|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| ­ |  |  | **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 |  |
|  |  |  | Administrative Data |  |  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| 1 | ALL | admdt | Admission date: | mm/dd/yyyy Computer will auto-fill   |  | | --- | | < = 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.   **Exclusion:** Admit to observation; Arrival date  **ONLY ALLOWABLE SOURCES:** Physician orders (priority data source), Face Sheet |
| 2 | ALL | dcdate | Discharge date: | mm/dd/yyyy  **Auto-filled: cannot be modified**  > = admdt | **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 | ICD-10-CM principal diagnosis code: | \_\_ \_\_ \_\_. \_\_ \_\_ \_\_ \_\_   |  | | --- | | **Computer will prepopulate from Pull List** | | **Will be prepopulated from the pull list and cannot be modified.** |
| 4 |  | vprincode | Is the diagnosis of ischemic stroke confirmed by physician documentation? 1. Yes  2. No | 1,\*2   |  | | --- | | Warning if 2 |   \*If 2, the case is excluded | **Ischemic stroke is the most common type of stroke. Obstruction of a blood vessel supplying the brain results either from a clot that has traveled in the blood from another part of the body (embolism) or from a clot that has formed in place (thrombus).**  **If the physician documents a diagnosis of ischemic stroke in the discharge summary or elsewhere in the medical record and ischemic stroke is coded as the principal diagnosis, the diagnosis would be confirmed. Select “Yes”. Other terms for ischemic stroke may include, but are not limited to:**   * **cerebrovascular accident (CVA)** * **cerebral infarction** * **cerebral infarction due to thrombosis** * **cerebral infarction due to embolism** * **cerebral infarction due to unspecified occlusion or stenosis of any cerebral artery**   **If documentation clearly indicates the stroke was a hemorrhagic stroke, select “No”. Other terms for hemorrhagic stroke include but are not limited to: subarachnoid hemorrhage, intracerebral hemorrhage, subdural hemorrhage.** |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| 5 | ALL | dcdispo | What was the patient’s discharge disposition on the day of discharge?  1. Home   * Assisted Living Facilities (ALFs) – includes assisted living care at nursing home/facility * Court/Law Enforcement – includes detention facilities, jails, and prison * Home – includes board and care, domiciliary, foster or residential care, group or personal care homes, retirement communities, and homeless shelters * Home with Home Health Services * Outpatient Services including outpatient procedures at another hospital, outpatient Chemical Dependency Programs and Partial Hospitalization   2. Hospice – Home (or other home setting as listed in #1 above)  3. Hospice – Health Care Facility   * General Inpatient and Respite, Residential and Skilled Facilities, and Other Health Care Facilities   4. Acute Care Facility   * Acute Short Term General and Critical Access Hospitals * Cancer and Children’s Hospitals * Department of Defense and Veteran’s Administration Hospitals   5. Other Health Care Facility   * Extended or Immediate Care Facility (ECF/ICF) * Long Term Acute Care Hospital (LTACH) * Nursing Home or Facility including Veteran’s Administration Nursing Facility * Psychiatric Hospital or Psychiatric Unit of a Hospital * Rehabilitation Facility including 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 | 1,2,3,4,5,6,7,99   |  | | --- | | **Computer will prepopulate from pull list** | | **Discharge disposition is prepopulated from the pull list and cannot be modified.** |
| 6 | ALL | dcdispom | Does the prepopulated discharge disposition (computer to display dcdispo value and description) match the discharge disposition documented in the medical record?  1. Yes  2. No | 1,2  If 1, go to vdcdispo  If 2, go to dcdispo2 | **Review all discharge documentation sources and verify if the prepopulated discharge disposition value matches the discharge disposition documented in the medical record.**  **Suggested data sources:** Discharge instruction sheet, discharge planning notes, discharge summary, nursing discharge notes, physician orders, progress notes, social service notes, transfer record |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 7 | ALL | dcdispo2 | Enter the patient’s discharge disposition on the day of discharge documented in the medical record.  1. Home   * Assisted Living Facilities (ALFs) – includes assisted living care at nursing home/facility * Court/Law Enforcement – includes detention facilities, jails, and prison * Home – includes board and care, domiciliary, foster or residential care, group or personal care homes, retirement communities, and homeless shelters * Home with Home Health Services * Outpatient Services including outpatient procedures at another hospital, outpatient Chemical Dependency Programs and Partial Hospitalization   2. Hospice – Home (or other home setting as listed in #1 above)  3. Hospice – Health Care Facility   * General Inpatient and Respite, Residential and Skilled Facilities, and Other Health Care Facilities   4. Acute Care Facility   * Acute Short Term General and Critical Access Hospitals * Cancer and Children’s Hospitals * Department of Defense and Veteran’s Administration Hospitals   5. Other Health Care Facility   * Extended or Immediate Care Facility (ECF/ICF) * Long Term Acute Care Hospital (LTACH) * Nursing Home or Facility including Veteran’s Administration Nursing Facility * Psychiatric Hospital or Psychiatric Unit of a Hospital * Rehabilitation Facility including 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 | 1,2,3,4,5,6,7,99  If 99, go to cmo1 | **This question will be answered if the prepopulated discharge disposition value does not match the discharge disposition documented in the medical record. Use the following guidelines and enter the discharge disposition documented in the record.**  **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 to skilled care. Enter “5”. * **Discharge disposition documentation in the discharge summary, post-discharge addendum, or a late entry, may be considered if written within 30 days after discharge date and prior to 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 documentation is contradictory, and you are unable to determine the latest documentation, select the disposition ranked highest (top to bottom) in the following list. * Acute Care Facility * Hospice – Health Care Facility * Hospice – Home * Other Health Care Facility * Home * Values “2” and “3” hospice includes discharges with hospice referrals and evaluations * 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 identifies the facility the patient is being discharged to by name only (e.g., Park Meadows) and does not reflect the type of facility or level of care, select “5”. * 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”.   * **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 |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 8 | | ALL | vdcdispo1  vdcdispo2  vdcdispo3  vdcdispo4  vdcdispo5  vdcdispo6  vdcdispo7  vdcdispo8  vdcdispo9  vdcdispo10 | | Review the medical record for documentation of the correct discharge disposition (computer to display: dcdispo 1 or 5, or if dcdispom = 1, display dcdispo 2, 3, 4, 6, or 7, or if dcdispom = 2, display dcdispo2) and answer “yes” or “no” accordingly.   |  |  | | --- | --- | | Discharge Disposition Data Source | 1 (yes)  2 (no)  If vdcdispo10 <>1, go to cmo1 | | 1. Discharge instructions |  | | 2. Discharge planning note |  | | 3. Discharge summary |  | | 4. Expanded admission/discharge/transfer (EADT) |  | | 5. Nursing discharge note |  | | 6. Physician orders |  | | 7. Progress note |  | | 8. Social services note |  | | 9. Transfer note |  | | 10. Other |  | | | | **In order to answer accurately, review each data source for documentation of the correct discharge status and answer “yes” or “no” based on whether the discharge disposition was documented in the data source.**  **Discharge disposition:**  1. Home  2. Hospice – Home (or other home setting as listed in #1)  3. Hospice – Health Care Facility  4. Acute Care Facility  5. Other Health Care Facility  6. Expired  7. Left Against Medical Advice/AMA  **If the correct discharge disposition is found in a data source that is not listed, enter “Yes” for value 10.** | |
| 9 | ALL | | | odcdispo | | Enter the name of the other discharge disposition data source.   |  | | --- | |  | | Text Field | **Enter the name of the other discharge disposition data source.**  **If the other discharge disposition data source is a note, enter the name of the local note title.** |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 10 | ALL | cmo1  cmo2  cmo3  cmo4  cmo5 | During this hospitalization, is there documentation of Comfort Measures Only (CMO)?   |  |  | | --- | --- | | **Comfort Measures Only Terms** | 1 Yes  2 No | | 1. Comfort Care/Comfort Measures/Comfort Measures Only |  | | 2. Dying care |  | | 3. Hospice care |  | | 4. Terminal care |  | | 5. Other comfort measures term |  | | 1,2  If all cmo = 2, go to clntrial  If cmo5 <> 1, go to vcmo1 | **Review the medical record for documentation of each comfort measures only term and answer “yes” or “no” accordingly.**  **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).  **Other terms may include:**   * Brain death/dead * DNR-CC * End of life care * Organ harvest * Terminal extubation   **If another CMO term is documented, answer “yes” to value 5.**   * Exclude a comfort measures term clearly described as negative or conditional (**Examples:** “No comfort care,” “Not appropriate for hospice care,” “Family requests CMO should the patient arrest”).   **Suggested Data Sources:** Discharge Summary; DNR/MOLST/POLST forms; Emergency department note; Physician orders; Progress notes |
| 11 | ALL | ocmo | Enter the other Comfort Measures Only term documented in the medical record.   |  | | --- | |  | | Text Field | **Enter the other Comfort Measures Only term documented in the medical record.**  **Other terms may include:**   * Brain death/dead * DNR-CC * End of life care * Organ harvest * Terminal extubation |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 12  13 | ALL | vcmo1  dtcmo1  vcmo2  dtcmo2  vcmo3  dtcmo3  vcmo4  dtcmo4  vcmo5  dtcmo5  vcmo6  dtcmo6 | Review the medical record for Comfort Measures Only (CMO) documentation and answer “yes” or “no” accordingly for each data source. For data sources that contain CMO documentation, enter the earliest date of the documentation in the data source.   |  |  |  |  | | --- | --- | --- | --- | | **CMO Data Source** | 1 Yes  2 No  If 2, auto-fill dtcmo as 99/99/9999  If vcmo6 <> 1, go to clntrial | **CMO Date**  mm/dd/yyyy   |  | | --- | | >=admdt and <=dcdate |   Will be auto-filled as 99/99/9999 if any vcmo = 2 | | 1. Discharge summary |  |  | | 2. DNR/MOLST/POLST forms |  |  | | 3. Emergency department note |  |  | | 4. Physician orders |  |  | | 5. Progress notes |  |  | | 6. Other |  |  | | **In order to answer accurately, review each data source for documentation of comfort measures only (and other comfort measures only terms) and answer “yes” or “no” based on whether comfort measures only was documented in the data source.**  **Comfort measures only (CMO) terms may include:**   |  |  | | --- | --- | | Brain death/dead | End of life care | | Comfort care | Hospice care | | Comfort measures | Organ harvest | | DNR-CC | Terminal care | | Dying care | Terminal extubation |   If CMO documentation is found in a data source that is not listed, enter “Yes” for value 6.  If CMO documentation is found in an emergency department note prior to admission date, enter admission date. |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| 14 | ALL | olcmo | Enter the name of the other CMO data source.   |  | | --- | |  | | Text Field | **Enter the name of the other CMO data source.**  **If the CMO data source is a note, enter the name of the local note title.** |
| 15 | ALL | clntrial | During this hospital stay, was the patient enrolled in a clinical trial in which patients with stroke were being studied?  1. Yes  2. No | 1,2 | **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; **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).  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.  **ONLY ACCEPTABLE SOURCE**: Signed consent form for clinical trial |
|  |  |  | **Discharge Medications** |  |  |
| 16 | STK6 | ldlc | Is there medical record documentation of a LDL-c less than 70 mg/dL within 30 days prior to hospital admission or during the hospitalization? 1. Yes  2. No | 1,2   |  | | --- | | Computer will prepopulate from pull list | | **Computer will prepopulate field from pull list.** |
| 17 | STK6 | ldlcm | Is there documentation in the medical record of a LDL-c less than 70mg/dL within 30 days prior to hospital admission or during the hospitalization?  1. Yes  2. No | 1,2  If 2, go to statindc2 | Documentation of a LDL-c less than 70 mg/dL within 30 days prior to hospital admission or anytime during the hospital stay is acceptable.  Direct or calculated fasting or non-fasting values are both acceptable.  **Suggested Data Sources:** Clinical reminders; Consultations; Discharge summary; Emergency department notes; History and physical; Lab reports; Progress notes; Reports scanned into VistA imaging |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 18 | STK6 | vldlc1  vldlc2  vldlc3  vldlc4  vldlc5  vldlc6  vldlc7  vldlc8  vldlc9  vldlc10 | Review the medical record for documentation of a LDL-c less than 70mg/dL within 30 days prior to hospital admission or during the hospitalization and answer “yes” or “no” accordingly for each data source.   |  |  | | --- | --- | | **LDL-c Data Source** | 1 Yes  2 No  If vldlc10 <> 1, go to statindc2 | | 1. Consultation |  | | 2. Discharge summary |  | | 3. Emergency department note |  | | 4. History and physical |  | | 5. Laboratory reports |  | | 6. Nursing progress notes |  | | 7. Physician progress notes |  | | 8. Clinical Reminder/Health Factor |  | | 9. Report Scanned into VistA Imaging |  | | 10. Other |  | | **In order to answer accurately, review each data source for documentation of LDL-c less than 70mg/dL within 30 days prior to hospital admission or during the hospitalization and answer “yes” or “no” accordingly.**  **If LDL-c documentation is found in a data source that is not listed, enter “Yes” for value 10.** |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| 19 | STK6 | olldlc | Enter the name of the other LDL-c data source.   |  | | --- | |  | | Text Field | **Enter the name of the other LDL-c data source.** If the LDL-c data source is a note, enter the name of the local note title. |
| 20 | STK6 | statindc2 | Was a statin medication prescribed at discharge?  1. Yes  2. No | 1,2   |  | | --- | | Computer will prepopulate from pull list | | Computer will prepopulate field from pull list. |
| 21 | STK6 | vstatindc | Is there documentation in the medical record that a statin medication was prescribed at discharge?  **Examples include, but are not limited to:**   * atorvastatin calcium (Lipitor) * fluvastatin sodium (Lescol) * lovastatin (Mevacor) (Altocor) * pitavastatin (Livalo) * pravastatin sodium (Pravacol) * rosuvastatin calcium (Crestor) * simvastatin (Zocor) * ezetimibe/simvastatin (Vytorin)   1. Yes  2. No | 1,2  If 2, go to nostatin2  If 1, auto-fill nostatin2 as 95 | **Review all discharge medication documentation to determine if a statin medication was prescribed at discharge.**   * In determining whether a statin medication was prescribed at discharge, it is not uncommon to see conflicting documentation amongst different medical record sources. For example, the discharge summary may list a statin medication that is not included in any of the other discharge medication sources (e.g., discharge orders). * In cases where there is a statin medication in 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 statin a discharge medication in the absence of contradictory documentation.** * **For patients discharged to a nursing home or community living center (CLC), answer “yes” if a statin medication was administered to the patient on the day of or day prior to discharge or administered to the patient post discharge on the first day of admission to the CLC.**   **Suggested data sources:** Consultation, Discharge summary, Medication reconciliation form, Physician orders, Progress notes |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 22 | STK6 | statname | Select the name of the statin medication prescribed at discharge.  1. Atorvastatin  2. Fluvastatin  3. Lovastatin  4. Pitavastatin  5. Pravastatin  6. Rosuvastatin  7. Simvastatin | 1,2,3,4,5,6,7 | **If a statin medication is part of a combination medication (e.g., atorvastatin/amlodipine), select the value that corresponds with the statin medication (e.g., value 1 for atorvastatin).** |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 23  24 | STK6 | vstat1  dtstat1  vstat2  dtstat2  vstat3  dtstat3  vstat4  dtstat4  vstat5  dtstat5  vstat6  dtstat6  vstat7  dtstat7  vstat8  dtstat8  vstat9  dtstat9  vstat10  dtstat10 | Review each data source for documentation that a statin medication was prescribed at discharge and answer “yes” or “no” accordingly.   |  |  |  |  | | --- | --- | --- | --- | | **Statin at discharge data source** | Vstat  1 (yes)  2 (no)  If 2, and data source is not flagged, auto-fill date as 99/99/9999 | **Date**  mm/dd/yyyy  If vstat10 <> 1, go to dcanthrm2   |  | | --- | | >= admdt and <= 1 day after dcdate | | | 1. Outpatient Prescriptions (Orders) |  |  | | 2. Outpatient Refills |  |  | | 3. Non-VA Medication |  |  | | 4. Inpatient Medication dispensed before discharge (day of discharge or day prior to discharge for patients discharged to nursing home or CLC) |  |  | | 5. Medication dispensed in CLC on first post discharge day |  |  | | 6. Discharge Summary |  |  | | 7. Nursing Discharge Instructions |  |  | | 8. Pharmacy discharge instructions |  |  | | 9. Physician discharge instructions |  |  | | 10. Other |  |  | | **The computer will flag the data source and prepopulate the date for each data source 1 – 5 as applicable based on data from the Pull List.**  **For prepopulated date fields, the abstractor will review the data source for documentation that a statin medication was prescribed and answer “yes” or “no” accordingly.**  **For date fields that are not prepopulated, the abstractor will review the data source for documentation that a statin medication was prescribed and answer “yes” or “no” and enter the date of the documentation.**  **If documentation of a statin medication prescribed at discharge is found in a data source that is not listed, enter “Yes” for value 10.** |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| 25 | STK6 | olstat | Enter the other location where documentation of prescription of statin medication at discharge was found in the medical record.  |  | | --- | |  | | Free text entry | Enter the other location where documentation of prescription of statin medication at discharge was found in the medical record. |
| 26 | STK6 | nostatin2 | Is there physician/APN/PA or pharmacist documentation of a reason for not prescribing a statin medication at discharge?  1. Allergy to statin medication  2. Physician/APN/PA or pharmacist documentation of a reason for not prescribing a statin medication at discharge  95. Not applicable  98. Patient/family refusal  99. No documented reason | 1,2,95,98,99  Will be auto-filled as 95 if vstatindc = 1  If 95 or 99, go to dcanthrm2 | * **With exception of allergy and patient/family refusal, reasons for not prescribing a statin medication at discharge must be documented by a physician/APN/PA or pharmacist.** * **Statin medication allergy:** a statin medication “allergy” or “sensitivity”,\ documented at any time during the hospital stay counts as an allergy regardless of what type of reaction might be noted. Documentation of an allergy/sensitivity to one particular statin medication is acceptable to take as an allergy to the entire class of statin medications (e.g., “allergic to atorvastatin”).   **Other reasons:**   * **If reasons are not mentioned in the context of statin medications, do not make inferences** (e.g., do not assume that a statin medicationwas not prescribed because of the patient’s history of alcoholism or severe liver disease alone). * Reasons must be explicitly documented (e.g., “Chronic liver failure – statins contraindicated”, “Hx muscle soreness with statins in past”) OR clearly implied (“No evidence of atherosclerosis - no statin therapy,” “No statin medications” [no reason given]). * Physician/APN/PA or pharmacist documentation of a hold or discontinuation of statin medications that occurs during the hospital stay constitutes a “clearly implied” reason for not prescribing a statin medication at discharge. A hold/discontinuation of all p.o. medications counts if statin medication p.o. was on order at the time of the notation.   **EXCEPTIONS:**  - Documentation of a **conditional** hold/discontinuation of a statin medication (e.g., “hold simvastatin if diarrhea persists.”) does not count as a reason for not prescribing a statin medication at discharge.  - Discontinuation of a particular statin medication documented in combination with the start of a different statin medication (i.e., switch in type of statin medication) does not count as a reason for not prescribing a statin medication at discharge.  - Discontinuation of a statin medication at a particular dose documented in combination with the start of a different dose of that statin (i.e., change in dosage) does not count as a reason for not prescribing a statin medication at discharge.  - Deferral of statin medication from one physician/APN/PA or pharmacist to another does NOT count as a reason for not prescribing a statin at discharge UNLESS the problem underlying the deferral is also noted.   * If there is documentation of a plan to initiate/restart a statin medication and the reason/problem underlying the delay is also noted, this constitutes a “clearly implied” reason for not proscribing a statin medication at discharge. * Reasons do NOT need to be documented at the time of discharge or otherwise associated specifically with discharge prescription. Documentation of reasons anytime during the stay is acceptable. * Reason documentation which refers to a more general medication class is not acceptable (e.g., “No cholesterol-reducers”, “Hold all lipid-lowering medications”). * If there is conflicting documentation in the record regarding a reason for not prescribing a statin med at discharge, accept as a “yes” for the applicable reason. * When the current record includes documentation of a pre-arrival reason for no statin medication, the following counts 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: * Pre-arrival statin medication allergy * Pre-arrival hold/discontinuation or notation such as “No statin medications” IF the underlying reason/problem is also noted (e.g., “Lipitor discontinued in transferring hospital secondary to severe diarrhea”). * Pre-arrival “other reason” as noted above. * Physician/APN/PA or pharmacist documentation of a pre-arrival hold, discontinuation of a statin medication, or “other reason” counts as a reason for not prescribing a statin medication at discharge ONLY if the underlying reason is noted.   **Examples of reasons for not prescribing a statin medication at discharge include, but are not limited to:** hepatic failure, hepatitis, myalgias, patient/family refusal, rhabdomyolysis  **Suggested data sources:** Consultation notes, Discharge summary, Emergency department record, History & physical, Medication administration record, Medication reconciliation form, Nursing notes, Pharmacy notes, Physician orders, Progress notes  **Excluded Data Sources:** Any documentation dated/timed after discharge, except discharge summary. |
| 27 | STK6 | vnostat1  vnostat2  vnostat3  vnostat4  vnostat5  vnostat6  vnostat7  vnostat8  vnostat9  vnostat10  vnostat11  vnostat12 | Review each data source for documentation of a reason for not prescribing statin therapy at discharge and answer “yes” or “no” accordingly.   |  |  | | --- | --- | | **Data Source** | 1 Yes  2 No  If vnostat12 <> 1, go to dcanthrm2 | | 1. Consultation |  | | 2. Cover sheet |  | | 3. Discharge summary |  | | 4. Emergency department notes |  | | 5. History and physical |  | | 6. Medication reconciliation form |  | | 7. Nursing progress notes |  | | 8. Pharmacy progress notes |  | | 9. Physician orders |  | | 10. Physician progress notes |  | | 11. Health Factor/Clinical Reminder |  | | 12. Other |  | | | **In order to answer this question accurately, it is necessary to review ALL relevant data sources for documentation of a reason for not prescribing a statin medication at discharge. For each data source listed, review that source in the medical record and answer “yes” or “no” accordingly.**  **If documentation of a reason for not prescribing statin therapy at discharge is found in a data source that is not listed, enter “Yes” for value 12.**    **Reasons for Not Prescribing Statin at Discharge:**   * Allergy to statin medication * Physician/APN/PA or pharmacist documentation of a reason for not prescribing a statin medication at discharge * Patient/family refusal |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| 28 | STK6 | olnostat | Enter the other location where documentation of a reason for not prescribing statin therapy at discharge was found in the medical record.  |  | | --- | |  | | Free text entry | Enter the other location where documentation of a reason for not prescribing statin therapy at discharge was found in the medical record. |
| 29 | STK2 | dcanthrm2 | Was an antithrombotic medication prescribed at discharge?  1. Yes  2. No | 1,2   |  | | --- | | Computer will prepopulate from pull list | | Computer will prepopulate field from pull list. |
| 30 | STK2 | vdcanthrm | Is there documentation in the medical record that an antithrombotic medication was prescribed at discharge?  **Examples of antithrombotic medications include, but are not limited to:**   * aspirin (many brands) * clopidogrel (Plavix) * dabigatran (Pradaxa) * enoxaparin (Lovenox) * fondaparinux (Arixtra) * heparin sodium IV * rivaroxaban (Xarelto) * warfarin (Coumadin)   1. Yes 2. No | 1,2  If 2, go to ynoanthrm  If 1, auto-fill ynoanthrm as 95 | **Review all discharge medication documentation to determine if an antithrombotic medication was prescribed at discharge.**   * In determining whether an antithrombotic medication 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 medication that is not included in any of the other discharge medication sources (e.g., discharge orders). * In cases where there is an antithrombotic medication in 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.** * **For patients discharged to a nursing home or community living center (CLC), answer “yes” if an antithrombotic medication was administered to the patient on the day of discharge or administered to the patient post discharge on the first day of admission to the CLC.**  Suggested data sources: Consultation, Discharge summary, Medication reconciliation form, Physician orders, Progress notes **Refer to TJC NQM, Appendix C, Table 8.2 for a list of antithrombotic medications.** |
| 31 | STK2 | wchanthrm1  wchanthrm2  wchanthrm3  wchanthrm4  wchanthrm5  wchanthrm6  wchanthrm7  wchanthrm8  wchanthrm9 | Which antithrombotic medication was prescribed at discharge?  **Indicate all that apply:**  1. aspirin  2.clopidogrel  3. dabigatran  4. enoxaparin  5. fondaparinux  6. heparin sodium IV  7. rivaroxaban  8. warfarin 9. Other | 1,2,3,4,5,6,7,8,9  If <> 9, go to vanth   |  | | --- | | Warning if vanticoag = 2 | | Cannot select yes for wchanthrm3-8 if vanticoag = 2 |   If wchanthrm3= -1, auto-fill wchcoag3 as -1  If wchanthrm4= -1, auto-fill wchcoag4 as -1  If wchanthrm5= -1, auto-fill wchcoag5 as -1  If wchanthrm6= -1, auto-fill wchcoag6 as -1  If wchanthrm7= -1, auto-fill wchcoag7 as -1  If wchanthrm8= -1, auto-fill wchcoag8 as -1 | **This list of medications is not all inclusive. Refer to TJC NQM, Appendix C, Table 8.2 for a list of antithrombotic medications.**  **If options are auto-filled, please review the medical record carefully to determine if other antithrombotic medications were prescribed at discharge.**  **Note: Some medications used for antithrombotic therapy are also used for anticoagulant therapy.** |
| 32 | STK2 | othrant2 | Enter the name of the other antithrombotic medication prescribed at discharge.   |  | | --- | |  | | Free text | **Enter the name of the other antithrombotic medication prescribed at discharge that was found in the medical record.** |
| 33  34 | STK2 | vanth1  dtanth1  vanth2  dtanth2  vanth3  dtanth3  vanth4  dtanth4  vanth5  dtanth5  vanth6  dtanth6  vanth7  dtanth7  vanth8  dtanth8  vanth9  dtanth9  vanth10  dtanth10 | Review each data source for documentation that an antithrombotic medication was prescribed at discharge and answer “yes” or “no” accordingly.   |  |  |  |  | | --- | --- | --- | --- | | **Antithrombotic at discharge data source** | vanth  1 (yes)  2 (no)  If 2 and data source is not flagged, auto-fill date as 99/99/9999 | **Date**  mm/dd/yyyy  If vanth10 <> 1, go to anticoag   |  | | --- | | >= admdt and <= 1 day after dcdate | | | 1. Outpatient Prescriptions (Orders) |  |  | | 2. Outpatient Refills |  |  | | 3. Non-VA Medication |  |  | | 4. Inpatient Medication dispensed before discharge (day of discharge for patients discharged to nursing home or CLC) |  |  | | 5. Medication dispensed in CLC on first post discharge day |  |  | | 6. Discharge Summary |  |  | | 7. Nursing Discharge Instructions |  |  | | 8. Pharmacy discharge instructions |  |  | | 9. Physician discharge instructions |  |  | | 10. Other |  |  | | | **The computer will flag the data source and prepopulate the date for each data source 1 – 5 as applicable based on data from the Pull List.**  **For prepopulated date fields, the abstractor will review the data source for documentation that an antithrombotic medication was prescribed and answer “yes” or “no” accordingly.**  **For date fields that are not prepopulated, the abstractor will review the data source for documentation that an antithrombotic medication was prescribed and answer “yes” or “no” and enter the date of the documentation.**  **If documentation of an antithrombotic medication prescribed at discharge is found in a data source that is not listed, enter “Yes” for value 10.** |
| 35 | STK2 | olanth | Enter the other location where documentation of prescription of an antithrombotic medication at discharge was found in the medical record.  |  | | --- | |  | | Free text entry | Enter the other location where documentation of prescription of an antithrombotic medication at discharge was found in the medical record. |
| 36 | STK2 | 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. Allergy to ALL antithrombotic medications  2. Physician/APN/PA or pharmacist documentation of a reason for not prescribing antithrombotic therapy at discharge  95. Not applicable  98. Patient/family refusal  99. No documented reason | 1,2,95,98,99  Will be auto-filled as 95 if vdcanthrm = 1  If 95 or 99, go to anticoag | * **With exception of allergy and patient/family refusal, reason for not prescribing antithrombotic therapy must be documented by a physician/APN/PA or pharmacist.** * **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]). * Physician/APN/PA or pharmacist documentation of a hold or discontinuation of an antithrombotic medication that occurs during the hospital stay constitutes a “clearly implied” reason for not prescribing antithrombotic therapy at discharge. A hold/discontinuation of all p.o. medications counts if an oral antithrombotic (e.g. clopidogrel) was on order at the time of the notation.   **EXCEPTIONS -The following do NOT count as a reason for not prescribing an antithrombotic at discharge:**  - Documentation of a conditional hold or discontinuation of an antithrombotic (e.g., “Hold ASA if guaiac positive”, Stop clopidogrel if rash persists”).  - Discontinuation of a particular antithrombotic documented in combination with the start of a different antithrombotic (e.g., “Change clopidogrel to aspirin” in progress note.  - Discontinuation of an antithrombotic at a particular dose documented in combination with the start of a different dose (e.g., “Increase Ecotrin 81 mg to 325 mg daily”).  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. * 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. * 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.   * When conflicting information is documented in a medical record, select “2”. * 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 if 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: * Pre-arrival hold/discontinuation or notation such as “No Coumadin” IF the underlying reason /problem is also noted (e.g., “Coumadin held in transferring hospital due to possible GI bleed”). * Pre-arrival “other reason” (other than hold/discontinuation or notation of “No ASA”) (e.g., “Hx GI bleeding with ASA” in transferring ED record)>   **Examples of reasons for not prescribing antithrombotic**  **therapy at discharge include, but are not limited to:**   * Allergy to all antithrombotic medications * Aortic dissection * Bleeding disorder * Brain/CNS cancer * CVA, hemorrhagic * Extensive/metastatic CA * Hemorrhage, any type * Intracranial surgery/biopsy * Patient/family refusal * Peptic ulcer * Planned surgery within 7 days following discharge * Risk of bleeding * Unrepaired intracranial aneurysm   **Refer to TJC NQM, 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. |
| 37 | STK2 | vynoanth1  vynoanth2  vynoanth3  vynoanth4  vynoanth5  vynoanth6  vynoanth7  vynoanth8  vynoanth9  vynoanth10  vynoanth11  vynoanth12 | Review each data source for documentation of a reason for not prescribing antithrombotic therapy at discharge and answer “yes” or “no” accordingly.   |  |  | | --- | --- | | **Data Source** | 1 Yes  2 No  If vynoanth12 <> 1, go to anticoag | | 1. Consultation |  | | 2. Cover sheet |  | | 3. Discharge summary |  | | 4. Emergency department notes |  | | 5. History and physical |  | | 6. Medication reconciliation form |  | | 7. Nursing progress notes |  | | 8. Pharmacy progress notes |  | | 9. Physician orders |  | | 10. Physician progress notes |  | | 11. Health Factors/Clinical Reminder |  | | 12. Other |  | | | **In order to answer this question accurately, it is necessary to review ALL relevant data sources for documentation of a reason for not prescribing an antithrombotic medication at discharge. For each data source listed, review that source in the medical record and answer “yes” or “no” accordingly.**  **If documentation of a reason for not prescribing antithrombotic therapy at discharge is found in a data source that is not listed, enter “Yes” for value 12.**  **Reasons for Not Prescribing Antithrombotic Therapy at Discharge:**   * Allergy to antithrombotic medication * Physician/APN/PA or pharmacist documentation of a reason for not prescribing antithrombotic medication at discharge * Patient/family refusal |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 38 | STK2 | othrsnloc | | Enter the other location where documentation of a reason for not prescribing antithrombotic therapy at discharge was found in the medical record.  |  | | --- | |  | | Free text entry | | Enter the other location where documentation of a reason for not prescribing antithrombotic therapy at discharge was found in the medical record. |
| 39 | STK3 | anticoag | | Was an anticoagulant medication prescribed at discharge?  1. Yes 2. No | 1,2   |  | | --- | | Computer will prepopulate from pull list | | | Computer will prepopulate field from pull list. |
| 40 | STK3 | vanticoag | | Is there documentation in the medical record that an anticoagulant medication was prescribed at discharge?  **Examples include, but are not limited to:**   * argatroban (Acova) * dabigatran (Pradaxa) * enoxaparin (Lovenox) * fondaparinux (Arixtra) * heparin sodium **IV only** * rivaroxaban (Xarelto) * warfarin (Coumadin)   1. Yes 2. No | 1,2  If 2, go to nocoag  If 1, auto-fill nocoag as 95 | | **Review all discharge medication documentation to determine if an anticoagulant medication was prescribed at discharge.**   * In determining whether an anticoagulant medication 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 anticoagulant medication that is not included in any of the other discharge medication sources (e.g., discharge orders). * In cases where there is an anticoagulant medication in 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 anticoagulant a discharge medication in the absence of contradictory documentation.** * **For patients discharged to a nursing home or community living center (CLC), answer “yes” if an anticoagulant medication was administered to the patient on the day of discharge or administered to the patient post discharge on the first day of admission to the CLC.**  Exclude: Heparin flush, Heparin SQ, Hep-lockSuggested data sources: Consultation, Discharge summary, Medication reconciliation form, Physician orders, Progress notes **Refer to TJC NQM, Appendix C, Table 8.3 for a list of anticoagulant medications.** |
| 41 | STK3 | wchcoag1  wchcoag2  wchcoag3  wchcoag4  wchcoag5  wchcoag6  wchcoag7  wchcoag8  wchcoag9 | Which anticoagulant medication was prescribed at discharge?  **Indicate all that apply:**   1. argatroban 2. dalteparin 3. dabigatran 4. enoxaparin 5. fondaparinux 6. heparin sodium **IV only** 7. rivaroxaban 8. warfarin 9. Other | | 1,2,3,4,5,6,7,8,9  If <> 9, go to vcoag1  wchcoag3,4,5,6,7,8 will be auto-filled as -1 if wchanthrm3,4,5,6,7,8 = -1 respectively   |  | | --- | | Warning if vdcanthrm = 2 | | Cannot select Yes for wchcoag1-8 if vdcanthrm = 2 |   If wchcoag3 = -1, auto-fill wchanthrm3 as -1  If wchcoag4 = -1, auto-fill wchanthrm4 as -1  If wchcoag5 = -1, auto-fill wchanthrm5 as -1  If wchcoag6 = -1, auto-fill wchanthrm6 as -1  If wchcoag7 = -1, auto-fill wchanthrm7 as -1  If wchcoag8 = -1, auto-fill wchanthrm8 as -1 | **This list of medications is not all-inclusive. Refer to TJC NQM, Appendix C, Table 8.3 for a list of anticoagulant medications.**  **If options are auto-filled, please review the medical record carefully to determine if other anticoagulant medications were prescribed at discharge.** Note: Some medications used for anticoagulant therapy are also used for antithrombotic therapy. | |
| 42 | STK3 | othcoag | Enter the name of the other anticoagulant medication prescribed at discharge.   |  | | --- | |  | | | Free text | **Enter the name of the other antitcoagulant medication prescribed at discharge that was found in the medical record.** | |
| 43  44 | STK3 | vcoag1  dtcoag1  vcoag2  dtcoag2  vcoag3  dtcoag3  vcoag4  dtcoag4  vcoag5  dtcoag5  vcoag6  dtcoag6  vcoag7  dtcoag7  vcoag8  dtcoag8  vcoag9  dtcoag9  vcoag10  dtcoag10 | Review each data source for documentation that an anticoagulant medication was prescribed at discharge and answer “yes” or “no” accordingly.   |  |  |  |  | | --- | --- | --- | --- | | **Anticoagulant at discharge data source** | vcoag  1 (yes)  2 (no)  If 2 and data source is not flagged, auto-fill date as 99/99/9999 | **Date**  mm/dd/yyyy  If vcoag10 <> 1, go to end   |  | | --- | | >= admdt and <= 1 day after dcdate | | | 1. Outpatient Prescriptions (Orders) |  |  | | 2. Outpatient Refills |  |  | | 3. Non-VA Medication |  |  | | 4. Inpatient Medication dispensed before discharge (day of discharge for patients discharged to nursing home or CLC) |  |  | | 5. Medication dispensed in CLC on first post discharge day |  |  | | 6. Discharge Summary |  |  | | 7. Nursing Discharge Instructions |  |  | | 8. Pharmacy discharge instructions |  |  | | 9. Physician discharge instructions |  |  | | 10. Other |  |  | | | | **The computer will flag the data source and prepopulate the date for each data source 1 – 5 as applicable based on data from the Pull List.**  **For prepopulated date fields, the abstractor will review the data source for documentation that an anticoagulant medication was prescribed and answer “yes” or “no” accordingly.**  **For date fields that are not prepopulated, the abstractor will review the data source for documentation that an anticoagulant medication was prescribed and answer “yes” or “no” and enter the date of the documentation.**  **If documentation of an anticoagulant medication prescribed at discharge is found in a data source that is not listed, enter “Yes” for value 10.** | |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| 45 | STK3 | olcoag | Enter the other location where documentation of prescription of an anticoagulant medication at discharge was found in the medical record.  |  | | --- | |  | | Free text entry | Enter the other location where documentation of prescription of an anticoagulant medication at discharge was found in the medical record. |
| 46 | STK3 | nocoag | Is there documentation by a physician/APN/PA or pharmacist in the medical record of a reason for not prescribing anticoagulation therapy at hospital discharge?  1. Allergy to ALL anticoagulation medications  2. Physician/APN/PA or pharmacist documentation of a reason for not prescribing anticoagulation therapy at discharge  95. Not applicable  98. Patient/family refusal  99. No documented reason | 1,2,95,98,99  Will be auto-filled as 95 if vanticoag = 1  If 95 or 99, go to end | * **With exception of allergy and patient/family refusal, reason for not prescribing anticoagulation therapy at hospital discharge must be documented by a physician/APN/PA or pharmacist.** * **If reasons are not mentioned in the context of anticoagulation therapy, do not make inferences** (e.g., do not assume that anticoagulation therapy was not prescribed because of a bleeding disorder unless documentation explicitly states so). * Reasons must be explicitly documented (e.g., “Active GI bleed – anticoagulation therapy contraindicated”, “No warfarin” [no reason given]). * Documentation of a hold or discontinuation of an anticoagulant medication that occurs during the hospital stay constitutes a “clearly implied” reason for not prescribing anticoagulation therapy at discharge. A hold/discontinuation of all p.o. medications counts if an oral anticoagulant medication (e.g., warfarin) was ordered at the time of the notation.   **EXCEPTIONS:**  - Documentation of a conditional hold/discontinuation of an anticoagulant medication does not count as a reason for not prescribing an anticoagulant medication at discharge (e.g., “Hold Coumadin if guaiac positive”, “Stop warfarin if rash persists”).  - Discontinuation of a particular anticoagulant medication documented in combination with the start of a different anticoagulant medication (i.e., switch type of anticoagulant medication) does not count as a reason for not prescribing an anticoagulant medication at discharge.  - Discontinuation of an anticoagulant medication at a particular dose documented in combination with the start of a different dose of that anticoagulant (i.e., change in dosage) does not count as a reason for not prescribing an anticoagulant medication at discharge.   * Deferral of an anticoagulant from one physician/APN/PA or pharmacist to another does NOT count as a reason for not prescribing an anticoagulant at discharge UNLESS the problem underlying the deferral is also noted. * If there is documentation of a plan to initiate/restart an anticoagulation and the reason/problem underlying the delay is also noted, this constitutes a “clearly implied” reason for not proscribing an anticoagulant at discharge. * Reasons do NOT need to be documented at discharge or otherwise linked to the discharge timeframe. Documentation of reasons anytime during the stay is acceptable. * An allergy or adverse reaction to one type of anticoagulant would NOT be a reason for not prescribing all anticoagulants. Another medication can be ordered. * When conflicting information is documented in a medical record, select “Yes.” * When the current record includes documentation of a pre-arrival reason for no anticoagulation therapy, the following counts 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: * Pre-arrival hold/discontinuation or notation such as "No Coumadin" IF the underlying reason/problem is also noted (e.g., “Coumadin held in transferring hospital due to possible GI bleed”). * Pre-arrival "other reason" (other than hold/discontinuation or notation of "No warfarin") (e.g., "Hx GI bleeding with warfarin" in transferring ED record).   **Examples of reasons for not prescribing anticoagulation therapy at discharge include, but are not limited to:**   * Allergy to all anticoagulant medications * Aortic dissection * Bleeding disorder * Brain/CNS cancer * CVA, hemorrhagic * Extensive/metastatic CA * Hemorrhage, any type * Intracranial surgery/biopsy * Patient/family refusal * Peptic ulcer * Planned surgery within 7 days following discharge * Risk of bleeding * Unrepaired intracranial aneurysm   **Refer to TJC NQM, Appendix C, Table 8.3 for a list of medications used for anticoagulation therapy.**  **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. |
| 47 | STK3 | vnocoag1  vnocoag2  vnocoag3  vnocoag4  vnocoag5  vnocoag6  vnocoag7  vnocoag8  vnocoag9  vnocoag10  vnocoag11vnocoag12 | Review each data source for documentation of a reason for not prescribing anticoagulant therapy at discharge and answer “yes” or “no” accordingly.   |  |  | | --- | --- | | **Data Source** | 1 Yes  2 No  If vnocoag12<> 1, go to end | | 1. Consultation |  | | 2. Cover sheet |  | | 3. Discharge summary |  | | 4. Emergency department notes |  | | 5. History and physical |  | | 6. Medication reconciliation form |  | | 7. Nursing progress notes |  | | 8. Pharmacy progress notes |  | | 9. Physician orders |  | | 10. Physician progress notes |  | | 11. Health Factor/Clinical Reminder |  | | 12. Other |  | | | **In order to answer this question accurately, it is necessary to review ALL relevant data sources for documentation of a reason for not prescribing an anticoagulant medication at discharge. For each data source listed, review that source in the medical record and answer “yes” or “no” accordingly.**  **If documentation of a reason for not prescribing anticoagulant therapy at discharge is found in a data source that is not listed, enter “Yes” for value 12.**  **Reasons for Not Prescribing Anticoagulant Therapy at Discharge:**   * Allergy to anticoagulant medication * Physician/APN/PA or pharmacist documentation of a reason for not prescribing anticoagulant medication at discharge * Patient/family refusal |
| 48 | STK3 | olnocoag | Enter the other location where documentation of a reason for not prescribing anticoagulant therapy at discharge was found in the medical record.  |  | | --- | |  | | Free text entry | Enter the other location where documentation of a reason for not prescribing anticoagulant therapy at discharge was found in the medical record. |