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| --- | --- | --- | --- | --- | --- | --- |
|  |  | | **Organizational Identifiers** |  |  | |
|  | VAMC  CONTROL  QIC  BEGDTE  REVDTE | | Facility ID Control Number  Abstractor ID  Abstraction Begin Date  Abstraction End Date | Auto-fill  Auto-fill  Auto-fill  Auto-fill  Auto-fill |  | |
|  |  | | Patient Identifiers |  |  | |
|  | SSN  PTNAMEF  PTNAMEL  BIRTHDT  SEX  MARISTAT  RACE | | Patient SSN First Name  Last Name  Birth Date  Sex  Marital Status  Race | Auto-fill: no change  Auto-fill: no change  Auto-fill: no change  Auto-fill: no change  Auto-fill: **can change**  Auto-fill: no change  Auto-fill: no change |  | |
|  |  | | **Administrative Data** |  |  | |
| 1 | admdt | | Date of admission to inpatient care: | mm/dd/yyyy  **Auto-filled: can be modified**   |  | | --- | | <= 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 | psyadmdt | | Date of admission to inpatient psychiatric care: | mm/dd/yyyy   |  | | --- | | >= admdt | | **Enter the exact date the patient was admitted to inpatient psychiatric care.**  **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** | |
| 3 | psydcdt | | Enter the date of discharge from inpatient psychiatric care. | mm/dd/yyyy   |  | | --- | | > = psyadmdt and <= dcdate | | Warning if < admdt | | **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.** | |
| 4 | psydctm | | Enter the time of discharge from inpatient psychiatric care. | \_\_\_\_\_  UMT | Enter the time the patient was discharged from inpatient psychiatric care in Universal Military Time. | |
| 5 | 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 ABI pull list. This date cannot be modified in order to ensure the selected episode of care is reviewed. | |
| 6 | princode | Enter the ICD-10-CM principal diagnosis code: | | \_\_ \_\_ \_\_. \_\_ \_\_ \_\_ \_\_  (3 alpha-numeric characters/decimal point/four alpha-numeric characters)  **Auto-filled: can be modified**   |  | | --- | | **Cannot enter 000.0000, 123.4567, or 999.9999** | | **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.** |
| 7 | othrcode1  othrcode2  othrcode3  othrcode4  othrcode5  othrcode6  othrcode7  othrcode8  othrcode9  othrcode10  othrcode11  othrcode12  othrcode13  othrcode14  othrcode15  othrcode16  othrcode17  othrcode18  othrcode19  othrcode20  othrcode21  othrcode22  othrcode23  othrcode24 | Enter the ICD-10-CM other diagnosis codes: | | \_\_ \_\_ \_\_. \_\_ \_\_ \_\_ \_\_  (3 alpha-numeric characters/decimal point/four alpha-numeric characters)  **Auto-filled: cannot be modified**  **If enabled, can enter up to 24 codes**  **If enabled, abstractor can enter xxx.xxxx in code field if no other diagnosis codes found**  **If princode or othrcode is not a code from Table 10.01, the case** **is excluded.** | **Will be auto-filled from PTF with up to 24 ICD-10CM other diagnosis codes.** **Cannot be modified.**  **If no other diagnosis codes are received from PTF, abstractor is to verify codes documented in the record and enter. If no other diagnosis codes are found in the record, enter xxx.xxxx.**  **Principal or other ICD-10-CM diagnosis code must be one of the codes listed in Joint Commission, Appendix A, Table 10.01.**  .  **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.** |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 8 | dcdispo | | What was the patient’s discharge disposition on the day of discharge?  1. Home   * Assisted Living Facilities (ALFs) – includes assisted 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   * 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 | | | 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: 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.   o Acute Care Facility  o Hospice – Health Care Facility  o Hospice – Home  o Other Health Care Facility  o Home   * Values “2” and “3” hospice include 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 by name only (e.g., Park Meadows) and does not reflect the type of facility of level of care, select “5”.   (Cont’d next page) | |
|  |  | |  | | |  | **Discharge disposition cont’d**   * 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 | |
| 9 | 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.** | |
| 10 | admscrn | | The following six questions contain required components for admission screening of patients admitted to inpatient psychiatric care. The required components are:   * Patient strengths * Psychological trauma history * Substance use * Alcohol use * Violence risk to others * Violence risk to self | Note: Contains information on general documentation guidelines for the following six questions. | | | **General documentation guidelines for admission screening of patients admitted to inpatient psychiatric care:**   * **The admission screening timeframe must have occurred within the first three days of admission for psychiatric care. The day after psychiatric 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.** * **If there is documentation that the patient is not a reliable historian, a relative or guardian if available, may answer the screening questions on behalf of the patient.**   **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 | |
| 11 | | strength | During the timeframe from [computer to display psyadmdt to psyadmdt + 3 days (or dcdate if psyadmdt + 3 days > dcdate)], is there documentation in the medical record that the patient was screened for at least **two** patient strengths by a Psychiatrist, Psychologist, APN, PA, Master of Social Work (MSW), or Registered Nurse?  Yes  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 psychiatric admission.) | 1,2,X | | | **Admission screening documentation by the listed qualified psychiatric practitioner must document the patient was screened for at least two patient strengths and note the strengths.**  **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, i.e., family, friends, peers * Cultural/spiritual/religious and community involvement * Access to housing/residential stability * Steady employment * Financial stability * Awareness of substance use issues * Knowledge of medications   If documentation within the first 3 days of admission does not include screening for a minimum of two patient strengths OR the screening was not performed, select value 2.  **If there is documentation the patient was medically unstable requiring transfer to a medical or surgical unit within the first 3 days of admission and admission screening for patient strengths was not completed, select value X.** | |
| 12 | | traumahx | During the timeframe from [computer to display psyadmdt to psyadmdt + 3 days (or dcdate if psyadmdt + 3 days > dcdate)], is there documentation in the medical record that the patient was screened for a psychological trauma history by a  Psychiatrist, Psychologist, APN, PA, Master of Social Work (MSW), or Registered Nurse?  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 psychiatric admission.) | 1,2,X | | | 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 * severe childhood neglect * victimization, e.g. disasters, criminal activities, identity 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   If screening for psychological trauma history was not performed within the first 3 days of admission, select value 2.  **If there is documentation the patient was medically unstable requiring transfer to a medical or surgical unit within the first 3 days of admission and admission screening for psychological trauma history was not completed, select value X.** | |
| 13 | | assessud | During the timeframe from [computer to display psyadmdt to psyadmdt + 3 days (or dcdate if psyadmdt + 3 days > dcdate)], is there documentation in the medical record that the patient was screened for substance use during the past 12 months by a Psychiatrist, Psychologist, APN, PA, Master of Social Work (MSW), or Registered Nurse?  **The admission screen for substance use must include the type, amount, frequency of use, and any problems due to past use.**   1. Yes 2. No   X. Unable to complete admission screening (Documentation in the medical record that a screening for substance use cannot be completed due to the patient’s inability or unwillingness to answer screening questions within the first 3 days of psychiatric admission.) | | 1,2,X | | | * **Substance use 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. For the purpose of this data element, substance refers to drugs used for purposes other than intended.** * **The intent of this data element is to screen the patient for substance use within the 12 months prior to admission.** **The screening must include the type, amount, frequency of use and any problems due to past use.** Documentation of substance use must at a minimum state over the past 12 months. Documentation of a past history of substance use should differentiate the use being either within the past 12 months or prior to the 12 month time frame. * Documentation of “no history” cannot be used, unless it is associated with a time frame. For example:   + “No history of substance use within the past 12 months.” OR   + “History of substance use 2 years ago.” * **If there is documentation the patient was medically unstable requiring transfer to a medical or surgical unit within the first 3 days of admission and admission screening for substance use was not completed, select value X.**   **Examples of problems due to past substance use include, but are not limited to:** Job loss, feeling that life is out of control and fear of what might happen, loss of family support, arrested for drug possession, sustained bodily harm for failure to pay for drugs, girlfriend/boyfriend/spouse ended relationship, loss of driver’s license, uncontrolled anger, attempted suicide, estranged from family members |
| 14 | | assesalc | During the timeframe from [computer to display psyadmdt to psyadmdt + 3 days (or dcdate if psyadmdt + 3 days > dcdate)], is there documentation in the medical record that the patient was screened for alcohol use during the past 12 months by a Psychiatrist, Psychologist, APN, PA, Master of Social Work (MSW), or Registered Nurse?  **The admission screen for alcohol use must include the type, amount, frequency of use, and any problems due to past use.**  1. Yes  2. No  X. Unable to complete admission screening (Documentation in the medical record that a screening for alcohol use cannot be completed due to the patient’s inability or unwillingness to answer screening questions within the first 3 days of psychiatric admission.) | | 1,2,X | | | * **The intent of this data element is to screen the patient for alcohol use within the 12 months prior to admission.** **The screening must include the type, amount, frequency of use and any problems due to past use.** * Documentation of alcohol use must at a minimum state over the past 12 months. Documentation of a past history of alcohol use should differentiate the use being either within the past 12 months or prior to the 12 month time frame. * Documentation of “no history” cannot be used, unless it is associated with a time frame. For example:   + “No history of alcohol use within the past 12 months.” OR   + “History of alcohol use 2 years ago.” * **If there is documentation the patient was medically unstable requiring transfer to a medical or surgical unit within the first 3 days of admission and admission screening for alcohol use was not completed, select value X.**   **Examples of problems due to past alcohol use include, but are not limited to:** Job loss, feeling that life is out of control and fear of what might happen, loss of family support, arrested for drug possession, sustained bodily harm for failure to pay for drugs, girlfriend/boyfriend/spouse ended relationship, loss of driver’s license, uncontrolled anger, attempted suicide, estranged from family members |
| 15 | | harmothr | During the timeframe from [computer to display psyadmdt to psyadmdt + 3 days (or dcdate if psyadmdt + 3 days > dcdate)], is there documentation in the medical record that the patient was screened for violence risk to others during the past 6 months by a Psychiatrist, Psychologist, APN, PA, Master of Social Work (MSW), or Registered Nurse?   1. Yes 2. No   X. Unable to complete admission screening (Documentation in the medical record that a screening for violence risk to others during 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 psychiatric admission.) | | 1,2,X | | | **Violence risk to others includes threats of violence and/or actual commission of violence toward others. 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.   * **The intent of this data element is to screen the patient for violence risk to others within the 6 months prior to admission.** Documentation of violence risk to others must at a minimum state over the past 6 months. Documentation of a past history of violence risk to others should differentiate the risk being either within the past 6 months or prior to the 6 month time frame. * Documentation of “no history” cannot be used, unless it is associated with a time frame. For example:   + “No history of violence risk to others within the past 6 months.” OR   + “History of violence risk to others over a year ago.” * **If the patient is admitted to psychiatric care for violence risk to others (e.g., homicidal thoughts), select value 1.** * **If there is documentation the patient was medically unstable requiring transfer to a medical or surgical unit within the first 3 days of admission and admission screening for violence risk to others was not completed, select value X.** |
| 16 | | harmself | During the timeframe from [computer to display psyadmdt to psyadmdt + 3 days (or dcdate if psyadmdt + 3 days > dcdate)], is there documentation in the medical record that the patient was screened for violence risk to self during the past 6 months by a Psychiatrist, Psychologist, APN, PA, Master of Social Work (MSW), or Registered Nurse**?**  **The admission screen for violence risk to self must include suicide ideation, plans/preparation and/or intent to act if ideation present, past suicidal behavior, and risk/protective factors.**   1. Yes 2. No   X. Unable to complete admission screening (Documentation in the medical record that a screening for violence risk to self during 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 psychiatric admission.) | | 1,2,X  If strength, traumahx, assessud, assesalc, harmothr, or harmself = 2 or X, auto-fill assessdt as 99/99/9999, and go to refrnext as applicable | | | * **The intent of this data element is to screen the patient for violence risk to self within the 6 months prior to admission.** Documentation of violence risk to self must at a minimum state over the past 6 months. Documentation of a past history of violence risk to self should differentiate the risk being either within the past 6 months or prior to the 6 month time frame. * Documentation of “no history” cannot be used, unless it is associated with a time frame. For example:   + “No history of violence risk to self within the past 6 months.” OR   + “History of violence risk to self over a year ago.”   **If the patient is admitted to psychiatric care for violence risk to self (e.g., suicidal thoughts) AND assessment of plans/preparation and/or intent to act, past suicidal behavior, and risk/protective factors are documented, select value 1.**  **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   **If there is documentation the patient was medically unstable requiring transfer to a medical or surgical unit within the first 3 days of admission and admission screening for violence risk to self was not completed, select value X.**  Cont’d next page |
|  | |  |  | |  | | | **Violence Risk to Self cont’d**  **Examples of risk factors may include but are not limited to:** Family history of suicide; previous suicide attempt(s); history of alcohol and substance abuse; history of mental disorders (particularly clinical depression); feelings of hopelessness; impulsive and/or aggressive tendencies; cultural and religious beliefs such as the belief that suicide is a noble resolution of a personal dilemma; local clusters of suicide; lack of social support and sense of isolation; loss (relational, social, work, or financial); physical illness; easy access to lethal means (weapons, etc.); history of trauma or abuse; unwillingness to seek help because of stigma attached to mental health disorders; barriers to accessing mental health treatment; exposure to others who have died by suicide  **Examples of protective factors may include but are not limited to:** receiving clinical care for mental, physical and substance use disorders; access to a variety of clinical interventions and support for help seeking; restricted access to highly lethal means of suicide (weapons, etc.); interpersonal relationships and supports (i.e., family, friends, peers, community); support through ongoing medical and mental health care relationships; skills in problem solving, conflict resolution and nonviolent handling of disputes; cultural and religious beliefs that discourage suicide and support self-preservation |
| 17 | | assessdt | Enter the date the admission screening was completed.  **Initial assessment must include screening for patient strengths, psychological trauma, substance use, alcohol 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, assesalc, 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 of the following:   * the patient or guardian refused the next level of care provider upon discharge from a hospital based inpatient psychiatric setting **OR** * the patient or guardian refused to authorize release of information **OR** * the patient was readmitted to the same facility within 5 days after discharge   3. The medical record contains documentation that the patient:   * eloped and was discharged **OR** * failed to return from leave and was discharged **OR** * was discharged from the hospital to another level of care outside of the hospital system **from a setting other than a *Psychiatric Care Setting*** **OR** * residence is not in the USA and patient is returning to another country after discharge   4. The medical record contains documentation that the patient was **NOT** referred to the next level of care provider upon discharge from a hospital based inpatient psychiatric setting for a reason other than above | | 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. * A referral to attend support groups, i.e., Alcoholics Anonymous (AA), Narcotics Anonymous (NA), etc. after discharge is not a referral to a next level of care provider. * 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.” * When value 2 or 3 is selected, creation and transmission of a continuing care plan is not required.   **The next level of care providers include:**   * Follow-up prescribing inpatient or outpatient clinician: the clinician who is responsible for managing the patient’s medication regimen after hospital discharge. * Prescribing inpatient or outpatient entity: the hospital or clinic that is responsible for managing the patient’s medication regimen 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.   **Cont’d next page** |
|  | |  | 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 | |  | | | **Referred cont’d**  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 |
| 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, go to end | | | **Refer to The Joint Commission Appendix C, 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. * All antipsychotic medications should be counted regardless of the indication for use or the reason documented for prescribing the antipsychotic medication. * Only use “Antipsychotic NOS” for new antipsychotics that are not yet listed in Table 10.0 in Appendix C. * 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 C, Table 10.1)**  **Only acceptable sources:** Aftercare discharge plan, discharge plan, final discharge summary, interim discharge summary, physician discharge orders, physician progress notes, referral form |
| 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** 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 a justification other than those listed in options 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” comprises a history of three or more failed trials in which there was a lack of sufficient improvement in symptoms or functioning. The documentation must 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. Both the recommended plan to taper to monotherapy and the cross-taper plan must include the name(s) of the medication(s) to be tapered.  **3 =** Augmentation of Clozapine is addition of another antipsychotic medication. This is 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, discharge plan, final discharge summary, history and physical, interim discharge summary, medication reconciliation form, physician discharge orders, physician progress notes, referral form |