|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  |  | | **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 |  |  | | --- | | Warning if admdt is > 6 months prior to 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 | 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. | |
| 5 | 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.** |
| 6 | 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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| --- | --- | --- | --- | --- | --- | --- | --- |
| 7 | 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 the medical record states the patient is being discharged to assisted living care or an assisted living facility (ALF) and the documentation also includes nursing home, intermediate care or skilled nursing facility, select Value “1” (“Home”). * 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”. * 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   (Cont’d next page) |
|  |  | |  | | |  | **Discharge disposition cont’d**   * 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 states the patient is being discharged to a nursing home, intermediate care or skilled nursing facility without mention of assisted living care or assisted living facility (ALF), select Value “5” (“Other Health Care Facility”). * 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”. * 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 |
| 8 | 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 ptstatdc 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.** |
| 9 | admscrn | | **The following 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, Advance Practice Nurse (APN), Physician’s Assistant (PA), Master of Social Work (MSW) and/or Registered Nurse (RN) within the first 3 days of admission. The admission screening may be completed by one or more of the listed qualified psychiatric practitioners. MSW titles may vary from state to state and acceptable titles include LMSW, LCSW, and LCSW-C.** * **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 |
| 10 | | 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, MSW, or RN?  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 a patient is unable to identify two strengths, but there is documentation the provider attempted to elicit the information and provided some guidance to help the patient identify strengths (e.g., prompted the patient with examples such as motivation and readiness for change; setting and pursuing goals; cultural/spiritual/religious and community involvement; etc.), select value 1.  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.** |
| 11 | | 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, MSW, or RN?  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.** |
| 12 | | 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, MSW, or RN?   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  If 2 or X, go to pauditc | | * **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.** * **The intent of this data element is to screen the patient for substance use during the 12 months prior to admission (i.e., has the patient used drugs for purposes other than intended during the past 12 months).** **The screening must include the type, amount, and frequency of use. If the screen is positive and any component is not documented, enter value 2.** * **All components of the screen for substance use must be documented in ONE note.** * 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.** |
| 13 | | druguse | Does the substance use screen document that the patient used any substance during the past 12 months?  1. Yes  2. No | | 1,2  If 2, go to pauditc | | For the purpose of this data element, substance refers to drugs used for purposes other than intended.  **If the substance use screen documents the use of any substance (e.g., smokes 1 marijuana joint couple of times a year) by the patient during the past 12 months, enter value 1.**  **If the substance use screen documents the patient has not used any substances during the past 12 months, enter value 2.** |
| 14 | | drugtype | Does the substance use screen document the type(s) of substance(s) used during the past 12 months?  1. Yes  2. No | | 1,2 | | **Documentation in the medical record must include the type(s) of substance(s) the patient used during the past 12 months.**  Type(s) of substances may include:   * Barbiturates * Benzodiazepines * Cannabis * Depressants * Hallucinogens * Inhalants * Muscle Relaxants * Narcotics * Opioids * Prescribed drugs * Stimulants * Tranquilizers * Other |
| 15 | | drugamt | Does the substance use screen document the amount of substance(s) used during the past 12 months?  1. Yes  2. No | | 1,2 | | **Documentation in the medical record must include the amount of substance(s) the patient used during the past 12 months.**  Amounts may vary depending on the type(s) of substance(s) used.  If documentation indicates the patient was asked about the amount of substance use, but the patient is unable to quantify the amount, i.e., states, “I don’t know how much”; it is acceptable to answer “Yes”. |
| 16 | | drugfreq | Does the substance use screen document the frequency of substances used during the past 12 months?  1. Yes  2. No | | 1,2 | | **Documentation in the medical record must include the frequency of substance use during the past 12 months.**  Frequency of use may include:   * Daily * Multiple times a week * Weekly * Multiple times a month * Monthly * Other   If documentation indicates the patient was asked about the frequency of substance use, but the patient is unable to quantify the frequency, i.e., states, “I don’t know how often”; it is acceptable to answer “Yes”. |
| 17 | | drugprob | Does the substance use screen document the patient was asked about any problems due to his/her substance use during the past 12 months?  3. Yes, the patient was asked about problems and reported there were problems  4. Yes, the patient was asked about problems and reported there were NO problems  99. The patient was not asked about problems or unable to determine from the medical record documentation | | 3,4,99  If 99, autofill assessdt as 99/99/9999 | | **If the substance use screen documents any problems due to substance use during the past 12 months, enter value “3”.**  **If the substance use screen indicates that the patient does not report any problems due to substance use during the past 12 months, enter value ”4”.**  **If the substance use screen indicates the patient was not asked about problems, select value “99”.**  **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 |
| 18 | | pauditc | 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 **using the AUDIT-C** by a Psychiatrist, Psychologist, APN, PA, MSW, or RN?  **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  If 2 or X go to harmothr | | **The intent of this data element is to screen the patient for alcohol use during the 12 months prior to admission using the AUDIT-C within the first 3 days of admission.**   * **All components of the screen for alcohol use must be documented in ONE note.**   **Screening for alcohol use = the patient was screened using AUDIT-C questions OR AUDIT-C question # 1 alone if answer was “never” (audc1=0).**  AUDIT-C:  Question #1 = “How often did you have a drink containing alcohol in the past year?”  Question #2 = “How many drinks containing alcohol did you have on a typical day when you were drinking in the past year?”  Question #3 = “How often did you have six or more drinks on one occasion in the past year?”  If AUDIT-C question #1 is answered “never”, AUDIT-C questions 2 and 3 are not applicable.  **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.** |
| 19 | | audc1 | Enter the score documented for AUDIT–C Question #1.  “How often did you have a drink containing alcohol in the past year?   1. Never 2. Monthly or less 3. Two to four times a month 4. Two to three times a week 5. Four or more times a week   99. Not documented | | 0,1,2,3,4,99  If 0, auto-fill audc2 and audc3 as 95, and go to alcscor | | AUDIT-C Question #1 = “How often did you have a drink containing alcohol in the past year?” Each answer is associated with the following scores:  Never 🡪 0  Monthly or less🡪 1  Two to four times a month 🡪 2  Two to three times a week 🡪 3  Four or more times a week 🡪 4  Not documented 🡪 99  Answers to Question #1 of the AUDIT-C are scored as indicated. If the patient’s answers are documented in the record, the abstractor may assign the score in accordance with the patient’s response. If the score of Question #1 is documented without the question, the abstractor may enter that score. If neither the question response nor the score of the individual question is documented, enter 99. |
| 20 | | audc2 | Enter the score documented for AUDIT-C Question #2.  “How many drinks containing alcohol did you have on a typical day when you were drinking in the past year?”   1. 0, 1 or 2 drinks 2. 3 or 4 3. 5 or 6 4. 7 to 9 5. 10 or more   95. Not applicable  99. Not documented | | 0,1,2,3,4,95,99  Will be auto-filled as 95 if audc1 = 0 | | AUDIT-C Question #2 = “How many drinks containing alcohol did you have on a typical day when you were drinking in the past year?” Each answer is associated with the following scores:  0 drinks 🡪 0  1 or 2 drinks 🡪 0  3 or 4 drinks 🡪 1  5 or 6 drinks 🡪 2  7 to 9 drinks 🡪 3  10 or more drinks 🡪 4  Not documented 🡪 99  Answers to Question #2 of the AUDIT-C are scored as indicated. If the patient’s answers are documented in the record, the abstractor may assign the score in accordance with the patient’s response. If the score of Question #2 is documented without the question, the abstractor may enter that score. If neither the question response nor the score of the individual question is documented, enter 99. |
| 21 | | audc3 | Enter the score documented for AUDIT-C Question #3.  “How often did you have six or more drinks on one occasion in the past year?”   1. Never 2. Less than monthly 3. Monthly 4. Weekly 5. Daily or almost daily   95. Not applicable  99. Not documented | | 0,1,2,3,4,95,99  Will be auto-filled as 95 if audc1 = 0 | | AUDIT-C Question #3 = “How often did you have six or more drinks on one occasion in the past year?” Each answer is associated with the following scores:  Never 🡪 0  Less than monthly 🡪 1  Monthly 🡪 2  Weekly 🡪 3  Daily or almost daily 🡪 4  Not documented 🡪 99  Answers to Question #3 of the AUDIT-C are scored as indicated. If the patient’s answers are documented in the record, the abstractor may assign the score in accordance with the patient’s response. If the score of Question #3 is documented without the question, the abstractor may enter that score. If neither the question response nor the score of the individual question is documented, enter 99. |
| 22 | | alcscor | Enter the total AUDIT-C score documented. | | \_\_ \_\_  Abstractor may enter default zz if the total score of the AUDIT-C is not documented in the record  **If alcscor >=1, go to alctype; else go to harmothr as applicable**   |  | | --- | | Whole numbers 0 - 12 | | | The abstractor may not enter the total AUDIT-C score calculated from the questions if it is NOT documented in the record.  If the total score is not documented in the record, enter default zz. |
| 23 | | alctype | Does the alcohol use screen document the type(s) of alcohol the patient used during the past 12 months?  1. Yes  2. No | | 1,2 | | **Documentation in the medical record must include the type(s) of alcohol the patient used during the past 12 months.**  Type(s) of alcohol may include:   * Beer * Wine * Liquor * Other |
| 24 | | alcprob | Does the alcohol use screen document the patient was asked about any problems due to his/her alcohol use during the past 12 months?  3. Yes, the patient was asked about problems and reported there were problems  4. Yes, the patient was asked about problems and reported there were NO problems  99. The patient was not asked about problems or unable to determine from the medical record documentation | | 3,4,99  If 99, autofill assessdt as 99/99/9999 | | **If the alcohol use screen documents any problems due to alcohol use during the past 12 months, enter value “3”.**  **If the alcohol use screen indicates that the patient does not report any problems due to alcohol use during the past 12 months, enter value “4”.**  **If the alcohol use screen indicates the patient was not asked about problems, enter value “99”.**  **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, girlfriend/boyfriend/spouse ended relationship, loss of driver’s license, uncontrolled anger, attempted suicide, estranged from family members |
| 25 | | 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, MSW, or RN?   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 during 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.** |
| 26 | | harmself1  harmself2  harmself4  harmself5  harmself6 | 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 the following components of violence risk to self **during the past 6 months** by a Psychiatrist, Psychologist, APN, PA, MSW, or RN**?**   |  |  | | --- | --- | | **Component** | **Field Format** | | 1. Suicide ideation during the past 6 months  1. Yes  2. No | 1,2  If 2, auto-fill suidea and suiplan as 95 | | 2. Past suicidal Behavior during the past 6 months  1. Yes  2. No | 1,2 | | 5. Risk factors during the past 6 months  1. Yes  2. No | 1,2 | | 6. Protective factors during the past 6 months  1. Yes  2. No | If harmself1,2,5,6 = 1, auto-fill harmself4 = 95, else go to harmself4.  If harmself1 = 1 go to suidea, else go to assessdt as applicable | | 4. 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. Yes  2. No  95. Not applicable | 1,2, 95  Will be auto-filled as 95, if harmself1,2,5,6 = 1  If strength, traumahx, assessud, pauditc, harmothr = 2 or X and harmself4 = 1 or 2, auto-fill assessdt as 99/99/9999, and go to ptstatdc as applicable; else go to assessdt. | | | | | * **The intent of this data element is to screen the patient for violence risk to self that occurred during 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.   **All components of the screen for violence risk to self must be documented in ONE note.**   * **Select value “1” if the component is addressed in the screen for violence risk to self.** * **If any of the components are NOT addressed in the screen for violence risk to self, select value “2” for that component.** * **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 “1” for harmself4** * **If there is NO 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 “2” for harmself4.** * **If there is NO documentation the patient was unwilling/unable to answer questions about violence risk to self, enter value “2” for harmself4.**   **(Cont. next Page)** |
|  | |  |  | |  | | **(harmself cont.)**  **Examples of risk factors for violence risk to self 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 related to violence risk to self 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 |
| 27 | | suidea | Is there Psychiatrist, Psychologist, APN, PA, MSW, or RN documentation in the admission screening note for violence risk to self that suicide ideation was present during the past 6 months?  1. Yes  2. No  95. Not applicable | | 1,2,95  Will be auto-filled as 95 if harmself1 = 2  If 2, auto-fill suiplan as 95 and go to assessdt as applicable | | **Suicide ideation may include, but is not limited to:**   * **Documentation of statements by the patient such as “I would be better off dead.”; “I should just kill myself.”; “I’ve thought about different ways to kill myself.”** |
| 28 | | suiplan | Is there Psychiatrist, Psychologist, APN, PA, MSW, or RN documentation in the admission screening note for violence risk to self that the patient was screened for plans/preparation and/or intent to act upon plans for suicide during the past 6 months?  1. Yes  2. No  95. Not applicable | | 1,2,95  Will be auto-filled as 95 if harmself1 = 2; OR if suidea = 2 | | **Plans/preparation and intent to act may include, but are not limited to:**   * **Documentation of statements by the patient such as “I have a gun and plan to use it on myself.”; “I’ve given all my stuff away, so no one will have to do that after I’m gone.”** |
| **If (strength, traumahx, assessud, pauditc, or harmothr, = 2 or X) or (alcprob = 99) or (drugprob = 99) or (harmself1, harmself2, harmself5 or harmself6 = 2) or (harmself4 = 1 or 2) or (suiplan = 2), auto-fill assessdt as 99/99/9999 and go to ptstatdc as applicable; else go to assessdt** | | | | | | | |
| 29 | | 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, pauditc, or harmothr, = 2 or X, or alcprob = 99, or drugprob = 99, or (harmself1 harmself2, harmself5, or harmself6 = 2) or harmself4 = 1 or 2, or suiplan = 2)   |  | | --- | | >=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 resevent; else go to ptstatdc** | | | | | | | |
| 30 | | ptstatdc | What was the patient’s status at the time the patient left the hospital based inpatient psychiatric care setting?  1. The medical record contains documentation that the patient was discharged from the hospital based inpatient psychiatric care setting under these circumstances:   * Patient is leaving the psychiatric unit within the acute care hospital AND the hospital facility completely.   2. The medical record contains documentation of one of the following:   * the patient eloped and was discharged * the patient failed to return from leave and was discharged * the patient has not yet been discharged from the hospital * the patient was transferred/discharged from the inpatient psychiatric unit in an acute care setting to another level of care (i.e. medical unit) and subsequently discharged from that level of care   3. Unable to determine from medical record documentation | | 1,\*2, 3  \*If 2, go to resevent | | **The intent of this data element is to identify and exclude patients with an unplanned departure resulting in discharge**   * Patients who discharge or transfer to another level of care in the same hospital are excluded from the measure population since they have not yet been discharged from the hospital. * Patients who are discharged from the psychiatric setting are included in the measure population.   **If the patient was in an acute-care hospital and had multiple admissions to the psychiatric unit during the hospitalization, this information should be abstracted at the time of discharge from the hospital.**  If the patient’s final hospital discharge is from the inpatient psychiatric care setting, select value 1.  When a patient checks out of a hospital against the advice of his physician (AMA), select value 2.  When a patient is released from a psychiatric inpatient stay directly after a court hearing, select value 2.  If the patient’s final hospital discharge is not from the inpatient psychiatric care setting, select value 2. 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 value 2.  Suggested data sources: discharge summary, progress notes, physician notes |
| 31 | | 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 resevent | | **Refer to The Joint Commission Appendix C, Table 10.0, 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. * **Do not include prn antipsychotic medications.** * 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 JCNQM Appendix C, Table 10.1)**  **Suggested Data Sources:** Aftercare discharge plan, discharge plan, final discharge summary, interim discharge summary, physician discharge orders, physician progress notes, referral form |
| 32 | | 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 |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  | **Restraint and Seclusion Events** |  |  |
| 33 | resevent | Is there documentation of a physical restraint event during the patient’s psychiatric hospitalization?  1. Yes  2. No | 1,2  If 2, go to secevent | **A physical restraint is any manual method or physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body or head freely when it is used as a restriction to manage a patient’s behavior or restrict the patient’s freedom of movement.**  **Examples of physical restraint include but are not limited to:**   * 2 point restraint * 4 point restraint * 5 point restraint * Body nets * Mittens for the purpose of preventing intentional self-harm * Wrist-to-waist restraints * Soft wrist restraints * Manual holds * Stapling * Jarvis * Leather restraints * Devices that serve multiple purposes such as a Geri   chair or side rails, when they have the effect of  restricting a patient’s movement and cannot be easily  removed by the patient, constitute a restraint.  **Exclude:**   * Devices such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets * Methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests * Methods that protect a patient from falling out of bed * Methods that permit the patient to participate in activities without the risk of physical harm (does not include a physical escort) * Restraint uses that are forensic or correctional   restrictions applied and used by outside law  enforcement  **Cont’d next page** |
|  |  |  |  | * Restraint uses that are forensic or correctional restrictions applied and used by designated hospital security personnel for the purpose of transporting the patient to court off the locked unit.   **Suggested data sources:** Licensed independent practitioner orders, nursing flow sheet, nursing notes, observation sheets, physician orders, progress notes, psychiatric notes, restraint monitoring form, restraint/seclusion flowsheet, restraint/seclusion notes, scanned notes (VistA Imaging), therapist notes |
| 34  35  36 | resdt  restartm  resendtm  restotmin | For each restraint event during the psychiatric hospitalization, enter the date the restraint event occurred and enter the time the restraints were initiated and discontinued.  **May enter multiple events.**   |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | | **Restraint Event Date**  **mm/dd/yyyy**   |  | | --- | | **>=psyadmdt and <= dcdate** | | **Restraint Event Start Time**  **UMT**  **Abstractor may enter 99:99** | **Restraint Event End Time**  **UMT**  **Abstractor may enter 99:99**   |  | | --- | | **If valid times are entered, resendtm -restartm must be > 0 and <= 1440 minutes** | | **If restartm and resendtm are valid, software will calculate total minutes for each event**   |  | | --- | | **Must be >0 and <= 1440 minutes** | | |  |  |  |  | |  |  |  |  | | | **This information is abstracted for each day on which a restraint event (*Event Type 1*) occurs during the patient’s psychiatric hospitalization. A patient may have multiple events during the psychiatric hospitalization.**   * When an event (*Event Type*) begins and ends on different dates (crosses midnight) this is considered 2 separate events; therefore, both dates must be documented in order to determine the total amount of time associated with each *Event Date*. * **Restraint Event start and end time must be entered as hour and minute (UMT).**   + For **start times** that include “seconds,” remove the seconds and record the time as is (e.g., 15:00:35 would be entered as 15:00).   + For **end times** that include “seconds,” round up to the next full minute (e.g., 15:00:35 would be entered as 15:01). * If a patient is in *Event Type* 1 (physical restraint(s)) and then placed into *Event Type* 2 (seclusion), the time for *Event Type* 1 (physical restraint(s)) STOPS. The initiation of *Event Type* 2 (seclusion) stops the time for *Event Type* 1 (physical restraint(s)). * Enter 99:99 when either the start or stop time of *Event Type* 1 (physical restraint) event is missing or unable to be determined from the medical record.   **Suggested data sources:** Licensed independent practitioner orders, nursing flow sheet, nursing notes, observation sheets, physician orders, progress notes, psychiatric notes, restraint/seclusion flowsheet, restraint/seclusion notes, seclusion monitoring form, scanned notes (VistA Imaging), therapist notes |
| 37 | lrestraint1  lrestraint2  lrestraint3  lrestraint4  lrestraint5  lrestraint6  lrestraint7  lrestraint8  lrestraint9  lrestraint10  lrestraint11  lrestraint12  lrestraint13  lrestraint14  lrestraint15  lrestraint16  lrestraint17  lrestraint18  lrestraint19  lrestraint20 | Select the location(s) where the documentation of the restraint event was found in the medical record.   |  | | --- | | **Location**  **Select All That Apply:** | | 1. Behavioral Restraint Flowsheet | | 2. Incidental note | | 3. Initial Restraint Application Assessment | | 4. Mental Health Restraint note | | 5. Nurse Restraint note | | 6. Nursing Release from restraint/seclusion note | | 7. Nursing Restraint Assessment note | | 8. Nursing Restraint Initial and Reassessment note | | 9. Nursing Restraint Initiation note | | 10. Nursing Restraint/Seclusion note | | 11. Physician Orders | | 12. Physician Release from Restraint/Seclusion note | | 13. Physician Restraint/Seclusion note | | 14. Restraint/Seclusion Interdisciplinary note | | 15. Restraint/Seclusion note | | 16. Restraint Discontinued note | | 17. Restraint Flowsheet | | 18. Restraint/Seclusion Removal/Debriefing Note | | 19. Scanned note/flowsheet | | 20. Other | | 1,2,3,4,5,6,7,8,9,10,11,  12,13,14,15,16,17,18,  19,20 | **NOTE:** **The intent of this question is to verify whether documentation of the restraint event is located in the specified data sources.**  Please review all data sources carefully and select ALL sources where documentation of the restraint event including date and time was found.  If restraint event documentation is found in a location not listed, answer “yes” to value 20 “other.” |
| 38 | secevent | Is there documentation of a seclusion event during the patient’s psychiatric hospitalization?  1. Yes  2. No | 1,2  If 2, go to end | **A seclusion event is the involuntary confinement of a patient alone in a room or an area where the patient is physically prevented from leaving.  The seclusion event may be documented as “seclusion,” but should ideally include more descriptive information such as that found in the examples below.**  **Examples of seclusion include but are not limited to:**   * Manually or electronically locked doors * One-way doors * The presence of staff proximal to the room preventing exit or the threat of consequences if the patient leaves the room   **Exclude:**   * Time-out * Quarantine due to infectious disease   Suggested data sources: Licensed independent practitioner orders, nursing flow sheet, nursing notes, observation sheets, physician orders, progress notes, psychiatric notes, restraint/seclusion flowsheet, restraint/seclusion notes, seclusion monitoring form, scanned notes (VistA Imaging), therapist notes |
| 39  40  41 | secdt  secstartm  secendtm  sectotmin | For each seclusion event during the psychiatric hospitalization, enter the date the seclusion event occurred and enter the time the seclusion event was initiated and discontinued.  **May enter multiple events.**   |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | | **Seclusion Event Date**  **mm/dd/yyyy**   |  | | --- | | **>=psyadmdt and <= dcdate** | | **Seclusion Event Start Time**  **UMT**  **Abstractor may enter 99:99** | **Seclusion**  **Event End Time**  **UMT**  **Abstractor may enter 99:99**   |  | | --- | | **If valid times are entered, secendtm -secstartm must be > 0 and <= 1440 minutes** | | **If secstartm and secendtm are valid, Software will calculate total minutes for each event**   |  | | --- | | **Must be >0 and <= 1440 minutes** | | |  |  |  |  | |  |  |  |  | | | **This information is abstracted for each day on which a seclusion event (*Event Type 2*) occurs during the patient’s psychiatric hospitalization. A patient may have multiple events during the psychiatric hospitalization.**   * When an event (*Event Type*) begins and ends on different dates (crosses midnight) this is considered 2 separate events; therefore, both dates must be documented in order to determine the total amount of time associated with each *Event Date*. * **Seclusion Event start and end time must be entered as hour and minute (UMT).**   + For **start times** that include “seconds,” remove the seconds and record the time as is (e.g., 15:00:35 would be entered as 15:00).   + For **end times** that include “seconds,” round up to the next full minute (e.g., 15:00:35 would be entered as 15:01). * If a patient is in *Event Type* 2 (seclusion) and then placed into *Event Type* 1 (physical restraint(s)), the time for *Event Type* 2 (seclusion) STOPS. The initiation of Event Type 1(physical restraint(s)) stops the time for *Event Type 2* (seclusion). * Enter 99:99 when either the start or stop time of *Event Type* 2 (seclusion) event is missing or unable to be determined from the medical record.   **Suggested data sources:** Licensed independent practitioner orders, nursing flow sheet, nursing notes, observation sheets, physician orders, progress notes, psychiatric notes, restraint/seclusion flowsheet, restraint/seclusion notes, seclusion monitoring form, scanned notes (VistA Imaging), therapist notes |
| 42 | lseclusion1  lseclusion2  lseclusion3  lseclusion4  lseclusion5  lseclusion6  lseclusion7  lseclusion8  lseclusion9  lseclusion10  lseclusion11  lseclusion12  lseclusion13  lseclusion14  lseclusion15  lseclusion16  lseclusion17  lseclusion18  lseclusion19  lseclusion20 | Select the location where the documentation of the seclusion event was found in the medical record.   |  | | --- | | **Location**  **Select All That Apply:** | | 1. Incidental note | | 2. Initial /Restraint Seclusion Assessment | | 3. Mental Health Seclusion note | | 4. Nurse Seclusion note | | 5. Nursing Release from restraint/seclusion note | | 6. Nursing Seclusion Assessment note | | 7. Nursing Seclusion Initial and Reassessment note | | 8. Nursing Seclusion Initiation note | | 9. Nursing Restraint/Seclusion note | | 10. Restraint/Seclusion note | | 11. Physician Orders | | 12. Physician Release from Restraint/Seclusion note | | 13. Physician Restraint/Seclusion note | | 14. Restraint/Seclusion Interdisciplinary note | | 15. Restraint/Seclusion note | | 16. Restraint/Seclusion Removal/Debriefing Note | | 17. Seclusion Discontinued note | | 18. Seclusion Flowsheet | | 19. Scanned note/flowsheet | | 20. Other | | 1,2,3,4,5,6,7,8,9,10,  11,12,13,14,15,16,17,  18,19,20 | **NOTE:** **The intent of this question is to verify whether documentation of the seclusion event is located in the specified data sources.**  Please review all data sources carefully and select ALL sources where documentation of the seclusion event including date and time was found.  If seclusion event documentation is found in a location not listed, answer “yes” to value 20 “other.” |