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|  |  | **Organizational Identifiers** |  |  |
|  | VAMC  CONTROL  QIC  BEGDTE  REVDTE | Facility ID Control Number  Abstractor ID  Abstraction Begin Date  Abstraction End Date | Pre-fill  QI pre-fill  Auto-fill  Auto-fill  Auto-fill |  |
|  |  | Patient Identifiers |  |  |
|  | SSN  FIN  PTNAMEF  PTNAMEL  BIRTHDT  SEX  RACE  ETHNICITY  COHORT  AGE | Patient SSN FIN  First Name  Last Name  Birth Date  Sex  Race  Ethnicity  Cohort  Age | Pre-fill: no change  Pre-fill: no change  Pre-fill: no change  Pre-fill: no change  Pre-fill: no change  Pre-fill: **can change**  Pre-fill: no change  Pre-fill: no change  Pre-fill: no change  Calculate age at ARRVDATE |  |
| 1 | arrvdate | Enter the **earliest** documented date the patient arrived in the emergency department at this VAMC. | mm/dd/yyyy  **Pre-filled: Can be modified**   |  | | --- | | >= stdybeg and <= stdyend | | **Pre-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 | 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 | Enter the E/M code documented for this emergency department encounter. | **\_\_ \_\_ \_\_ \_\_ \_\_**  **Pre-filled: can be modified**   |  | | --- | | **Warning: code must be on OP Table 1.0** |   If code is not on OP Table 1.0, case is excluded | Will pre-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.  **Exclusion Statement:** Documentation of an E/M code not on OP Table 1.0 excludes the case from the Hospital Outpatient (HOP) Measures. |
| 4 | princode | Enter the ICD-10-CM principal diagnosis code. | \_\_ \_\_ \_\_. \_\_ \_\_ \_\_ \_\_  (3 alpha-numeric characters/decimal point/four alpha-numeric characters)  **Pre-filled: can be modified**   |  | | --- | | **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.**  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 | 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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| 6 | dccode | 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 | obsev | During the Emergency Department visit was the patient placed into observation services?  1. Yes  2. No | 1,2 | | **Review the emergency department (ED) documentation to determine if the patient was placed into observation services.**  When a patient is placed into observation, their clinical workflow may vary from patients who are not placed into observation prior to departure from the ED.  Additional guidance on abstracting ED Departure Time for patients placed into observation is in the EDCTM rules.  **Only acceptable sources:** ED record, ED physician/APN/PA order for observation status |
| 8 | edcdt | 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. * A discharge date listed on a disposition sheet may be used. * **Observation Services: For patients who are placed into observation services, enter the date of the physician/APN/PA order for observation services as ED Departure Date**. * 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 |
| 9 | edctm | 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 obsev = 1, 99:99, or 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.**   * The actual departure time must be documented:  **Note that signature time is NOT acceptable.** * If there is a discharge time listed on the disposition sheet, this may be used for ED Departure Time. * 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.* * Do not use the time the discharge order was written because it may not represent the actual time of departure. * **Observation Services:**    + **For patients who are placed into observation services, use the time of the physician/APN/PA order for observation services.**   + If the physician/APN/PA observation order time is after the documented ED departure time, use the documented ED departure time per the above guidelines. * 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, Transfer Time; Transport documented time  **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; else go to ctmriord as applicable** | | | | | |
| 10 | ecg | 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 ctmriord as applicable**   |  | | --- | | 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 |
| 11 | ecginter | 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 equivalent * Transmural 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 ctmriord as applicable** | | **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,” or “likely”, disregard that finding (neither Inclusion nor Exclusion). This is not an all-inclusive list of qualifiers.  |  |  | | --- | --- | | **Qualifiers/Modifiers** | | | Qualifiers: and/or, (+/-), cannot exclude, cannot rule out, consider, 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, mild, sub-acute | |
| 12 | fibrintx | 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.** |
| 13 | fibtxdt | Enter the date primary fibrinolytic therapy was administered at this facility. | mm/dd/yyyy  Abstractor can 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. |
| 14 | fibtxtm | Enter the time primary fibrinolytic therapy was administered at this facility. | \_\_\_\_\_ UMT  Abstractor can 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. |
| 15 | 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.) |
| 16 | nofibtx | 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 mmHg or DBP > 110 mmHg) * 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 |
| 17 | tranaci | 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.” * The reason for transfer must be a defined acute coronary intervention (ACI). As such, if implicit reasons for transfer, such as “Patient has STEMI” or “Transferred for cardiology consult to discuss possible cath lab” are listed, 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 |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **If princode is on OP Table 8.0 (Appendix A), go to ctmriord; else go to end.** | | | | |
|  |  | **Imaging for Stroke Patients** |  |  |
| 18 | ctmriord | 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 |
| 19 | ctmridt | Enter the date the earliest Head CT or MRI Scan interpretation was completed/reported. | mm/dd/yyyy  Abstractor can enter 99/99/9999   |  | | --- | | >=arrvdate and <=edcdt | | * Enter the date associated with the documented interpretation time of the Head CT or MRI Scan.   + Examples of documentation that may include the date of the Head CT or MRI Scan are listed below:     - CT head w/o contrast resulted (date)     - Imaging final result CT Head w/o contrast (date)     - Results were relayed to physician/discussed with physician (date)     - Imaging result in the EHR: Electronically signed by: MD (date)     - CT/MRI scan report date/time * 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. |
| 20 | ctmritm | Enter the time the earliest Head CT or MRI Scan interpretation was completed/reported. | \_\_\_\_\_  UMT  Abstractor can enter 99:99   |  | | --- | | >=arrvdate/arrvtime and <= edcdt/edctm | | * 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.   **Examples:**   * 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. * Preliminary CT dictated by radiologist at 2205. ED physician documents “Findings discussed directly with radiologist at 2209.” Head CT or MRI Scan Interpretation Time is 2205. * Nurse documents “CT scan completed at 1400; physician notified of results at 1445.” Head CT or MRI Scan Interpretation Time is 1445. * 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. |
| 21 | lastwell | 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 * Syncope * Seizure   **Suggested Data Sources:** Ambulance record, Code Stroke form, ED record, History and physical, nursing flow sheets, progress notes, transfer sheet |
| 22 | lastwelldt | Enter the date the patient was last known to be well or at his or her baseline state of health. | mm/dd/yyyy  Abstractor can enter 99/99/9999   |  | | --- | | <= 3 days prior to or = arrvdate |  |  | | --- | | Warning if 99/99/9999 and lastwell = 1 | | ***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 |
| 23 | lastwelltm | Enter the time the patient was last known to be well or at his or her prior baseline state of health. | \_\_\_\_\_  UMT  Abstractor can enter 99:99   |  | | --- | | <= 3 days prior to arrvdate/arrvtime and < arrvdate/arrvtime |  |  | | --- | | Warning if 99:99 and lastwell = 1 | | ***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 |