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|  |  | **Organizational Identifiers** |  |  |
|  | VAMCCONTROLQICBEGDTEREVDTE | Facility IDControl NumberAbstractor IDAbstraction Begin DateAbstraction End Date | Auto-fillAuto-fillAuto-fillAuto-fillAuto-fill |  |
|  |  | Patient Identifiers |  |  |
|  | SSNPTNAMEFPTNAMELBIRTHDTSEXMARISTATRACE | Patient SSNFirst NameLast NameBirth DateSex Marital StatusRace | Auto-fill: no changeAuto-fill: no changeAuto-fill: no changeAuto-fill: no changeAuto-fill: **can change**Auto-fill: no changeAuto-fill: no change |  |
|  |  | Administrative Data |  |  |

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| 1 | admdt | Admission date:  | mm/dd/yyyy**Auto-filled: can be modified**

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| < = dcdate |

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

**ONLY ALLOWABLE SOURCES:** Physician orders (priority data source), face sheet**Exclusion:** admit to observation, arrival date |
| 2 | dcdate | Discharge date: | mm/dd/yyyy**Auto-filled: cannot be modified** | **Auto-filled. Cannot be modified**The computer auto-fills the discharge date from the RAPID pull list. This date cannot be modified in order to ensure the selected episode of care is reviewed.  |
| 3 | princode | Enter the ICD-10-CM principal diagnosis code. | \_\_ \_\_ \_\_. \_\_ \_\_ \_\_ \_\_(3 alpha-numeric characters/decimal point/four alpha-numeric characters)**Auto-filled: can be modified**

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

\***If code is not listed in JCNQM Appendix A, Table 8.1, the record is excluded**. | **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.** * **Principal diagnosis code must be one of the codes listed in the Joint Commission National Quality Measures (JCNQM) Appendix A, Table 8.1.**

**Exclusion Statement:** Although coding designated the case for inclusion in JCNQM stroke population, documentation in the record does not confirm an ICD-10-CM principal diagnosis code of ischemic stroke. |

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| 4 | othdx1othdx2othdx3othdx4othdx5othdx6othdx7othdx8othdx9othdx10othdx11othdx12othdx13othdx14othdx15othdx16othdx17othdx18othdx19othdx20othdx21othdx22othdx23othdx24 | Enter the ICD-10-CM other diagnosis codes. | \_\_ \_\_ \_\_. \_\_ \_\_ \_\_ \_\_(3 alpha-numeric characters/decimal point/four alpha-numeric characters)**Auto-filled: cannot be modified****If enabled, can enter up to 24 codes****If enabled, abstractor can enter xxx.xxxx in code field if no other diagnosis codes found** | **Will be auto-filled from PTF with up to 24 ICD-10-CM other diagnosis codes. Cannot be modified.****If no other diagnosis codes are received from PTF, abstractor is to verify codes documented in the record and enter. If no other diagnosis codes are found in the record, enter xxx.xxxx.** |

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| 5 | prinpxprinpxdt | Enter the ICD-10-PCS principal procedure code and date. Date

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

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| **Cannot enter 0000000** |

mm/dd/yyyyAbstractor can enter 99/99/9999 in date field if there is not principal procedureIf no principal procedure, auto-fill othrpx and othrpxdt with xxxxxxx and 99/99/9999

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| > = admdt and< = dcdate |

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

**If no procedure was performed during the episode of care, fill ICD-10-PCS code field with default code xxxxxxx. Do not enter 9999999 or 0000000 to indicate no procedure was performed.** **Date of the principal procedure is to be filled with 99/99/9999 if no procedure was performed.**If the principal procedure date is unable to be determined from the medical record documentation, or if the procedure date documented in the record is obviously in error (e.g. 02/42/20xx) and no other documentation is found that provides this information, enter 99/99/9999. |
| 6 | othrpx1othrpx2othrpx3othrpx4othrpx5(codes)othpxdt1othpxdt2othpxdt3othpxdt4othpxdt5(dates) | Enter the ICD-10-PCS other procedure codes and dates. Code Date

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 | \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_**(Must be 7 alpha-numeric characters)**xxxxxxx in code field if no other procedure was performed

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| **Cannot enter 0000000** |

mm/dd/yyyyAbstractor can enter 99/99/9999 is no other procedure was performed

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| > = admdt and< = dcdate |

Can enter 5 codes and dates | **Can enter 5 procedure codes, other than the principal procedure code.** Enter the ICD-10-PCS codes and dates corresponding to each of the procedures performed, beginning with the procedure performed most immediately following the admission. * If no other procedures were performed, enter default code xxxxxxx in the code field and default date 99/99/9999 in the date field.
* If no other procedure was performed, it is only necessary to complete the xxxxxxx and 99/99/9999 default entries for the first code and date. It is not necessary to complete the default entry five times.

If the date of a procedure is unable to be determined from the medical record documentation, or if the procedure date documented in the record is obviously in error (e.g. 02/42/20xx) and no other documentation is found that provides this information, enter 99/99/9999. |

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| 7 | dcdispo | What was the patient’s discharge disposition on the day of discharge?1. Home* Assisted Living Facilities (ALFs) – includes assisted living care at nursing home/facility
* Court/Law Enforcement – includes detention facilities, jails, and prison
* Home – includes board and care, domiciliary, foster or residential care, group or personal care homes, retirement communities, and homeless shelters
* Home with Home Health Services
* Outpatient Services including outpatient procedures at another hospital, outpatient Chemical Dependency Programs and Partial Hospitalization

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

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

5. Other Health Care Facility* Extended or Immediate Care Facility (ECF/ICF)
* Long Term Acute Care Hospital (LTACH)
* Nursing Home or Facility including Veteran’s Administration Nursing Facility
* Psychiatric Hospital or Psychiatric Unit of a Hospital

**Cont’d next page****Discharge disposition value 5 cont’d*** Rehabilitation Facility including, but not limited to: Inpatient Rehabilitation Facility/Hospital, Rehabilitation Unit of a Hospital, Chemical Dependency/Alcohol Rehabilitation Facility
* Skilled Nursing Facility (SNF), Sub-Acute Care or Swing Bed
* Transitional Care Unit (TCU)
* Veteran’s Home

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

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

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

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

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|  |  | **CMO/Clinical Trial** |  |  |
| 8 | comfort | When is the earliest physician, APN, or PA documentation of comfort measures only?1. Day of arrival (day 0) or day after arrival (day 1)2. Two or more days after arrival (day 2 or greater) 3. Comfort measures only documented during hospital stay, but timing unclear99. Comfort measures only was not documented by the physician/APN/PA or unable to determine  | 1,2,3,99

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| Warning if comfort = 2 |

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

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| **Inclusion (Only acceptable terms)** |
| Brain death/dead | End of life care |
| Comfort care | Hospice |
| Comfort measures | Hospice care |
| Comfort measures only (CMO) | Organ harvest |
| Comfort only | Terminal care |
| DNR-CC | Terminal extubation |

* **Determine the earliest day the physician/APN/PA documented CMO. If any of the inclusion terms are documented by the physician/APN/PA, select option “1,” “2,” or “3,” accordingly.** Example: “Discussed comfort care with family on arrival” noted in day 2 progress note – Select “2.”
* **Physician/APN/PA documentation of CMO mentioned in the following context is acceptable:**
	+ Comfort measures only recommendation
	+ Order for consultation/evaluation by hospice care
	+ Patient/family request for comfort measures only
	+ Plan for comfort measures only
	+ Referral to hospice care service
	+ Discussion of comfort measures
* **State-authorized portable orders (SAPOs):**
	+ SAPOs = specialized forms/identifiers authorized by state law; translate patient’s preferences about specific end-of-life treatment decisions into portable medical orders.

**Examples:** DNR-Comfort Care form; MOLST (Medical Orders for Life-Sustaining Treatment); POLST (Physician Orders for Life-Sustaining Treatment); Out-of-Hospital DNR (OOH DNR)Cont’d next page***CMO cont’d*** * + SAPO in the record, dated and signed prior to arrival with any inclusion term checked, select value “1.”
	+ SAPO listing any CMO option, select value “1,” “2,” or “3” as applicable
	+ Use only the most recently dated/signed SAPO if more than one in record. Disregard undated SAPOs.
	+ If a SAPO is dated prior to arrival and there is documentation on day of arrival or day after arrival that patient does not want CMO, and no other documentation regarding CMO is found in the record, disregard the SAPO.
* **Disregard documentation of an Inclusion term in the following situations:**
	+ Documentation (other than SAPOs) that is dated prior to arrival or documentation which refers to the pre-arrival time period (e.g., comfort measures only order in previous hospitalization record, “Pt. on hospice at home” in physician ED note).
	+ Inclusion term clearly described as negative or conditional (**Examples:** “No comfort care,” “Not appropriate for hospice care,” “Family requests CMO should the patient arrest”).
	+ If documentation makes clear it is not being used as an acronym for Comfort Measures Only (e.g., “hx dilated CMO” - Cardiomyopathy context).
* **If there is physician/APN/PA documentation of an inclusion term in one source that indicates the patient is CMO, AND there is physician/APN/PA documentation of an inclusion term in another source that indicates the patient is NOT CMO, the source that indicates the patient is CMO would be used to select value “1,” “2,” or “3” for this data element.**

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

Cont’d next pageCMO cont’d**Suggested Data Sources:** Consultation notes, Discharge summary, DNR/MOLST/POLST forms, Emergency Department record, History and physical, Physician orders, Progress notes**Excluded data source:** Restraint order sheet |
| 9 | clntrial | During this hospital stay, was the patient enrolled in a clinical trial in which patients with stroke were being studied?1. Yes2. No | 1,2 | **ONLY ACCEPTABLE SOURCE**: **Signed consent form for clinical trial****In order to answer “Yes”, BOTH of the following must be documented:**1. **There must be a signed consent form for the clinical trial.** For the purposes of abstraction, a clinical trial is defined as an **experimental study** in which research subjects are recruited and assigned a treatment/intervention and their outcomes are measured based on the intervention received. Treatments/interventions most of include use of drugs, surgical procedures, and devices. Often a control group is used to compare with the treatment/intervention. Allocation of different interventions to participants is usually randomized; **AND** 2**. There must be documentation on the signed consent form that during this hospital stay the patient was enrolled in a clinical trial in which patients with stroke were being studied.** Patients may be newly enrolled in a clinical trial during the hospital stay or enrolled in a clinical trial prior to arrival and continued active participation in that clinical trial during this hospital stay.**In the following situations, select "No":**1. **There is a signed patient consent form for an observational study only**. Observational studies are non-experimental and involve no intervention (e.g., registries). Individuals are observed (perhaps with lab draws, interviews, etc.), data is collected, and outcomes are tracked by investigators. Although observational studies may include the assessment of the effects of an intervention, the study participants are not allocated into intervention or control groups.2. **It is not clear whether the study described in the signed patient consent form is experimental or observational**.3. **It is not clear which study population the clinical trial is enrolling**. Assumptions should not be made if the study population is not specified. |

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|  |  | **Discharge Medication** |  |  |
| 10 | dcanthrm | Was antithrombotic therapy prescribed at discharge?**Examples of antithrombotic therapy include, but are not limited to: aspirin, aspirin/dipyridamole, clopidogrel (Plavix), warfarin (Coumadin), dabigatran (Pradaxa), fondaparinux (Arixtra), heparin IV, ticlopidine**1. Yes2. No | 1,2\*If 1, go to end  | **Refer to JCNQM, Appendix C, Table 8.2 for a list of antithrombotic medications.****Review all discharge medication documentation to determine if antithrombotic therapy was prescribed at discharge**. In determining whether antithrombotic therapy was prescribed at discharge, it is not uncommon to see conflicting documentation amongst different medical record sources. For example, the discharge summary may list an antithrombotic that is not included in any of the other discharge medication sources (e.g., discharge orders). * In cases where there is an antithromboticin one source that is not mentioned in other sources, it should be interpreted as a discharge medication (select "Yes") unless documentation elsewhere in the medical record suggests that it was NOT prescribed at discharge - **Consider the antithrombotic a discharge medication in the absence of contradictory documentation.**
* If documentation is contradictory (e.g., physician noted “d/c Plavix” in the discharge orders, but Plavix is listed in the discharge summary’s discharge medication list), or after careful examination of circumstances, context, timing, etc., documentation raises enough questions, the case should be deemed "unable to determine" (select "No").
* Consider documentation of a hold on an antithrombotic after discharge in one location and a listing of that antithrombotic as a discharge medication in another location as contradictory ONLY if the timeframe on the hold is not defined (e.g., “Hold Plavix”). Examples of a hold with a defined timeframe include “Hold Plavix x2 days” and “Hold ASA until after stress test.”
* If an antithrombotic is NOT listed as a discharge medication, and there is only documentation of a hold or plan to delay initiation/restarting of antithrombotic therapy after discharge (e.g., “Hold Plavix x2 days,” “Start Plavix as outpatient,” “Hold Plavix”), select “No.”
* If two discharge summaries are included in the medical record, use the one with the latest date/time. If one or both are not dated or timed, and you cannot determine which was done last, use both. This also applies to discharge medication reconciliation forms. Use the dictated date/time over transcribed date/time, file date/time, etc.

***Cont’d next page******Antithrombotic prescribed at discharge cont’d**** Disregard an antithrombotic medication documented only as a recommended medication for discharge (e.g., “Recommend sending patient home on aspirin”). **Documentation must be clearer that an antithrombotic was actually prescribed at discharge.**
* Disregard documentation of an antithrombotic prescribed at discharge when noted only by medication class (e.g., “Antithrombotic Prescribed at Discharge: Yes” on a core measures form). The antithrombotic must be listed by name.

**Exclude:** Heparin Flush, Heparin SQ, Hep-Lock**Suggested data sources:** consultation notes, discharge summary, medication reconciliation form, physician orders, progress notes |

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| 11 | ynoanthrm | Is there documentation by a physician/APN/PA or pharmacist in the medical record of a reason for not prescribing antithrombotic therapy at discharge?1. **Yes**, Allergy to ALL antithrombotic medications2. **Yes**, Physician/APN/PA or pharmacist documentation of a reason for not prescribing antithrombotic therapy at discharge98. Patient/family refusal99. No documented reason | 1,2,98,99 | * **With exception of allergy and patient/family refusal, reason for not prescribing antithrombotic therapy must be documented by a physician/APN/PA or pharmacist.**
* An allergy or adverse reaction to one type of antithrombotic would NOT be a reason for not prescribing all antithrombotic agents. Another medication can be ordered.
* **Consider the terms "anticoagulant", "antiplatelet", and "blood thinners" synonymous with antithrombotic therapy. If there is physician/APN/PA or pharmacist documentation of a reason associated with these terms, select “2.” For example, "no blood thinners due to history of bleeding disorder”, select “2.”**
* Reasons do NOT need to be documented at discharge or otherwise linked to the discharge timeframe: Documentation of reasons anytime during the hospital stay is acceptable.
* **If reasons are not mentioned in the context of antithrombotics, do not make inferences** (e.g., do not assume that antithrombotic therapy was not prescribed because of a bleeding disorder unless documentation explicitly states so).
* Reasons must be explicitly documented (e.g., “Active GI bleed - antithrombotic therapy contraindicated,” “No ASA” [no reason given]).
* **For patients prescribed ticagrelor (Brilinta) as antithrombotic therapy at discharge due to a history of acute coronary syndrome (ACS), NSTE-ACS treated with early invasive strategy and/or coronary stenting, or other indications, select “2.”**
* Documentation of "do not continue" or “do not convert” a home antithrombotic medication to an inpatient medication, or an inpatient antithrombotic medication to a discharge medication, does not count as a reason for not prescribing antithrombotic therapy at discharge. Do not infer that an antithrombotic medication was not prescribed or discontinued without explicit documentation of a reason for not prescribing an antithrombotic medication at discharge.**Example:** Patient on Plavix 75 mg daily while an inpatient. During discharge medication reconciliation, physician notes “do not continue” next to Plavix, select “99.”

***Cont’d next page******Reason for not prescribing antithrombotic cont’d**** Deferral of antithrombotic therapy from one physician/APN/PA or pharmacist to another UNLESS the problem underlying the deferral is also noted. Examples:

 “Consulting neurologist to evaluate pt for warfarin therapy” -  select “99”. “Rule out GI bleed. Start ASA if OK with gastroenterology.”  - select “2”.* If there is documentation of a plan to initiate/restart antithrombotic therapy, and the reason/problem underlying the delay in starting/restarting antithrombotic therapy is also noted, this constitutes a “clearly implied” reason for not prescribing antithrombotic therapy at discharge. **Acceptable examples (select “2”):** - “Stool Occult Blood positive. - May start Coumadin as outpatient.” - “Start ASA if hematuria subsides.” **Unacceptable examples (select “99”):** - “Consider starting Coumadin in a.m.” - “May add Plavix when pt. can tolerate”
* When the current record includes documentation of a pre-arrival reason for no antithrombotic, the following counts as a reason regardless of whether this documentation is included in a pre-arrival record made part of the current record or whether it is noted by hospital staff during the current hospital stay:
	+ Example: “Hx GI bleeding with ASA” in transferring ED record)
* When conflicting information is documented in a medical record, select “99”.

**Refer to JCNQM, Appendix C, Table 8.2 for a comprehensive list of Antithrombotic Medications****Suggested data sources:** Consultation notes, Discharge summary, Emergency Department record, History & physical, Medication administration record, Medication reconciliation form, Physician orders, Progress notes**Excluded Data Sources:** Any documentation dated/timed after discharge, except discharge summary. |