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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 Data |  |  |

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| 1. | admdt | Admission date: | mm/dd/yyyy **Auto-filled: can be modified**   |  | | --- | | < = dcdt | | **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 or non-acute inpatient care. * Examples of non-acute inpatient care include but are not limited to rehabilitation units, skilled nursing facilities, respite care * For patients who are admitted to Observation status and subsequently admitted to acute inpatient care, abstract the date that the patient was admitted to acute inpatient care. Do **NOT** abstract the date that the patient was admitted to Observation.   **Suggested Data Sources:** Face sheet, EADT  **Exclusion:** admit to observation, arrival date |
| 2 | dcdt | Discharge date: | mm/dd/yyyy  **Auto-filled: cannot be modified** | **Auto-filled; cannot be modified**  The computer auto-fills the discharge date from the VHA RAPID pull list. This date cannot be modified in order to ensure the selected episode of care is reviewed. |
| 3 | readm | During the timeframe from (computer to display dcdt) through (computer to display dcdt + 30 days) was there documentation of a readmission or direct transfer to an acute or non-acute inpatient care setting? 1. Yes  2. No | 1,2  If 2, go to dochospce | If a discharge is followed by a readmission or direct transfer to an acute or non-acute inpatient care setting on the date of discharge through 30 days after discharge (31 days total), this is acceptable.   * Examples of non-acute inpatient care include but are not limited to rehabilitation units, skilled nursing facilities, respite care   **Suggested data sources:** Admission assessment, ED notes, History and physical,Outpatient **p**rimary provider notes; Inpatient discharge summary |
| 4 | readmdt | Enter the date for the most recent readmission that occurred from (computer to display dcdt) through (computer to display dcdt + 30 days). | mm/dd/yyyy   |  | | --- | | >= dcdt and < = dcdt + 30 days | | The readmission date is the date the patient was actually readmitted or transferred to acute inpatient or non-acute inpatient care.   * Examples of non-acute inpatient care include but are not limited to rehabilitation units, skilled nursing facilities, respite care |
| 5 | readmdcdt | Enter the discharge date for the most recent readmission that occurred on (computer to enter readmdt). | mm/dd/yyyy  Abstractor may enter 99/99/9999   |  | | --- | | >= readmdt and  < =stdyend | | Discharge date is the date the patient physically left the facility to which he/she was readmitted.  If unable to determine discharge date for the readmission, enter 99/99/9999. Example: Discharge summary indicates patient was discharged to non-VAMC facility and no documentation of discharge is found in the medical record. |
| 6 | dochospce | Is one of the following documented in the medical record?The patient is enrolled in a VHA or community-based Hospice programThe patient has a diagnosis of cancer of the liver, pancreas, or esophagusOn the problem list it is documented the patient’s life expectancy is less than 6 months? 1. Yes  2. No | \*1,2  \*If 1, the case is excluded.  If 1, go to end | A “yes” answer to this question will exclude the case from the Transition of Care (TOC) measures.  Although all noted conditions may be applicable to the case, only one is necessary for exclusion from the TOC measures.  The stage of cancer of the liver, esophagus, or pancreas is not applicable. Even if the patient is newly diagnosed, the case is excluded.  Patient’s life expectancy of less than six months must be documented on the problem list or in the computer field “health factors,” without exception.  **Acceptable:** Enrollment in a VHA or community-based Hospice  **Unacceptable:** Enrollment in a VHA Palliative Care program or HBPC.  **Exclusion Statement: Documentation of hospice enrollment; a diagnosis of cancer of the liver, pancreas, or esophagus; or life expectancy less than 6 months excludes the case from the Transition of Care measures.** |
| 7 | vapcp | Is there documentation in the medical record the patient’s primary care provider (PCP) or ongoing care provider is a VA provider?  1. Yes  2. No | 1,2 | Documentation must clearly indicate the patient’s PCP or ongoing care provider is a VA provider.   * Primary care practitioner/provider (PCP) - A physician or non-physician (e.g., nurse practitioner, physician assistant) who provides primary care medical services. * If the patient had more than one PCP identify the PCP who most recently provided care to the patient. * If the patient did not visit a PCP or does not have a PCP, identify the ongoing care provider who most recently provided care to the patient. * Ongoing care provider - The practitioner who assumes responsibility for the patient’s care in and out of the hospital (e.g. physician, NP or PA practicing in a specialty area, such as cardiology, surgery, orthopedics, etc.). |
| 8 | ntfyadm | For the inpatient admission on (computer to display admdt), is there documentation in the outpatient record of receipt of notification of inpatient admission on the day of admission or the following day?  1. Yes  2. No | 1,2 | **Documentation must include evidence of receipt of notification of inpatient admission on the day of admission or the following day.**  Admission refers to the date of inpatient admission or date of admission for an observation stay that turns into an inpatient admission.  **Documentation must include evidence of receipt of notification of inpatient admission that includes evidence of the date when the documentation was received. Any of the following examples meet criteria:**   * Communication between inpatient providers or staff and the patient’s PCP or ongoing care provider (e.g., phone call, email, fax). * Communication about admission between emergency department and the patient’s PCP or ongoing care provider (e.g., phone call, email, fax). * Communication about admission to the patient’s PCP or ongoing care provider through a health information exchange; an automated admission, discharge and transfer (ADT) alert system; or a shared electronic medical record system. * If the PCP co-signs the inpatient provider note on the day of admission or the following day, then this meets criteria for the Notification of Inpatient Admission.   Example of acceptable documentation:  ED Admission Note statement: I have added the PCP as a cosigner to this note on 7/18/18. Receipt acknowledged by PCP Dr. X on 7/18/18.   * Indication that the patient’s PCP or ongoing care provider admitted the patient to the hospital. * Indication that a specialist admitted the patient to the hospital and notified the patient’s PCP or ongoing care provider. * Indication that the PCP or ongoing care provider placed orders for tests and treatments any time during the patient’s inpatient stay. * Documentation that the PCP or ongoing care provider performed a preadmission exam or received communication about a planned inpatient admission. The time frame that the planned inpatient admission must be communicated is not limited to the day of admission or the following day; documentation that the PCP or ongoing care provider performed a preadmission exam or received notification of a planned admission prior to the admit date also meets criteria. The planned admission documentation or preadmission exam must clearly pertain to the denominator event.   **Exclude:**The following examples of documentation do not count:   * + - Documentation that the patient or the patient’s family notified the patient’s PCP or ongoing care provider of the admission.     - Documentation of notification that does not include a time frame or date when the documentation was received. |
| 9 | dccomp1  dccomp2  dccomp3  dccomp4  dccomp5  dccomp6  dccomp7  dccomp99 | For the inpatient admission on (computer to display admdt), is there documentation the discharge information for the discharge on (If readm = 2, computer to display dcdt OR if readm = 1, computer to display readmdcdt),  includes the following required components?  **Select all that apply:**  1. The practitioner responsible for the patient’s care during the inpatient stay  2. Procedures or treatment provided  3. Diagnoses at discharge  4. Current medication list  5. Medication allergies  6. Testing results, documentation of pending tests or no tests pending  7. Instructions to the PCP or ongoing care provider for patient care  99. None of the above | 1,2,3,4,5,6,7,99   |  | | --- | | Hard Edit: dccomp99 cannot = -1 if any dccomp1-dccomp7 = -1. | | Review all discharge documentation to determine if the following components are included.  **At a minimum, the discharge information must include all of the following:**   * The practitioner responsible for the patient’s care during the inpatient stay * Procedures or treatment provided * Diagnoses at discharge * Current medication list * Medication allergies * Testing results, or documentation of pending tests or no tests pending * Instructions to the PCP or ongoing care provider for patient care.   **If none of the components are included in the discharge information, select 99.**  **Suggested data sources:** Discharge summary, Discharge instructions, Discharge/Transfer summary |
| 10 | ntfydc | For the inpatient admission on (computer to display admdt), is there documentation in the record of receipt of discharge information on (If readm = 2, computer to display dcdt to dcdt + 1 day OR if readm = 1, computer to display readmdcdt to readmdcdt + 1 day).  1. Yes  2. No | 1,2 | **Documentation must include evidence of receipt of discharge information on the day of discharge or the following day with evidence of the date when the documentation was received.** Discharge information may be included in, but not limited to, a discharge summary or summary of care record or be located in structured fields in an EHR.  If the PCP co-signs the inpatient provider note on the day of discharge or the following day, then this meets criteria for the Receipt of Discharge Information.   * Example of acceptable documentation:   Discharge Summary Note statement: I have added the PCP as a cosigner to this note on 7/18/18. Receipt acknowledged by PCP Dr. X on 7/18/18.  At a minimum, the discharge information must include all of the following:   * The practitioner responsible for the patient’s care during the inpatient stay * Procedures or treatment provided * Diagnoses at discharge * Current medication list * Medication allergies * Testing results, or documentation of pending tests or no tests pending * Instructions to the PCP or ongoing care provider for patient care   **Exclude:**The following examples of documentation do not count:   * + - Documentation that the patient or the patient’s family notified the patient’s PCP or ongoing care provider of the discharge.     - Documentation of notification that does not include a time frame or date when the documentation was received.   **Suggested data sources:** Discharge summary, Discharge instructions, Discharge/Transfer summary |

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| 11 | opvst | During the timeframe from [(If readm = 2 computer to display dcdt + 1day) through (computer to display dcdt + 30 days)] OR [(if readm = 1, computer to display readmdcdt + 1 day) through (computer to display readmdcdt + 30 days)] was there documentation of an outpatient visit with the patient’s primary provider or ongoing care provider? An outpatient visit may include:   * A face to face outpatient visit * Telehealth visit * Telephone visit * Transitional care management services   1. Yes  2. No | 1,2  If 2, auto-fill opvstdt as 99/99/9999 | **Do not include any outpatient visit that occurs on the date of discharge.**  The following meet criteria for an outpatient visit:   * An outpatient visit * Telehealth visit * A telephone visit. * Transitional care management services.   Documentation must include evidence of patient engagement within 30 days after discharge. Either of the following meets criteria:   * An outpatient visit, including office visits and home visits. * A synchronous telehealth visit where real-time interaction occurred between the patient and PCP or ongoing provider via telephone or videoconferencing.   **A phone call from a staff member to check on the patient after discharge does not meet criteria.** |
| 12 | opvstdt | Enter the earliest date of the outpatient visit during the 30 days after the discharge date. | mm/dd/yyyy   |  | | --- | | If readm = 2, > dcdt and <= dcdt + 30 days; If readm = 1, > readmdcdt and <= readmdcdt + 30 days, | | Enter the earliest date of the outpatient visit after the discharge date. If there was a readmission within 30 days of the initial admission, use the earliest date after the readmission discharge date. |

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| 13 | medrec | During the timeframe from [(If readm = 2 computer to display dcdt) through (computer to display dcdt + 30 days) OR (if readm = 1, computer to display readmdcdt) through (computer to display readmdcdt + 30 days)] is there documentation in the outpatient record of medication reconciliation conducted by a physician, Advanced Practice Nurse (APN), Physician’s Assistant (PA), clinical pharmacist or registered nurse.  1. Yes  2. No | 1,2  If 2, auto-fill medrecdt as 99/99/9999 | **Documentation in the outpatient medical record must include evidence of medication reconciliation and the date when it was performed.** Any of the following meet criteria:   * Documentation of the current medications with a notation that the provider reconciled the current and discharge medications. * Documentation of the current medications with a notation that references the discharge medications (e.g., no changes in medications since discharge, same medications at discharge, discontinue all discharge medications). * Documentation of the patient’s current medications with a notation that the discharge medications were reviewed. * Documentation of a current medication list, a discharge medication list and notation that both lists were reviewed on the same date of service. * Documentation of the current medications with evidence that the patient was seen for post-discharge hospital follow-up with evidence of medication reconciliation or review. * Documentation in the discharge summary that the discharge medications were reconciled with the most recent medication list in the outpatient medical record. There must be evidence that the discharge summary was filed in the outpatient chart on the date of discharge through 30 days after discharge (31 total days). * Notation that no medications were prescribed or ordered upon discharge. |
| 14 | medrecdt | Enter the earliest date of the encounter in which the medication reconciliation took place. | mm/dd/yyyy   |  | | --- | | If readm = 2, >= dcdt and <= dcdt + 30 days OR if readm = 1, >= readmdcdt and <= readmdcdt + 30 days | | Enter the earliest date of the encounter in which the medication reconciliation took place. |
| 15 | nonva | On ([If readm = 2, computer to display dcdt] OR [if readm = 1, computer to display readmdcdt]), is there documentation in the medical record the patient was discharged or transferred to a non-VA facility?  1. Yes  2. No | 1,2 | A non-VA facility may include but is not limited to:   * Acute care hospital not associated with the VA * Community skilled nursing facility, nursing home or other long-term care facility * Community hospice facility |