VHA EXTERNAL PEER REVIEW PROGRAM
HOSPITAL BASED INPATIENT PSYCHIATRIC SERVICES INSTRUMENT
Third Quarter FY2014

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
		Organizational Identifiers		
	VAMC	Facility ID	Auto-fill	
	CONTROL	Control Number	Auto-fill	
	QIC	Abstractor ID	Auto-fill	
	BEGDTE	Abstraction Begin Date	Auto-fill	
	REVDTE	Abstraction End Date	Auto-fill	
		Patient Identifiers		
	SSN	Patient SSN	Auto-fill: no change	
	PTNAMEF	First Name	Auto-fill: no change	
	PTNAMEL	Last Name	Auto-fill: no change	
	BIRTHDT	Birth Date	Auto-fill: no change	
	SEX	Sex	Auto-fill: can change	
	MARISTAT	Marital Status	Auto-fill: no change	
	RACE	Race	Auto-fill: no change	
		Administrative Data		

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1	admdt	Date of admission to inpatient care:	mm/dd/yyyy **Auto-filled: can be modifie** <= dcdate	**Auto-filled; can be modified if abstractor determines that the date is incorrect.** • Admission date is the date the patient was actually admitted to acute inpatient 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 (priority data source), face sheet **Exclusion:** admit to observation, arrival date
2	admtm	Time of admission to inpatient care:	____ UMT **Auto-filled: can be modified**	**Auto-filled; can be modified** Abstractor to verify admission time is correct. If correction is necessary, enter time in Universal Military Time. **Admission time = time when the patient was formally admitted to inpatient status.** **Exclusion: Admit to observation time, Arrival time**
3	psyadmdt	Date of admission to inpatient psychiatric care:	mm/dd/yyyy **Auto-filled: can be modified**	**Auto-filled; can be modified if abstractor determines that the date is incorrect.** **In hospitals with an inpatient psychiatric unit, the Psychiatric Admission Date may be different from the original hospital admission date.** **If the patient was in an acute-care hospital and had multiple admissions to the psychiatric unit during their hospitalization, enter the date of the first admission to the psychiatric unit.** Exclusion: admission to observation, arrival date

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4	psydcdt	Enter the date of discharge from inpatient psychiatric care.	mm/dd/yyyy Auto-filled; can be modified > = psyadmdt Warning if < admdt	**Auto-filled; can be modified if the abstractor determines that the date is incorrect.** **Enter the exact date the patient was discharged from inpatient psychiatric care. If the patient left against medical advice or expired, enter the date of occurrence.**
5	psydctm	Enter the time of discharge from inpatient psychiatric care.	___ UMT	Enter the time in Universal Military Time.
6	dcdate	Discharge date from hospital:	mm/dd/yyyy **Auto-filled. Cannot be modified** > = admdt	**Auto-filled; cannot be modified.** The computer auto-fills the discharge date from the OABI pull list. This date cannot be modified in order to ensure the selected episode of care is reviewed.
7	dctime	Time of discharge from hospital:	___ UMT > = admdt/admtm	**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:** a 24-hour period from midnight to midnight using a 4-digit number of which the first two digits indicate the hour and the last two digits indicate the minute.

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8	princode	Enter the ICD-9-CM principal diagnosis code:	__ __ __ . __ __ (3 digits/decimal point/two digits) **Auto-filled; can be modified** **Cannot enter 000.00, 123.45, or 999.99**	**Will auto-fill from PTF with ability to change. Do NOT change the principal diagnosis code unless the principal diagnosis code documented in the record is not the code displayed in the software.**
9	othrcode1 othrcode10 othrcode11 othrcode12 othrcode13 othrcode14 othrcode15 othrcode16 othrcode17 othrcode2 othrcode3 othrcode4 othrcode5 othrcode6 othrcode7 othrcode8 othrcode9	Enter the ICD-9-CM other diagnosis codes:	__ __ __ . __ __ (3 digits/decimal point/two digits) **Auto-filled; can be modified** **Can enter 17 codes** **If princode or othrcode is not a code from Table 10.01, the case is excluded.** Abstractor can enter xxx.xx **Cannot enter 000.00, 123.45, or 999.99**	**Can enter 17 ICD-9-CM other diagnosis codes. Will auto-fill from PTF with ability to change. If the "other diagnoses" codes are incorrect, enter the codes as documented in the medical record.** If entered manually, use the codes listed in discharge diagnosis (DD) under the reports tab. **Principal or other ICD-9-CM diagnosis code must be one of the codes listed in Joint Commission, Appendix A, Table 10.01.** Enter xxx.xx in code field if no other diagnosis codes exist for this record. **Exclusion statement: Mental disorder was not coded as the principal diagnosis or other diagnosis as required for inclusion in the Hospital Based Inpatient Psychiatric Services National Hospital Quality Measures.**
10	dcdispo	What was the patient's discharge disposition on the day of discharge? 1. Home • Assisted Living Facilities (ALFs) - includes assisted	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.** • **Only use documentation written on the day prior to discharge or the day of discharge when abstracting this data element.** For example:

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		living care at nursing home/facility • Court/Law Enforcement - includes detention facilities, jails, and prison • Home - includes board and care, domiciliary, foster or residential care, group or personal care homes, retirement communities, 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 (or other home setting as listed in #1 above) 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		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 to skilled care. Enter "5". • **Discharge disposition documentation in the discharge summary, post-discharge addendum, or a late entry, may be considered if written within 30 days after discharge date and prior to pull list date.** • **If there is documentation that further clarifies the level of care that documentation should be used to determine the correct value to abstract. If documentation is contradictory, use the latest documentation.** For example: Discharge planner note from day before discharge states "XYZ Nursing Home". Nursing discharge note on day of discharge states "Discharged: Home." Select "1". • If documentation is contradictory, and you are unable to determine the latest documentation, select the disposition ranked highest (top to bottom) in the following list. ◦ Acute Care Facility ◦ Hospice - Health Care Facility ◦ Hospice - Home ◦ Other Health Care Facility ◦ Home • Values "2" and "3" hospice includes discharges with hospice referrals and evaluations. • 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". • If the medical record identifies the facility the patient is being discharged to

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		• 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) • Veteran's Home 6. Expired 7. Left Against Medical Advice/AMA 99. Not documented or unable to determine		by name only (e.g., Park Meadows) and does not reflect the type of facility of level of care, select "5". • If the medical record states only that the patient is being discharged and does not address the place or setting to which the patient was discharged, select "1". • Selection of option "7" (left AMA): ◦ Explicit "left against medical advice" documentation is not required (e.g., "Patient is refusing to stay for continued care"- select "7"). **For the purposes of this data element, a signed AMA form is not required.** ◦ If any source states the patient left against medical advice, select value "7", regardless of whether the AMA documentation was written last. ◦ Documentation suggesting that the patient left before discharge instructions could be given without "left AMA" documentation does not count. **Excluded Data Sources:** Any documentation prior to the last two days of hospitalization, coding documents **Suggested Data Sources:** Discharge instruction sheet, discharge planning notes, discharge summary, nursing discharge notes, physician orders, progress notes, social service notes, transfer record

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11	psycare	Did the patient receive care in an inpatient psychiatric care setting? 1. Yes 2. No	1, *2 **If 1 and LOS >3 days, go to strength; else if 1, go to refrnext as applicable** ***If 2, the case is excluded from JC Hospital Based Inpatient Psychiatric Services quality measures. Go to end.**	**In order to answer "1", there must be documentation in the medical record that the patient was receiving care primarily for a psychiatric diagnosis in an inpatient psychiatric setting, i.e. a psychiatric unit of an acute care hospital or a free-standing psychiatric hospital.** Psychiatric Units that treat dual diagnosis patients (patients with **both** substance use disorders and psychiatric diagnoses) are included in the HBIPS measures. **Exclude: Patient with a psychiatric diagnosis who received care in an inpatient unit OTHER than a psychiatric unit within an acute-care hospital or free standing psychiatric hospital** Example: Chemical Dependency Units that treat patients primarily for substance use disorders and occasionally psychiatric diagnoses are excluded from the HBIPS measures. Suggested data sources: Discharge summary, ED record, physician orders **Exclusion Statement:** **Lack of medical record documentation that the patient was receiving psychiatric care in an inpatient psychiatric setting excludes the case from the Joint Commission HBIPS quality measures.**
12	strength	Is there documentation in the medical record that the patient was screened for at least **two** patient strengths within the first three days of admission? **Psychiatrist, Psychologist, APN, PA, Master of Social Work (MSW), or Registered Nurse documentation only** 1. Yes 2. No X. Unable to complete admission screening (Documentation in the medical record that screening for patient strengths cannot be completed due to the patient's inability or unwillingness to answer screening questions within the first 3 days of admission.)	1, 2, X	• **The admission screening timeframe must have occurred within the first three days of admission for psychiatric care. The day after admission is defined as the first day.** • **If the patient was in an acute-care hospital and had multiple admissions to the psychiatric unit during their hospitalization, select the first admission to the psychiatric unit for abstraction.** • **Documentation may be accepted from an admission screening completed by a psychiatrist, psychologist, APN, PA, MSW, and/or RN within the first 3 days of admission. The admission screening may be completed by one or more of the listed qualified psychiatric practitioners.** • **An admission screen performed in an ambulatory setting, i.e. emergency department, crisis center which results in an admission to an inpatient psychiatric care setting, can be used if the screen is documented in the medical record.**

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				Examples of adult and older adult patient strengths may include, but are not limited to: • Assessment of patient optimism that change can occur • Motivation and readiness for change • Setting and pursuing goals • Attempting to realize one's potential • Managing surrounding demands and opportunities • Exercising self-direction • Vocational interests, i.e. hobbies • Interpersonal relationships and supports • Cultural/spiritual/religious and community involvement • Access to housing/residential stability • Steady employment • Financial stability • Awareness of substance use issues • Knowledge of medications **Suggested data sources:** Biopsychological assessment, ED record, functional skills assessment, history and physical, interdisciplinary plan of care, initial assessment form, nursing notes, physician progress notes, psychiatrist admission form, referral packet, social work assessment
13	traumahx	Is there documentation in the medical record that the patient was screened for a psychological trauma history within the first 3 days of admission? **Psychiatrist, Psychologist, APN, PA, Master of Social Work (MSW), or Registered Nurse documentation only** 1. Yes 2. No X. Unable to complete admission screening (Documentation in the medical record that a screening for a psychological trauma history cannot be completed due to the patient's inability or unwillingness to answer screening questions within the first 3 days of admission.)	1, 2, X	• **The admission screening timeframe must have occurred within the first three days of admission for psychiatric care. The day after admission is defined as the first day.** • **If the patient was in an acute-care hospital and had multiple admissions to the psychiatric unit during their hospitalization, select the first admission to the psychiatric unit for abstraction.** • **Documentation may be accepted from an admission screening completed by a psychiatrist, psychologist, APN, PA, MSW, and/or RN within the first 3 days of admission. The admission screening may be completed by one or more of the listed qualified psychiatric practitioners.** • **An admission screen performed in an ambulatory setting, i.e.**

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				emergency department, crisis center which results in an admission to an inpatient psychiatric care setting, can be used if the screen is documented in the medical record. Traumatic life experiences are defined as those that result in responses to life stressors characterized by significant fear, anxiety, panic, terror, dissociation, feelings of complete powerless or strong emotions that have long term effects on behaviors and coping skills. (American Psychiatric Association, 1994). Examples of psychological trauma may include but are not limited to: • physical abuse • sexual abuse • emotional abuse • victimization, e.g. disasters, criminal activities, identify theft • combat experiences • witnessing others being harmed or victimized • any significant injury or life-threatening disease • significant psycho-social loss, e.g. bankruptcy, traumatic family loss **Suggested data sources:** Biopsychological assessment, ED record, functional skills assessment, history and physical, interdisciplinary plan of care, initial assessment form, nursing notes, physician progress notes, psychiatrist admission form, referral packet, social work assessment

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14	assessud	Within the first 3 days of admission, is there documentation in the medical record that the patient was screened for alcohol and substance use which occurred over the past 12 months? **Psychiatrist, Psychologist, APN, PA, Master of Social Work (MSW), or Registered Nurse documentation only** 1. Yes 2. No X. Unable to complete admission screening (Documentation in the medical record that a screening for alcohol and substance use cannot be completed due to the patient's inability or unwillingness to answer screening questions within the first 3 days of admission.)	1, 2, X	• **The admission screening timeframe must have occurred within the first three days of admission for psychiatric care. The day after admission is defined as the first day.** • **If the patient was in an acute-care hospital and had multiple admissions to the psychiatric unit during their hospitalization, select the first admission to the psychiatric unit for abstraction.** • **Documentation of a past history of substance use must at a minimum state over the past 12 months or over a longer period of time, i.e., life time history. Documentation of "no history" cannot be used, unless the minimum timeframe of 12 months or longer is specified.** • **Documentation may be accepted from an admission screening completed by a psychiatrist, psychologist, APN, PA, MSW, and/or RN within the first 3 days of admission. The admission screening may be completed by one or more of the listed qualified psychiatric practitioners.** • **An admission screen performed in an ambulatory setting, i.e. emergency department, crisis center which results in an admission to an inpatient psychiatric care setting, can be used if the screen is documented in the medical record.** Substance abuse is defined as the use of psychoactive or mood altering substances, i.e. prescription medications, over the counter medications, inhalants, organic substances, illegal substances, and street drugs. **In order to select "1,"** there must be documentation in the medical record by one of the qualified psychiatric practitioners that the initial assessment contained a screening for the use of alcohol and substance abuse which occurred over the past twelve (12) months. **Suggested data sources:** Biopsychological assessment, ED record, functional skills assessment, history and physical, individual plan of service, initial assessment form, nursing notes, physician progress notes, psychiatric assessment/admission form, referral packet, social worker assessment, substance abuse assessment

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15	harmothr	Is there documentation in the medical record that the patient was screened for violence risk to others over the past 6 months within the first 3 days of admission? **Psychiatrist, Psychologist, APN, PA, Master of Social Work (MSW), or Registered Nurse documentation only** 1. Yes 2. No X. Unable to complete admission screening (Documentation in the medical record that a screening for violence risk to others over the past 6 months cannot be completed due to the patient's inability or unwillingness to answer screening questions within the first 3 days of admission.)	1, 2, X	• **The admission screening timeframe must have occurred within the first three days of admission for psychiatric care. The day after admission is defined as the first day.** • **If the patient was in an acute-care hospital and had multiple admissions to the psychiatric unit during their hospitalization, select the first admission to the psychiatric unit for abstraction.** • **Documentation may be accepted from an admission screening completed by a psychiatrist, psychologist, APN, PA, MSW, and/or RN within the first 3 days of admission and must indicate the patient was screened for violence risk to others over the past 6 months. The admission screening may be completed by one or more of the listed qualified psychiatric practitioners.** • **Documentation of a past history of violence risk to others must at a minimum state over the past 6 months or over a longer period of time, i.e., life time history. Documentation of "no history" cannot be used, unless the minimum timeframe of 6 months or longer is specified.** • **An admission screen performed in an ambulatory setting, i.e. emergency department, crisis center which results in an admission to an inpatient psychiatric care setting, can be used if the screen is documented in the medical record.** **Examples of violence risk to others include, but are not limited to:** • Thoughts of harm to others • Intentional infliction of harm on someone else by the patient • Homicidal thoughts by the patient • Thoughts of harming someone else by the patient **Suggested data sources:** Biopsychological assessment, functional skills assessment, history and physical, interdisciplinary plan of care, nursing notes, physician progress notes, psychiatrist admission form, referral packet, substance abuse assessment
16	harmself	Is there documentation in the medical record that the patient	1, 2, X	• **The admission screening timeframe must have occurred within the**

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		was screened for violence risk to self over the past 6 months <u>within the first 3 days of admission?</u> **Psychiatrist, Psychologist, APN, PA, Master of Social Work (MSW), or Registered Nurse documentation only** 1. Yes 2. No X. Unable to complete admission screening (Documentation in the medical record that a screening for violence risk to self over the past 6 months cannot be completed due to the patient's inability or unwillingness to answer screening questions within the first 3 days of admission.)	If strength, traumahx, assessud, harmothr, or harmself = 2 or X, auto-fill assessdt as 99/99/9999, and go to refrnext as applicable	**first three days of admission for psychiatric care. The day after admission is defined as the first day.** • **If the patient was in an acute-care hospital and had multiple admissions to the psychiatric unit during their hospitalization, select the first admission to the psychiatric unit for abstraction.** • **Documentation may be accepted from an admission screening completed by a psychiatrist, psychologist, APN, PA, MSW, and/or RN <u>within the first 3 days of admission</u> and must indicate the patient was screened for violence risk to self over the past 6 months. The admission screening may be completed by one or more of the listed qualified psychiatric practitioners.** • **Documentation of a past history of violence risk to self must at a minimum state over the past 6 months or over a longer period of time, i.e., life time history. Documentation of "no history" cannot be used, unless the minimum timeframe of 6 months or longer is specified.** • **An admission screen performed in an ambulatory setting, i.e. emergency department, crisis center which results in an admission to an inpatient psychiatric care setting, can be used if the screen is documented in the medical record.** **Examples of violence risk to self include, but are not limited to:** • Past suicide attempts by the patient • Intentional cutting, burning, bruising or damaging of self by the patient • Inappropriate substance use • Suicidal thoughts in the past six months by the patient • Specific suicide plan in the past six months by the patient • Past suicide attempts by anyone in the patient's family **Suggested data sources:** Biopsychological assessment, functional skills assessment, history and physical, interdisciplinary plan of care, nursing notes, physician progress notes, psychiatrist admission form, referral packet, substance abuse assessment

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17	assessdt	Enter the date the admission screening was completed. **Initial assessment must include screening for patient strengths, psychological trauma, alcohol/substance use, risk of violence to others, and risk of violence to self.**	mm/dd/yyyy Will be auto-filled as 99/99/9999 if strength, traumahx, assessud, harmothr, or harmself = 2 or X >=psyadmdt and < = 3 days after psyadmdt and <= psydcdt	**All components of admission screening must be completed within the first 3 days of admission.** **If the admission screen containing all components was performed in an ambulatory setting, i.e. emergency department, crisis center that resulted in an admission to an inpatient psychiatric care setting, enter the admission date as the date the admission screening was completed.** Enter the exact date. The use of 01 to indicate missing month and day is not acceptable.
		IF DCDISPO = 6, go to end, else go to refrnext		
18	refrnext	Is there documentation in the medical record that the patient was referred to the next level of care provider upon discharge from a hospital based inpatient psychiatric setting? **Select one option:** 1. The medical record contains documentation that the patient was referred to the next level of care provider upon discharge from the hospital based inpatient psychiatric setting 2. The medical record contains documentation that the patient or guardian refused the next level of provider upon discharge from a hospital based inpatient psychiatric setting **OR** refused to authorize release of information. 3. The medical record contains documentation that the patient: • eloped **OR** • failed to return from leave and was discharged **OR** • was discharged from the hospital **from a setting other than a *Psychiatric Care Setting*** to another level of care outside of the hospital system. 4. The medical record contains documentation that the patient was **NOT** referred to the next level of care provider upon	1, 2, *3, 4, 5 ***If 3, data collection ends, else go to psymedc**	**Read the options carefully. The intent is to determine whether the patient was referred to the next level of care provider upon discharge from the hospital based inpatient psychiatric setting.** • If the patient was not referred to the next level of care provider upon discharge, review the documentation to determine if there is documentation of a reason why the patient was not referred. • When a patient checks himself out of a hospital against the advice of his doctor (AMA) this is not the same as an elopement. The patient should still be offered a referral to a next level of care provider. If the patient refuses the referral, select "2." • When a patient is released from a psychiatric inpatient stay directly after a court hearing, select allowable value 3. • If the patient's final hospital discharge is not from the *Psychiatric Care Setting*, select value 3. **Example:** Patient is initially admitted to psychiatric unit and then transferred to medical/surgical unit. Final hospital discharge is from the medical/surgical unit, select 3. • If the patient checks out AMA and is not offered a referral to next level of care provider, select "5." **The next level of care providers include:**

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		discharge from a hospital based inpatient psychiatric setting for a reason other than options 1 - 3. 5. The medical record does not contain documentation that the patient was referred to the next level of care provider upon discharge from a hospital based inpatient psychiatric setting OR unable to determine from the medical record		• Follow-up prescribing inpatient or outpatient clinician: the clinician who is responsible for managing the patient's medication regime after hospital discharge. • Prescribing inpatient or outpatient entity: the hospital or clinic that is responsible for managing the patient's medication regime after hospital discharge. • Treating inpatient or outpatient clinician: the clinician who is responsible for the primary treatment of the patient in the absence of medications. • Treating inpatient or outpatient entity: the hospital or clinic that is responsible for the primary treatment of the patient in the absence of medications. Examples of inpatient and outpatient clinicians include but are not limited to: primary care physician, psychiatrist, advanced practice nurse (APN), physician assistant (PA), Master of Social Work, and psychologist. **If the patient was in an acute-care hospital and had multiple admissions to the psychiatric unit during the hospitalization, only abstract this information at the time of discharge from the hospital.** **Suggested data sources:** Aftercare discharge plan, continuing care plan, discharge plan, final discharge summary, interim discharge summary, medication reconciliation form, physician discharge orders, physician progress notes, referral form

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19	psymedc	Enter the documented number of scheduled antipsychotic medications prescribed for the patient at discharge.	__ __ Whole numbers 0 to 99 **Abstractor can enter zz** If psymedc > = 2, go to whymor1 If psymedc (< = 1 or zz) AND refrnext = 2, go to end, else go to carplndx	**Refer to Joint Commission Appendix B, Table 10.0, Antipsychotic medications.** **Do not include prn antipsychotic medications.** An antipsychotic medication is defined as any group of drugs, such as the phenothiazines, butyrophenones, or serotonin-dopamine antagonists, which are used to treat psychosis. An antipsychotic medication is also called a neuroleptic. Some examples are Abilify, haldol, mellaril, navane, olanzapine, risperdal, stelazine, and others. If the patient is on two forms of the same medication (i.e., PO and IM) this would be counted as one antipsychotic medication. Only use "Antipsychotic NOS" for new antipsychotics that are not yet listed in Table 10.0 in Appendix B. If unable to determine the number of scheduled antipsychotic medications that were prescribed for the patient at discharge, enter default zz. **If the patient was in an acute-care hospital and had multiple admissions to the psychiatric unit during the hospitalization, only abstract this information at the time of discharge from the hospital.** **Exclude: PRN antipsychotic medications, short acting intramuscular antipsychotic medications such as haldol injectable short acting (refer to JC Appendix B, Table 10.1)** **Only acceptable sources:** Aftercare discharge plan, continuing care plan, discharge plan, final discharge summary, interim discharge summary, physician discharge orders, physician progress notes, referral form

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20	whymor1	Is there documentation in the medical record of appropriate justification for discharging the patient on two or more routine antipsychotic medications? 1. The medical record contains documentation of a history of a minimum of three failed multiple trials of monotherapy 2. The medical record contains documentation of a recommended plan to taper to monotherapy due to previous use of multiple antipsychotic medications or a **OR** documentation of a cross-taper in progress at the time of discharge 3. The medical record contains documentation of augmentation of Clozapine 4. Documentation of another justification other than option 1 - 3 5. The medical record does not contain documentation supporting the reason for being discharged on two or more antipsychotic medications **OR** unable to determine from medical record documentation	1, 2, 3, 4, 5	**If the patient was in an acute-care hospital and had multiple admissions to the psychiatric unit during their hospitalization, only abstract this information at the time of discharge from the hospital.** **1** = Failed multiple trials of antipsychotic monotherapy is defined as a history of three or more failed trials in which there was a lack of sufficient improvement in symptoms or functioning. The documentation should include at a minimum the names of the antipsychotic medications that previously failed. **2** = A cross-taper plan is defined as a plan to decrease the dosage of one or more antipsychotic medication while increasing the dosage of another antipsychotic medication to a level which results in controlling the patient's symptoms with one antipsychotic medication. The cross-taper plan must list the name(s) of the medications intended to increase and the name(s) of the medications to be tapered. **The recommended plan to taper to monotherapy must appear in the continuing care plan transmitted to the next level of care provider.** If an addendum about the recommended plan to taper to monotherapy is added to the continuing care plan in the medical record, it must occur within 5 days after discharge or prior to transmission of the continuing care plan. **3** = Augmentation of Clozapine = adding another antipsychotic medication in addition to the clozapine. Usually done when the patient is still experiencing disabling psychiatric symptoms despite use of clozapine. **4** = Documentation of another justification (reason) for discharging the patient on two or more routine antipsychotic medications **Suggested data sources:** Aftercare discharge plan, continuing care plan, discharge plan, final discharge summary, history and physical, interim discharge summary, medication reconciliation form, physician discharge orders, physician progress notes, referral form
		If refrnext = 2, go to end; else go to carplndx		

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21	carplndx	Is there documentation in the medical record of a continuing care plan which <u>includes the principal discharge diagnosis?</u> 1. The medical record contains a continuing care plan which includes the principal discharge diagnosis 2. The medical record does not contain a continuing care plan which includes the principal discharge diagnosis or unable to determine from medical record documentation	1, 2, If 2, auto-fill plndxsen as 2, and go to careason	**If the patient was in an acute-care hospital and had multiple admissions to the psychiatric unit during the hospitalization, only abstract this information at the time of discharge from the hospital or at the time of final discharge from the psychiatric unit.** • **A continuing care plan may consist of one document or several documents which could be considered a continuing care packet. The VAMC must be able to identify which document(s) make up the continuing care plan and the hospital must identify what specific documents are transmitted to the next level of care provider within the required timeframe.** • **If the continuing care plan is not titled as such, please ask the liaison to identify which documents make up the continuing care plan.** **Suggested data sources:** Aftercare discharge plan, continuing care plan, discharge plan, final discharge summary, interim discharge summary, medication reconciliation form, physician discharge orders, physician progress notes, referral form

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22	plndxsen	Is there documentation in the medical record the continuing care plan which included the principal diagnosis was transmitted to the next level of care provider **no later than the fifth post-discharge day?** 1. Yes 2. No	1, 2 If 2, auto-fill plndxdt as 99/99/9999	**The first post-discharge day is defined as the day after discharge. Giving a copy of the continuing care plan to the patient does not comprise transmission.** • **If the documentation specifies that the next level of care provider is a VA provider, select "1". Example: Patient will follow-up with Dr. Smith at VA Mental Health Care Clinic on 8/05/20XX at 11:00 AM.** • **Methods for transmitting the post-discharge continuing care plan include, but are not limited to: FedEx, CPRS access, ambulance transport personnel.** **If the patient has referrals to more than one clinician or entity for follow-up, the prescribing clinician or entity is considered to be the primary next level of care provider. The order of precedence for transmission of the continuing care plan is listed below:** • Follow-up prescribing inpatient or outpatient clinician or entity: the clinician, hospital, or clinic that is responsible for managing the patient's medication regime after hospital discharge. • Treating inpatient or outpatient clinician or entity: the clinician, hospital, or clinic that is responsible for the primary treatment of the patient in the absence of medications. If an addendum about the principal diagnosis is added to the continuing care plan in the medical record, it must occur within 5 days after discharge or prior to transmission of the continuing care plan.

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
23	plndxdt	Enter the date the continuing care plan which included the principal discharge diagnosis was transmitted to the next level of care provider.	mm/dd/yyyy <= 1 day prior to or = dcdate and < = 5 days after dcdate	**The first post-discharge day is defined as the day after discharge. Giving a copy of the continuing care plan to the patient does not comprise transmission.** **Methods for transmitting the post-discharge continuing care plan include, but are not limited to: FedEx, CPRS access, ambulance transport personnel.** Enter the exact date. The use of 01 to indicate missing month or day is not acceptable.
24	careason	Is there documentation in the medical record of a continuing care plan which contains the reason for hospitalization? 1. The medical record contains a continuing care plan which includes the reason for hospitalization 2. The medical record does not contain a continuing care plan which includes the reason for hospitalization or unable to determine from medical record documentation	1, 2 If 2, auto-fill caresent as 2, and go to plndcmed	**The reason for hospitalization should be a short synopsis describing the events the patient experienced prior to this hospitalization. The reason for hospitalization may be listed as the triggering or precipitating event.** If the patient was in an acute-care hospital and had multiple admissions to the psychiatric unit during the hospitalization, only abstract this information at the time of discharge from the hospital or at the time of final discharge from the psychiatric unit. • **A continuing care plan may consist of one document or several documents which could be considered a continuing care packet. The VAMC must be able to identify which document(s) make up the continuing care plan and the hospital must identify what specific documents are transmitted to the next level of care provider within the required timeframe.** • **If the continuing care plan is not titled as such, please ask the liaison to identify which documents make up the continuing care plan.** **Suggested data sources:** Aftercare discharge plan, continuing care plan, discharge plan, final discharge summary, interim discharge summary, medication reconciliation form, physician discharge orders, physician progress notes, referral form

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
25	caresent	Is there documentation in the medical record the continuing care plan including the reason for hospitalization was transmitted to the next level of care provider **no later than the fifth post-discharge day?** 1. Yes 2. No	1, 2 If 2, auto-fill plnreadt as 99/99/9999	**The first post-discharge day is defined as the day after discharge. Giving a copy of the continuing care plan to the patient does not comprise transmission.** • **If the documentation specifies that the next level of care provider is a VA provider, select "1". Example: Patient will follow-up with Dr. Smith at VA Mental Health Clinic on 8/05/20XX at 11:00 AM.** • **Methods for transmitting the post-discharge continuing care plan include, but are not limited to: FedEx, CPRS access, ambulance transport personnel.** **If the patient has referrals to more than one clinician or entity for follow-up, the prescribing clinician or entity is considered to be the primary next level of care provider. The order of precedence for transmission of the continuing care plan is listed below:** • Follow-up prescribing inpatient or outpatient clinician or entity: the clinician, hospital, or clinic that is responsible for managing the patient's medication regime after hospital discharge. • Treating inpatient or outpatient clinician or entity: the clinician, hospital, or clinic that is responsible for the primary treatment of the patient in the absence of medications. If an addendum about the reason for hospitalization is added to the continuing care plan in the medical record, it must occur within 5 days after discharge or prior to transmission of the continuing care plan.
26	plnreadt	Enter the date the continuing care plan which included the reason for hospitalization was transmitted to the next level of care provider.	mm/dd/yyyy <= 1 day prior to or = dcdate and < = 5 days after dcdate	**The first post-discharge day is defined as the day after discharge. Giving a copy of the continuing care plan to the patient does not comprise transmission.** **Methods for transmitting the post-discharge continuing care plan include, but are not limited to: FedEx, CPRS access, ambulance transport personnel.** Enter the exact date. The use of 01 to indicate missing month or day is not acceptable.

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
27	plndcmed	Is there documentation in the medical record the continuing care plan contained: • the discharge medications, and • dosage and indication for use, OR • states no medications prescribed at discharge 1. Yes 2. No	1, 2 If 2, auto-fill send5med as 2, and go to planext	**All medications must have the names, dosage and indications for use listed in the continuing care plan. The indications for use can be as short as one or two words, but must be present for all medications, not just psychotropic medications.** **Include routinely scheduled medications and PRN medications.** **Medications include prescription medications, sample medications, herbal remedies, vitamins, nutriceuticals, and over the counter drugs and any product designated by the FDA as a drug.** **If the patient was in an acute-care hospital and had multiple admissions to the psychiatric unit during the hospitalization, only abstract this information at the time of discharge from the hospital or at the time of final discharge from the psychiatric unit.** • **A continuing care plan may consist of one document or several documents which could be considered a continuing care packet. The VAMC must be able to identify which document(s) make up the continuing care plan and the hospital must identify what specific documents are transmitted to the next level of care provider within the required timeframe.** • **If the continuing care plan is not titled as such, please ask the liaison to identify which documents make up the continuing care plan.** **Suggested data sources:** Aftercare discharge plan, continuing care plan, discharge plan, final discharge summary, interim discharge summary, medication reconciliation form, physician discharge orders, physician progress notes, referral form

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
28	send5med	Was the continuing care plan including discharge medications (or noting no meds were ordered at discharge) transmitted to the next level of care provider **no later than the fifth post-discharge day?** 1. Yes 2. No	1, 2 If 2, auto-fill plnmedt as 99/99/9999	**The first post-discharge day is defined as the day after discharge. Giving a copy of the continuing care plan to the patient does not comprise transmission.** • **If the documentation specifies that the next level of care provider is a VA provider, select "1". Example: Patient will follow-up with Dr. Smith at VA Mental Health Care Clinic on 8/05/20XX at 11:00 AM.** • **Methods for transmitting the post-discharge continuing care plan include, but are not limited to: FedEx, CPRS access, ambulance transport personnel.** **If the patient has referrals to more than one clinician or entity for follow-up, the prescribing clinician or entity is considered to be the primary next level of care provider. The order of precedence for transmission of the continuing care plan is listed below:** • Follow-up prescribing inpatient or outpatient clinician or entity: the clinician, hospital, or clinic that is responsible for managing the patient's medication regime after hospital discharge. • Treating inpatient or outpatient clinician or entity: the clinician, hospital, or clinic that is responsible for the primary treatment of the patient in the absence of medications. If an addendum about the discharge medications is added to the continuing care plan in the medical record, it must occur within 5 days after discharge or prior to transmission of the continuing care plan.

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
29	plnmedt	Enter the date the continuing care plan which included the discharge medications was transmitted to the next level of care provider.	mm/dd/yyyy <= 1 day prior to or = dcdate and < = 5 days after dcdate	**The first post-discharge day is defined as the day after discharge. Giving a copy of the continuing care plan to the patient does not comprise transmission.** **Methods for transmitting the post-discharge continuing care plan include, but are not limited to: FedEx, CPRS access, ambulance transport personnel.** Enter the exact date. The use of 01 to indicate missing month or day is not acceptable.

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
30	planext	Is there documentation in the medical record the continuing care plan contained next level of care recommendations? 1. The medical record contains a continuing care plan which includes next level of care recommendations 2. The medical record does not contain a continuing care plan which included next level of care recommendations OR unable to determine from medical record documentation	1, 2 If 2, auto-fill plnexsen as 2, and go to end	**Next level of care recommendations may include, but are not limited to:** appointment with next level of care clinician or clinic, Axis III follow-up, social work and benefits follow-up, pending legal issues (e.g., follow-up with probation officer), peer support, i.e. Alcoholics Anonymous, Narcotics Anonymous, home-based services. **If the patient was in an acute-care hospital and had multiple admissions to the psychiatric unit during the hospitalization, only abstract this information at the time of discharge from the hospital or at the time of final discharge from the psychiatric unit.** • **A continuing care plan may consist of one document or several documents which could be considered a continuing care packet. The VAMC must be able to identify which document(s) make up the continuing care plan and the hospital must identify what specific documents are transmitted to the next level of care provider within the required timeframe.** • **If the continuing care plan is not titled as such, please ask the liaison to identify which documents make up the continuing care plan.** • The next level of care providers include the follow-up prescribing inpatient or outpatient clinician, prescribing inpatient or outpatient entity, the treating inpatient or outpatient clinician, or the treating inpatient or outpatient entity. If the patient has referrals to more than one clinician or entity for follow-up, the prescribing clinician or entity is considered to be the primary next level of care provider. **Suggested data sources:** Aftercare discharge plan, continuing care plan, discharge plan, final discharge summary, interim discharge summary, medication reconciliation form, physician discharge orders, physician progress notes, referral form

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
31	plnexsen	Is there documentation in the medical record the continuing care plan including next level of care recommendations was transmitted to the next level of care provider **no later than the fifth post-discharge day?** 1. Yes 2. No	1, 2 If 2, auto-fill plnexdt as 99/99/9999	**The first post-discharge day is defined as the day after discharge. Giving a copy of the continuing care plan to the patient does not comprise transmission.** • **If the documentation specifies that the next level of care provider is a VA provider, select "1". Example: Patient will follow-up with Dr. Smith at VA Mental Health Care Clinic on 8/05/20XX at 11:00 AM.** • **Methods for transmitting the post-discharge continuing care plan include, but are not limited to: FedEx, CPRS access, ambulance transport personnel.** **If the patient has referrals to more than one clinician or entity for follow-up, the prescribing clinician or entity is considered to be the primary next level of care provider. The order of precedence for transmission of the continuing care plan is listed below:** • Follow-up prescribing inpatient or outpatient clinician or entity: the clinician, hospital, or clinic that is responsible for managing the patient's medication regime after hospital discharge. • Treating inpatient or outpatient clinician or entity: the clinician, hospital, or clinic that is responsible for the primary treatment of the patient in the absence of medications. If an addendum about the next level of care recommendations is added to the continuing care plan in the medical record, it must occur within 5 days after discharge or prior to transmission of the continuing care plan.

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
32	plnextdt	Enter the date the continuing care plan which included next level of care recommendations was transmitted to the next level of care provider.	mm/dd/yyyy <= 1 day prior to or = dcdate and < = 5 days after dcdate	**The first post-discharge day is defined as the day after discharge. Giving a copy of the continuing care plan to the patient does not comprise transmission.** **Methods for transmitting the post-discharge continuing care plan include, but are not limited to: FedEx, CPRS access, ambulance transport personnel.** Enter the exact date. The use of 01 to indicate missing month or day is not acceptable.