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| ­ ­ |  | **Organizational Identifiers** |  |  |
|  | VAMC  CONTROL  QIC  BEGDTE  REVDTE | Facility ID Control Number  Abstractor ID  Abstraction Begin Date  Abstraction End Date | Pre-fill  QI pre-fill  Auto-fill  Auto-fill  Auto-fill |  |
|  |  | Patient Identifiers |  |  |
|  | SSN  FIN  PTNAMEF  PTNAMEL  BIRTHDT  SEX  RACE  ETHNICITY  COHORT  AGE | Patient SSN FIN  First Name  Last Name  Birth Date  Sex  Race  Ethnicity  Cohort  Age | Pre-fill: no change  Pre-fill: no change  Pre-fill: no change  Pre-fill: no change  Pre -fill: no change  Pre -fill: **can change**  Pre-fill: no change  Pre-fill: no change  Pre-fill: no change  Calculate age at ADMDT |  |
|  |  | Administrative Data |  |  |
| 1 | admdt | Admission date: | mm/dd/yyyy **pre-filled: can be modified**   |  | | --- | | < = dcdt | | **Pre-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 or non-acute inpatient care, abstract the date that the patient was admitted to acute or non-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  **pre-filled: cannot be modified** | **Pre-filled; cannot be modified**  The computer pre-fills the discharge date from the VHA API-PM pull list. This date cannot be modified in order to ensure the selected episode of care is reviewed. |

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| 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?  Non-acute inpatient care includes, but is not limited to rehabilitation units, skilled nursing facilities, respite care  1. Yes  2. No | 1,2  If 2, go to nonva | **Review all sources for documentation of a readmission or direct transfer to an acute or non-acute inpatient setting on the date of discharge through 30 days after discharge (31 days total).** Readmission or direct transfer includes **VHA and non-VHA (community) facilities**.  **Include: VHA and non-VHA acute inpatient or non-acute inpatient care facilities (i.e., rehabilitation units, skilled nursing facilities, respite care)**  **Exclude:** Domiciliary admission and Residential Rehabilitation Treatment Program (RRTP) are considered residential, NOT a non-acute inpatient admission.  **Suggested data sources:** Admission assessment, ED notes, History and physical,Outpatientprimary provider notes; Inpatient discharge summary; Remote data notes |
| 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 * If there is **only one readmission** during the timeframe, enter the date of that readmission. * **Example:**   Acute Inpatient Admission (ADMDT): 10/30/2020  Discharge home (DCDT): 11/12/2020  **Readmission to acute inpatient**: 11/22/20; enter 11/22/20 for READMDT  Discharged home: 11/25/20   * If there **are multiple readmissions**, enter the **date of the** **most recent** readmission. * **Example:**   Acute Inpatient Admission (ADMDT): 10/30/2020  Discharge (direct transfer) to CLC (DCDT): 11/12/2020  Readmission to acute inpatient: 11/22/2020  Discharge (direct transfer) to CLC: 11/27/2020  Discharge from CLC to home: 11/30/20  READMDT: Enter 11/27/2020 (date of the most recent readmission (direct transfer to CLC) during specified timeframe) |
| 5 | readmdcdt | Enter the discharge date for the most recent direct transfer or readmission. | mm/dd/yyyy  Abstractor may enter 99/99/9999   |  | | --- | | >= readmdt and  < =stdyend | | Discharge date is the date the patient physically left the acute inpatient or non acute inpatient VHA or non VHA facility to which he/she was readmitted or transferred.   * If there is **only one readmission** during the timeframe, enter the **discharge date** of that readmission. * If there **are multiple readmissions**, enter the **discharge** **date of the** **most recent** readmission. * **Example:**   Acute Inpatient Admission (ADMDT): 10/30/2020 Discharge (direct transfer) to CLC (DCDT): 11/12/2020  Readmission to acute inpatient: 11/22/2020  Discharge (direct transfer) to CLC: 11/27/2020 Discharge from CLC to home: 11/30/2020  READMDCDT: Enter 11/30/2020 (discharge date from the most recent readmission)   * 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. * If the date of discharge for the most recent readmission is after the study end date, enter 99/99/9999   **Example:**  Inpatient Admission 11/01/2020  Discharge to CLC: 11/08/2020  Readmission to Inpatient: 11/12/2020  Discharge to CLC 11/14/2020 and still is a patient  there after 12/01/2020  READMDCDT - Enter 99/99/9999 |

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| 6 | nonva | For the discharge on (if readm = 1 and readmdcdt = valid date, computer to display readmdcdt; else display dcdt) is there documentation in the medical record the patient was discharged or transferred to a non-VHA facility?  1. Yes 2. No | | 1,2 | A non-VHA facility may include but is not limited to:   * Acute care hospital not associated with the VHA * Community skilled nursing facility, nursing home or other long-term care facility * Community hospice facility |
| 7 | ptexpire | Is there documentation that the patient expired during the timeframe from 01/01/2024 to 06/30/2024.1. Yes2. No | | 1,2  **\*If 1, the case is excluded.** | If the patient dies during this study period, select value “1” and the case will be excluded.  **Exclusion Statement: Documentation that the patient expired during the study period excludes the case from the Transition of Care measures**. |
| 8 | dochospce | At any time during the year prior to [(If readm = 2 computer to display admdt) through (computer to display dcdt)] OR [(if readm = 1, computer to display readmdt) through (computer to display stdyend)] 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.** | | 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.** |

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| 9 | vapcp | During the year prior to (computer to display admdt) 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.  In order to answer “Yes” the patient must have at least one visit with a Primary care Practitioner/provider (PCP) **OR** **an ongoing care provider** during the specified timeframe.   * PCP - A physician or non-physician (e.g., nurse practitioner, physician assistant) who provides primary care medical services. * Licensed practical nurses and registered nurses are not considered PCPs. * Primary Care Physician includes: General or family practice physicians; Geriatricians; General internal medicine physicians; Obstetricians/gynecologists (OB/GYN) * 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, mental health, surgery, orthopedics, etc.). |

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| 10 | ntfyadm | For the inpatient admission on (computer to display admdt), is there documentation in the medical record of receipt of notification to the PCP or ongoing provider of the inpatient admission on the day of admission through 2 days after the admission (3 total days)?  1. Yes  2. No | 1,2  If readmdcdt = 99/99/9999, go to end   |  | | --- | | Warning if 2 and vapcp = 1 | | **Documentation must include evidence of receipt of notification of inpatient admission on the day of admission through 2 days after admission.**  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.**  **Documentation of:**   * Communication about admission with the patient’s PCP or ongoing care provider through a shared electronic medical record (EMR) system. * 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. * Indication that the patient’s PCP or ongoing care provider admitted the patient to the hospital. * An admission consult requested by the PCP is acceptable. * 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.   Cont’d next page   * 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 through 2 days after admission (3 total days); 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.   **Note:** When an ED visit results in an inpatient admission, notification that a provider sent the patient to the ED does not meet criteria.   * **Evidence that the PCP or ongoing care provider communicated with the ED about the admission meets criteria.**   **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 to the non-VA PCP or ongoing provider that does not include a time frame or date when the documentation was received. |

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| 11 | dccomp1  dccomp2  dccomp3  dccomp4  dccomp6  dccomp7  dccomp99 | For the discharge on (computer to display, if readm = 2 display dcdt OR if readm = 1 readmdcdt), is there documentation the discharge information includes the following required components?  **Select all that apply:**  1. The name of the practitioner responsible for the patient’s care during the inpatient stay  2. Procedures or treatment provided (such as colonoscopy, surgery, wound debridement, mental health counseling)  3. Diagnoses at discharge  4. Current medication list  6. Testing results, documentation of pending tests OR no tests pending (refer to D/D rules)  7. Instructions for patient care post-discharge  99. None of the above | 1,2,3,4,6,7,99   |  | | --- | | Hard Edit: dccomp99 cannot = -1 if any dccomp1-dccomp7 = -1. | | Discharge information may be included in, but not limited to, discharge summary, discharge instructions, summary of care discharge note, transfer summary. Review all discharge documentation to determine if all of the following components are documented in the record on the day of discharge through 2 days after the discharge (3 total days).  Documentation in the outpatient medical record must include evidence or documentation of receipt of discharge information or that it is accessible to the PCP or ongoing care provider.  **At a minimum, the discharge information must include all of the following documentation:**   * The name of the practitioner responsible for the patient’s care during the inpatient stay * Procedures or treatment provided and discussed in the discharge information (i.e., scans completed during admission, medications prescribed for diagnoses during admission, blood transfusions, IV fluids for rehydration, mechanical ventilation or breathing treatments, etc.)   + For example, “CT of abdomen during admission showed possible sigmoid malignancy” or “iron deficiency anemia received iv iron x 3 days” Hemoglobin low on admission, 2 units PRBCs infused, monitored H/H results during hospitalization.” * Diagnoses at discharge * Current medication list * A summary of tests completed during the admission with results; or documentation of “no tests ordered during this admission” or “no tests pending” for this admission.   + Example of tests include, but are not limited to: labs, x-rays, scans   + For example, the discharge summary states “admitted with Epigastric pain/colitis/n/v/elevated lipase: lipase elevated on admission and normalized at discharge” or “Pneumonia: community acquired, most recent WBC count 7.2” or “recent CXR showed minimal changes.”   Cont’d next page   * + **Note**: Test results are not required to be in the same section of the discharge information document. * Instructions for patient care post-discharge that include documentation of what should be done next to assist in the transition of care from inpatient to outpatient.   + Examples that meet criteria include, but are not limited to: scheduled lab tests, scheduled procedures and upcoming appointments with specialists   + Examples of documentation in the discharge information include but are not limited to the following: “Labs prior to next PCP appointment” or “Follow up with PCP on March 24” or “Consult placed to oncology for new diagnosis colon cancer” possible sigmoid malignancy, patient will need EGD/colonoscopy outpatient” or “history of PTSD, depression, is willing to reinstate MH counseling and order for MH counseling is present in the medical record at discharge or “Referred to MH counseling for diagnosis of depression”   + **Note:** Documentation that only states “Discharge instructions were provided to the patient” does NOT meet criteria.   **If none of the components are included in the discharge information, select “99”.** |

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| 12 | ntfydc | For the discharge on (computer to display, if readm = 2, dcdt to dcdt + 2 days OR if readm = 1, readmdcdt to readmdcdt + 2 days), is there documentation in the medical record of receipt of discharge information?  1. Yes  2. No | 1,2   |  | | --- | | Warning if 2 and vapcp = 1 | | **Documentation must include evidence of receipt of discharge information on the day of discharge through 2 days after the discharge (3 total days) with evidence of the date when the documentation was received.**   * When using a shared EMR system, documentation of a “received date” in the EMR is not required to meet criteria. Evidence that the information (e.g., discharge summary with all required components) was located/accessible in the shared EMR on the day of discharge through 2 days after the discharge (3 total days) meets criteria to select value “1” or Yes for Receipt of Discharge Information indicator. * Discharge information may be included in, but not limited to, discharge summary, discharge instructions, summary of care discharge note, transfer summary * If the PCP co-signs the inpatient provider note on the day of discharge through 2 days after the discharge (3 total days), then this meets criteria for the Receipt of Discharge Information.   **Note:** If the PCP or ongoing care provider is the discharging provider, the discharge information must be documented in the medical record on the day of discharge through 2 days after the discharge (3 total days).  **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 to the non-VA PCP or ongoing provider that does not include a time frame or date when the documentation was received. |

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| 13 | 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 a Physician/APN/PA, Clinical Nurse Specialist (CNS), or licensed clinical staff responsible for the patient’s care? An outpatient visit may include:   * Face to face outpatient visit * Telehealth visit (e-visit, virtual check-in) * Telephone visit * Home Based Primary Care (HBPC) visit * Transitional care management services (CPT code 99495 or 99496)   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 intent of the Patient Engagement After Inpatient Discharge indicator is interaction between the patient and acceptable healthcare provider in an outpatient setting after discharge. This indicator does not require evidence/reference to the hospital discharge.**  **Documentation must include evidence of patient engagement within 30 days after discharge at an acceptable outpatient visit (e.g., office visits, home visits, telehealth visits).**  The engagement visit may be performed by a Physician/APN/PA, CNS, or licensed clinical staff responsible for the patient’s care including a Licensed Psychologist (PhD/PsyD), LCSW, LCSW-C, LMSW, LISW, LMFT, LPMHC, APRN (NP/CNS), PA, Clinical Pharmacist (RPH/PharmD), clinical pharmacy specialist, or Registered Nurse (RN).  **Any of the following meet criteria:**   * An outpatient visit, including office visits, home visits, HBPC visits * A telephone visit * A synchronous telehealth visit where real-time interaction occurred between the patient and PCP OR **ongoing provider** via telephone or videoconferencing * Transitional care management services encounter with documentation of CPT code 99495 or 99496   **Outpatient visit such as a telephone call for prescription refills or to schedule an appointment are not acceptable. Note:** if the patient is unable to communicate with the provider, interaction between the patient’s caregiver and the provider meets criteria. |
| 14 | 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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| 15 | 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 by a physician, Advanced Practice Nurse (APN), Physician’s Assistant (PA), clinical pharmacist or registered nurse that the discharge medications were reconciled with the current medications?  1. Yes  2. No | 1,2  If 2, auto-fill medrecdt as 99/99/9999 | **Medication reconciliation is a type of review in which the discharge medications are reconciled with the most recent medication list in the outpatient medical record.**  **Medication reconciliation must be documented in the medical record by a physician/APN/PA, clinical pharmacist or registered nurse.**  The timeframe for medication reconciliation includes the date of discharge to 30 days after discharge for a total of 31 days.  Documentation must indicate the inpatient discharge medications are reconciled with the medications the patient is taking outpatient.  **Any of the following documented in an outpatient encounter meets criteria to select value “1”:**   * Documentation of the current medications with a notation that the provider reconciled the current and discharge medications. For example, “current medication list updated to include all discharge medications.” * Documentation of the current medications with a notation that references the discharge medications (i.e. the PCP documented one week past discharge “medication reconciliation complete with recent hospital discharge list and medications patient reports taking post discharge.” * 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. Evidence that the patient was seen for post-discharge hospital follow-up requires documentation that indicates the provider was aware of the patient’s hospitalization or discharge. * **Exclude:** “post-op/surgery follow-up” notes without a reference to “hospitalization”, “admission” or “inpatient stay” in the medication reconciliation note.   **Cont’d next page**   * **Examples:** * PCP Note: 2/22/21 TITLED – “TWO DAY POST DISCHARGE NOTE”, documents “inpatient discharge medications were reconciled and the current medication list follows: zofran PO Q8 prn, ASA 81mg PO qday, Lisinopril 20 mg PO qday. Amoxicillin ordered at discharge D/C, dose complete, select value “1”. * PCP telephone note titled “Post Hospital Discharge Follow-up Visit” contains a current medication list and states “medication reconciliation complete and includes medications ordered post hospitalization;” select value “1”. If there is no mention of hospitalization or inpatient admission as part of the medication reconciliation process, select value “2”.   **Inpatient Discharge Summary:**   * 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. (i.e., “no changes in current medications since hospital discharge.”).   **For the purposes of this review additional information follows:**   * Medication reconciliation assesses whether medication reconciliation occurred. It does not attempt to assess the quality of the medication list documented in the medical record or the process used to document the most recent medication list in the medical record. * Documentation of a review of medications with the patient/caregiver is not necessary to answer “Yes”. * Medication reconciliation does not require the patient to be present.   **Cont’d next page**   * Documentation in the outpatient medical record must include evidence of medication reconciliation and the date when it was performed. * Documentation should include a comparison between the outpatient medication list and the inpatient discharge medications or must include notation that outpatient medications were reconciled with the inpatient discharge medication list. * **Example:** the PCP note states “Patient discharged from the hospital on the following medications (discharge medications listed in note) A current list of outpatient medications including those prescribed at discharge include the following medications (list of current medications),” select value “1”. |
| 16 | medrecdt | 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)], enter the earliest date on 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** on which the medication reconciliation took place during the specificed timeframe displayed in the question. |