

REVSTAT

REVIEW STATUS (not abstracted)

- 0. Abstraction has not begun
- 1. Abstraction in progress
- 2. Abstraction completed w/o errors
- 3. TVG failure (exclusion)
- 4. Record contains missing required answers (error record)
- 5. Administrative exclusion from all measures

CATNUM

Sample category

- 10. Inpt AMI primary dx
- 29. Inpt Heart Failure
- 41. Inpt Pneumonia
- 42. Inpt AMI primary/prin dx
- 53. Inpt Surgery
- 55. Inpt Surgery - type 10

LEFTDATE (PN Validation)

Discharge date: (rcvd on pull list).

LEFTIME (PN Validation)

Time of Discharge

ADMDT (PN Validation)

Date of admission to acute inpatient care

PNEADMTM (PN Validation)

Time of admission to acute inpatient care:

DTOFDC (IHF)Discharge date:
(rcv'd on pull list)**WHATIME** (IHF)

Discharge time:

ENTRADM (IHF)

Admission date:

HFADMTIME (q4 IHF)

Admission time:

DCDATE (ACS Validation)

Enter the date of discharge (rcvd on pull list).

DCTIME (ACS Validation)

Enter the time of discharge.

ADMDT (ACS Validation)Enter the date the patient was formally
admitted to inpatient status at this VAMC.**ADMTIME** (ACS Validation)Enter the time the patient was formally
admitted to inpatient status at this VAMC.

Set Variables
DISCHDT = DCDATE
ADMITDT = ADMDT
DISCHTM = DCTIME
ADMITTM = ADMTIME

Set Variables
DISCHDT = DTOFDC
ADMITDT = ENTRADM
DISCHTM = WHATIME
ADMITTM = HFADMTIME

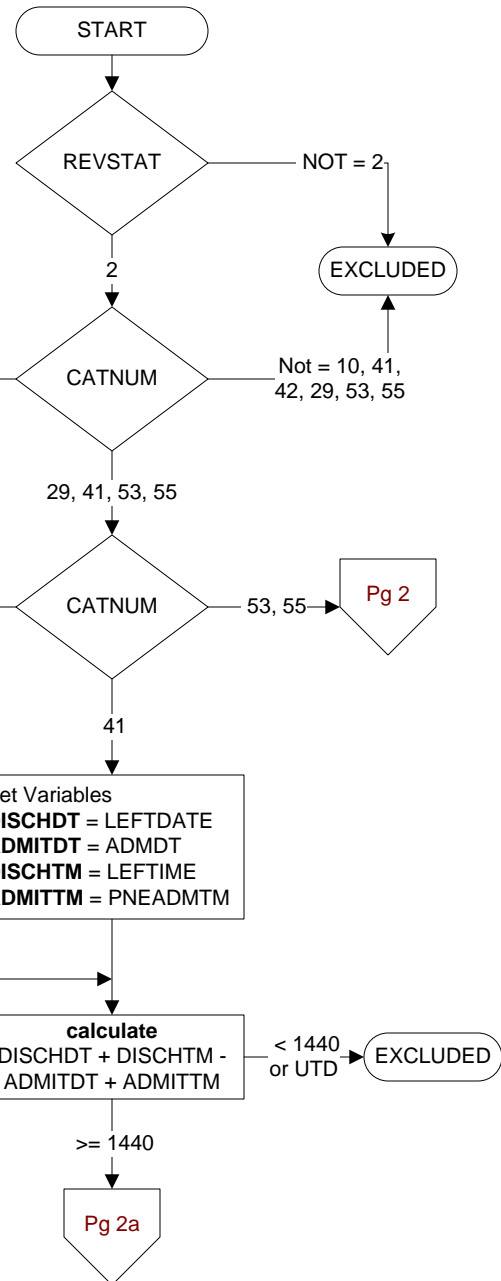
Set Variables
DISCHDT = LEFTDATE
ADMITDT = ADMDT
DISCHTM = LEFTIME
ADMITTM = PNEADMTM

calculate
 $\text{DISCHDT} + \text{DISCHTM} - \text{ADMITDT} + \text{ADMITTM}$

≥ 1440

Pg 2a

< 1440
or UTD



DTOFDC (SCIP)
Discharge Date

SIPDCTM (SCIP)
Time of discharge:.

SIADMDT (SCIP)
Date of admission to inpatient care:

SIPADMTM (SCIP)
Time of admission to inpatient care:

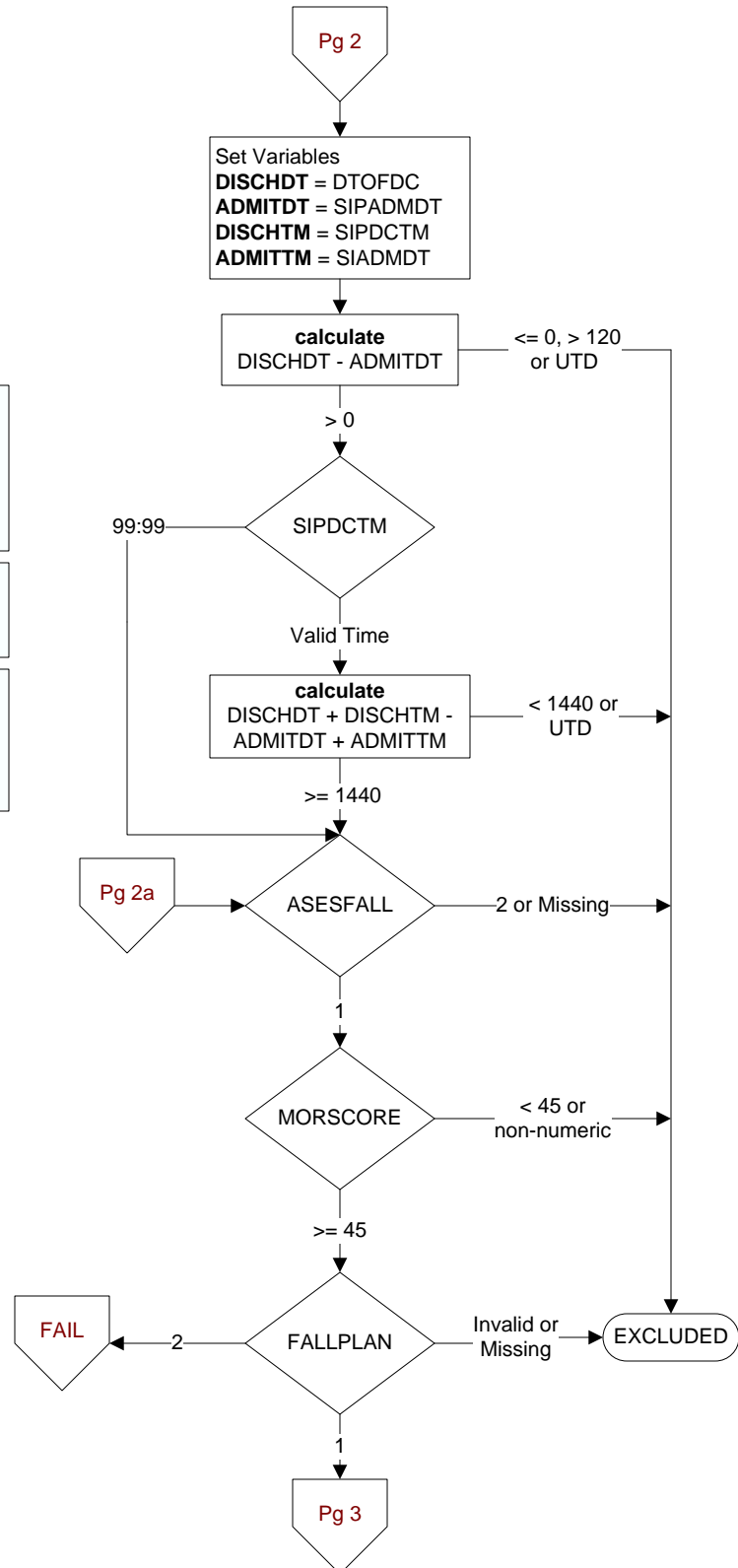
ASESFALL (Fall)
Does the medical record document the patient was assessed for risk of falls using the Morse Fall Scale during this hospital stay?
1. Yes
2. No

MORSCORE (Fall)
Enter the result of the Morse Fall Scale.
(If the MFS score is not documented, enter default zzz.)

FALLPLAN (Fall)
Does the record document a care plan to minimize the risk of fall/injury?
1. Yes
2. No

FALPLNDT (Fall)
Enter the date the first fall/injury care plan was documented in the record.

FALPLNTM (Fall)
Enter the time the first fall/injury care plan was documented in the record.



FALPLNDT (Fall)
Enter the date the first fall/injury care plan was documented in the record.

FALPLNTM (Fall)
Enter the time the first fall/injury care plan was documented in the record.

