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| **If fl\_dementia = 1, go to demendx; else go to admdate** | | | | |
|  |  | **Dementia** |  |  |
| 1 | demendx | During the time frame from (computer to display stdybeg – 12 months to stdyend), does the record document a new diagnosis of dementia as evidenced by one of the following ICD-9-CM codes?  **(046.1, 046.11, 046.19, 046.3, 290.0, 290.10, 290.11, 290.12, 290.13, 290.20, 290.21, 290.3, 290.40, 290.41, 290.42,290.43, 291.2, 292.82, 294.10, 294.11, 294.8, 331.0, 331.11, 331.19, 331.2, 331.7, 331.82, 331.89, 331.9, 333.0 or 333.4)**  1. Yes  2. No | 1,2  **If 2 and fl\_inpt = 1, go to admdate; else if 2, the case is excluded.** | **The new diagnosis of dementia or other condition associated with dementia may be found on a problem list or in health factors, but must be verified by physician/APN/PA documentation in the record during the past year.**  **Dementia diagnosis recorded during an outpatient or inpatient encounter is acceptable. Each health factor should have an associated date that represents the date the health factor was recorded.**  **For the purposes of this question, acceptable dementia diagnosis includes:**   |  |  | | --- | --- | | **ICD-9** | **Diagnosis** | | **046.1** | Jakob-Creutzfeldt disease | | **046.11** | Variant Jakob- Creutzfeldt disease | | **046.19** | Other and unspecified Jakob- Creutzfeldt disease | | **046.3** | Progressive multifocal leukoencephalopathy | | **290.0** | Senile dementia uncomplicated | | **290.10** | Presenile dementia uncomplicated | | **290.11** | Presenile dementia with delirium | | **290.12** | Presenile dementia with delusional features | | **290.13** | Presenile dementia with depressive features | | **290.20** | Senile dementia with delusional features | | **290.21** | Senile dementia with depressive features | | **290.3** | Senile dementia with delirium | | **290.40** | Vascular dementia uncomplicated | | **290.41** | Vascular dementia with delirium | | **290.42** | Vascular dementia with delusions | | **290.43** | Vascular dementia with depressed mood | | **291.2** | Alcohol-induced persisting dementia | | **292.82** | Drug-induced persisting dementia | | **294.10** | Dementia in conditions classified elsewhere without behavioral disturbance | | **294.11** | Dementia in conditions classified elsewhere with behavioral disturbance | | **294.8** | Other persistent mental disorders due to conditions classified elsewhere [“DEMENTIA NOS”] | | **331.0** | Alzheimer's disease | | **331.11** | Pick's disease | | **331.19** | Other frontotemporal dementia | | **331.2** | Senile degeneration of brain | | **331.7** | Cerebral degeneration in diseases classified elsewhere | | **331.82** | Dementia with lewy bodies | | **331.89** | Other cerebral degeneration | | **331.9** | Cerebral degeneration unspecified | | **333.0** | Other degenerative diseases of the basal ganglia | | **333.4** | Huntington's chorea |   Suggested data sources: Clinic/progress notes (e.g. primary care, neurology, geriatrics, psychiatry), history and physical, discharge summary, HBPC notes  **Exclusion: No documentation of a new dementia diagnosis during the past year and no inpatient admission during the past year excludes the case from Frail Elderly review.** |
| 2 | demedxdt | Enter the earliest date during the past year when the new diagnosis of dementia was documented in the record. | mm/dd/yyyy   |  | | --- | | < = 12 months prior to or = stdybeg and <= stdyend | | **Enter the exact date. The use of 01 to indicate missing month or day is not acceptable.** |
| 3 | demcisx | During the time frame from (computer display demedxdt – 6 months to demedxdt + 1 month), did the physician/APN/PA document the date of onset and course of cognitive signs and symptoms?  1. Yes  2. No | 1,2 | **The intent of the question is to determine if a physician/APN/PA documented the approximate date of onset or approximate length of time cognitive impairment problem existed (e.g., days, weeks, etc.) and how the cognitive impairment developed over time (e.g., slowly worsening, fluctuating, stable following initial onset) prior to the diagnosis of dementia.**  Multiple notes during the time frame may be used, but the chief complaint or history must refer to cognitive impairment or signs/symptoms of cognitive impairment.  Cognitive signs/symptoms may include, but are not limited to memory loss, dementia, and confusion.  For example, physician notes, “CC – trouble with memory. Patient states he has been forgetting things. States started 1 year ago and seems to be getting worse.”  Suggested data sources: Clinic/progress notes (e.g. primary care, neurology, geriatrics, psychiatry, etc.), history and physical, HBPC notes |
| 4 | demhx1  demhx2  demhx3  demhx4  demhx5  demhx6  demhx7  demhx8  demhx9  demhx10  demhx99 | During the time frame from (computer display demedxdt – 6 months to demedxdt + 1 month), which of the following were documented in the patient’s history and/or review of systems?  **Indicate all that apply:**  1. History of head trauma  2. History of psychiatric disease  3. History of cardiovascular disease or cardiovascular disease risk factors  4. Family history of dementia or other cognitive impairment  5. Social history to include drug and alcohol use  6. Medication review  7. Functional status  8. Driving status  9. Access to firearms  10. Behavioral symptoms  99. None of the above | 1,2,3,4,5,6,7,8,9,10,99  If 99 or if < 4 items = -1, go to nodemhx; else auto-fill nodemhx as 95, and go to dempecog   |  | | --- | | Cannot enter 99 with any other number | | **The history and/or review of system components may be accepted from clinic/progress notes and/or history and physicals performed on different dates during the specified time frame.**  **Documentation of the presence or absence of terms associated with items 1- 4 is acceptable (e.g., no history of head trauma and history of depression, select “1” and “2”).**  **History of head trauma** - Search for trauma , head trauma, TBI, traumatic brain injury  **History of psychiatric illness** - Any reference to psychiatric illness in HPI, PMH or ROS. Relevant terms include, but are not limited to, depression, anxiety, post-traumatic stress disorder, PTSD, schizophrenia, bipolar disorder and psychosis.  **History of cardiovascular disease or risk factors** - Any reference to history of hypertension, diabetes, hyperlipidemia, CAD, peripheral arterial disease, CVA. May be in history, past medical history, or on problem list  **Family history of dementia or other cognitive impairment** - Family history header present in progress note or specific reference to family history in history of present illness.  **Social history** **must** include patient history of drug and alcohol use. Documentation that social history is “non-contributory” is unacceptable.  **Medication review** – Review of active medication list; Reference to medication reconciliation; Reference to medications as possible cause of cognitive symptoms in assessment.  **Functional status** –ADL Tool: Katz Index of Independence in Activities of Daily Living; Standardized IADL standardized tool: Instrumental Activities of Daily Living Scale (IADL) M.P. Lawton and E.M. Brody  Other functional status tools are acceptable but must be standardized and published and the questions and scoring must be in accordance with the authentic screening tool.  **Driving status** - Reference in history or assessment regarding driving status.  **Access to firearms** - Reference in history or assessment regarding access to firearms.  **Cont’d next page**  **Patient’s History cont’d**  **Behavioral symptoms –** Examples include but are not limited to agitation, aggression, apathy, wandering, impulsivity, disinhibition, sleep-wake cycle changes, inappropriate sexual behavior.  Suggested data sources: Clinic/progress notes (e.g. primary care, neurology, geriatrics, psychiatry, etc.), history and physical, HBPC notes |
| 5 | nodemhx | During the time frame from (computer display demedxdt – 6 months to demedxdt + 1 month), did a physician/APN/PA document the patient’s history and/or review of systems were unable to be obtained?  1. Yes  2. No  95. Not applicable | 1,2,95  Will be auto-filled as 95 if > = 4 items demhx = -1 | **In order to answer “1” there must be physician/APN/PA documentation during the specified timeframe that information regarding the patient’s history and/or review of systems was unable to be obtained from the patient or caregiver.**  **Examples include, but are not limited to:**   * **Patient is non-communicative.** * **Patient is poor historian.** * **Patient unable to answer questions and no caregiver present.** |

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| 6 | dempecog | During the time frame from (computer display demedxdt – 6 months to demedxdt + 1 month), did a physician/APN/PA, RN, licensed social worker, or psychologist document cognitive assessment using a standardized and published tool?  1. Yes  2. No | 1,2 | **Cognitive Assessment must be performed using a standardized and published tool OR documentation of neuropsychiatric testing by psychology. Objective cognitive testing may be performed by a physician/APN/PA, RN, licensed social worker, or psychologist.**  Examples of Brief Cognitive Tools include, but are not limited to:  **Blessed Orientation-Memory-Concentration Test (BOMC)** - six questions to assess orientation to time, recall of a short phrase, counting backward, and reciting the months in reverse order  **Mini-Cog** – this test has minimal language requirements making it better for educational or cultural variations. The Mini-Cog combines a three item word recall with drawing the hands on a clock.  **General Practitioner Assessment of Cognition (CPCOG)** – This screen was developed for the primary care setting and is available in different languages. It includes a short patient assessment and follow up interview with the patient’s caregiver.  **Short Test of Mental Status (STMS)** – The evaluator provides a name and address, ask about the date and awareness of current news and ends with seeking patient recall of the name and address. A follow up interview with the caregiver seeks information about changes in patient memory and behavior.  **St. Louis University Mental Status Exam (SLUMS)** – This is a brief exam containing oral and written items. It includes recall, orientation to date and time, simple math, and recall of other general information. It is more sensitive than the MMSE.  **Montreal Cognitive Assessment (MoCA)** – This assessment is a one page, 30 point test and evaluates visio-spacial relationships, recall, language, attention, concentration, working memory and orientation.  **If another Brief Cognitive Tool is used, the instrument must be standardized and published, and the questions and scoring must be in accordance with the authentic screening tool.**  Suggested data sources: Clinic/progress notes (e.g. primary care, neurology, geriatrics, psychiatry, psychology, etc.), history and physical, HBPC notes, social worker notes |

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| 7 | dementpe | During the time frame from (computer display demedxdt – 6 months to demedxdt + 1 month), did the physician/APN/PA, \*psychologist, or \*licensed MSW document a physical exam?  1. Yes  2. No | 1,2  If 2, go to demlab1 | **Physical exam may include cardiovascular, neurological, mental status, observation of behavioral symptoms, vision and hearing status.**  **\*Mental status exam and observation of behavioral symptoms may be documented by a psychologist or licensed MSW.**  Suggested data sources: Clinic/progress notes (e.g. primary care, neurology, geriatrics, psychiatry, etc.), history and physical, HBPC notes |
| 8 | dempe1  dempe2  dempe3  dempe4  dempe5  dempe6  dempe99 | During the time frame from (computer display demedxdt – 6 months to demedxdt + 1 month), did the physical exam (s) document any of the following?  **Indicate all that apply:**  1. Cardiovascular exam  2. Neurological exam  3. Mental status  4. Observation of behavioral symptoms  5. Vision status  6. Hearing Status  99. None of the above | 1,2,3,4,5,6,99 | **The physical exam components may be accepted from clinic/progress notes and/or history and physicals performed on different dates during the specified time frame.**  **1) Cardiovascular exam** - Exam header may include heart, CV, vascular, pulses  **2) Neurological exam** - Exam header may include Neuro, Neurologic or Neurological  **3) Mental status** – exam may be performed by a psychologist or licensed MSW  **4) Observation of behavioral symptoms** - Statements under general appearance or orientation statement are acceptable such as "agitated", A&O x3. May be documented by a psychologist or licensed MSW  **5) Vision Status:** – May include documentation of visual acuity, visual fields to confrontation, CNII intact, exam by optometry or ophthalmology  **6) Hearing Status**- May include documentation of CN VIII intact; hard of hearing, reference to hearing aid, audiogram.  **NOTE: Vision and Hearing Status may be documented together as part of a sensory exam.**  Suggested data sources: Clinic/progress notes (e.g. primary care, neurology, geriatrics, psychiatry, audiology, eye clinic, etc), history and physical, HBPC notes |

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| 9 | demlab1  demlab2  demlab4  demlab5  demlab6  demlab7  demlab9  demlab10  demlab11  demlab99 | During the time frame from (computer display demedxdt – 6 months to demedxdt + 1 month), were any of the following lab tests performed?  **Indicate all that apply:**  1. Thyroid stimulating hormone (TSH)  2. Vitamin B12  4. Electrolytes (NA, K, CL, CO2)  5. Calcium  6. Complete blood count (CBC)  7. Liver function test (hepatic panel)  9. Glucose  10. Urinalysis  11. Serum Creatinine  99. None of the above | 1,2,4,5,6,7,9,10, 11,99  **\*If fl\_inpt = 1, go to admdate; else go to end** | **Lab tests performed at any VAMC or performed outside the VA and documented in the record during the specified time frame are acceptable.**  **Some lab tests may be performed as part of a panel (e.g., electrolytes included in BMP) and are acceptable.**  **Liver function test includes alkaline phosphatase, AST, direct bilirubin, ALT, and GGT.**  Suggested data sources: Lab package, clinic/progress notes, history and physical |
|  |  | **Hospitalization** |  |  |

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| 10 | admdate | Enter the admission date. | mm/dd/yyyy  Auto-filled: can be modified   |  | | --- | | < = 12 months prior to or = stdybeg and < = stdyend | | **Auto-filled; can be modified if abstractor determines that the date is incorrect.**  **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.  **ONLY ALLOWABLE SOURCES:** Physician orders, face sheet |
| 11 | admtime | Enter the admission time. | \_\_\_\_\_  UMT  Auto-filled: can be modified | This is the time of formal admission to the inpatient acute care setting.  **Will be auto-filled and can be modified if inaccurate.** |
| 12 | dcdate | Enter the date of discharge for the most recent acute care hospitalization. | mm/dd/yyyy  Auto-filled: Cannot be modified   |  | | --- | | > = admdate and < = stdyend | | **The computer will auto-fill the discharge date from the OQP pull list.**  This date cannot be modified in order to ensure the selected episode of care is reviewed. |

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| 13 | dctime | Enter the discharge time. | \_\_\_\_\_  UMT  If dcdate/dctime – admdate/admtime < 48 hours, go to end. | **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.  **Suggested sources for patient who expire:**  Death record, resuscitation record, physician progress notes, physician orders, nurses notes  **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.  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.  **Exclusion statement: Length of stay less than 48 hours excludes the case from designated frail elderly inpatient measures.** |

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| 14 | dcdispo | What was the patient’s discharge disposition on the day of discharge?  1. Home   * Assisted Living Facilities * Court/Law Enforcement – includes detention facilities, jails, and prison * Board and care, domiciliary, foster or residential care, group or personal care homes, 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  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 | **Discharge disposition: The final place or setting to which the patient was discharged on the day of discharge.**  **Notes for Abstraction:**   * **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 back to skilled care. Enter “5”. * **Consider discharge disposition documentation in the discharge summary or a post-discharge addendum as day of discharge documentation, regardless of when it was dictated/written.** * **If documentation is contradictory, use the latest documentation. If there is documentation that further clarifies the level of care that documentation should be used to determine the correct value to abstract.** For example: Nursing discharge note documents that the patient is being discharged to “XYZ” Hospital. The Social Service notes from the day before discharge further clarify that the patient will be transferred to the rehab unit of “XYZ” Hospital, select option “5”. * **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”.** * **To select option “7” there must be explicit documentation that the patient left against medical advice.** Examples:   Progress notes state that patient requests to be discharged but that discharge was medically contraindicated at this time. Nursing notes reflect that patient left against medical advice and AMA papers were signed, select value “7”.  Physician order written to discharge to home. Nursing notes reflect that patient left before discharge instructions could be given, select value “1”.  **Suggested Data Sources:** Discharge instruction sheet, discharge planning notes, discharge summary, nursing discharge notes, physician orders, progress notes, social service notes, transfer record  **Excluded Data Sources:** Any documentation prior to the day of or day before discharge |
| 15 | comfort | When is the earliest physician, APN, or PA documentation of comfort measures only?  1. Day of arrival (day 0) or day after arrival (day 1)  2. Two or more days after arrival (day 2 or greater)  3. Comfort measures only documented during hospital stay, but timing unclear  99. Comfort measures only was not documented by the physician/APN/PA or unable to determine | 1,2,3,99  If 99, auto-fill cmodt as 99/99/9999 and go to admicu   |  | | --- | | Warning if 2 | | **Only accept terms identified in the list of inclusions. No other terminology will be accepted. Day of arrival is day 0.**   |  |  | | --- | --- | | **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 |  |  * **Determine the earliest day the physician/APN/PA DOCUMENTED comfort measures only in the ONLY ACCEPTABLE SOURCES.** Do not factor in when comfort measures only was actually instituted**.** E.g., “Discussed comfort care with family on arrival” noted in day 2 progress note – Select “2.” * **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, referral to hospice care service. * If any of the inclusions are documented **in the ONLY ACCEPTABLE SOURCES**, select option “1,” “2,” or “3” accordingly, unless otherwise specified.   **Disregard documentation of an Inclusion term in the following situations:**   * Inclusion term clearly described as negative (e.g. “No comfort care,” “Not appropriate for hospice care,” “Declines hospice care”).   **NOTE:** If an Inclusion term is clearly described as negative in one source and NOT described as negative in another source, the second source would count for comfort measures only. (e.g., On Day 0, the physician documents, “The patient is not a hospice candidate.” On Day 3, the physician orders a hospice consult. Select “2.”)  **Cont’d next page** |
|  |  |  |  | **Comfort Measures Only cont’d**   * Do not use documentation that is dated prior to arrival or   documentation which refers to the pre-arrival time period (e.g., comfort measures only order in previous hospitalization record, “Pt. on hospice at home” in discharge summary).  **EXCEPTION:** State-authorized portable orders (SAPOs). SAPOs are specialized forms, Out-of-Hospital DNR (OOH DNR) or Do Not Attempt Resuscitation (DNAR) orders, or identifiers authorized by state law, that translate a patient’s preferences about specific-end-of-life treatment decisions into portable medical orders  **Examples:** DNR-Comfort Care form, MOLST (Medical Orders for Life- Sustaining Treatment), POLST (Physician Orders for Life-Sustaining Treatment)   * Inclusion terms not clearly selected on a pre-printed order form, even if orders are signed by physician/APN/PA.   **Examples:** Home Health/Hospice order form - “Hospice” not circled or selected; DNR-Comfort Care order form - option “Comfort Care” not checked or selected.   |  |  | | --- | --- | | **Exclusion (Only acceptable exclusion terms)\*:** | | | DNR-CCA | DNRCC-Arrest | | DNR-Comfort Care Arrest | DNRCCA | | DNRCC-A | Palliative care/measures |   **ONLY ACCEPTABLE SOURCES:** Discharge summary, DNR/MOLST/POLST forms, physician orders, progress notes  **Excluded data source:** Restraint order sheet |

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| 16 | cmodt | Enter the date comfort measures only was initially documented in the record. | mm/dd/yyyy  Will be auto-filled as 99/99/9999 if comfort = 99  If comfort = 1 and dcdispo = 1 or 2, go to idcneed; else if comfort = 1 and dcdispo <> 1 or 2, go to end   |  | | --- | | >= admdate and <=dcdate | | **Do not factor in when comfort measures only was actually instituted.** E.g., “Discussed comfort care with family on arrival” noted in 02/21/20XX progress note and palliative care saw patient on 2/23/20XX; enter 02/21/20XX.  Enter the exact date. The use of 01 to indicate missing day or month is not acceptable.  **Exclusion statement: Documentation of comfort measures only the day of or day after arrival and discharge disposition other than home or hospice - home excludes the case from designated frail elderly inpatient measures.** |
|  |  | **ICU** |  |  |
| 17 | admicu | Was the patient admitted or transferred to the intensive care unit at this VAMC during this hospitalization?  1. Yes  2. No   1. Unable to determine | 1,2,99  Auto-filled: can be modified  **If 2 or 99, go to ptnoamb** | **Auto-filled; can be modified if abstractor determines that the patient was not admitted or transferred to the intensive care unit at this VAMC during this hospitalization.**  **Any time spent in the ICU is included.**  Do not use abstractor judgment based on the type of care administered to the patient. The level of intensive care MUST be documented.Direct admits, admissions via theED, or transfers from lower level of inpatient care are included.  Do **not** include PCU unless identified as a Pulmonary Care Unit.  **Exclude:**   * ED, OR, or procedure units as inpatient units * **Intermediate care unit (IMCU)** Step down unit: * A post critical care unit for patients that are hemodynamically stable who can benefit from close supervision and monitoring such as frequent pulmonary toilet, vital signs, and/or neurological and neurovascular checks. * Inpatient units with telemetry monitoring that are not intensive care units * Post coronary care unit (PCCU) |
| 18 | icuadmdt | Enter the ICU admission date. | mm/dd/yyyy   |  | | --- | | >= admdate and <= dcdate | | If the patient had more than one ICU stay during this hospitalization, enter the date of the first ICU admission/transfer. |
| 19 | icuadmtm | Enter the ICU admission time. | UMT   |  | | --- | | >= admdate/admtime and <= dcdate/dctime | | If the patient had more than one ICU stay during this hospitalization, enter the admission time of the first ICU admission/transfer. |
| 20 | icudcdt | Enter the ICU discharge date. | mm/dd/yyyy   |  | | --- | | >= icuadmdt and <= dcdate | | If the patient had more than one ICU stay during this hospitalization, enter the discharge date of the first ICU admission/transfer. |
| 21 | icudctm | Enter the ICU discharge time. | UMT   |  | | --- | | >= icuadmdt/icuadmtm and <= dcdate/dctime | | If the patient had more than one ICU stay during this hospitalization, enter the discharge time of the first ICU admission/transfer. |
| **If icudcdt/icudctm - icuadmdt/icuadmtm >= 48 hours, go to noanswer; if icudcdt/icudctm - icuadmdt/icuadmtm < 48 hours and icuadmdt – admdate > 3 days; go to ptnoamb; if icudcdt/icudctm - icuadmdt/icuadmtm < 48 hours and icuadmdt – admdate < =3 days, go to anesendt as applicable** | | | | |

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| 22 | noanswer | During the ICU stay, did the physician/APN/PA document that the patient did not have decision-making capacity?  1. Yes  2. No | 1,2  If 1, auto-fill ptpref as 95 and go to idsurro | **Physician/APN/PA documentation that the patient is cognitively impaired, unable to answer questions, comatose, or lacks decision making capacity is acceptable.**  Suggested data sources: consultation notes, progress notes |
| 23 | icupalcar | During the ICU stay, did the physician/APN/PA, registered nurse, or social worker refer the patient for a palliative care consult?  1. Yes  2. No | 1,2  If 1, go to ptnoamb as applicable   |  | | --- | | Warning if 1 and comfort = 99 | | **In order to answer “1”, there must be documentation of a palliative care referral.**  **Exception: If there is documentation that the patient was seen by palliative care during this hospitalization but prior to the ICU admission, notation indicating the palliative care team was notified of ICU transfer or need to re-evaluate the patient is acceptable.** |
| 24 | ptpref | During the ICU stay, did the physician/APN/PA, registered nurse, or social worker discuss preferences for care with the patient?  1. Yes  2. No  95. Not applicable | 1,2,95  Will be auto-filled as 95 if noanswer = 1  If 1 or 2, go to ptnoamb as applicable | Preferences for care may include ANY of the following: CPR, artificial fluid or nutrition, symptom management, such as but not limited to, antibiotics for pneumonia, desire for palliative care, review of previous advance directive or life sustaining treatment plan  If an Advanced Directive was dated and signed during this ICU stay, answer “1.”  Suggested data sources: nursing notes, progress notes, social work notes |
| 25 | idsurro | During the ICU stay, did the physician/APN/PA, registered nurse, or social worker identify a surrogate?  1. Yes  2. No | 1,2  If 1, auto-fill tryidsur as 95, and go to surpref  If 2, auto-fill surpref as 95 | The surrogate is the individual(s) authorized to make health care decisions on behalf of a patient who lacks decision-making capacity.  A surrogate may be a family member.  Suggested data sources: nursing notes, progress notes, social work notes |
| 26 | tryidsur | During the ICU stay, did the physician/APN/PA, registered nurse, or social worker document at least two attempts to identify a surrogate?  1. Yes  2. No | 1,2,95  Will be auto-filled as 95 if idsurro = 1  If 1 or 2, go to ptnoamb as applicable | The surrogate is the individual(s) authorized to make health care decisions on behalf of a patient who lacks decision-making capacity.  A surrogate may be a family member.  Suggested data sources: nursing notes, progress notes, social work notes |

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| 27 | surpref | During the ICU stay, did the physician/APN/PA, registered nurse, or social worker discuss preferences for care with the caregiver/surrogate?  1. Yes  2. No  95. Not applicable | 1,2,95  Will be auto-filled as 95 if idsurro = 2  If 1 or 2, go to ptnoamb as applicable | Preferences for care may include ANY of the following: CPR, artificial fluid or nutrition, symptom management, such as but not limited to, antibiotics for pneumonia, desire for palliative care, review of previous advance directive or life sustaining treatment plan  If an Advanced Directive was dated and signed during this hospitalization, answer “1.” |
| **If icuadmdt – admdate > 3 days; go to ptnoamb; else if icuadmdt – admdate < =3 days, go to anesendt as applicable** | | | | |
|  |  | **Ambulation** |  |  |
| 28 | ptnoamb | Does the record document that the patient was bedridden prior to admission?  1. Yes  2. No | 1,2  If 1, go to anesendt as applicable | If the record indicates that the patient was restricted to bed due to a decline in condition over the past few weeks, but was not bedridden prior to the onset of the condition, answer “2.”  Suggested data sources: ED notes, nursing admission notes, nursing assessment, therapy assessments, H&P |
| 29 | ptcoma | Upon admission or during the first 48 hours after admission, does the record document at least one of the following?   * Patient comatose * Patient unable to cooperate   1. Yes  2. No | 1,2  If 1, go to anesendt as applicable | The reason the patient is unable to cooperate is not relevant. If the record documents the patient is comatose or unable to cooperate, answer “1.”  Suggested data sources: ED notes, nursing admission notes, nursing assessment, therapy assessments, H&P |
| 30 | preamb | Did the record document that the patient was ambulatory without use of assistive/supportive devices prior to admission?  1. Yes  2. No | 1,2  If 2, go to anesendt as applicable | In order to answer “1”, there must be documentation that the patient is able to ambulate or walk without use of supportive devices.  Assistive/supportive devices include, but are not limited to: canes, walkers, scooters, wheelchairs. If the record documents anything other than independent ambulation (e.g., bedridden at home) or documentation is contradictory, answer “2.” If the record documents use of any assistive/supportive device, answer “2.”  Suggested data sources: Nursing admission notes, nursing assessment, therapy assessments, H&P, provider orders (for therapy) |
| **If fl\_surgery = 1, go to anesendt; else go to postamb** | | | | |

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| 31 | anesendt | Enter the anesthesia end date. | mm/dd/yyyy  Abstractor can enter 99/99/9999   |  | | --- | | >= admdate and <= dcdate | | **The Anesthesia End Date occurs when the operative anesthesia provider signs-off the care of the patient to the person assuming the postoperative anesthesia care in the post-anesthesia care area, intensive care unit, or other non-PACU recovery area.**  **NOTE: The anesthesia record is the priority data source for this element.**   * If a valid Anesthesia End Date is found on the anesthesia record, enter that date. * If a valid Anesthesia End Date is not documented on the anesthesia record, use other suggested data sources (e.g., intraoperative record, circulator record, post-anesthesia evaluation record, operating room notes) to determine the Anesthesia End Date. * If an anesthesia end date is not documented, use surrounding documentation to determine the date anesthesia ended. Example: The anesthesia start date is 10/01/2010, anesthesia start time is 23:20 and anesthesia end time is 00:45. Abstract anesthesia end date as 10/02/2010 because the date would change if the anesthesia ended after midnight. * If the Anesthesia End Date cannot be determined in ANY source, abstractor can enter 99/99/9999. * If the Anesthesia End Date documented in the record is obviously in error (e.g. 02/42/2010) and no other documentation is found that provides this information, enter 99/99/9999. |
| 32 | postamb | Was the patient ambulated by the end of POD 2?  1. Yes  2. No | 1,2  If 1, go to hospamb as applicable | **The Anesthesia End Date is postoperative day zero (POD 0).**  **Postoperative day 2 (POD 2) ends at midnight of the second postoperative day.**  Any documented attempt at ambulation (e.g., ambulation “ad lib”, ambulate with or without assistive device or assistance) is acceptable.  Suggested data sources: nursing notes, nursing care plan, physician orders, progress notes, physical/occupation therapy notes |
| 33 | ynoamb | Did the physician/APN/PA or nurse document a contraindication to ambulation by the end of POD 2?  1. Yes  2. No | 1,2 | Reasons may include, but are not limited to:   * Mobility is contraindicated due to patient’s medical condition (e.g. joint fracture, open incision). * Patient refuses to ambulate   Suggested data sources: nursing notes, nursing care plan, physician orders, progress notes, physical/occupation therapy notes |
| **If anesendt – admdate <= 3 days, go to admadl** | | | | |
| 34 | hospamb | By the end of hospital day 2, was a plan for mobility documented?  1. Yes  2. No | 1,2 | **Day of admission is hospital day 0. Hospital day 2 ends at midnight of the second hospital day.**  A mobility plan may include, but is not limited to:   * Any attempt at ambulation (ad lib, with/without assistive device or assistance) * Stationary activities (range of motion, recumbent bicycling, arm cycle) * Performing activities of daily living (grooming, toileting, feeding self) * Out of bed to chair   Exclude documentation of restricted mobility only (e.g. restraints, non-weight bearing, bedrest)  Suggested data sources: nursing notes, nursing care plan, physician orders, progress notes, physical/occupation therapy notes |
| 35 | admadl | Upon admission or during the 48 hours after admission, was an assessment of the patient’s activities of daily living (ADLs) performed using a standardized and published tool?  1. Yes  2. No | 1,2  If 2, auto-fill adltool2 as 95 and go to admiadl | Activities of daily living include bathing, dressing, toileting, transferring, continence, and feeding.  **ADL assessment tool - an assessment tool that has been standardized and published. The tool must be named and the result of the assessment must be documented in accordance with the specific tool used (e.g., positive or negative, numeric value, or other designation).**  **Example of standardized and published ADL assessment tool: Katz Index of Independence in Activities of Daily Living**  **If the patient was admitted for surgery, an assessment of the patient’s ADLs using a standardized and published tool documented in a pre-admission assessment note during the 30 days prior to admission is acceptable.**  Suggested data sources: H&P, initial hospital assessment, intake assessment, other clinical staff notes |

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| 36 | adltool2 | What standardized and published tool was used to assess ADLs?  1. Katz Index of Independence in Activities of Daily Living Scale  2. Other  95. Not applicable | 1,2,95  Will be auto-filled as 95 if admadl = 2 | **Katz Index of Independence in Activities of Daily Living assesses the patient’s independence or dependence in six areas: bathing, dressing, toileting, transferring, continence, and feeding.**  The total points range from 0 (patient very dependent) to 6 (patient independent).  **If another ADL standardized and published tool is used, the tool must be named and the result of the assessment must be documented in accordance with the specific tool used (e.g., positive or negative, numeric value, or other designation).** |
| 37 | admiadl | Upon admission or during the 48 hours after admission, was an assessment of the patient’s instrumental activities of daily living (IADLs) performed using a standardized and published tool?  1. Yes  2. No | 1,2  If 2 and dcdispo = 6 or 7, go to end; else if 2, auto-fill iadltool2 as 95and go to dcadl as applicable | Instrumental activities of daily living includes ability to use telephone, shopping, food preparation, housekeeping, laundry, mode of transportation, responsibility for own medications, and ability to handle finances.  **IADL assessment tool - an assessment tool that has been standardized and published. The tool must be named and the result of the assessment must be documented in accordance with the specific tool used (e.g., positive or negative, numeric value, or other designation).**  **Example of standardized and published IADL assessment tool: Instrumental Activities of Daily Living Scale (IADL) M.P. Lawton and E.M. Brody**  **If the patient was admitted for surgery, an assessment of the patient’s IADLs using a standardized tool documented in a pre-admission assessment note during the 30 days prior to admission is acceptable.**  Suggested data sources: H&P, initial hospital assessment, intake assessment, other clinical staff notes |
| 38 | iadltool2 | What standardized and published tool was used to assess IADLs?  1. Lawton Instrumental Activities of Daily Living Scale  2. Other  95. Not applicable | 1,2,95  Will be auto-filled as 95 if admiadl = 2 | **Lawton Instrumental Activities of Daily Living Scale assesses eight domains of independent living skills: ability to use telephone, shopping, food preparation, housekeeping, laundry, mode of transportation, responsibility for own medications, and ability to handle finances.**  Lawton summary score ranges from 0 (low function, dependent) to 8 (high function, independent).  **If another IADL standardized and published tool is used, the tool must be named and the result of the assessment must be documented in accordance with the specific tool used (e.g., positive or negative, numeric value, or other designation).** |
| **If dcdispo = 6 or 7, go to end. If dcdispo <> 6 or 7 and (admadl = 1 and admiadl = 1), go to dcadl; else if dcdispo <> 6 or 7, go to idcneed as applicable.** | | | | |
| 39 | dcadl | On the day of or day prior to discharge, was an assessment of the patient’s activities of daily living (ADLs) performed using the same standardized and published tool that was used to assess ADLs upon admission?   1. Yes 2. No | 1,2 | In order to answer “1,” the documentation must clearly indicate that ADLs were assessed on the day of or day prior to discharge using the same standardized and published tool that was used to assess ADLs upon admission.  **ADL assessment tool - an assessment tool that has been standardized and published. The tool must be named and the result of the assessment must be documented in accordance with the specific tool used (e.g, positive or negative, numeric value, or other designation).**  **Example of standardized and published ADL assessment tool: Katz Index of Independence in Activities of Daily Living**  Suggested data sources: Discharge summary, discharge nursing note, progress notes, clinical staff notes |

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| 40 | dciadl | On the day of or day prior to discharge, was an assessment of the patient’s instrumental activities of daily living (IADLs) performed using the same standardized and published tool that was used to assess IADLs upon admission?   1. Yes 2. No | 1,2 | In order to answer “1,” the documentation must clearly indicate that IADLs were assessed on the day of or day prior to discharge using the same standardized and published tool that was used to assess IADLs upon admission.  **IADL assessment tool - an assessment tool that has been standardized and published. The tool must be named and the result of the assessment must be documented in accordance with the specific tool used (e.g, positive or negative, numeric value, or other designation).**  **Example of standardized and published IADL assessment tool: IADL standardized and published tool: Instrumental Activities of Daily Living Scale (IADL) M.P. Lawton and E.M. Brody**  Suggested data sources: Discharge summary, discharge nursing note, progress notes, clinical staff notes |
| **If dcdispo = 1 or 2, go to idcneed; else go to end.** | | | | |
| 41 | idcneed | Prior to discharge, were any post discharge needs identified for the patient?  1. Yes  2. No | 1,2  If 2, auto-fill pteduc as 95 | **Post discharge needs may include, but are not limited to: ability to live alone versus need for support from others, ability to take medications, care for wounds/catheters or other medical needs.**  Suggested data sources: Discharge planning notes, discharge summary, discharge nursing note, progress notes, clinical staff notes |
| 42 | needhh | Prior to discharge, was the patient evaluated for home health care services?  1. Yes  2. No | 1,2 | Answer “1” if the patient was evaluated for home health care services regardless of whether home health care services were deemed necessary.  Suggested data sources: Discharge summary, progress notes, clinical staff notes, social work notes |

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|  |  | **Discharge Instructions** |  |  |
|  | dcinstr | Does the medical record contain a copy of written discharge instructions or documentation of educational material given to the patient or caregiver at discharge, addressing all of the following:   * Date of discharge * Diagnoses * Discharge medications * Diet * Activity * Condition * Patient education * Follow-up with physician/APN/PA   **Note:** instructions do not have to be individually tailored to each patient. | **Note: each element of discharge instruction is counted individually, but all eight instruction categories must be addressed to meet the measure** | Written instructions given anytime during the hospital stay are acceptable. Hospitals may use pre-printed discharge instruction sheets, brochures, booklets, teaching sheets, videos, CDs, and /or DVDs to provide discharge instructions.  **General documentation guidelines for discharge instructions (please see applicable question for specific requirements):**   * Documentation must clearly convey that the patient/caregiver was given a copy of the material to take home. When the material is present in the medical record and there is no documentation which clearly suggests that a copy was given, the inference should be made that it was given **IF** the patient’s name or the medical record   number appears on the material **AND** hospital staff or the patient/caregiver has signed the material.   * **Use only the documentation provided in the medical record itself.** Do not review and use outside materials in abstraction. Do not make assumptions about what content may be covered in material documented as given to the patient/caregiver. * If the patient refused written discharge instruction or other educational material, answer “yes.” * 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.   **Only acceptable source:** Discharge instructions |
| 43 | dcdt | Date of discharge?  1. Yes  2. No | 1,2 | This question refers to documentation of the date of discharge in the discharge instructions given to the patient/caregiver. |
| 44 | dcdx | Diagnoses?  1. Yes  2. No | 1,2 | Answer “1” if at least one medical diagnosis is documented in the discharge instructions. Do not count discharge diagnoses documented in the physician discharge summary. |

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| 45 | dcmeds | All discharge medications?  1. Yes  2. No | 1,2 | Instructions must include the **NAMES, dose, frequency, and route** of all discharge medications. Specific names are not required for laxatives, antacids, vitamins, or herbs. Oxygen is not considered a medication.  **The patient must receive a written list of ALL his/her discharge medications, and the record should contain evidence the patient was educated regarding these medications.**  **While the suggested data sources may be used to determine all medication being prescribed at discharge, the discharge instructions must contain all discharge medications in order to answer “1.”**  **1) Determine all medications being prescribed at discharge from the medical record documentation.**  **2) Review the written discharge medication instructions to verify that all discharge medications are on the list.**  If there is conflicting documentation among different medical record sources, the following guidelines apply:   * In cases where there is a medication in one source that is not mentioned in another source, it should be interpreted as a discharge medication unless documentation suggests that it was NOT prescribed at discharge. **Consider the medication a discharge medication in the absence of contradictory documentation (see below)**. * If documentation is **contradictory** (e.g., physician noted “dc lisinopril” in discharge orders, but lisinopril is listed in discharge summary), or careful examination of the circumstances raises enough questions about whether a medication was prescribed at discharge, the case should be deemed unable to determine and answered as “2.” * If there is documentation of a plan to start/restart a medication after discharge or a hold on a medication for a defined timeframe (e.g. “Start Plavix as outpatient”, “Hold furosemide for 2 days”) and the medication is NOT listed as a discharge medication elsewhere, the medication on hold is not required to be in the discharge instructions.   + If the medication IS listed as a discharge medication elsewhere, the medication is required to be in the discharge instructions.   **Discharge meds cont’d**  **Suggested data sources:** Discharge instruction sheet, discharge notes, discharge summary, medication reconciliation note |
| 46 | dcdiet | Diet after discharge?  1. Yes  2. No | 1,2 | Any diet instructions are acceptable. The diet/fluid intake instructions do not need to be specific to diagnoses.  If a pre-printed discharge instruction sheet is present in the record, but the section addressing instruction for diet is left blank, do not consider the specific instruction to have been given. |
| 47 | dcact | Activity level after discharge?  1. Yes  2. No | 1,2 | Consider the following as acceptable if clearly documented: Activity as tolerated, cardiac rehab, exercise instructions, no strenuous activity, physical therapy, regular activity, regular walking, rest, restrict activity  If a pre-printed discharge instruction sheet is present in the record, but the section addressing instruction for activity level is left blank, do not consider the specific instruction to have been given. |
| 48 | dcond | Condition on discharge?  1. Yes  2. No | 1,2 | Documentation of condition on discharge may include, but is not limited to: stable, alert, ambulatory, wound status (if applicable). |
| 49 | pteduc | Patient education on post-discharge needs?  1. Yes  2. No  95. Not applicable | 1,2,95  Will be auto-filled as 95 if idcneed = 2 | **Post discharge needs may include, but are not limited to: ability to live alone versus need for support from others, ability to take medications, care for wounds/catheters or other medical needs,** Documentation of patient education on any identified need is acceptable (e.g. wound care). |
| 50 | dcfolo | Follow-up with physician/APN/PA after discharge?  1. Yes  2. No | 1,2 | Written discharge instructions for follow-up must indicate that the follow-up is to be with one of the designated health care providers or in an office or clinic setting. Follow-up in a disease or case management program is acceptable. Written instructions given to the patient/caregiver to call for an appointment is also acceptable.  **Exclude:** Follow-up for ancillary service only, (e.g. lab, radiology, etc.), follow-up prn or as needed, follow-up noted as non-applicable, none, or left blank.  If a pre-printed discharge instruction sheet is present in the record, but the section addressing instruction for follow-up is left blank, do not consider the specific instruction to have been given. |