

Section Q: MORTALITY

Section Intent: Capture the survival status of a patient on a longitudinal basis. This section allows sites with a follow-up program to document known death and death date of patients over time.

Sequence #	Data Field	Data Field Intent	Field Name Clarification	Source Document
3020	Mort-Mortality	Indicate whether the patient has been declared dead within this hospital or any time after discharge from this hospitalization. This includes all causes of death, including those causes clearly unrelated to the operation.	Allows for those sites with longitudinal follow-up programs to record a patient's death that has occurred beyond the procedure admission. The mortality field is to be coded "Yes" when the patient is identified as a death. This could be while the patient is in the hospital for the current procedure, within 30 days of the procedure or "long term" meaning whenever the patient dies in the future. This could be six months, five years, or anytime in the future.	Discharge summary Longitudinal follow-up process (example on page 8) Physician progress notes Query hospital based readmission program
3030	Mort-DC Status	Indicate whether the patient was alive or dead at discharge from the hospitalization in which surgery occurred.	Indicate if the patient was "alive" or "dead" at the time of discharge.	Death certificate Discharge summary Physician progress note

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3040	Mort-30d Status	Capture whether the patient was alive or dead at 30 days post surgery (whether in the hospital or not).	<p>Seq# 3040 may be “Alive” but Seq# 3030 may be “Dead” if the death was > 30 days from the date of surgery.</p> <p>Seq# 3030 may be “Dead” if the date of death occurred < 30 days from the date of surgery and then Seq# 3040 would be “Dead”.</p> <p>Seq# 3040 may be “Alive” and Seq# 3030 may be “Dead” if the date of death occurred > 30 days, but during initial hospitalization.</p> <p><i>Example: A patient had valve repair on 6/28 and was discharged home on 7/5 and then the patient was readmitted on 7/13 with sepsis and required redo valve surgery on 7/20 and ultimately died on 7/25: The readmission would be recorded on the first 2.61 data collection form and a second data collection form would need to be generated for the second procedure. In order to accurately capture this patient’s outcomes, the death needs to be recorded on both data collection forms.</i></p>	<p>Clinic follow-up visit note Discharge summary Longitudinal follow-up process (example on page 8) Outpatient record Query hospital based readmission program</p>

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3050	Mort-Op Death	<p>Capture whether the patient had a operative mortality: Include both:</p> <ul style="list-style-type: none"> (1) All deaths occurring during the hospitalization in which the operation was performed, even if after 30 days. (2) Those deaths occurring after discharge from the hospital, but within 30 days of the procedure unless the cause of death is clearly unrelated to the operation. 	<p>If a death occurs outside of the hospital but within 30 days, it is considered surgically related unless it is clearly unrelated to the operative procedure. Example of a non Operative Mortality is if the death was the result of an accident/trauma or cancer.</p> <p><i>Example # 1: After several days postoperatively, a patient is transferred to a Rehab Hospital and eventually dies in the Rehab Hospital (having never gone home after the surgery:</i></p> <p><i>The STS definition for operative mortality includes all deaths occurring during the hospitalization in which the operation was performed even if after 30 days. In the above case the death should be coded as “Yes” for operative mortality if it occurred within the 30 day time frame. If the patient was discharged to Rehab and expired greater than 30 days this would be coded “No”.</i></p> <p><i>Example # 2: A patient was admitted for a hip replacement and it was discovered that he had a MI. The patient had a CABG two days later. Fourteen days after the CABG the patient had the hip replacement. Twenty eight days later the patient expired. The patient never left the hospital. Code “Yes” to capture all deaths occurring during the hospitalization in which the operation was performed.</i></p>	<p>Clinic follow-up visit note Death certificate Discharge summary Longitudinal follow-up process (example on page 8) Outpatient record</p>

Sequence #	Data Field	Data Field Intent	Field Name Clarification	Source Document
3050 (continued)	Mort-Op Death		<p><i>Example # 3: A patient was transferred after surgery from an acute care hospital (Hosp A) to another acute care hospital (Hosp B) (for higher level of renal care) and ultimately died over 30 days beyond the procedure. The patient never left Hospital B: This would not be considered an operative mortality because it is considered a discharge from Hospital "A". Therefore, if the patient was discharged from the hospital in which the operation was performed and died outside of the 30 day window code "No". If the patient died within 30 days code "Yes".</i></p> <p><i>Example # 4: A patient is discharged from an acute care hospital after cardiac surgery to a skilled nursing care unit of the hospital and then readmitted to the hospital and dies within 30 days of the procedure: This would be considered "Yes" for operative mortality because the patient died within 30 days of surgery.</i></p> <p><i>Example # 5: A patient is readmitted to acute care hospital from a skilled nursing unit and dies 30 days beyond the procedure: This would not be considered an operative mortality because the patient was discharged from the hospital in which the operation was performed and the death occurred outside the 30 day window.</i></p>	

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3050 (continued)	Mort-Op Death		<p>DNR scenarios:</p> <p><i>Example # 6: Two patients had renal consults pre-op due to elevated creatinine and both developed post-op renal failure requiring dialysis. In both cases the patients were moving along in their progress but decided they did not want to continue dialysis and initiated DNR requests. Both patients never left the hospital and both expired within 30 days of the surgical procedure.</i></p> <p><i>Example # 7: Pt is readmitted on postoperative day seven with a diagnosis that plausibly could be related to the CABG procedure, but is certainly a treatable condition (e.g.-cholecystitis, UTI, pneumonia, etc.). The family, however, says, "Dad has had a good life...we refuse to let you treat him." DNR status is initiated and the patient expires one week later.</i></p> <p><i>For both of these scenarios operative mortality should be coded as "Yes". Irregardless of the DNR status, the patients expired within 30 days of the procedure and the cause of death is not clearly unrelated to the surgery.</i></p>	
3060	Mort-Date	Capture the date the patient was declared dead.	<p>Record the date of death regardless of its time interval from the surgical procedure.</p> <p>If date of death is known, Seq # 3020 must be "Yes", and Seq #'s 3030, 3040 and 3050 must be completed as appropriate.</p>	<p>Death certificate Discharge summary Longitudinal follow-up process (example on page 8) Outpatient record Physician progress notes Query hospital based readmission program</p>

Sequence #	Data Field	Data Field Intent	Field Name Clarification	Source Document
3070	Mort-Location	<p>Capture the patient's location at the time of death:</p> <p>Operating Room (OR during the initial surgery)</p> <p>Hospital (Other than Operating Room)</p> <p>Home</p> <p>Other Care Facility</p> <p>OR During Reoperation</p> <p>Unknown</p>	<p>Capture if the patient died in the operating room at the time of the primary surgical procedure.</p> <p>Capture if the patient died within the hospital but outside the operating room during either the primary procedure or readmission.</p> <p>Capture if the patient died in a private home setting.</p> <p>Capture if the patient died while in a Nursing Home, Extended Care Facility/TCU/Skilled Nursing Unit or Facility, Hospice Unit, or Rehabilitation Center.</p> <p>Capture if the patient required a return to the OR suite for any reason during the initial hospitalization and died while in the OR suite.</p> <p>Capture if unable to determine the location where the patient died.</p>	<p>Death certificate</p> <p>Discharge summary</p> <p>Longitudinal follow-up process (example on page 8)</p> <p>Outpatient record</p> <p>Physician progress notes</p> <p>Query hospital based readmission program</p>

Sequence #	Data Field	Data Field Intent	Field Name Clarification	Source Document
3080	Mort-Prim Cause	<p>Indicate the PRIMARY cause of death, i.e. the first significant abnormal event which ultimately led to death. Choose one of the following:</p> <p>Cardiac = Myocardial infarction, arrhythmia disorder, cardiomyopathy, heart failure</p> <p>Neurologic = Stroke, cerebral bleed, embolism or other neurological event</p> <p>Renal = Renal Failure and/or dialysis</p> <p>Vascular = Peripheral (arterial circulation) disorder such as embolic event or circulatory dysfunction</p> <p>Infection = Any systemic or organ infection (i.e. sepsis, sternal or wound, subacute bacterial endocarditis, cellulites)</p> <p>Pulmonary = Respiratory insufficiency or failure; pneumonia, ARDS, ventilator dependence, pulmonary edema</p>	<p>If there is a cause of death then Seq#'s 3020, 3030, 3040, 3050, 3060 and 3070 should be completed as appropriate.</p> <p>If the patient died due to multiple organ system failure, select the system that either was the initiator of the Multisystem Organ Failure (MSOF) or the primary cause of the patient's demise (patient scenario may be: patient had a massive stroke 24 hours after surgery and never woke up, developed new renal failure with dialysis, pneumonia and ventilator dependence (unable to be extubated) and gangrenous bowel secondary to multiple emboli with sepsis. Cause of death would be neurologic).</p> <p><i>Example: A patient develops a large pneumothorax post op which then causes the patient to develop asystole and death occurs: The primary cause of death would be the FIRST significant event which ultimately leads to the patient's death. Code "Pulmonary" because the first event is the pneumothorax.</i></p>	<p>Clinic follow-up visit note Death certificate Discharge summary Longitudinal follow-up process (example on page 8) Outpatient record Physician progress notes</p>

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3080 (continued)	Mort-Prim Cause	<p>Valvular = Either native and or prosthetic valve dysfunction or failure due to mechanical or structural failure.</p> <p>Unknown = Unable to determine the cause of death.</p> <p>Other = Cause other than those listed above; accidental, trauma, cancer or other surgical interventions that led to the patients death.</p>		

Example for capturing Longitudinal Follow-up Documentation for Mortality at 30 Days

Last Name	First Name	Social Security Number	Medical Record Number	Date of Birth	Cardiac Rehabilitation Referral 30 days Post Operation (PO)	SS Death Index 30 days or > Post Operation	ER or Outpatient Procedures
DOE	JOHN	555-00-0000	434400	01/01/2007	No	Death 3/21/2007	
NURSE	RITA	000-12-1234	535456	01/03/2007	Yes	Alive	ER Admit 4/02/2007