check Out Time, ED Departure Time, ED Discharge Time, ED Leave Time, ED Order for Observation Status  **Excludes, but is not limited to:** Discharge Instructions Time, Disposition Time, Report Called Time |
| **If dccode = 4a or 4d AND princode is on OP Table 1.1 (Appendix A), go to ecg; if dccode = 4a or 4d AND princode or othrcode is on OP Table 1.1a (Appendix A), go to cardpain; else go to painmed as applicable** | | | | | | |
| 11 | cardpain  OP-4,OP-5 | Was there physician/APN/PA or RN documentation that the patient’s chest pain was presumed to be cardiac in origin?  1. Yes  2. No | | 1,2  If 2, go to painmed as applicable   |  | | --- | | Warning if 2 | | | * If there is documentation of a differential/working diagnosis of acute myocardial infarction select “Yes.” * Disregard documentation of inclusions/exclusions described with terms indicating the condition is not acute, such as “history of.” * If there is documentation by the nurse or physician of an exclusion term, select “No,” unless there is a working/differential diagnosis of AMI continue to select “Yes.”   **Inclusion Guidelines:**   * Acute coronary syndrome * Acute myocardial infarction (AMI) * Angina * Cardiac * Cardiac Chest Pain * Chest Pain * Chest tightness * Heart attack * Ischemia * Myocardial Infarction * Unstable angina   The following qualifiers should be abstracted as positive findings if listed with any of the above inclusion terms: appears to have, cannot exclude, cannot rule out, consider, consistent with (c/w), could/may/might be/have been/have had/indicate, diagnostic of, differential diagnosis, evidence of, indicative of, likely, most likely, , possible, probable, questionable (?), representative of, risk of, rule(d) out (r/o), suggestive of, suspect, suspicious, versus (vs), working diagnosis  **Exclusion Guidelines:**   * Atypical Chest Pain * Chest Pain musculoskeletal * Chest Pain qualified by a non-cardiac cause * Chest wall pain * Non Cardiac Chest Pain * Non-specific Chest Pain (R07.9 Chest Pain, unspecified) * Traumatic Chest Pain * Trauma   Cont’d next page |
|  |  |  | |  | | Chest Pain cont’d   * MVA (Motor Vehicle Accident)   **Excluded Data Sources:** Chest X-Ray reports, radiology reports |
| 12 | ecg  OP-5 | Was an electrocardiogram (ECG) performed within one hour prior to emergency department arrival or in the ED prior to transfer? 1. Yes  2. No | | 1,2  **If 2, auto-fill ecginter as 2 and go to asaed**   |  | | --- | | Warning if 2 | | | * If there is an ECG performed within one hour prior to arrival select “Yes.” * If there are multiple ECGs performed within one hour prior to emergency department arrival and/or in the ED prior to transfer, select “Yes.” * If a pre-hospital ECG (i.e., ECG performed prior to ED arrival) cannot be confirmed as a 12-lead ECG based on documentation or the ECG strip, then abstract “No” for *ECG*. * In contrast, if there is documentation of an ECG performed in the ED (i.e. ECG performed after ED arrival) that is not specified as a 12-lead ECG, then abstract “Yes” for *ECG*.   **Suggested Data Sources:** ambulance record, ED record |
| 13 | ecgdt  OP-5 | Enter the date the earliest ECG was performed. | | mm/dd/yyyy   |  | | --- | | > =arrvdate and <= edcdt | | | **In the event the patient had an ECG performed within 60 minutes prior to arrival at the emergency department, enter the date the patient arrived at this emergency department.**  If there are 2 ECGs performed (one prior to arrival and one after arrival) abstract the ECG performed prior to arrival.  If no ECGs were performed within 60 minutes prior to arrival, and multiple ECGs were performed after arrival, abstract the ECG performed closest to arrival.  **Determining ECG Date**  **The abstractor can accept only the date and time printed on the ECG tracing for ECGs performed in the ED.**  Enter the exact date. The use of 01 to indicate missing day or month is not applicable. |
| 14 | ecgtm  OP-5 | Enter the time the earliest ECG was performed. | | \_\_\_\_\_  UMT   |  | | --- | | >=arrvdate/arrvtime and < = edcdt/edctm | | | **In the event the patient had an ECG performed within 60 minutes prior to arrival at the emergency department, enter the time the patient arrived at this emergency department.**   * If there are 2 ECGs performed (one within 60 minutes prior to arrival and one after arrival) abstract the ECG performed prior to arrival. **NOTE: If abstracting the ECG performed prior to arrival, enter the ED arrival time as the ECG time.** * If no ECGs were performed within 60 minutes prior to arrival, and multiple ECGs were performed after arrival, abstract the ECG performed closest to arrival.   **Determining ECG Time**  **The abstractor can accept only the date and time printed on the ECG tracing for ECGs performed in the ED.**  Time must be entered in Universal Military Time. |
| 15 | ecginter  OP-1,OP-2,OP-3 | Is there documentation of ST-segment elevation on the ECG performed closest to emergency department arrival?  |  | | --- | | **ST-segment Elevation Inclusion Guidelines** | | * myocardial infarction (MI) with any mention of location or combinations of locations (e.g., anterior, apical, basal, inferior, lateral, posterior, or combination) IF DESCRIBED AS ACUTE/EVOLVING (e.g., “posterior AMI”) * Q wave MI, IF DESCRIBED AS ACUTE/EVOLVING * ST ↑ * ST, ST abnormality, or ST changes consistent with injury or acute/evolving MI * ST-elevation (STE) * ST-elevation myocardial infarction (STEMI) * ST-segment noted as ­>/= .10mV * ST-segment noted as >/= 1mm * STEMI or equivalentTransmural MI, IF DESCRIBED AS ACUTE/EVOLVING |   1. Yes  2. No | | 1,2  Will be auto-filled as 2 if ecg = 2  **If 2, go to asaed** | | **This data element refers to the ECG performed closest to emergency department arrival.ST-SEGMENT ELEVATION: new or presumed new ST-segment elevation >/= .10mV in more than one lead.**  **ECG Interpretation is defined as:**   * 12-lead tracing with name/initials of the physician/APN/PA who reviewed the ECG signed or typed on the report, **OR** * Physician/APN/PA documentation of ECG findings in another source (e.g., ED notes, progress notes). * Do not measure ST-segments or attempt to determine if there is ST elevation from the tracing itself. * **Identify the ECG performed closest to arrival, either before or after emergency department arrival, but not more than 1 hour prior to arrival. Must be prior to any procedures (cardiac cath or PCI).** * **Exception:** If the pre-arrival ECG and the first ECG performed after arrival are exactly the same amount of time away from hospital arrival (e.g., both ECGs are 10 minutes away from Arrival Time), use the first ECG performed after hospital arrival.   **Hierarchy for ECG interpretation:**  1. If there is a cardiologist’s note that refers to interpretation of the ECG performed closest to ED arrival, use this interpretation. **If the ECG interpretation differs between the cardiologist and another physician, use the cardiologist interpretation.**  **2. If there is discrepancy in interpretation between two physicians and neither is a cardiologist, use the interpretation done closest to the ACS event.**  3. A 12-lead ECG report in which the name or initials of the physician/APN/PA who reviewed the ECG is signed or typed on the report. An electronic ECG “reading” must also be” signed off” by the physician/APN/PA.  4. Any physician interpretation of ECG findings. Interpretations may be taken from documentation of ECG findings in ED notes, admission note, or progress note. |
|  |  |  | |  | | |  | | --- | | **ST Elevation Exclusion Guidelines** | | * Documentation of the absence of STEMI (In reference to the ECG performed closest to arrival), e.g., “No STEMI,” “not consistent with STEMI,” “not diagnostic of STEMI.” * Non Q wave MI (NQWMI) * Non ST-elevation MI (NSTEMI) * ST ↑ clearly described as confined to ONE lead * ST ↑ with **any** mention of early repolarization, left ventricular hypertrophy (LVH), normal variant, pericarditis, or Printzmetal/Printzmetal's variant in one interpretation * ST, ST abnormality, or ST changes consistent with injury or acute/evolving MI OR any of the “myocardial infarction” (MI) Inclusion terms described using one of the negative modifiers or qualifiers listed in Appendix H, Table 2.6, Qualifiers and Modifiers Table (except “possible”) * ST-segment elevation, or any of the other ST-segment elevation Inclusion terms, with any mention of pacemaker/pacing (unless atrial only or nonfunctioning pacemaker) in one interpretation * ALL ST-elevation (ST↑, STE) in one interpretation is described in one or more of the following ways: * Minimal, * Non-diagnostic * Non-specific * ST-elevation or ST-segment noted as greater than or equal to .10mV/1mm AND described using one of the negative modifiers or qualifiers listed in Appendix H, Table 2.6, Qualifiers and Modifiers Table (except “possible”) * ST-elevation or ST-segment noted as less than .10mV in elevation * ST-elevation or ST-segment noted as less than 1mm in elevation * **(cont’d next page)** | |
|  |  |  | |  | | |  | | --- | | **ST Elevation Exclusion Guidelines (cont’d)** | | * old, chronic, age unknown, recent, previously seen, unchanged, no new changes, no acute changes, no significant changes when compared to a prior ECG. **EXCEPTION: When the ST-elevation on the ECG done closest to arrival is described as previously seen on an ECG done by EMS or physician office prior to arrival, this ST-elevation may count as an Inclusion.** * Do not consider “Subendocardial” an MI “location” (e.g., “acute Subendocardial MI” should be disregarded). |  * If any of the inclusion terms are described using the qualifier “possible,” “probable,” or “potential,” disregard that finding (neither Inclusion nor Exclusion),  |  |  | | --- | --- | | **Qualifiers/Modifiers** | | | **Qualifiers:** **and/or, (+/-), cannot exclude, cannot rule out, could/may/might be, could/may/might have, could/may/might have been, could/may/might have had, could/may/might indicate, questionable (?)**, risk **of, ruled out (r’d/o, r/o’d), suggestive of, suspect, or suspicious** | **Modifiers**: **borderline, insignificant, not significant, no significance, minor, scant, slight, sub-clinical, subtle, trace, trivial** | |
| 16 | fibrintx  OP-1,OP-2, OP-3 | Did the patient receive fibrinolytic therapy at this emergency department? 1. Yes  2. No | | 1,2  If 1, auto-fill nofibtx as 95  If 2, go to nofibtx | | **Fibrinolytic therapy is the administration of a pharmacological agent intended to cause lysis of a thrombus (destruction or dissolution of a blood clot).**   * In the event the patient was brought to the hospital via ambulance and fibrinolytic therapy was infusing at the time of arrival, select “Yes.” * In the event the patient was brought to the emergency department via ambulance and fibrinolytic therapy was infused during transport **but was completed** at the time of emergency department arrival, select “No.” * If the first dose of reteplase (Retavase) is given in the ambulance and the second dose is given in the emergency department, select “Yes.” * **Exclude fibrinolytics given during or after a PCI**.   **Classes of fibrinolytic drugs and examples include:**   * Tissue Plasminogen Activators (tPA)   -Alteplase (Activase; rtPA)  -Retaplase (Retavase)  -Tenecteplase (TNK-tPA)  -Streptokinase  -Natural streptokinase (Kabikinase, Streptase, SK)   * Combination   -Anisoylated plasminogen streptokinase activator complex (APSAC)  **Refer to Appendix C, OP Table 1.3, Fibrinolytic Agents.** |
| 17 | fibtxdt  OP-1,OP-2 | Enter the date primary fibrinolytic therapy was administered at this facility. | | mm/dd/yyyy  Abstractor may enter 99/99/9999   |  | | --- | | > =arrvdate and <= edcdt | | | * Check emergency department notes, medication administration record, and nursing notes for specific date fibrinolytic therapy was administered**.** * If there are two or more different fibrinolytic administration dates (either different fibrinolytic episodes or corresponding with the same episode), enter the date the earliest fibrinolytic agent was initiated. * If the patient was brought to the hospital via ambulance and fibrinolytic therapy was infusing at the time of hospital arrival, enter the date the patient arrived at the hospital. * Enter the exact date. Entry of 01 for month or day is not acceptable. * If the date primary fibrinolytic therapy was initiated is unable to be determined from medical record documentation, enter 99/99/9999. * If the date documented in the medical record is obviously in error (not valid, e.g. 03-**42-**20xx) and no other documentation is found, enter 99/99/9999. |
| 18 | fibtxtm  OP-1,OP-2 | Enter the time primary fibrinolytic therapy was administered at this facility. | | \_\_\_\_\_ UMT  Abstractor may enter 99:99   |  | | --- | | >=arrvdate/arrvtime and <= edcdt/edctm | | | * **If fibrinolytic therapy was initiated in the ambulance and was infusing at the time of arrival, use the hospital arrival time.** * If there are two or more different fibrinolytic administration times (either different fibrinolytic episodes or corresponding with the same episode), enter the earliest time the fibrinolytic agent was initiated. * Time must be in Universal Military Time. If the time is in the a.m., conversion is not required. If the time is in the p.m., add 12 to the clock time hour. * If the time primary fibrinolytic therapy was initiated is unable to be determined from medical record documentation, enter 99:99. * If the time documented in the medical record is obviously in error (not valid, e.g. **33**:00) and no other documentation is found, enter 99:99. |
| 19 | fibdelay | Is there a reason documented by a physician, APN, or PA for a delay in initiating fibrinolytic therapy after hospital arrival?   1. Yes 2. No | | 1,2  If 1 or 2, go to tranaci | | **Reasons for delay in fibrinolytic therapy should be collected regardless of how soon after arrival it was ultimately initiated or how minimal the delay.**   * **Physician/APN/PA documentation must be clear in the record that:**   **(1) a “hold,” “delay,” “deferral”, or “wait” in initiating fibrinolysis/reperfusion actually occurred, AND**  **(2) the underlying reason for that delay was non-system in**  **nature**.  **Do NOT make inferences from documentation of a sequence**  **of events alone. Examples of ACCEPTABLE**  **physician/APN/PA documentation:**   * “Hold on fibrinolytics. Will do CAT scan to rule out bleed.” * “Patient waiting for family and clergy to arrive - wants to consult with them before fibrinolysis.” * “Fibrinolysis delayed due to need to control BP before administering fibrinolysis.” * “Fibrinolytic therapy initially deferred due to shock.”   **EXCEPTIONS that do NOT require documentation that a**  **delay in initiating fibrinolytic therapy occurred:**  **1. Physician/APN/PA documentation that cardiopulmonary arrest, mechanical circulatory assist device placement, or intubation occurred within 30 minutes after arrival**. In order to be acceptable, documentation must be CLEAR that the arrest, mechanical circulatory assist device placement, or intubation occurred within 30 minutes after arrival (use the earliest time documented to confirm the cardiopulmonary arrest occurred within 30 minutes).   |  | | --- | | **Inclusion Guidelines: Cardiopulmonary arrest** | | * Cardiac arrest * Cardiopulmonary resuscitation (CPR) * Defibrillation * Respiratory arrest * Ventricular fibrillation (V-fib) |   **Cont’d next page** |
|  |  |  | |  | | |  | | --- | | **Inclusion Guidelines: Intubation** | | * Endotracheal intubation (ETI) * Mechanical ventilation * Nasotracheal intubation (NTI) * Orotracheal intubation | | **Inclusion Guidelines: Mechanical circulatory assist devices** | | * Aortic balloon pump * Biventricular assist device (BiVAD) * Intra-aortic balloon (IAB) * Intra-aortic balloon counterpulsation (IABC) * Intra-aortic balloon pump (IABP) * Intra-aortic counterpulsation (IAC) * Intra-aortic counterpulsation balloon pump (IACBP) * Left ventricular assistive device (LVAD) * Percutaneous ventricular assist device (PVAD) * Ventricular assist device (VAD) |   **2. Physician/APN/PA documentation of initial patient/family refusal of fibrinolysis/reperfusion**   * **System reasons for delay are NOT acceptable, regardless of any linkage to the delay in the fibrinolysis/reperfusion. Examples of system reasons include but are not limited to:** * Equipment-related (e.g., IV pump malfunction) * Staff related issues (e.g., waiting for medication to be sent from pharmacy) * Consultation with other clinician that is not clearly linked to a patient-centered (non-system) reason for delay * **If unable to determine whether a documented reason is system in nature, select “2.”**   The following examples are **NOT** acceptable documentation of reasons for a delay in initiating fibrinolytic therapy:  “Patient is discussing PCI with family” (Not specific enough - no mention of reperfusion/fibrinolytic therapy.) “Fibrinolytics contraindicated - too high risk.” (Effect on timing/delay of fibrinolysis not documented.)  **Cont’d next page** |
|  |  |  | |  | | **Reason for delay cont’d**  “ST-elevation on initial ECG resolved. Chest pain now recurring. Begin lytics.” (Requires clinical judgment - linkage to delay in fibrinolysis not clear.)  “Patient presented to ED with non-cardiac symptoms. AMI confirmed later that morning. Fibrinolytic therapy started.” (Requires clinical judgment - linkage to delay in fibrinolysis not documented.) |
| 20 | nofibtx  OP-3 | Is there physician/APN/PA or pharmacist documentation of a contraindication or reason for not administering fibrinolytic therapy?  1. Yes, physician/APN/PA or pharmacist documented reason for not administering fibrinolytic therapy  2. Yes, physician/APN/PA documented the patient has a diagnosis of cardiogenic shock  95. Not applicable  98. Patient/caregiver refused fibrinolytic therapy  99. No documentation of reason for not administering fibrinolytic therapy or unable to determine | | 1,2,95,98,99  Will be auto-filled as 95 if fibrintx = 1 | | * When conflicting information is documented in a medical record, a positive finding (fibrinolytic allergy) should take precedence over a negative finding (no known allergy). * If a contraindication/reason listed under the Inclusion Guidelines for Abstraction is clearly documented in the content of the Emergency Department record, then this is sufficient to abstract value 1 for this data element. There does not need to be explicit documentation of a rationale by a provider linking the documented contraindication/reason and the decision to not administer fibrinolytic therapy if the contraindication/reason is listed under the Inclusion Guidelines for Abstraction. * If a contraindication/reason for not administering fibrinolytic therapy that is not listed under the Inclusion Guidelines for Abstraction is clearly documented in the content of the Emergency Department record, and there is clear documentation by a physician/APN/PA or pharmacist linking this contraindication/reason to the decision to not administer fibrinolytic therapy, then this is also sufficient to abstract value 1 for this data element. * In situations where there is documentation that would support more than one of the allowable values, 1, 2, 98, or 99, select the lowest value. **Example:** Patient has a documented contraindication from the inclusion list and a diagnosis of cardiogenic shock, select value “1.”   **Cont’d next page** |
|  |  |  | |  | | **Reason no fibrinolytics cont’d**  **Inclusion Guidelines for Abstraction:**  **Contraindications**   * Any prior intracranial hemorrhage * Known structural cerebral vascular lesion (e.g. AVM) Known malignant intracranial neoplasm (primary or metastatic) * Ischemic stroke within 3 months EXCEPT acute ischemic stroke within 3 hours * Suspected aortic dissection * Active bleeding or bleeding diathesis (excluding menses) * Significant closed head trauma or facial trauma within 3 months * Severe uncontrolled hypertension on presentation (SBP > 180 mm Hg or DBP > 110 mm Hg) * History of prior ischemic stroke > 3 months, dementia, or known intracranial pathology not covered in contraindications * Traumatic or prolonged (> 10 minutes) CPR or major surgery (< 3 Weeks) * Recent (within 2 to 4 weeks) internal bleeding * Noncompressible vascular punctures * For streptokinase/anistreplase: prior expose (> 5 days ago) or prior allergic reaction to these agents * Pregnancy * Active peptic ulcer * **Current use of any of the following anticoagulants prior to arrival:** apixaban (Eliquis), warfarin (Coumadin, Jantoven), dabigatran (Pradaxa), rivaroxaban (Xarelto)   **Risk:** Cardiogenic Shock |
| 21 | tranaci  OP-3 | Was there documentation the patient was transferred from this facility’s emergency department to another facility for acute coronary intervention?  1. There was documentation the patient was transferred from this facility’s emergency department to another facility specifically for acute coronary intervention  2. There was documentation the patient was admitted to observation status prior to transfer  3. There was documentation the patient was transferred from this facility’s emergency department to another facility for reasons other than acute coronary intervention or unable to determine reason for transfer from medical record | | 1,2,3 | | * To select value “1,” documentation must include a specifically defined reason for transfer such as “Percutaneous Coronary Intervention (PCI),” “Angioplasty,” “for cardiac cath,” or “for cath lab.” * The Inclusion Guidelines for Abstraction is not an all-inclusive list. If the acute coronary intervention is not listed in the Inclusion Guidelines for Abstraction, but it is a defined reason for transfer, this is sufficient to select value “1.” * To select value “2,” there must be documentation of a physician/APN/PA order to admit to observation status. * If a patient receives acute coronary intervention prior to transfer, then select value “3.”   **Inclusion Guidelines:**   * Acute angiogram * Acute cardiac intervention * Acute coronary intervention * Angioplasty * Cath lab * Cardiac catheterization * Interventional cardiology * Percutaneous Coronary Intervention * Primary Percutaneous Coronary Intervention * Primary PCI * PCI |
| 22 | asaed  OP-4 | Was aspirin received within 24 hours prior to emergency department arrival or administered in the emergency department prior to transfer? 1. Yes  2. No | | 1,2  If 1, auto-fill noasa as 95 and go to painmed as applicable | | * **Appendix C, OP Table 1.1, Aspirin and Aspirin-Containing Medications, referred to in the Inclusion Guidelines for Abstraction, is not all-inclusive. If there is documentation the patient received an aspirin/aspirin-containing medication that is not on Appendix C, OP Table 1.1, Aspirin and Aspirin-Containing Medications, you may abstract a “Yes” for this data element.**   **In the absence of explicit documentation that the patient received aspirin within 24 hours prior to *Arrival Time*:**   * **In cases where the patient was received as a transfer from another hospital (inpatient, outpatient, ED, observation):**   + Aspirin listed as “home” medication: Do **not** make inferences. Additional documentation is needed which clearly suggests the patient took aspirin at home within 24 hours prior to *Arrival Time*. * Aspirin listed as “current” medication:   + If there is documentation that aspirin was a current medication at the transferring facility (e.g., aspirin noted on transfer summary, aspirin noted as “current medication” in your facility’s H&P), then infer aspirin was taken within 24 hours prior to *Arrival Time*, unless documentation suggests otherwise.   + If documentation suggests “current” aspirin refers to home regimen or documentation is not clear whether “current” means patient was on aspirin at the transferring facility or at home, do **not** make inferences. Additional documentation is needed which clearly suggests the patient either took aspirin at home or at the transferring facility within 24 hours prior to *Arrival Time*. * **In non-transfer cases**: Aspirin listed as “current” or “home” medication should be inferred as taken within 24 hours prior to *Arrival Time*, unless documentation suggests otherwise (e.g., Documentation that aspirin is on hold prior to arrival for a scheduled procedure). * If ASA is listed as home medication and last dose is noted as the day prior to arrival but no time, then infer aspirin was taken within 24 hours.   **Cont’d next page** |
|  |  |  | |  | | **Aspirin cont’d**   * When aspirin is noted only as received prior to arrival, without information about the exact time it was received (e.g. “baby ASA x4” per the “Treatment Prior to Arrival” section of the Triage Assessment), infer that the patient took it within 24 hours prior to *Arrival Time*, unless documentation suggests otherwise. * Aspirin documented as a PRN current/home medication does not count unless documentation is clear it was taken within 24 hours prior to *Arrival Time*. * If there is documentation in the ED record that aspirin was administered in the ED prior to transferring the patient to another facility or inpatient services, then select “Yes”.   **Inclusion:** Refer to Appendix C, OP Table 1.1, Aspirin and Aspirin-Containing Medications.  **Exclusion:** Aggrenox (aspirin/dypyridamole) |
| 23 | noasa  OP-4 | Was there documentation of a reason for not administering aspirin on arrival?  1. Aspirin allergy   3. One or more of the medications listed in the Inclusion List as pre-arrival medication  95. Not applicable   1. Other reason for not prescribing aspirin on arrival documented by a physician/APN/PA or pharmacist 2. Patient refusal of aspirin documented by physician/APN/PA or pharmacist   99. No documented reason or unable to determine | | 1,3,95,97,98,99  Will be auto-filled as 95 if asaed = 1 | | **1. Aspirin allergy:** “allergy” or “sensitivity” documented prior to arrival or in the medical record counts as an allergy regardless of what type of reaction might be noted (e.g. “Allergies: ASA - Upsets stomach” - select “1.”) Documentation of an allergy/sensitivity to one particular type of aspirin is acceptable to take as an allergy to the entire class of aspirin-containing medications (e.g., “Allergic to Empirin”).  **3. One or more of the medications listed in the Inclusion List** **as pre-arrival medication:** consider a medication listed in the Inclusion List to be a pre-arrival medication (a reason for not prescribing aspirin on arrival) if there is documentation the patient was on it prior to arrival, regardless of setting. Include cases where there is indication the medicationwas on temporary hold or the patient has been non-compliant/self-discontinued their medication (e.g., refusal, side effects, cost).  **Inclusion List** **(Pre-arrival medications that count as an automatic reason for no aspirin):**   * apixaban (Eliquis) * dabigatran (Pradaxa) * rivaroxiban (Xarelto) * warfarin/warfarin sodium (Coumadin/Jantoven)   **97.** **“Other reason” documented by a physician/APN/PA or pharmacist:**   * Reasons must be explicitly documented (e.g., “Chronic hepatitis - No ASA”) or clearly implied (e.g., “GI bleeding with aspirin in past,” “ASA contraindicated.” aspirin on pre-printed order form is crossed out, “No aspirin” [no reason given]) * If reasons are not mentioned in the context of aspirin, do not make inferences. **Examples:** (a) If the patient is taking clopidogrel (Plavix) or ticlopidine hydrochloride (Ticlid), clinician documentation must specify the use of this drug is the reason aspirin was not given. (b) Do not assume that aspirin is not being prescribed because of the patient’s history of peptic ulcer disease (PUD) alone.   **Cont’d next page** |
|  |  |  | |  | | **Reason no aspirin cont’d**   * Documentation of a pre-arrival hold or discontinuation of aspirin or notation such as “no aspirin” counts as a reason for not administering aspirin. * Documentation which refers to a more general medication class is not acceptable (e.g., “Hold all anticoagulants”). **EXCEPTION:** Documentation of a reason for not prescribing "antiplatelets" should be considered implicit documentation of a reason for no aspirin on arrival (e.g., "Antiplatelet therapy contraindicated”). * If there is conflicting documentation in the record regarding a reason for not administering aspirin on arrival, accept as a “yes” for the applicable reason.   **98.** **Patient refusal:** Documentation by a physician/APN/PA or pharmacist that the patient refused aspirin or refused all medications is acceptable. |
| **If dccode = 1, 2, 3, 4a, 4b, 4c, 4d, or 5 and princode is on OP Table 9.0 (Appendix A), go to painmed; else go to ctmriord as applicable.** | | | | | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  | **Pain Management Long Bone Fracture** |  |  |
| 24 | painmed  OP-21 | Was there documentation the patient received intranasal or parenteral pain medication during this emergency department visit?  1. Yes  2. No | 1,2  If 2, go to ctmriord as applicable | **For patients aged 18 years or greater, if intranasal or parenteral (intramuscular, intravenous, or subcutaneous) pain medication (including anesthesia/analgesia) is administered, select “Yes.”**  **NOTE:** For patients aged 18 years or greater, **if initial pain medication administration is oral**, select “No.”   * There must be documentation in the medical record the medication was administered in the emergency department, not just ordered. * There must be documentation in the medical record of the medication route either in the physician orders or the medication administration documentation. * Medication administration documentation must include the signature or initials of the person administering the medication. * If there is documentation in the medical record the patient received pain medication (e.g., self-administration, physician’s office or ambulance) prior to arrival, select “No.” * If there is documentation of routine pain medications on the home medication list, it can be assumed these medications were taken within 24 hours prior to arrival. Select “No.” **EXCEPTION:** If the pain medications are listed as taken on a PRN (as needed) basis, do not assume pain medications were taken within 24 hours prior to arrival unless there is documentation of administration in that timeframe. * If there is physician/APN/PA or nursing documentation of a reason for not administering pain medication (e.g., patient unconscious, decreased respiratory rate, patient refusal, pain score of 0), select “No.”   **Refer to Appendix C, OP Table 9.1 for a list of pain medications.**  **Anesthesia or Analgesia:**   * Epidural, spinal, or regional anesthesia/analgesia * Nerve block(median, ulnar, radial, posterior tibial, sural, saphenous, deep peroneal, superficial peroneal, femoral, brachial plexus, etc.) * Regional or peripheral nerve block * Lidocaine block   **Cont’d next page** |
|  |  |  |  | **Pain Medication cont’d**   * Intravenous anesthesia/analgesia * Procedural sedation * Interscalene block * IV regional anesthesia/analgesia * Saddle block * Caudal block * Bier block   **Exclusion Guidelines:** Transdermal Pain Medications  Suggested data sources: Nurses notes, physician notes, medication administration record |
| 25 | painmedt  OP-21 | Enter the date the earliest intranasal or parenteral pain medication was administered. | mm/dd/yyyy   |  | | --- | | >= arrvdate and <=edcdt |   Abstractor may enter 99/99/9999 | * **Abstract the date of the earliest intranasal or parenteral pain medication administered closest to arrival.** * If there are multiple administration dates documented for the exact same medication, use the earliest date. * Enter the exact date. * The medical record must be abstracted as documented (taken at “face value”). When the date documented is obviously in error (not a valid format/range or outside of the parameters of care) **and** no other documentation is found that provides this information, the abstractor should enter “99/99/9999.” * If the date of intranasal or parenteral pain medication administration is unable to be determined from medical record documentation, abstract 99/99/9999.   Suggested data sources: ED record |
| 26 | painmedtm  OP-21 | Enter the time the earliest intranasal or parenteral pain medication was administered. | \_\_\_\_\_  UMT   |  | | --- | | >=arrvdate/arrvtime and <= edcdt/edctm |   Abstractor may enter 99:99 | * **Abstract the time of the earliest intranasal or parenteral pain medication administered closest to arrival.** * If there are multiple administration times documented for the exact same medication, use the earliest time. * Enter the time in Universal Military Time. * The medical record must be abstracted as documented (taken at “face value”). When the time documented is obviously in error (not a valid format/range or outside of the parameters of care) **and** no other documentation is found that provides this information, the abstractor should enter “99:99.” * If the time of intranasal or parenteral pain medication administration is unable to be determined from medical record documentation, abstract 99:99.   Suggested data sources: ED record |
| **If princode is on OP Table 8.0 (Appendix A), go to ctmriord; else go to end.** | | | | |
|  |  | **Imaging for Stroke Patients** |  |  |
| 27 | ctmriord  OP-23 | Was a computerized tomography (CT) or Magnetic Resonance Imaging (MRI) scan of the head ordered by the physician/APN/PA during the emergency department visit?  1. Yes  2. No | 1,2  If 2, go to end | If there is documentation a Head CT or MRI Scan is ordered during the emergency department visit but is cancelled, and there are no other Head CT or MRI Scans ordered during the emergency department visit, abstract “No”.  **For purposes of the Head CT or MRI Scan Order use these priority sources:**   * Nurses notes * Physician notes/orders * Radiology notes |
| 28 | ctmridt  OP-23 | Enter the date the earliest Head CT or MRI Scan interpretation was completed/reported. | mm/dd/yyyy   |  | | --- | | >=arrvdate and <=edcdt |   Abstractor may enter 99/99/9999 | * Enter the date associated with the documented interpretation time of the Head CT or MRI Scan. * The date the earliest Head CT or MRI scan interpretation was completed/reported is the date the results are available to the physician/APN/PA. * If multiple Head CT or MRI Scans are documented, abstract the date of the earliest interpretation. * The medical record must be abstracted as documented (taken at “face value”). When the date documented is obviously in error (not a valid format/range or outside of the parameters of care) **and** no other documentation is found that provides this information, the abstractor should enter “99/99/9999.” * If the date of interpretation of the Head CT or MRI scan is unable to be determined from medical record documentation, enter 99/99/9999. |
| 29 | ctmritm  OP-23 | Enter the time the earliest Head CT or MRI Scan interpretation was completed/reported. | \_\_\_\_\_  UMT   |  | | --- | | >=arrvdate/arrvtime and <= edcdt/edctm |   Abstractor may enter 99:99 | * The time the earliest Head CT or MRI scan interpretation was completed/reported is the time the results are available to the physician/APN/PA. * If multiple Head CT or MRI Scans are documented, abstract the time of the earliest interpretation. * The medical record must be abstracted as documented (taken at “face value”). When the time documented is obviously in error (not a valid format/range or outside of the parameters of care) **and** no other documentation is found that provides this information, the abstractor should enter “99:99.” * If the time of interpretation of the Head CT or MRI scan is unable to be determined from medical record documentation, enter 99:99. * The dictation time or the time of a preliminary interpretation may be abstracted if it is known to be an accurate representation of when the earliest head CT or MRI scan interpretation time occurred. * Head CT or MRI Scan Interpretation Time should not be abstracted as the time the results of the scan were relayed to the ED physician/APN/PA if an earlier interpretation time is documented.   **Example:** Radiology Head CT report at 1100. ED physician notes: “Received Head CT report at 1130.” Enter Head CT or MRI Scan Interpretation Time as 1100.   * If the Head CT or MRI Scan Interpretation is documented prior to arrival, enter 99:99. * It is acceptable to use nurse documentation of a Head CT or MRI Scan interpreted by a physician. The interpretation must be performed by the physician/APN/PA, but it can be documented by a nurse. |
| 30 | lastwell  OP-23 | Is there documentation that the date and time of last known well was witnessed or reported?  1. Yes  2. No | 1,2  **If 2, go to end** | **Last Known Well: The date and time prior to hospital arrival at which it was witnessed or reported that the patient was last known to be without the signs and symptoms of the current stroke or at his or her baseline state of health.**   * Select “Yes,” if BOTH a *Date Last Known Well* and a *Time Last Known Well* are documented. * For patients with a documented date and time of witnessed onset of stroke signs and symptoms, select “Yes”. Example: “Wife reported that while eating dinner with patient, right corner of mouth started to droop and speech slurred about 6:00 PM this evening.” * Select “No” if there is any physician/APN/PA documentation that *Time Last Known Well* is unknown/uncertain. * Documentation must explicitly state that the *Time Last Known Well* is unknown/uncertain/unclear. Documentation that time of symptom onset is unknown/uncertain/unclear is also acceptable when *Time Last Known Well* is not documented. If *Last Known Well* is not explicitly documented as unknown, do not make inferences (e.g., do not assume that patient awoke with stroke so *Last Known Well* unknown unless explicitly documented). * If one physician documents a *Time Last Known Well* and another documents time of symptom onset unknown, select Yes. * If one physician documents a *Time Last Known Well* and nurse/EMS documents *Last Known Well* unknown, select Yes. * If one physician documents *Time Last Known Well* unknown and another documents a *Time Last Known Well*, select No. *Exception:* If the physician documents *Last Known Well* as unknown and the same physician crosses out unknown or mentions in a later note that *Last Known Well* is now known with a time documented, select Yes. * If the Time Last Known Well is clearly greater than 2 hours prior to hospital arrival AND no specific time is documented, select “No.” Example: “Patient OK last night.” Select “No” because no other documentation of a specific time/time range/time reference was present in the medical record and the time is required for *Time Last Known Well*. |
|  |  |  |  | * If there is no documentation that *Last Known Well* or stroke signs/symptoms occurred prior to hospital arrival but there is documentation that *Last Known Well* first occurred after *Arrival Time* (e.g., in-house stroke), select No.   **Signs and Symptoms of Stroke:**   * Sudden numbness or weakness of the face, arm or leg, especially on one side of the body * Sudden confusion, trouble speaking or understanding * Sudden trouble seeing in one or both eyes * Sudden trouble walking, dizziness, loss of balance or coordination * Sudden severe headache   **Suggested Data Sources:** Ambulance record, Code Stroke form, ED record, History and physical, nursing flow sheets, progress notes, transfer sheet |
| 31 | lastwelldt  OP-23 | Enter the date the patient was last known to be well or at his or her baseline state of health. | mm/dd/yyyy  Abstractor may enter 99/99/9999   |  | | --- | | <= 3 days prior to or = arrvdate | | ***Date Last Known Well* is the date prior to hospital arrival at which the patient was last known to be well without the signs and symptoms of the current stroke or at his or her baseline of health.**   * If the date last known well is documented as a specific date and entered as *Date Last Known Well* on a “Code Stroke” form or stroke-specific electronic template, enter that date as the *Date Last Known Well.* Documentation of *Date Last Known Well* on a stroke-specific form or template should be selected regardless of other dates last known well documented elsewhere in the medical record.   Exceptions:   * **Any** physician/APN/PA documentation that last known well/onset of signs/symptoms is unknown/uncertain/unclear takes precedence over specific time on a Code Stroke Form. * References in relation to *Arrival Date* are acceptable (e.g., today, tonight, this evening, and this morning). The *Date Last Known Well* and the *Arrival Date* may be the same date or a different date. Examples:   + “Wife reports patient normal this evening until approximately 9 PM.” Hospital arrival is 0030 on 12-10-20xx. *Date Last Known Well* is 12-09-20xx.   + “Patient states he felt perfectly fine earlier today. At noon, he began to have trouble seeing.” Hospital arrival is 3:59 PM on 12-10-20xx.” *Date Last Known Well* is 12-10-20xx. * If a reference to date last known well is documented without a specific date, enter that date for *Date Last Known Well.* If multiple dates are documented, select the earliest date.   Examples:   * + “Patient last known well today (day of arrival).” Select Arrival Date for *Date Last Known Well.*   + “Patient normal yesterday” (day before arrival) documented in ED note and consult note documents that patient was last known to be well on Monday (two days prior to arrival). Select Monday’s date for *Date Last Known Well.*   **Cont’d next page** |
|  |  |  |  | **Date Last Known Well cont’d**   * A Code Stroke Form is used by the stroke team or ED staff to document the acute stroke process. See the inclusion list for acceptable terms used for a Code Stroke Form. The list is not all-inclusive. * *Date Last Known Well* on a Code Stroke Form may be documented by a nurse or other member of the care team authorized to serve as a scribe. * The medical record must be abstracted as documented (taken at “face value”). When the date documented is obviously in error (not a valid date/format) and no other documentation is found that provides this information, enter 99/99/9999. Example: Documentation indicates the date last known well was 03-42-20xx. No other medical record documentation provides a valid date. Enter 99/99/9999.   **Suggested Data Sources:** Ambulance record, Code Stroke form, ED record, History and Physical, IV flow sheets, Medication Administration record, Nursing flow sheets, progress notes, transfer sheet  **Inclusion Guidelines for Abstraction**  **Code Stroke Form**   * Stroke Activation Form * Stroke Alert Form * Stroke Assessment Form * Stroke Intervention Form * Stroke Rapid Response Form * Thrombolysis Checklist * tPA Eligibility Form   **Exclusion Guidelines for Abstraction**  **Code Stroke Form**   * Stroke Education Form * Core Measure Form |
| 32 | lastwelltm  OP-23 | Enter the time the patient was last known to be well or at his or her prior baseline state of health. | \_\_\_\_\_  UMT  Abstractor may enter 99:99   |  | | --- | | <= 3 days prior to arrvdate/arrvtime and < arrvdate/arrvtime | | ***Time Last Known Well* is the time prior to hospital arrival at which the patient was last known to be well without the signs and symptoms of the current stroke or at his or her baseline of health.**   * If the time last known well is documented as a specific time and entered as *Time Last Known Well* on a “Code Stroke” form or stroke-specific electronic template, enter that time as the *Time Last Known Well.* Documentation of *Time Last Known Well* on a stroke-specific form or template should be selected regardless of other times last known well documented elsewhere in the medical record.   *Exceptions:*   * **Any** physician/APN/PA documentation that *last known well*/onset of signs/symptoms is unknown/uncertain/unclear takes precedence over specific time on a Code Stroke Form. * Crossing out of a specific time on a Code Stroke Form and a specific time documented on the same or different Code Stroke Form, use the specific time that is not crossed out. * A specific time on a Code Stroke Form and another time reference documented, e.g., 8 hours, on the same or different Code Stroke Forms, use the specific time. * Multiple specific times on the same or different Code Stroke Forms, use abstraction guidelines for multiple times *Last Known Well*. * If unable to determine if a form is a Code Stroke Form, continue to review the medical record for *Time Last Known Well* documentation in other sources. * If the time last known well is documented as being a specific number of hours prior to arrival (e.g., felt left side go numb 2 hours ago) rather than a specific time, subtract that number from the time of ED arrival and enter that time as the *Time Last Known Well*. * If the time last known well is noted to be a range of time prior to ED arrival (e.g., felt left side go numb 2-3 hours ago), assume the maximum time from the range (e.g., 3 hours), and subtract that number of hours from the time of arrival to compute the *Time Last Known Well*.   **Cont’d next page** |
|  |  |  |  | **Time last known well cont’d**   * If both the *Time Last Known Well* and symptom onset are documented, select the *Time Last Known Well.* Examples: * H&P states, “Patient watching TV with family and complained of blurred vision in both eyes at 8:30 PM.” ED MD notes, “Patient normal at 8:30 PM.” Time Last Known Well is 2030. * “Patient was doing well at 4:30 PM – noticed difficulty speaking around 6 pm.” *Time Last Known Well* is 1630 * “Patient normal at 2200 before going to bed. Awoke at 0200 with headache and took two aspirin before returning to sleep. OK at 0700 and went to work. Felt confused, unable to speak without slurring at 0800.” *Time Last Known Well* is 0700. * If the only time documented is time of symptom onset without mention of when the patient was last known well, use the time of symptom onset for *Time Last Known Well.*   **Example:**   * Sudden onset headache one hour before ED arrival,” documented by ED physician. Arrival time 19:24. No other documentation referencing time last known well available in the medical record. *Time Last Known Well* 18:24. * If there are multiple times of last known well documented in the absence of the *Time Last Known Well* explicitly documented on a “Code Stroke” form, use physician documentation first before other sources, e.g., nursing, EMS. * If multiple times of last known well are documented by different physicians or the same provider, use the earliest time documented. * If there is documentation of one or more episodes of stroke symptoms AND documentation of symptom resolution between episodes, use the time of the most recent (last) episode prior to arrival, regardless is all symptoms resolved prior to arrival. Example: “Wife noticed slurred speech at 8:30 last night. Without symptoms early this morning. Wife noticed slurred speech again at 09:00 during breakfast.” *Time Last Known Well* is 09:00.” |
|  |  |  |  | * A Code Stroke Form is used by the stroke team or ED staff to document the acute stroke process. See the inclusion list for acceptable terms used for a Code Stroke Form. The list is not all-inclusive. * *Time Last Known Well* on a Code Stroke Form may be documented by a nurse or other member of the care team authorized to serve as a scribe. * If the time is noted to be “less than” a period of time prior to ED arrival, assume the maximum range. Example: *Time Last Known Well* less than one hour ago. Subtract one hour from the time of arrival to compute *Time Last Known Well*. * The medical record must be abstracted as documented (taken at “face value”). When the time documented is obviously in error (not a valid time) and no other documentation is found that provides this information, enter 99:99. Example: Documentation indicates the time last known well was 33:00. No other medical record documentation provides a valid date. Enter 99:99.   **Suggested Data Sources:** Ambulance record, Code Stroke form, ED record, History and physical, Nursing flow sheet, progress notes, transfer sheet  **Inclusion Guidelines for Abstraction:**  **Code Stroke Form**   * Stroke Activation Form * Stroke Alert Form * Stroke Assessment Form * Stroke Intervention Form * Stroke Rapid Response Form * Thrombolysis Checklist * tPA Eligibility Form   **Exclusion Guidelines for Abstraction:**  **Code Stroke Form**   * Stroke Education Form * Core Measure Form |