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|  |  | |  | **Organizational Identifiers** |  |  |
|  |  | | VAMC  CONTROL  QIC  BEGDTE  REVDTE | Facility ID Control Number  Abstractor ID  Abstraction Begin Date  Abstraction End Date | Auto-fill  Auto-fill  Auto-fill  Auto-fill  Auto-fill |  |
|  |  | |  | Patient Identifiers |  |  |
|  |  | | SSN  PTNAMEF  PTNAMEL  BIRTHDT  SEX  MARISTAT  RACE | Patient SSN First Name  Last Name  Birth Date  Sex  Marital Status Race | Auto-fill: no change  Auto-fill: no change  Auto-fill: no change  Auto-fill: no change  Auto-fill: **can change**  Auto-fill: no change  Auto-fill: no change |  |
|  |  | |  | Administrative Codes |  |  |
| 1 | ALL | | princode | ICD-9-CM principal diagnosis code: | \_\_ \_\_ \_\_. \_\_ \_\_  (3 digits/decimal point/two digits)   |  | | --- | | **Cannot enter 000.00, 123.45, or 999.99** |   \***If code is not listed in TJC 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 Joint Commission Appendix A, Table 8.1.**   **Suggested data sources:** Admission discharge, expanded admission/discharge, transfer, discharge diagnosis  **Exclusion Statement:**  **Although coding designated the case for inclusion in the Joint Commission Stroke National Hospital Inpatient Quality Measures population, documentation in the record does not confirm an ICD-9-CM principal diagnosis code of stroke.** |
| 2 | ALL | | Lprincod1  Lprincod2  Lprincod3  Lprincod4 | Select the location(s) where the principal diagnosis code is found in the EHR.  **Select all that apply:**  1. Admission/discharge  2. Discharge diagnosis  3. Expanded admission/discharge/transfer (EADT)  4. Other | 1,2,3,4  If <> 4, go to othdx1 | **In order to answer this question accurately, it is necessary to review all relevant data sources for documentation of principal diagnosis code.** |
| 3 | ALL | | Oprincod | Enter the name of the other location (s). (More than one location may be entered).   |  | | --- | |  | |  | | Text field | **If the location is a note, enter the name of the local note title.** |
| 4 | | ALL | othdx1  othdx2  othdx3  othdx4  othdx5  othdx6  othdx7  othdx8  othdx9  othdx10  othdx11  othdx12 | ICD-9-CM other diagnosis codes: | \_\_ \_\_ \_\_. \_\_ \_\_  (3 digits/decimal point/two digits)  Can enter 12 codes   |  | | --- | | **Cannot enter 000.00, 123.45, or 999.99** | | **Abstractor can enter xxx.xx in code field if no other dx found** | | **Will auto-fill from the PTF with ability to change. If the “other diagnoses” codes are incorrect, enter the codes as documented in the medical record.**  If entered manually, use the codes listed in discharge diagnosis (DD) under the reports tab.  Enter xxx.xx in code field if no other diagnoses codes exist for this record. |

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| 5 | ALL | prinpx  prinpxdt | Enter the ICD-9-CM principal procedure code and date.  Date   |  |  | | --- | --- | | \_\_ \_\_. \_\_ \_\_ | \_\_/\_\_/\_\_\_\_ | | \_\_ \_\_. \_\_ \_\_  **If there is no principal procedure, the abstractor can enter xx.xx in code field and**  **99/99/9999 in date field**   |  | | --- | | **Cannot enter 00.00** |   mm/dd/yyyy  **Abstractor can enter 99/99/9999**  **If there is no principal procedure, auto-fill othrpx and othpxdt with xx.xx and 99/99/9999**  If prinpx = ICD-9 code on TJC Table 8.3, Appendix A, auto-fill carintv as 1   |  | | --- | | > = 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 WVMI if you are uncertain.   **If no procedure was performed during the episode of care, fill ICD-9-CM code field with default code xx.xx. Do not enter 99.99 or 00.00 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 the 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 | ALL | othrpx1  othrpx2  othrpx3  othrpx4  othrpx5  (codes)  othpxdt1  othpxdt2  othpxdt3  othpxdt4  othpxdt5  (dates) | Enter the ICD-9-CM other procedure codes and dates. | \_\_ \_\_. \_\_ \_\_ **If no other procedure was performed, the abstractor can enter xx.xx in code field and 99/99/9999 in date field**   |  | | --- | | **Cannot enter 00.00** |   mm/dd/yyyy  **Abstractor can enter 99/99/9999**  **Can enter 5 codes and dates**  If othrpx = ICD-9 code on TJC Table 8.3, Appendix A, auto-fill carintv as 1   |  | | --- | | > = admdt and < = dcdate | | **Can enter 5 procedure codes, other than the principal procedure code.** Enter the ICD-9-CM 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 xx.xx 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 xx.xx 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. |
| 7 | ALL | Lpxcode1  Lpxcode2  Lpxcode3  Lpxcode4 | Select the location(s) where the procedure code(s) is found in the EHR.  **Select all that apply:**  1. Expanded admission/discharge/transfer (EADT)  2. ICD Procedures  3. ICD Surgeries  4. Other | 1,2,3,4  If <> 4, go to edpt | **In order to answer this question accurately, it is necessary to review all relevant data sources for documentation of procedures code. Procedure codes are usually found under the Reports tab.** |
| 8 | ALL | Opxcode | Enter the name of the other location (s). (More than one location may be entered).   |  | | --- | |  | |  | | Text field | **If the location is a note, enter the name of the local note title.** |

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|  | |  |  | **Admission Data** |  |  |
| 9 | ALL | | edpt | Did the patient receive care/services in the Emergency Department of this VAMC? 1. Yes  2. No | 1,2  If 2, go to arrvdate | **For the purposes of this data element an Emergency Department (ED) patient is defined as any patient receiving care or services in the ED of this VAMC.**   * If the patient presents to the ED for outpatient services such as lab work and the patient receives the service in the ED, enter “1”. * A patient seen in an Urgent Care, ER Fast Track, etc. is NOT considered an ED patient unless the patient received services in the Emergency Department at this VAMC (e.g., patient treated at an urgent care and transferred to the main campus ED is considered an ED patient, but a patient seen at the urgent care and transferred to the hospital as a direct admit would not be considered an ED patient). * For patients presenting to the ED who do NOT receive care or services in the ED, enter “2” (e.g., patient is sent to hospital from physician office and presents to ED triage and is instructed to proceed straight to floor).   **Exclude:** **Urgent Care, fast track ED, terms synonymous with Urgent Care** |

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| 10 | ALL | Ledarrv1  Ledarrv2  Ledarrv3  Ledarrv4  Ledarrv5  Ledarrv6  Ledarrv7  Ledarrv8  Ledarrv9  Ledarrv10  Ledarrv11 | Select the location(s) where **date and time of ED arrival** is found in the electronic health record (EHR).  **Select all that apply:**  1. Emergency Department note  2. Nursing admission assessment  3. Observation notes  4. Outpatient registration form  5. Past clinic visits  6. Procedure note  7. Scanned document (VISTA imaging)  8. Transfer note  9. Triage note  10. Vital sign record  11. Other | 1,2,3,4,5,6,7,8,9,10,11 | **In order to answer this question accurately, it is necessary to review all relevant data sources for documentation of ED arrival date and time and select all that apply.** |
| 11 | ALL | Leddep1  Leddep2  Leddep3  Leddep4  Leddep5  Leddep6  Leddep7  Leddep8  Leddep9  Leddep10  Leddep11 | Select the location(s) where **date and time of ED departure** is found in the electronic health record (EHR).  **Select all that apply:**  1. Emergency Department note  2. Nursing admission assessment  3. Observation notes  4. Outpatient registration form  5. Past clinic visits  6. Procedure note  7. Scanned document (VISTA imaging)  8. Transfer note  9. Vital sign record  10. Triage note  11. Other | 1,2,3,4,5,6,7,8,9,10,11  If Ledarrv and Leddep <> 11, go to arrvdate | **In order to answer this question accurately, it is necessary to review all relevant data sources for documentation of ED departure date and time and select all that apply.** |

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| 12 | ALL | Oeddttm | Enter the name of the other location (s). (More than one location may be entered).   |  | | --- | |  | |  | | Text field | **If the location is a note, enter the name of the local note title.** |
| 13 | stk5 | arrvdate | Enter the **earliest** documented date the patient arrived at acute care at this VAMC. | mm/dd/yyyy  Abstractor may enter 99/99/9999 if arrival date is unable to be determined   |  | | --- | | < = admdt and < = dcdate | | **Arrival date is the earliest recorded date on which the patient arrived in the hospital’s acute care setting where care for stroke could be most appropriately provided**. Arrival date may differ from admission date.   * **Review all data sources where arrival date is documented to determine the earliest date the patient arrived at the ED, nursing floor, or observation, or as a direct admit to the cath lab. Use the earliest date documented unless other documentation suggests the patient was not in the hospital on that date. The intent is to utilize any documentation which reflects processes that occurred in the ED or hospital.** * 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 date at the first facility. * For Observation Status:   + If the patient was admitted to observation from the ED of the hospital, use the date the patient arrived at the ED.   + If the patient was admitted to observation from an outpatient setting of the hospital, use the date the patient arrived at the ED or on the floor for observation care. * 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 subsequently admitted to acute inpatient, use the date the patient presents to the ED or arrives on the floor for acute inpatient care as the arrival date. * For Direct Admits:   + If the patient is a “Direct Admit” to the cath lab, use the earliest date the patient arrived at the cath lab (or cath lab staging/holding area) as the arrival date.   **Cont’d next page**  **Arrival date cont’d**   * + For “Direct Admits” to acute inpatient or observation, use the earliest date the patient arrived at the nursing floor or in observation as the arrival date.   **Suggested data sources:** Emergency Department record (includes ED vital sign record, ED Outpatient Registration form, triage record, ECG, lab or x-ray reports, etc., if these services were rendered while the patient was an ED patient), nursing admission assessment /admitting note, observation record, procedure notes (such as cardiac cath, bronchoscopy, endoscopy), vital signs graphic record, past clinic visit  Only enter 99/99/9999 if the arrival date is unable to be determined from the medical record documentation. If the arrival 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. |
| 14 | stk5 | Larrvdt1  Larrvdt2  Larrvdt3  Larrvdt4  Larrvdt5  Larrvdt6  Larrvdt7  Larrvdt8  Larrvdt9  Larrvdt10  Larrvdt11  Larrvdt12 | Select the location(s) where the arrival date is found in the EHR.  **Select all that apply:**  1. Discharge summary  2. Emergency Department note  3. Expanded admission/discharge/transfer (EADT)  4. Nursing admission assessment  5. Observation notes  6. Outpatient registration form  7. Past clinic visits  8. Procedure note  9. Scanned document (VISTA imaging)  10. Triage note  11. Vital sign record  12. Other | 1,2,3,4,5,6,7,8,9,10,11,12  If <> 12, go to arrvtime | **In order to answer this question accurately, it is necessary to review all relevant data sources for documentation of arrival date.** |

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| 15 | ALL | Oarrvdt | Enter the name of the other location (s). (More than one location may be entered).   |  | | --- | |  | |  | | Text field | **If the location is a note, enter the name of the local note title.** |
| 16 | stk5 | arrvtime | Enter the **earliest** documented time the patient arrived at acute care at this VAMC. | \_\_\_\_\_  UMT **If unable to find the time of arrival, the abstractor can enter 99:99**   |  | | --- | | < =admdt/admtm and < dcdate/dctime | | **Arrival time is the earliest recorded time the patient arrived in this hospital’s acute care setting where care for stroke could be most appropriately provided**.   * **Review all data sources where arrival time is documented to determine the earliest date the patient arrived at the ED, nursing floor, or observation, or as a direct admit to the cath lab. Use the earliest time documented unless other documentation suggests the patient was not in the hospital at that time. The intent is to utilize any documentation which reflects processes that occurred in the ED or hospital.** * 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. * For Observation Status:   + If the patient was admitted to observation from the ED of the hospital, use the time the patient arrived at the ED.   + If the patient was admitted to observation from an outpatient setting of the hospital, use the time the patient arrived at the ED or on the floor for observation care. * 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 subsequently admitted to acute inpatient, use the time the patient presents to the ED or arrives on the floor for acute inpatient care as the arrival time.   + If the time the patient arrived on the floor is not documented by the nurse, enter the admission time recorded in EADT.   **Cont’d next page**  **Arrival time cont’d**   * For Direct Admits:   + If the patient is a “Direct Admit” to the cath lab, use the earliest time the patient arrived at the cath lab (or cath lab staging/holding area) as the arrival time.   + For “Direct Admits” to acute inpatient or observation, use the earliest time the patient arrived at the nursing floor or in observation as the arrival time.   **Suggested data sources:** Emergency Department record (includes ED vital sign record, ED Outpatient Registration form, triage record, ECG, lab or x-ray reports, etc., if these services were rendered while the patient was an ED patient), nursing admission assessment /admitting note, observation record, procedure notes (such as cardiac cath, bronchoscopy, endoscopy), vital signs graphic record  **If unable to determine the time of arrival, enter default time 99:99.** If the arrival time documented in the record is obviously in error (e.g. 33:00) and no other documentation is found that provides this information, enter 99:99. |

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| 17 | Stk5 | Larrvtm1  Larrvtm2  Larrvtm3  Larrvtm4  Larrvtm5  Larrvtm6  Larrvtm7  Larrvtm8  Larrvtm9  Larrvtm10  Larrvtm11  arrvtm1  arrvtm2  arrvtm3  arrvtm4  arrvtm5  arrvtm6  arrvtm7  arrvtm8  arrvtm9  arrvtm10 | Select the location(s) where the arrival time is found in the EHR and enter the arrival time documented in the data source.   |  |  |  | | --- | --- | --- | | **Data Source**  **1,2,3,4,5,6,7,8,9,10,11**  **If <> 11, go to admdt**  **Select All that Apply:** | **UMT**   |  | | --- | | **< =admdt/admtm and < dcdate/dctime** | | | 1. Emergency Department note |  | | 2. Expanded admission/discharge/transfer (EADT) |  | | 3. Nursing admission assessment |  | | 4. Observation notes |  | | 5. Outpatient registration form |  | | 6. Past clinic visits |  | | 7. Procedure note |  | | 8. Scanned document (VISTA imaging) |  | | 9. Triage note |  | | 10. Vital sign record |  | | 11. Other |  | | | * **In order to answer this question accurately, it is necessary to review all relevant data sources for documentation of arrival time.** * **Arrival time is the earliest recorded time the patient arrived in this hospital’s acute care setting where care for stroke could be most appropriately provided**. * **Review all data sources where arrival time is documented to determine the earliest time the patient arrived at the ED, nursing floor, or observation, or as a direct admit to the cath lab.** * **Use the earliest time documented unless other documentation suggests the patient was not in the hospital at that time. The intent is to utilize any documentation which reflects processes that occurred in the ED or hospital.** |
| 18 | ALL | Oarrvtm | Enter the name of the other location (s). (More than one location may be entered).   |  | | --- | |  | |  | | Text field | **If the location is a note, enter the name of the local note title.** |

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| 19 | ALL | admdt | Date of admission to acute inpatient care: | mm/dd/yyyy  **Auto-filled: can be modified**   |  | | --- | | > = arrvdate and < = dcdate | | **Auto-filled; can be modified if abstractor determines that the date is incorrect. Review all data sources where admission date is documented in the record.**  **Exclusion:** admit to observation, arrival date  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.  **Suggested data sources:** admission/discharge, cover sheet, expanded ADT, nursing admission assessment, physician orders |
| 20 | ALL | Ladmdt1  Ladmdt2  Ladmdt3  Ladmdt4  Ladmdt5  Ladmdt6  Ladmdt7  Ladmdt8 | Select the location(s) where the admission date is found in the EHR.  **Select all that apply:**  1. Admission/discharge  2. Cover sheet  3. Discharge diagnosis  4. Discharge summary  5. Expanded admission/discharge/transfer (EADT)  6. Nursing admission assessment  7. Physician orders  8. Other | 1,2,3,4,5,6,7,8  If <> 8, go to admtm | **In order to answer this question accurately, it is necessary to review all relevant data sources for documentation of admission date.** |

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| 21 | ALL | Oadmdt | Enter the name of the other location (s). (More than one location may be entered).   |  | | --- | |  | |  | | Text field | **If the location is a note, enter the name of the local note title.** |
| 22 | ALL | admtm | Time of admission to acute inpatient care: | UMT **Auto-filled: can be modified**   |  | | --- | | > = arrvdate and < dcdate/dctime | | **Auto-filled; can be modified**  Abstractor to verify admission time is correct. Review all data sources where admission time is documented in the record.  DO NOT use ED discharge time or patient transfer time.  **Suggested data sources:** admission/discharge, cover sheet, expanded ADT, nursing admission assessment, physician orders |
| 23 | ALL | Ladmtm1  Ladmtm2  Ladmtm3  Ladmtm4  Ladmtm5  Ladmtm6 | Select the location(s) where the admission time is found in the EHR.  **Select all that apply:**  1. Admission/discharge  2. Cover sheet  3. Expanded admission/discharge/transfer (EADT)  4. Nursing admission assessment  5. Physician orders  6. Other | 1,2,3,4,5,6  If <> 6, go to dcdate | **In order to answer this question accurately, it is necessary to review all relevant data sources for documentation of admission time.** |
| 24 | ALL | Oadmtm | Enter the name of the other location (s). (More than one location may be entered).   |  | | --- | |  | |  | | Text field | **If the location is a note, enter the name of the local note title.** |

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|  |  |  | **Discharge Data** |  |  |
| 25 | ALL | dcdate | Discharge date: | mm/dd/yyyy  **Auto-filled. Cannot be modified**  > = admdt | The computer will auto-fill the discharge date from the OABI pull list. This date cannot be modified in order to ensure the selected episode of care is reviewed.  **Review all data sources where discharge date is documented in the record.** |
| 26 | ALL | Ldcdt1  Ldcdt2  Ldcdt3  Ldcdt4  Ldcdt5  Ldcdt6  Ldcdt7  Ldcdt8  Ldcdt9 | Select the location(s) where the discharge date is found in the EHR.  **Select all that apply:**  1. Admission/discharge  2. Discharge summary  3. Expanded admission/discharge/transfer (EADT)  4. Nursing discharge note  5. Patient discharge instructions  6. Pharmacy discharge instructions  7. Physician discharge note  8. Physician orders  9. Other | 1,2,3,4,5,6,7,8,9  If <> 9, go to dctime | **In order to answer this question accurately, it is necessary to review all relevant data sources for documentation of discharge date.** |
| 27 | ALL | Odcdate | Enter the name of the other location (s). (More than one location may be entered).   |  | | --- | |  | |  | | Text field | **If the location is a note, enter the name of the local note title.** |

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| 28 | ALL | dctime | Enter the time of discharge: | \_\_\_\_\_\_ UMT   |  | | --- | | > admdt/admtm | | **Does not auto-fill. Discharge time must be entered.**  **Includes the time the patient was discharged from acute care, left against medical advice (AMA), or expired during this stay.**  If the patient expired, use the time of death as the discharge time.  **For other patients:**  If the time of discharge is NOT documented in the nurses notes, discharge/transfer form, or progress notes, enter the discharge time documented in EADT under the “Reports Tab.”  Enter time in Universal Military Time: a 24-hour period from midnight to midnight using a 4-digit number of which the first two digits indicate the hour and the last two digits indicate the minute.  Converting time to military time:  If time is in the a.m., no conversion is required.  If time is the p.m., add 12 to the clock hour time.  **Suggested data sources:** Death note, discharge/transfer form, nurses notes, EADT, physician progress notes, resuscitation record |
| 29 | ALL | Ldctm1  Ldctm2  Ldctm3  Ldctm4  Ldctm5  Ldctm6 | Select the location(s) where the discharge time is found in the EHR.  **Select all that apply:**  1. Admission/discharge  2. Discharge summary  3. Expanded admission/discharge/transfer (EADT)  4. Nursing discharge note  5. Physician discharge note  6. Other | 1,2,3,4,5,6  If <> 6, go to dcdispo | **In order to answer this question accurately, it is necessary to review all relevant data sources for documentation of discharge time.** |
| 30 | ALL | Odctime | Enter the name of the other location (s). (More than one location may be entered).   |  | | --- | |  | |  | | Text field | **If the location is a note, enter the name of the local note title.** |

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| 31 | STK3  STK6 | 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)   6. Expired  7. Left Against Medical Advice/AMA  99. Not documented or unable to determine | 1,2,3,4,5,6,7,99   |  | | --- | | Warning if 99 | | **Discharge disposition: The final place or setting to which the patient was discharged on the day of discharge.**   * **Only use documentation from the day of or the day before 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”. * **Consider discharge disposition documentation in the discharge summary, post-discharge addendum, or a late entry as day of discharge documentation, regardless of when it was dictated/written.** * **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.   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 * 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 of level of care, select “5”.   **Cont’d next page**  **Discharge disposition cont’d**   * 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 |

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| 32 | STK3  STK6 | Ldcdispo1  Ldcdispo2  Ldcdispo3  Ldcdispo4  Ldcdispo5  Ldcdispo6  Ldcdispo7  Ldcdispo8  Ldcdispo9  Dcdispo1  Dcdispo2  Dcdispo3  Dcdispo4  Dcdispo5  Dcdispo6  Dcdispo7  Dcdispo8 | Select the location(s) where discharge disposition is found in the EHR and enter the discharge disposition documented in the data source.   |  |  |  | | --- | --- | --- | | **Data Source**  **1,2,3,4,5,6,7,8,9**  **If <> 9, go to comfort**  **Select all that apply:** | **Discharge Disposition**  1,2,3,4,5,6,7,99   |  | | --- | | 99 cannot be entered if dcdispo <> 99 | | | 1. Discharge summary |  | | 2. Expanded admission/discharge/transfer (EADT) |  | | 3. Nursing Discharge Instructions |  | | 4. Nursing Discharge Note |  | | 5. Physician Discharge Instructions |  | | 6. Physician Discharge Note |  | | 7. Physician orders |  | | 8. Transfer record |  | | 9. Other |  | | **This question is applicable regardless of whether discharge disposition was documented or unable to be determined for this patient during the hospitalization.**  **In order to answer accurately, select all relevant data sources where documentation of discharge disposition may be found in the medical record.**  **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  99. Not documented or unable to determine |

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| 33 | ALL | Odcdispo | Enter the name of the other location (s). (More than one location may be entered).   |  | | --- | |  | |  | | Text field | **If the location is a note, enter the name of the local note title.** |
|  |  |  | **CMO/Clinical Trial** |  |  |
| 34 | STK3  STK5  STK6 | comfort | Is there physician, APN, or PA documentation of comfort measures only during the hospitalization?  1. Yes  2. No | 1,2  **If 1, go to Lcmodttm1; else if 2, go to Lcomfort1** | **Comfort Measures Only:** refers to medical treatment of a dying person where the natural dying process is permitted to occur while assuring maximum comfort. It includes attention to the psychological and spiritual needs of the patient and support for both the dying patient and the patient’s family. Comfort Measures Only is commonly referred to as “comfort care” by the general public. It is not equivalent to a physician order to withhold emergency resuscitative measures such as Do Not Resuscitate (DNR).  **Only accept terms identified in the list of inclusions. No other terminology will be accepted.**   |  |  | | --- | --- | | **Inclusion (Only acceptable terms)** | | | Brain death/dead | End of life care | | Comfort care | Hospice | | Comfort measures | Hospice care | | Comfort measures only CMO) | Organ harvest | | Comfort only | Terminal care | | DNR-CC |  |  * **Consider comfort measures only documentation in the discharge summary as documentation on the last day of the hospitalization, regardless of when the summary is dictated.** * **Physician/APN/PA documentation of comfort measures only 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 * **Documentation of “CMO should be disregarded if documentation makes clear it is not being used as an acronym for Comfort Measures Only (e.g., “hx dilated CMO” - Cardiomyopathy context).**   **Cont’d next page**  **CMO cont’d**  **Suggested data sources:** Discharge summary, DNR/MOLST/POLST forms, Emergency Department record, physician orders, progress notes  **Excluded data source:** Restraint order sheet |

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| 35 | STK3  STK5  STK6 | Lcmodttm1  Lcmodttm2  Lcmodttm3  Lcmodttm4  Lcmodttm5  Lcmodttm6  Lcmodt1  Lcmodt2  Lcmodt3  Lcmodt4  Lcmodt5  Lcmotm1  Lcmotm2  Lcmotm3  Lcmotm4  Lcmotm5 | Select the location(s) where comfort measures only (CMO) documentation is found in the EHR and enter the date and time of CMO documented in the data source.   |  |  |  |  |  | | --- | --- | --- | --- | --- | | **CMO Data Source**  **1,2,3,4,5,6**  **If 6, go to Ocomfort; else go to clntrial**  **Select all that apply:** | **CMO Date**  mm/dd/yyyy   |  | | --- | | >=arrvdate and <=dcdate | | **CMO Time**  **UMT**   |  | | --- | | >=arrvdate  /arrvtime and <=dcdate/  dctime | | | 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, indicate all relevant data sources where documentation of CMO date and time may be found in the medical record. Enter the date and time of CMO documented for each data source.** |

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| 36 | STK3  STK5  STK6 | Lcomfort1  Lcomfort2  Lcomfort3  Lcomfort4  Lcomfort5  Lcomfort6 | Select the location(s) where comfort measures only documentation is found in the EHR.  **Select all that apply:**  1. Discharge summary  2. DNR/MOLST/POLST forms  3. Emergency department note  4. Physician orders  5. Progress notes  6. Other | 1,2,3,4,5,6  If <> 6, go to clntrial | **This question is applicable if CMO was not documented for this patient during the hospitalization.**  **In order to answer accurately, indicate all relevant data sources where documentation of CMO may be found in the medical record.** |
| 37 | ALL | Ocomfort | Enter the name of the other location (s). (More than one location may be entered).   |  | | --- | |  | |  | | Text field | **If the location is a note, enter the name of the local note title.** |

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| 38 | ALL STK | 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 |
| 39 | ALL STK | Lclntrial1  Lclntrial2  Lclntrial3  Lclntrial4  Lclntrial5  Lclntrial6 | Select the location(s) where clinical trial documentation is found in the EHR.  **Select all that apply:**  1. Clinical Trial Consent form  2. Cover sheet  3. Emergency department note  4. Progress note  5. Scanned document (VISTA imaging)  6. Other | 1,2,3,4,5,6  If <> 6, go to carintv | **This question is applicable regardless of whether enrollment of the patient in a clinical trial for stroke during the hospital stay was documented.**  **In order to answer accurately, select all relevant data sources where documentation of clinical trial may be found in the medical record.** |

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| 40 | ALL | Oclntrial | Enter the name of the other location (s). (More than one location may be entered).   |  | | --- | |  | |  | | Text field | **If the location is a note, enter the name of the local note title.** |
|  |  |  | **Carotid Intervention** |  |  |
| 41 | ALL STK | carintv | Was a carotid intervention (procedure) performed during this episode of care?  1. Yes  2. No | 1,2  Will be auto-filled as 1 if prinpx or othrpx = ICD-9 code on TJC Table 8.3, Appendix A | **Carotid Intervention:**   |  |  | | --- | --- | | **Code** | **Description** | | **00.61** | **Percutaneous angioplasty of extracranial vessels** | | **00.62** | **Percutaneous angioplasty of intracranial vessels** | | **00.63** | **Percutaneous insertion of carotid artery stent** | | **00.64** | **Percutaneous insertion of other extracranial artery stent** | | **00.65** | **Percutaneous insertion of intracranial vascular stent** | | **38.02** | **Incision of vessel, other vessels of head and neck** | | **38.12** | **Endarterectomy, other vessels of head and neck** | | **38.22** | **Percutaneous angioscopy** | | **38.30** | **Resection of vessel with anastomosis, unspecified site** | | **38.31** | **Resection of vessel with anastomosis, intracranial vessels** | | **38.32** | **Resection of vessel with anastomosis, other vessels of head and neck** | | **38.42** | **Resection of vessel with replacement, other vessels of head and neck** | | **39.28** | **Extracranial-intracranial (ECIC) vascular bypass** | | **88.41** | **Arteriography of cerebral arteries** |  * **This question will be auto-filled as “yes” if one of the designated ICD-9 procedure codes is entered in prinpx or othrpx.** * **In order to answer “1”, the carotid intervention must be performed after admission and prior to discharge.**   **Suggested data sources:** Consultation, history and physical, operating room (surgery) report, physician orders, progress notes |

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| 42 | ALL  STK | carintop | Was a carotid intervention (procedure) performed as an outpatient immediately prior to hospital admission?  1. Yes  2. No | 1,2  If 2 and carintv = 2, go to afib | * If the patient is directly admitted to the hospital post-procedure following an elective carotid intervention performed as an outpatient, select “Yes”. **Example:**   Patient scheduled for elective carotid endarterectomy right side  on 05/17/20xx at 08:30. Patient checks into outpatient surgery at 06:13 and proceeds to the O.R., then to PACU. Patient status is changed to inpatient at 11:35 on 05/17/20xx. Patient discharged home on 05/18/20xx.  **Carotid Intervention:**   |  |  | | --- | --- | | **Code** | **Description** | | **00.61** | **Percutaneous angioplasty of extracranial vessels** | | **00.62** | **Percutaneous angioplasty of intracranial vessels** | | **00.63** | **Percutaneous insertion of carotid artery stent** | | **00.64** | **Percutaneous insertion of other extracranial artery stent** | | **00.65** | **Percutaneous insertion of intracranial vascular stent** | | **38.02** | **Incision of vessel, other vessels of head and neck** | | **38.12** | **Endarterectomy, other vessels of head and neck** | | **38.22** | **Percutaneous angioscopy** | | **38.30** | **Resection of vessel with anastomosis, unspecified site** | | **38.31** | **Resection of vessel with anastomosis, intracranial vessels** | | **38.32** | **Resection of vessel with anastomosis, other vessels of head and neck** | | **38.42** | **Resection of vessel with replacement, other vessels of head and neck** | | **39.28** | **Extracranial-intracranial (ECIC) vascular bypass** | | **88.41** | **Arteriography of cerebral arteries** |   **Suggested data sources:** Consultation, history and physical, operating room (surgery) report, physician orders, progress notes |

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| 43 | ALL STK | Lcarintv1  Lcarintv2  Lcarintv3  Lcarintv4  Lcarintv5  Lcarintv6  Lcarintv7  Lcarintv8 | Select the location(s) where carotid intervention procedure documentation is found in the EHR.  **Select all that apply:**  1. Consultation note  2. Discharge summary  3. Expanded admission/discharge/transfer (EADT)  4. History and Physical  5. OR (Surgery) Report  6. Physician orders  7. Progress notes  8. Other | 1,2,3,4,5,6,7,8  If <> 8, go to ecarintv | **In order to answer this question accurately, it is necessary to review all relevant data sources for documentation of carotid intervention.** |
| 44 | ALL | Ocarintv | Enter the name of the other location (s). (More than one location may be entered).   |  | | --- | |  | |  | | Text field | **If the location is a note, enter the name of the local note title.** |

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| 45 | ALL STK | ecarintv | Was the carotid intervention (procedure) described as elective?  1. Yes  2. No | 1,2  If 2, go to afib | **Patients admitted for an acute stroke are not considered to have been admitted solely for the purpose of the performance of elective carotid intervention.**   * If the patient was admitted for an acute stroke, even if a carotid intervention was performed after admission, select “No”. * When documentation clearly indicates that the carotid intervention is elective, (e.g., admitting orders to obtain informed consent for a carotid procedure; pre-operative testing completed prior to admission; surgical orders for carotid endarterectomy dated prior to arrival; physician office visit documentation prior to arrival stating, “CEA with Dr. X planned in the near future”), select “Yes”. * When the patient is directly admitted to the hospital post-procedure following an elective carotid intervention performed as an outpatient, select “Yes”. **Example:**   Patient scheduled for elective carotid endarterectomy right side on 05/17/20xx at 08:30. Patient checks into outpatient surgery at 06:13 and proceeds to the O.R., then to PACU. Patient status is changed to inpatient at 11:35 on 05/17/20xx. Patient discharged home on 05/18/20xx.   * When documentation of the procedure is not linked with “elective”, select “No”. |

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| 46 | ALL STK | Lelecint1  Lelecint2  Lelecint3  Lelecint4  Lelecint5  Lelecint6  Lelecint7 | Select the location(s) where the elective carotid intervention documentation is found in the EHR.  **Select all that apply:**  1. Consultation note  2. Discharge summary  3. History and Physical  4. OR (Surgery) Report  5. Physician orders  6. Progress notes  7. Other | 1,2,3,4,5,6,7  If <> 7, go to afib | **In order to answer this question accurately, it is necessary to review all relevant data sources for documentation of elective carotid intervention.** |
| 47 | ALL | Oelecintv | Enter the name of the other location (s). (More than one location may be entered).   |  | | --- | |  | |  | | Text field | **If the location is a note, enter the name of the local note title.** |
|  |  |  | **Atrial Fib/flutter** |  |  |

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| 48 | STK3 | afib | Was a current finding of atrial fibrillation/flutter documented in the EHR?  1. Yes  2. No | 1,2  Will be auto-filled as 1 if othdx = 427.31 or 427.32  If 1, go to Lafib Nosory of atrial fibrillation/flutter or current finding or atrial fibrillation/flutter documented in the medical record? | **Current finding of atrial fibrillation/flutter: Documentation that the patient has current atrial fibrillation or flutter on EKG.**   * Documented current finding of atrial fibrillation/flutter as described in the above statement meets this data element. * Documentation of atrial fibrillation or flutter on current EKG, select “Yes”. * Diagnosis of current atrial fibrillation or flutter anywhere in the medical record, select “Yes”. * See the inclusion list for acceptable examples of documentation. The list is not all-inclusive.   **Include:** AF, A-fib, atrial fibrillation, atrial flutter, atrial fibrillation described as persistent or paroxysmal), PAF  **Exclude:** Premature atrial contraction (PAC), paroxysmal atrial tachycardia (PAT), paroxysmal supraventricular tachycardia (PST)  **Suggested data sources:** consultation, discharge summary, EKG report, Holter monitor report, problem list, progress notes |
| 49 | STK3 | hxafib | Was a history of atrial fibrillation/flutter documented in the EHR?  1. Yes  2. No | 1,2  If 1, go to Lafib  If 2, go to carablNosory of atrial fibrillation/flutter or current finding or atrial fibrillation/flutter documented in the medical record? | * Documented past history of atrial fibrillation/flutter anywhere in the medical record, select “Yes”. * See the inclusion list for acceptable examples of documentation. The list is not all-inclusive. * Documented history of atrial fibrillation or flutter that terminated within 8 weeks following CABG, select “No”. * Documented history of transient and entirely reversible episode of atrial fibrillation or flutter due to thyrotoxicosis, select “No”.   **Include:** AF, A-fib, atrial fibrillation, atrial flutter, atrial fibrillation described as persistent or paroxysmal), PAF, history of any remote episode of documented atrial fibrillation or flutter except within 8 weeks following CABG  **Exclude:** Premature atrial contraction (PAC), paroxysmal atrial tachycardia (PAT), paroxysmal supraventricular tachycardia (PST)  **Suggested data sources:** consultation, discharge summary, EKG report, Holter monitor report, problem list, progress notes |

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| 50 | STK3 | Lafib1  Lafib2  Lafib3  Lafib4  Lafib5  Lafib6  Lafib7  Lafib8 | Select the location(s) where history/current finding of atrial fibrillation/flutter is found in the EHR.  **Select all that apply:**  1. Consultation  2. Discharge summary  3. EKG report  4. History and Physical  5. Holter monitor report  6. Problem list  7. Progress notes  8. Other | 1,2,3,4,5,6,7,8  If <> 8, go to cardabl | **In order to answer this question accurately, it is necessary to review all relevant data sources for documentation of atrial fibrillation/flutter.** |
| 51 | STK3 | Oafib | Enter the name of the other location (s). (More than one location may be entered).   |  | | --- | |  | |  | | Text field | **If the location is a note, enter the name of the local note title.** |
| 52 | STK3 | cardabl | Was a history of a cardiac (atrial) ablation procedure documented in the EHR?  1. Yes  2. No | 1,2  If 2, go to iviatpa | **Cardiac (atrial) ablation is a procedure that is used to destroy small areas in the heart that may be causing cardiac rhythm problems.**  **Suggested data sources:** consultation, discharge summary, history and physical, problem list, procedure notes, progress notes, surgery reports |

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| 53 | STK3 | Lcarabl1  Lcarabl2  Lcarabl3  Lcarabl4  Lcarabl5  Lcarabl6  Lcarabl7  Lcarabl8 | Select the location(s) where history of cardiac ablation procedure is found in the EHR.  **Select all that apply:**  1. Consultation  2. Discharge summary  3. History and Physical  4. Problem list  5. Procedure notes  6. Progress notes  7. Surgery reports  8. Other | 1,2,3,4,5,6,7,8  If <> 8, go to iviatpa | **In order to answer this question accurately, it is necessary to review all relevant data sources for documentation of cardiac ablation procedure.** |
| 54 | STK3 | Ocarabl | Enter the name of the other location (s). (More than one location may be entered).   |  | | --- | |  | |  | | Text field | **If the location is a note, enter the name of the local note title.** |
|  |  |  | **Thrombolytic Therapy** |  |  |
| 55 | STK5 | iviatpa | Did the patient receive intravenous (IV) or intra-arterial (IA) thrombolytic (t-PA) therapy at this VAMC or within 24 hours prior to arrival?  1. Yes  2. No | 1,2  If 2, go to antithrom | Documentation in the medical record must reflect that the patient received IV or IA thrombolytic (t-PA) therapy at this VAMC or within 24 hours prior to arrival, (i.e., drip and ship).  **ONLY Acceptable Thrombolytic Therapy for Stroke:**  Activase, Altepase, Intra-arterial (IA) t-PA, Intravenous (IV) t-PA, Recombinant t-PA, Tissue plasminogen activator  **Suggested data sources:** Emergency room record, medication records, progress notes, transfer forms, medical transport records |
| 56 | STK5 | tpadt  tpatm  tparoute | Enter the date, time, and route of administration of thrombolytic (t-PA) therapy.   |  |  |  | | --- | --- | --- | | Date | Time | Route  1. IV  2. IA | |  |  |  | | mm/dd/yyyy   |  | | --- | | <= 1 day prior to arrvdate and <=dcdate |   \_\_\_\_\_\_  UMT   |  | | --- | | <= 24 hours prior to arrvtime and <=dctime |   1,2 | The date and time of t-PA administration must be known and entered accurately. |
| 57 | STK5 | Livtpa1  Livtpa2  Livtpa3  Livtpa4  Livtpa5  Livtpa6  Livtpa7  Livtpa8 | Select the location(s) where administration (or receipt) of intravenous (IV) or intra-arterial (IA) thrombolytic (t-PA) therapy is found in the EHR.  **Select all that apply:**  1. Consultation  2. Discharge summary  3. Emergency department notes  4. History and physical  5. Medication administration record  6. Progress notes  7. Transfer note  8. Other | 1,2,3,4,5,6,7,8  If <> 8, go to antithrom | **In order to answer this question accurately, it is necessary to review all relevant data sources for documentation of administration/receipt of intravenous (IV) or intra-arterial (IA) thrombolytic (t-PA) therapy.** |
| 58 | STK5 | Oivtpa | Enter the name of the other location (s). (More than one location may be entered).   |  | | --- | |  | |  | | Text field | **If the location is a note, enter the name of the local note title.** |

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| 59 | STK5 | antithrom | Was antithrombotic therapy administered by the end of hospital day 2?  **Examples of antithrombotic therapy include, but are not limited to: Aspirin, clopidogrel (Plavix), warfarin (Coumadin), dabigatran, enoxaprin, fondaparinux, heparin IV, ticlopidine, Zorprin**  1. Yes  2. No | 1,2  If 1, auto-fill noanthrom as 95  If 2, go to noanthrom | * **To compute end of hospital day 2, count the arrival date as hospital day 1. If antithrombotic therapy was administered by 11:59 P.M. of hospital day two, select “Yes” for this data element.** * **Documentation of antithrombotic administration must be found within the timeframe of arrival to the end of hospital day 2*. It is not necessary to review documentation outside of this timeframe to answer this data element.*** * For antithrombotic therapy administered in the Emergency Department/observation area prior to the end of hospital day 2, select “Yes”. * Antithrombotic therapy administration information must demonstrate actual administration of the medication.   Example: Do not use physician orders as they do not demonstrate administration of the antithrombotic therapy (in the ED this may be used if signed/initialed by a nurse).   * When antithrombotic is noted as a “home” or “current” medication or documentation indicates that it was received prior to hospital arrival only, select “No”.   **Refer to TJC Appendix C, Table 8.2 for a list of medications used for antithrombotic therapy.**  **Suggested data sources:** Emergency department record, Medication administration record, progress notes, nursing flow sheet, nursing notes  **Excluded data sources:** EMS or ambulance documentation,  any documentation dated/timed prior to hospital arrival or after hospital day 2 |

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| 60 | STK5 | Lanthrom1  Lanthrom2  Lanthrom3  Lanthrom4  Lanthrom5 | Select the location(s) where administration of antithrombotic therapy is found in the EHR.  **Select all that apply:**  1. Emergency department notes  2. Medication administration record  3. Nursing progress notes  4. Physician progress notes  5. Other  teludes consultation)ion documentation was found in the electronic health record (EHR).f transient and entir | 1,2,3,4,5  If <> 5, go to prelipmed | **In order to answer this question accurately, it is necessary to review all relevant data sources for documentation of administration of antithrombotic therapy.** |
| 61 | STK5 | Oanthrom | Enter the name of the other location (s). (More than one location may be entered).   |  | | --- | |  | |  | | Text field | **If the location is a note, enter the name of the local note title.** |

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| 62 | STK5 | noanthrom1  noanthrom2  noanthrom95  noanthrom98  noanthrom99 | Is there documentation by a physician/APN/PA or pharmacist in the medical record of a reason for not administering antithrombotic therapy by end of hospital day 2?  **Select all that apply:**  1. Allergy to ALL antithrombotic medications  2. Physician/APN/PA or pharmacist documentation of a reason for not prescribing antithrombotic therapy by end of hospital day 2  95. Not applicable  98. Patient/family refusal  99. No documented reason | 1,2,95,98,99  Will be auto-filled as 95 if antithrom = 1  If 99, go to prelipmed | * To compute end of hospital day 2, count the arrival date as hospital day 1. If a reason for not administering antithrombotic therapy was documented by 11:59 P.M. of hospital day 2, select “Yes” for this data element. * **Documentation for allowable value “Yes” must be found within the timeframe of arrival to the end of hospital day 2. It is not necessary to review documentation outside of this timeframe.** * **With exception of allergy and patient/family refusal, reason for not administering 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 administered because of a bleeding disorder unless documentation explicitly states so). * **An allergy or adverse reaction to one type of antithrombotic would NOT be a reason for not administering all antithrombotic agents. Another medication can be ordered.**   **Examples of reasons for not administering antithrombotic therapy by the end of hospital day 2 include, but are not limited to:**   * Allergy to or complication related to antithrombotic * Aortic dissection * Bleeding disorder * Brain/CNS cancer * Extensive/metastatic CA * Hemorrhage, any type * Intracranial surgery/biopsy * Patient/family refusal * Peptic ulcer * Planned surgery during hospital stay * Risk of bleeding * Unrepaired intracranial aneurysm * Other reason documented by physician/APN/PA or pharmacist   **Cont’d next page**  **Reason for not administering antithrombotic medication cont’d**   * Physician/APN/PA or pharmacist documentation of a hold on an antithrombotic medication or discontinuation of an antithrombotic medication that occurs the day of or day after hospital arrival constitutes a “clearly implied” reason for not administering antithrombotic therapy by end of hospital day 2. * A hold/discontinuation of all p.o. medications counts if an antithrombotic was on order at the time of the notation. * For patients on warfarin therapy prior to hospital arrival, but placed on hold the day of or day after arrival due to “high INR”, select “2”.   **Suggested data sources:** Consultation, emergency department record, history & physical, medication reconciliation form, progress notes |

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| 63 | STK5 | Lnoanthr1  Lnoanthr2  Lnoanthr3  Lnoanthr4  Lnoanthr5  Lnoanthr6  Lnoanthr7  Lnoanthrom1  Lnoanthrom2  Lnoanthrom3  Lnoanthrom4  Lnoanthrom5  Lnoanthrom6 | Select the location(s) where reason for not administering antithrombotic therapy is found in the EHR and enter the reason documented in the data source.   |  |  | | --- | --- | | **Data Source**  **If <> 7, go to prelipmed**  **Select all that apply:** | **Reason**  **1,2,98** | | 1. Consultation |  | | 2. Emergency department notes |  | | 3. History and physical |  | | 4. Nursing progress notes |  | | 5. Pharmacy progress notes |  | | 6. Physician progress notes |  | | 7. Other |  | | | **In order to answer this question accurately, it is necessary to review all relevant data sources for documentation of a reason for not administering antithrombotic therapy by end of hospital day 2.**  **Reasons for Not Administering Antithrombotic Therapy:**  1. Allergy to ALL antithrombotic medications  2. Physician/APN/PA or pharmacist documentation of a reason for not prescribing antithrombotic therapy by end of hospital day 2  98. Patient/family refusal |
| 64 | STK5 | Onoanthr | Enter the name of the other location (s). (More than one location may be entered).   |  | | --- | |  | |  | | Text field | **If the location is a note, enter the name of the local note title.** |
|  |  |  | **Statin and LDL** |  |  |
| 65 | STK6 | prelipmed | Is there documentation the patient was on a lipid-lowering medication (statin and/or non-statin) prior to hospital arrival?  1. Yes  2. No | 1,2  If 2, go to preldl | If there is documentation that the patient was on a lipid-lowering medication at home but there is indication it was on temporary hold or the patient has been non-compliant/self-discontinued their medication (e.g., refusal, side effects, cost), select “Yes”.  When conflicting information is documented in a medical record, select “Yes”.  **Refer to TJC Appendix C, Table 1.6 for a comprehensive list of Lipid-Lowering Medications**  **Suggested data sources:** Consultation, Emergency department record, history & physical, medication reconciliation form, nursing admission assessment, progress notes |

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| 66 | STK6 | Lprelip1  Lprelip2  Lprelip3  Lprelip4  Lprelip5  Lprelip6  Lprelip7 | Select the location(s) where documentation that the patient was on a lipid-lowering medication prior to arrival is found in the EHR.  **Select all that apply:**  1. Consultation  2. Emergency department notes  3. History and physical  4. Medication reconciliation form  5. Nursing progress notes  6. Physician progress notes  7. Other  teludes consultation)ion documentation was found in the electronic health record (EHR).f transient and entir | 1,2,3,4,5,6,7,95  If <> 7, go to preldl | **In order to answer this question accurately, it is necessary to review all relevant data sources for documentation the patient was on a lipid-lowering medication prior to arrival.** |
| 67 | STK6 | Oprelip | Enter the name of the other location (s). (More than one location may be entered).   |  | | --- | |  | |  | | Text field | **If the location is a note, enter the name of the local note title.** |
| 68 | STK6 | preldl | Was the LDL-cholesterol (LDL-c) measured within 30 days prior to hospital arrival?  1. Yes  2. No | 1,2  If 2, go to postldl | * For the purposes of this question, it is necessary to search documentation that occurred within 30 days prior to hospital arrival. * If there is documentation that LDL-c testing was done within 30 days prior to hospital arrival but no LDL-c values are available, select “No”. * The medical record must be abstracted as documented (taken at “face value”). When the LDL-c value documented is obviously in error (not a valid number) and no other documentation is found that provides this information, the abstractor should select “No”. * Disregard LDL-c values reported in units of mmol/L or any other unit of measurement other than mg/dL or mg/100 ml. If the unit of measurement is not documented, assume the unit of measurement is mg/dL.   **Suggested data sources:** Consultation, emergency department record, history & physical, laboratory reports, progress notes |

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| 69 | STK6 | preldlval | Enter the highest LDL-c value in mg/dL or mg/100ml measured within the 30 days prior to hospital arrival. | \_\_ \_\_ \_\_   |  | | --- | | Whole numbers only  Hard edit: Must be > 0 | | * For this measurement, enter the highest LDL-c level within 30 days prior to hospital arrival. * Direct and calculated (indirect) LDL-c values are acceptable. * If an LDL-c value on the laboratory report conflicts with that from another source of documentation for the same specimen, use the value from the laboratory report. * If a laboratory report documents discrepant LDL-c values for the same specimen, use the highest value. * If sources other than a laboratory report document discrepant LDL-c values for the same specimen, use the highest value.   **Disregard any number to right of decimal (e.g., LDL-c reported as 98.6; enter 98).** |
| 70 | STK6 | preldldt  preldltm | Enter the date and time the highest LDL-c value was reported within 30 days prior to hospital arrival.   |  |  | | --- | --- | | Date | Time | |  |  | | mm/dd/yyyy   |  | | --- | | <= 30 days prior to and < arrvdate |   \_\_\_\_\_  UMT | Use the date and time of the laboratory report, not the date the sample was drawn. |

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| 71 | STK6 | postldl | Was the LDL-cholesterol (LDL-c) measured within the first 48 hours after hospital arrival?  1. Yes  2. No | 1,2  If 2 and preldl = 1, go to lpreldl  If 2 and preldl = 2, go to statindc | If there is documentation that LDL-c testing was done within the first 48 hours after hospital arrival but no LDL-c values are available, select “No”.  The medical record must be abstracted as documented (taken at “face value”). When the LDL-c value documented is obviously in error (not a valid number) and no other documentation is found that provides this information, the abstractor should select “No”.  **Suggested data sources:** Consultation, emergency department record, history & physical, laboratory reports, progress notes |
| 72 | STK6 | arrldlval | Enter the highest LDL-c value in mg/dL or mg/100ml measured within the first 48 hours after hospital arrival. | \_\_ \_\_ \_\_   |  | | --- | | Whole numbers only  Hard edit: Must be > 0 | | * For this measurement, enter the highest LDL-c level measured within the first 48 hours after hospital arrival. * Direct and calculated (indirect) LDL-c values are acceptable. * If an LDL-c value on the laboratory report conflicts with that from another source of documentation for the same specimen, use the value from the laboratory report. * If a laboratory report documents discrepant LDL-c values for the same specimen, use the highest value. * If sources other than a laboratory report document discrepant LDL-c values for the same specimen, use the highest value.   **Disregard any number to right of decimal (e.g., LDL-c reported as 98.6; enter 98).** |
| 73 | STK6 | arrldldt  arrldltm | Enter the date and time the highest LDL-c value was reported during the first 48 hours after hospital arrival.   |  |  | | --- | --- | | Date | Time | |  |  | | mm/dd/yyyy   |  | | --- | | <= 2 days after arrvdate |   \_\_\_\_\_  UMT   |  | | --- | | <= 48 hours after arrvtime | | Use the date and time of the laboratory report, not the date the sample was drawn. |

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| 74 | STK6 | Lpreldl1  Lpreldl2  Lpreldl3  Lpreldl4  Lpreldl5  Lpreldl6  Lpreldl7  Lpreldl8 | Select the location(s) where documentation of LDL-c is found in the EHR.  **Select all that apply:**  1. Consultation  2. Discharge summary  3. Emergency department notes  4. History and physical  5. Laboratory reports  6. Nursing progress notes  7. Physician progress notes  8. Other | 1,2,3,4,5,6,7,8  If <> 8, go to statindc | **In order to answer this question accurately, it is necessary to review all relevant data sources for documentation the LDL-c was measures within the first 48 hours after hospital arrival or 30 days prior to hospital arrival.** |
| 75 | STK6 | Opreldl | Enter the name of the other location (s). (More than one location may be entered).   |  | | --- | |  | |  | | Text field | **If the location is a note, enter the name of the local note title.** |

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| 76 | STK6 | statindc | Was a statin medication 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 1, auto-fill nostatin as 95  If 2, go to nostatin | * **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).** * **All discharge medication documentation available in the chart should be reviewed and taken into account by the abstractor.** * 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.** * Disregard documentation of statin prescribed at discharge when noted only by medication class (e.g., “Statin Prescribed at Discharge: Yes” on a core measures form). The statin must be listed by name.   **Refer to TJC Appendix C, Table 8.1 for a comprehensive list of Statin Medications.**  Suggested data sources: consultation, discharge summary, medication reconciliation form, physician orders, progress notes |

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| 77 | STK6 | Lstatin1  Lstatin2  Lstatin3  Lstatin4  Lstatin5  Lstatin6  Lstatin7  Lstatin8  Lstatin9  Lstatin10  Lstatin11  Lstatin12  Lstatin13 | Select the location(s) where documentation that a statin medication was prescribed at discharge is found in the EHR.  **Select all that apply:**  1. Consultation  2. Cover sheet  3. Discharge summary  4. Emergency department notes  5. Medication reconciliation form  6. Nursing discharge instructions  7. Nursing progress notes  8. Pharmacy discharge instructions  9. Pharmacy progress notes  10. Physician discharge instructions  11. Physician orders  12. Physician progress notes  13. Other | 1,2,3,4,5,6,7,8,9,10,11,12,13  If <> 13, go to anticoag | **In order to answer this question accurately, it is necessary to review all relevant data sources for documentation the patient was prescribed a statin medication at discharge.** |
| 78 | STK6 | Ostatin | Enter the name of the other location (s). (More than one location may be entered).   |  | | --- | |  | |  | | Text field | **If the location is a note, enter the name of the local note title.** |

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| 79 | STK6 | nostatin1  nostatin2  nostatin95  nostatin98  nostatin99 | Is there physician/APN/PA or pharmacist documentation of a reason for not prescribing a statin medication at discharge?  **Select all that apply:**  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 statin = 1  If 99, go to anticoag | * **With exception of allergy and patient/family refusal, reason for not prescribing a statin medication at discharge must be documented by a physician/APN/PA or pharmacist.** * **Statin medication allergy:** Where there is documentation of a statin medication “allergy” or “sensitivity”, regard this as documentation of a statin medication 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:**   * Reasons for not prescribing a statin medication at discharge must be explicitly documented (e.g., “CPK elevated. Lipid lowering therapy contraindicated.”) or clearly implied (e.g., “Hx of muscle soreness with statins in the past.”) * If reasons are not mentioned in the context of statin medications, do not make inferences (e.g., do not assume that a statin medication is not prescribed because of the patient’s history of alcoholism or severe liver disease.) * 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. * Physician/APN/PA or pharmacist documentation of a hold on statin medication or discontinuation of a statin medication during hospitalization constitutes a “clearly implied” reason for not prescribing a statin medication at discharge.   **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.   Cont’d next page  **Reason for not prescribing statin at discharge cont’d**   * 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. * 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. * 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, rhabdomyolysis  **Suggested data sources:** Consultation, discharge summary, Emergency department record, history & physical, medication reconciliation form, nursing notes, pharmacy notes, physician orders, progress notes |

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| 80 | STK6 | Lnostat1  Lnostat2  Lnostat3  Lnostat4  Lnostat5  Lnostat6  Lnostat7  Lnostat8  Lnostat9  Lnostat10  Lnostat11  Lnostatin1  Lnostatin2  Lnostatin3  Lnostatin4  Lnostatin5  Lnostatin6  Lnostatin7  Lnostatin8  Lnostatin9  Lnostatin10 | Select the location(s) a where reason for not prescribing statin therapy at discharge is found in the EHR and enter the reason documented in the data source.   |  |  | | --- | --- | | **Data Source**  **1,2,3,4,5,6,7,8,9,10,11**  **If <> 11, go to anticoag**  **Select all that apply:** | **Reason**  **1,2,98** | | 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. 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.**  **Reasons for Not Prescribing Statin 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  98. Patient/family refusal |
| 81 | STK6 | Onostat | Enter the name of the other location (s). (More than one location may be entered).   |  | | --- | |  | |  | | Text field | **If the location is a note, enter the name of the local note title.** |

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|  |  |  | **Anticoagulation Medication** |  |  |
| 82 | STK3 | anticoag | Was anticoagulation therapy prescribed at discharge?  **Examples include, but are not limited to:**   * argatroban * dabigatran (Pradaxa) * dalteparin (Fragmin) * enoxaparin (Lovenox) * fondaparinux (Arixtra) * heparin **IV only** * rivaroxaban (Xarelto) * tinzaparin (Innohep) * warfarin (Coumadin)   1. Yes  2. No | 1,2  If 1, auto-fill  noantcoag as 95  If 2, go to noantcoag | * **In determining whether anticoagulation 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 anticoagulant that is not included in any of the other discharge medication sources (e.g., discharge orders).** * **All discharge medication documentation available in the chart should be reviewed and taken into account by the abstractor.** * 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.** * Disregard documentation of anticoagulant prescribed at discharge when noted only by medication class (e.g., “Anticoagulant Prescribed at Discharge: Yes” on a core measures form). The anticoagulant must be listed by name.   **Refer to TJC Appendix C, Table 8.3 for a list of medications used for anticoagulation therapy.**  **Exclude:** **Heparin SQ**  **Suggested data sources:** consultation, discharge summary, medication reconciliation form, physician orders, progress notes |

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| 83 | STK3 | Lantcog1  Lantcog2  Lantcog3  Lantcog4  Lantcog5  Lantcog6  Lantcog7  Lantcog8  Lantcog9  Lantcog10 | Select the location(s) where documentation that anticoagulation therapy was prescribed at discharge is found in the EHR.  **Select all that apply:**  1. Consultation  2. Discharge summary  3. Emergency department notes  4. History and physical  5. Medication reconciliation form  6. Nursing progress notes  7. Pharmacy progress notes  8. Physician orders  9. Physician progress notes  10. Other | 1,2,3,4,5,6,7,8,9,10  If <> 10, go to end | **In order to answer this question accurately, it is necessary to review all relevant data sources for documentation that anticoagulation therapy was prescribed at discharge.** |
| 84 | STK3 | Oantcog | Enter the name of the other location (s). (More than one location may be entered).   |  | | --- | |  | |  | | Text field  **\*Go to end** | **If the location is a note, enter the name of the local note title.** |

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| 85 | STK3 | noantcoag1  noantcoag2  noantcoag95  noantcoag98  noantcoag99 | 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?  **Select all that apply:**  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 anticoag = 1  If 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.** * **Reasons must be explicitly documented** (e.g., “Active GI bleed – anticoagulation therapy contraindicated”, “No warfarin” [no reason given]). * **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 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.   **Examples of reasons for not prescribing anticoagulation therapy at discharge include, but are not limited to:**   * Allergy to ALL anticoagulation medications * Aortic dissection * Bleeding disorder * Brain/CNS cancer * Extensive/metastatic CA * Hemorrhage * Intracranial surgery/biopsy * Patient/family refusal * Peptic ulcer * Planned surgery within 7 days following discharge * Risk of bleeding * Unrepaired intracranial aneurysm * Physician/APN/PA or pharmacist 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.   Cont’d next page  Reason for not prescribing anticoagulation cont’d  **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.   **Suggested data sources:** Cover sheet, consultation, discharge summary, Emergency department record, history & physical, medication administration record, medication reconciliation form, physician orders, progress notes |

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| 86 | STK3 | Lnoantcog1  Lnoantcog2  Lnoantcog3  Lnoantcog4  Lnoantcog5  Lnoantcog6  Lnoantcog7  Lnoantcog8  Lnoantcog9  Lnoantcog10  Lnoantcog11  Noantcog1  Noantcog2  Noantcog3  Noantcog4  Noantcog5  Noantcog6  Noantcog7  Noantcog8  Noantcog9  Noantcog10 | Select the location(s) a where reason for not prescribing anticoagulation therapy at discharge is found in the EHR and enter the reason documented in the data source.   |  |  | | --- | --- | | **Data Source**  **1,2,3,4,5,6,7,8,9,10,11**  **If <> 11, go to end**  **Select all that apply:** | **Reason**  **1,2,98** | | 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. 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 anticoagulation therapy at discharge.**  **Reasons for Not Prescribing Anticoagulation Therapy at Discharge:**  1. Allergy to ALL anticoagulation medications  2. Physician/APN/PA or pharmacist documentation of a reason for not prescribing anticoagulation therapy at discharge  98. Patient/family refusal |
| 87 | STK3 | Onoantcog | Enter the name of the other location (s). (More than one location may be entered).   |  | | --- | |  | |  | | Text field | **If the location is a note, enter the name of the local note title.** |