

VHA EXTERNAL PEER REVIEW PROGRAM
ACUTE CORONARY SYNDROME INSTRUMENT
CONTINUING INPATIENT CARE AND ASSESSMENT MODULE
Third Quarter FY2014

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
1	advrsent1 advrsent2 advrsent7 advrsent9 advrsent11 advrsent12 advrsent13 advrsent99	At any time during this episode of care, did any of the following events occur? Enter dates for all that apply: 1. reinfarction 2. cardiogenic shock 7. cardiac arrest 9. blood transfusion (whole blood or packed red cells only) 11. suspected bleeding event 12. heart failure 13. CVA/stroke 99. none of these events	1, 2, 7, 9, 11, 12, 13, 99 mm/dd/yyyy mm/dd/yyyy mm/dd/yyyy mm/dd/yyyy If advrsent13 = valid date, go to wicthtype, else if advrsent13 = null, auto-fill wicthtype as 95 and go to strstst >= acutedt and <= dcdte	1. Reinfarction: clinical evidence of further vessel occlusion and cardiac muscle damage that is distinct from the presenting event. Diagnosis must be documented by a clinician. 2. Cardiogenic shock: sustained (> 30 Minutes) episode of systolic blood pressure < 90 mm/Hg and/or the requirement for parenteral inotropic or vasopressor agents or mechanical support (e.g., intra-aortic balloon pump [IABP], extracorporeal circulation, ventricular assist devices). The abstractor may not make this determination. The diagnosis of cardiogenic shock must be documented by a clinician. 7. Cardiac arrest: sudden cessation of cardiac activity such that the patient becomes unresponsive with no normal breathing and no signs of circulation. May be reversed, usually by CPR and/or defibrillation or cardioversion, or cardiac pacing. 9. Blood transfusion: administration of one or more units of packed red blood cells (PRBC) or whole blood. 11. Suspected bleeding event: suspected or confirmed bleeding event observed and documented in the medical record that was associated with any of the following: 1) hemoglobin drop of >= 3 gm/dL; 2) transfusion of whole blood or PRBC; 3) procedural intervention/surgery at the bleeding site to stop or correct the bleeding (such as surgical closure of the arteriotomy site, endoscopy with cautery of a GI bleed). 12. Heart Failure (congestive heart failure [CHF]): clinician documentation of clinical signs/symptoms of heart failure, diagnosis of heart failure/CHF, diagnosis of pulmonary edema. Chest x-ray evidence of pulmonary edema may be taken from the chest x-ray report, but the abstractor must be certain the x-ray was done during this episode of care but not on initial presentation to the hospital. 13. CVA/stroke: loss of neurological function caused by an ischemic or hemorrhagic event with residual symptoms at least 24 hours after onset or leading to death. Diagnosis must be documented by a clinician.

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2	wichtype	Does the record document the type of stroke? 1. hemorrhagic 2. thromboembolic (ischemic) 3. thromboembolic with hemorrhagic conversion 4. other/unknown 95. not applicable 99. type of stroke not documented	1, 2, 3, 4, 95, 99 If advrsent13 = null will be auto-filled as 95	Type of stroke must be documented in the record by a physician, APN, or PA.

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3	stressdt2 stressdt3 stressdt4 stressdt5 stressdt6 strstst1 stressdt1 strstst3 strstst4 strstst5 strstst6 strstst99 strstst2	<div>Were any of the following non-invasive stress tests for myocardial ischemia performed during this episode of care?</div> <table><tr><th>Check the box if this stress test was performed. Indicate all that apply:</th><th>Enter the date the stress test was performed.</th></tr><tr><td>1. Standard Exercise Stress Test</td><td>mm/dd/yyyy</td></tr><tr><td>2. Stress Echocardiogram</td><td>mm/dd/yyyy</td></tr><tr><td>3. Stress Testing with SPECT MPI</td><td>mm/dd/yyyy</td></tr><tr><td>4. Stress Testing with Cardiac Magnetic Resonance (CMR)</td><td>mm/dd/yyyy</td></tr><tr><td>5. Stress Testing with Computerized Tomographic Angiography (CTA)</td><td>mm/dd/yyyy</td></tr><tr><td>6. Coronary Calcium Scoring</td><td>mm/dd/yyyy</td></tr><tr><td>99. No stress test performed or unable to determine</td><td></td></tr></table>	Check the box if this stress test was performed. Indicate all that apply:	Enter the date the stress test was performed.	1. Standard Exercise Stress Test	mm/dd/yyyy	2. Stress Echocardiogram	mm/dd/yyyy	3. Stress Testing with SPECT MPI	mm/dd/yyyy	4. Stress Testing with Cardiac Magnetic Resonance (CMR)	mm/dd/yyyy	5. Stress Testing with Computerized Tomographic Angiography (CTA)	mm/dd/yyyy	6. Coronary Calcium Scoring	mm/dd/yyyy	99. No stress test performed or unable to determine		<div>1, 2, 3, 4, 5, 6, 99</div> <div>strstst99 cannot be checked with any other box</div> <div>For any strstst = -1, abstractor must enter date before going to the next strstst checkbox</div> <div>For any strstst <> -1, clear corresponding date field</div> <div>> = acutedt and < = dcdte</div>	<div>Patients with an uncomplicated MI may undergo a non-invasive evaluation for ischemia to identify increased cardiovascular risk prior to discharge from the hospital. Applies to both STEMI and NSTEMI. Documentation by the physician, APN, or PA in the progress notes that a stress test was done either at the VAMC or elsewhere, during this episode of care, should be accepted. Documentation of the report in the radiology package is also acceptable.</div> <div><ul style="list-style-type: none">• Standard Exercise Stress Test: ECG is done while the patient performs physical activity on a treadmill or bicycle• Stress Echocardiogram: ultrasound assessment of the pumping function of the heart and status of the heart valves. immediately following activity such as treadmill or stationary bicycle• Stress Testing with SPECT MPI: isotope tracer thallium injected one to two minutes before end of exercise or immediately thereafter. Heart is imaged both immediately following exercise and at rest. May also be done with dipyridamole (Persantine) if patient unable to exercise. May be referred to as "Nuclear Stress Test".• Stress Testing with Cardiac Magnetic Resonance (CMR): dipyridamole or adenosine injected to mimic effect of exercise on the heart; contrast dye is injected; radiowaves and strong magnetic field produce images of the heart and coronary arteries.• Stress Testing with Computerized Tomography Angiogram (CTA): uses advanced CT technology, along with intravenous (IV) contrast material, to three-dimensional pictures of the moving heart and great vessels. May also be called multi-slice computed tomography (MSCT), cardiac CT, cardiac CAT.• Coronary Calcium Scoring: uses computed tomography (CT) to check for buildup of calcium in plaque on the walls of the coronary arteries</div>
Check the box if this stress test was performed. Indicate all that apply:	Enter the date the stress test was performed.																			
1. Standard Exercise Stress Test	mm/dd/yyyy																			
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4	cathdun	<p>Was a diagnostic cardiac catheterization (cath) performed during this episode of care?</p> <p>1. cath done at this VAMC (or patient sent out for cath and returned in 12 hours)</p> <p>2. transferred to another VAMC for cath</p> <p>3. transferred to a community hospital for cath or transfer-in had diagnostic cath at VHA or community hospital</p> <p>99. diagnostic cath not done</p>	<p>1, 2, 3, 99</p> <p>If 99, auto-fill entrdone as 99/99/9999 and cathrep as 95</p> <p>If 1, 2, or 3, auto-fill ynocath as 95 and cathpdc as 95</p>	<p>Cardiac catheterization: an invasive procedure used to diagnose certain heart conditions. A thin flexible tube (catheter) is inserted into an artery or vein in the arm or groin. From there it can be advanced into the chambers of the heart or the coronary arteries to do tests and or treatments on the heart. When dye is injected into the coronary arteries, the procedure is called coronary angiography or coronary arteriography. Cardiac cath without treatment of coronary artery blockage is considered the diagnostic portion of the procedure. If a treatment (angioplasty or insertion of a stent) is done, this is considered the interventional portion of the procedure (percutaneous coronary intervention or PCI).</p> <p>If the patient had a diagnostic cardiac cath and also had a PCI, answer "1".</p> <p>If the patient did not have an emergent PCI, but later during the episode of care, had a cardiac cath in which the degree of blockage was determined but no attempt was made to treat the blockage, or no treatment (or only medical treatment) was deemed necessary, answer "1."</p> <p>If the patient was transferred to another facility on a non-emergent basis later in the stay for a cardiac cath and possible PCI, answer "2" or "3" as applicable.</p> <p>If patient was sent out for a cath and returned in 12 hours, it is considered the same as being done at this VAMC.</p>
5	ynocath	<p>Did a clinician document a reason for not performing a diagnostic cardiac catheterization (cath) during this episode of care?</p> <p>1. Yes</p> <p>2. No</p> <p>95. Not applicable</p>	<p>1, 2, 95</p> <p>If cathdun = 1, 2, or 3, will be auto-filled as 95</p> <p>If 1, auto-fill cathpdc as 95</p>	<p>Reasons for not performing a diagnostic cath must be documented in the record by a cardiologist, cardiology fellow, or cardiology resident under appropriate supervision by the attending physician.</p> <p>Reasons may include but are not limited to documentation:</p> <ul style="list-style-type: none"> • that stress test is a more reasonable first approach for this patient • of known coronary artery lesion(s) not amenable to revascularization by PCI • that patient age, debilitation, or co-morbidities preclude cardiac cath • of known coronary artery blockage(s) that cannot be treated by PCI and a CABG is being considered or is scheduled • that patient and/or family refused cardiac cath

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6	entrdone	Enter the date the diagnostic cardiac catheterization was performed.	mm/dd/yyyy If cathdun = 99, will be auto-filled as 99/99/9999 <div style="border: 1px solid black; padding: 5px;"> If cathdun = 1, > = acutedt and < = dcdte If cathdun = 2, >= acutedt and < = 3 days after dcdte If cathdun = 3, < = 3 days prior to or = acutedt and < = 3 days after dcdte </div>	If more than one <u>diagnostic</u> cardiac cath was performed, use the date of the first cath performed. Do not confuse diagnostic cath with primary emergent cath/PCI done to restore reperfusion. Enter the exact date. Do not use 01 to indicate missing day or month
7	cathrep	Enter the result of the cardiac catheterization: 1. Evidence of obstructive CAD 2. No evidence of obstructive CAD 95. not applicable 99. Unable to determine.	1, 2, 95, 99 If cathdun = 99, will be auto-filled as 95	Evidence of obstructive CAD: >50% left main stenosis and/or > 70% stenosis of a major epicardial artery.
8	cathpdc	Does the record document a plan for cardiac catheterization post-discharge? 1. yes 2. no 3. documented plan considered cath but patient deemed not a candidate 95. not applicable 98. patient refused post-discharge cardiac cath	1, 2, 3, 95, 98 If cathdun = 1, 2, or 3, or if ynocath = 1 will be auto-filled as 95	There must be documented evidence that a post-discharge cardiac catheterization was planned, although a definitive appointment date is not required. 98 = there must be definitive documentation in the record that a post-discharge cardiac cath was recommended, and the patient (or family) refused a cardiac cath following discharge. Response #3: If the clinician documents that the patient is not a candidate for a post-discharge cath, then it is considered that the care has been considered and that the decision to do nothing more is the PLAN. Do not accept documentation that is anything other than a firm decision that a post-discharge cath is not appropriate (i.e., not acceptable: no cath at this time, cath contraindicated at present, too sick to cath at this time).

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#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
9	lvfdoc2	During the past five years, is there documentation in the medical record of the patient's left ventricular systolic function (LVSF)/ejection fraction (EF)? 1. Yes 2. No	1, 2 If 2, auto-fill eftstdt as 99/99/9999, and acslowef as 95	Left Ventricular Systolic Function (LVSF) assessment: diagnostic measure of left ventricular contractile performance/wall motion. Ejection fraction (EF) is an index of LVSF. EF may be recorded in quantitative (EF=30%) or qualitative (moderate left ventricular systolic dysfunction) terms. Tests used to determine LVSF/EF = echocardiogram, radionuclide ventriculography (MUGA, RNV, nuclear heart scan, nuclear gated blood pool scan), or cardiac cath with left ventriculogram (LV gram). Start by looking for documentation of LVSF/EF during the current admission. EF may be taken from any knowledge of EF or left ventricular systolic dysfunction (LVSD) documented in the record during the past five years. Use the most recent EF found. Exclude: akinesis, dyskinesis, or hypokinesis not described as left ventricular; cardiomyopathy not described as endstage; contractility/hypocontractility; left ventricular compliance, dilatation/dilation, or hypertrophy; BNP blood test
10	eftstdt	Enter the date of the most recent test for left ventricular systolic function (EF.)	mm/dd/yyyy If lvfdoc2 = 2, eftstdt will be auto-filled as 99/99/9999 If lvfdoc2 = 1, but no date available, abstractor can enter 99/99/9999 <div style="border: 1px solid black; padding: 2px; width: fit-content;">< = 5 years prior to or = acutedt and < = dcdate</div>	This question has changed to ask the date the EF was measured. Year is acceptable at a minimum if the left ventricular systolic function was assessed in the past prior to hospitalization, and this is the only date available. Enter exact day and month if test was recent and dates are available.
11	acslowef	Is the left ventricular systolic function (LVSF) documented as an ejection fraction (EF) less than 40% or narrative description consistent with moderate or severe systolic dysfunction (LVSD)? 1. yes 2. no	1, 2, 95 If lvfdoc2 = 2, will be auto-filled as 95	LVSD: impairment of LV performance. EF is an index of LVSF. Use the most recent description of EF/LVSF found (test done closest to discharge). EF < 40% select "1"; EF >= 40% select "2". Guidelines for prioritizing LVSF/EF/LVSD documentation: 1) LVSF assessment test report findings take precedence over findings documented in other sources (e.g. progress notes)

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		95. not applicable		<p>2) Final report findings take priority over preliminary findings. Assume findings are final unless labeled as preliminary.</p> <p>3) Conclusion (impression, interpretation, or final diagnosis) section of report takes priority over other sections.</p> <p>**If test for EF/LVSF was not performed during hospital stay, look for documentation of <u>pre-arrival</u> EF/LVSF test results documented in the record. Apply guidelines 1 - 3 above.</p> <p><u>Priority order for conflicting documentation when there are 2 or more different descriptions of EF/LVSF:</u></p> <p>1) Use the lowest calculated EF (e.g. 30%)</p> <p>2) Use lowest estimated EF. Estimated EFs often use descriptors such as "about," "approximate," or "appears." (e.g. EF appears to be 35%). Estimated EF may be documented as a range (use mid-point) or less than or greater than a given number.</p> <p>3) Use worst narrative description WITH severity specified (e.g., LVD/LVSD described as marked, moderate, moderate-severe, severe, significant, substantial, or very severe; EF described as low, poor, or very low)</p> <p>4) Use narrative description WITHOUT severity specified (e.g., biventricular dysfunction; LVD, LVSD, systolic dysfunction; LV systolic failure; LVF, LVSF, EF) described as abnormal, compromised, decreased, reduced.</p> <p>5) Disregard the following terminology when reviewing the record for documentation of LVSF/LVSD. If documented, continue reviewing for LVSF/LVSD inclusions outlined in the Inclusion lists,</p> <ul style="list-style-type: none"> • Diastolic dysfunction, failure, function, or impairment • Ventricular dysfunction not described as left ventricular or systolic • Ventricular failure not described as left ventricular or systolic • Ventricular function not described as left ventricular or systolic <p>E.g., Impression section of echo report states only "diastolic dysfunction". Findings section states "EF 35%". Disregard "diastolic dysfunction" in the Impression section and answer "Yes" due to EF 35%.</p> <p><u>Include:</u></p> <ul style="list-style-type: none"> • Any terms (biventricular dysfunction; LVD/LVSD/systolic dysfunction; diffuse, generalized or global hypokinesis; LV akinesis/

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				<p>hypokinesis/dyskinesis; LV systolic failure) described as marked, moderate, moderate-severe, severe, significant, substantial, or very severe; OR where severity is NOT specified</p> <ul style="list-style-type: none">• biventricular heart failure described as moderate or severe• end stage cardiomyopathy <p><u>Exclude:</u></p> <p>1) Any terms (see above)described as mild-moderate</p> <p>2) diastolic dysfunction, failure, function or impairment</p> <p>3) ventricular dysfunction, failure, or function not described as left ventricular</p> <p>4) Any terms (see above) described using one of the following: negative Qualifiers or Modifiers:</p> <table><tr><th colspan="2">JC Appendix H, Table 2.6 Qualifiers/Modifiers</th></tr><tr><td>Qualifiers: and/or, (+/-), cannot exclude, cannot rule out, could/may/might be, could/may/might have, could/may/might have been, could/may/might have had, could/may/might indicate, questionable (?), risk of, ruled out (r'd/o, r/o'd), suggestive of, suspect, or suspicious</td><td>Modifiers: borderline, insignificant, not significant, no significant, minor, scant, slight, sub-clinical, subtle, trace, trivial</td></tr></table>	JC Appendix H, Table 2.6 Qualifiers/Modifiers		Qualifiers: and/or, (+/-), cannot exclude, cannot rule out, could/may/might be, could/may/might have, could/may/might have been, could/may/might have had, could/may/might indicate, questionable (?), risk of, ruled out (r'd/o, r/o'd), suggestive of, suspect, or suspicious	Modifiers: borderline, insignificant, not significant, no significant, minor, scant, slight, sub-clinical, subtle, trace, trivial
JC Appendix H, Table 2.6 Qualifiers/Modifiers								
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12	smokcigs	Did the adult patient smoke cigarettes any time during the year prior to hospital arrival? 1. yes 2. no or unable to determine from medical record documentation	1, 2 If 1, go to tobcess If 2, auto-fill tobcess as 95	<p>This question refers only to smoking cigarettes and is not pertinent to other forms of tobacco. If the record documents "tobacco use" or "+smoker" but the type of product is not specified, assume this refers to cigarette smoking unless documentation in another Only Acceptable Source suggests that the tobacco product is pipe, cigar, or chewing tobacco.</p> <p>If there is <u>definitive</u> documentation anywhere in the ONLY ACCEPTABLE SOURCES that the patient either currently smokes or is an ex-smoker that quit less than one year prior hospital arrival, select "yes," regardless of whether or not there is conflicting documentation.</p> <p>Examples of smoking within the past year include, but are not limited to: "Former smoker. Quit recently." "History - quit smoking 7 months ago" "Quit smoking several months ago" "Social habits = current smoking" "Tobacco history - current cigarette smoker"</p> <p>If there is NO definitive documentation of current smoking or smoking within one year prior to arrival in any of the ONLY ACCEPTABLE SOURCES select "No." The following examples would not count as inclusions (select "No"):</p> <ul style="list-style-type: none"> • "Smoked in the last year: ?" • "Probable smoker" • "Most likely quit 3 months ago" <p>Disregard documentation of smoking history or history of tobacco use if current smoking status or timeframe that patient quit is not defined (e.g., "20 pk/yr smoking history", "History of tobacco abuse").</p> <p>Do not include documentation of smoking history referenced as a risk factor (e.g., "risk factor: tobacco," "risk factor: smoking,"), where current smoking status is indeterminable.</p> <p>ONLY ACCEPTABLE SOURCES: Emergency department record, history and physical, nursing admission assessment/nursing admission notes, respiratory therapy notes, Smoking/Tobacco Use assessment forms</p> <p>Exclude: Documentation from a transferring facility or a previous admission</p>

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13	tobcess	Did the patient/caregiver receive smoking/tobacco use cessation advice or counseling during the hospitalization? 1. Yes 2. No 95. Not applicable	1, 2, 95 If smokeigs = 2, will be auto-filled as 95	<p>The caregiver is defined as the patient's family or any other person (e.g., home health, prison official or other law enforcement provider) who will be responsible for care of the patient after discharge.</p> <p>Adult Smoking Counseling: Documentation indicating the patient/caregiver received one of the following:</p> <ul style="list-style-type: none"> • Direct discussion with patient/caregiver to stop smoking (stop using tobacco) whether or not the patient is currently smoking • Viewing a smoking/tobacco use cessation video • Given brochure or handouts on smoking/tobacco use cessation • Referred to a smoking cessation class or clinic • Prescribed a smoking cessation aid, e.g., Habitrol, Nicoderm, Nicorette, Nicotrol, Prostep, or Zyban during hospital admission or at discharge • Prescription of Wellbutrin/bupropion during hospital stay or at discharge, if specifically prescribed as a smoking cessation aid. <p>If the patient smoked within the year prior to arrival but does not currently smoke, they should still be advised not to smoke. Cessation counseling is still required.</p> <p>Respond "1" if the patient/caregiver was given advice, a brochure, pamphlet, or video relative to smoking cessation even if the patient uses another form of tobacco.</p> <p>If the patient refused smoking cessation advice or counseling during this hospital stay, answer "1."</p> <p>2 = advice/counseling not done, or unable to determine from medical record documentation</p> <p>Data Sources: Consultation notes, Discharge instruction sheet, Discharge summary, ED record, H&P, Medication administration record, Nursing notes, Progress notes, Respiratory therapy notes, Teaching sheet</p> <p>Exclude: any documentation dated/timed after discharge except discharge summary and operative/procedure/diagnostic test reports (from procedure done during hospital stay).</p>
		If dedispo =2, 3, 4, 6 or 7, go out of ACS		