

**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

START

REVSTAT

NOT = 2

EXCLUDED

CATNUM

Not = 10, 41,  
42, 29, 53, 55

29, 41, 53, 55

CATNUM

29

Pg 2

41

Set Variables

**DISCHDT** = LEFTDATE  
**ADMITDT** = ADMDT  
**DISCHTM** = LEFTIME  
**ADMITTM** = PNEADMTM

calculate

$$\text{DISCHDT} + \text{DISCHTM} - \text{ADMITDT} + \text{ADMITTM}$$
< 1440  
or UTD

EXCLUDED

&gt;= 1440

Pg 2a

**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:

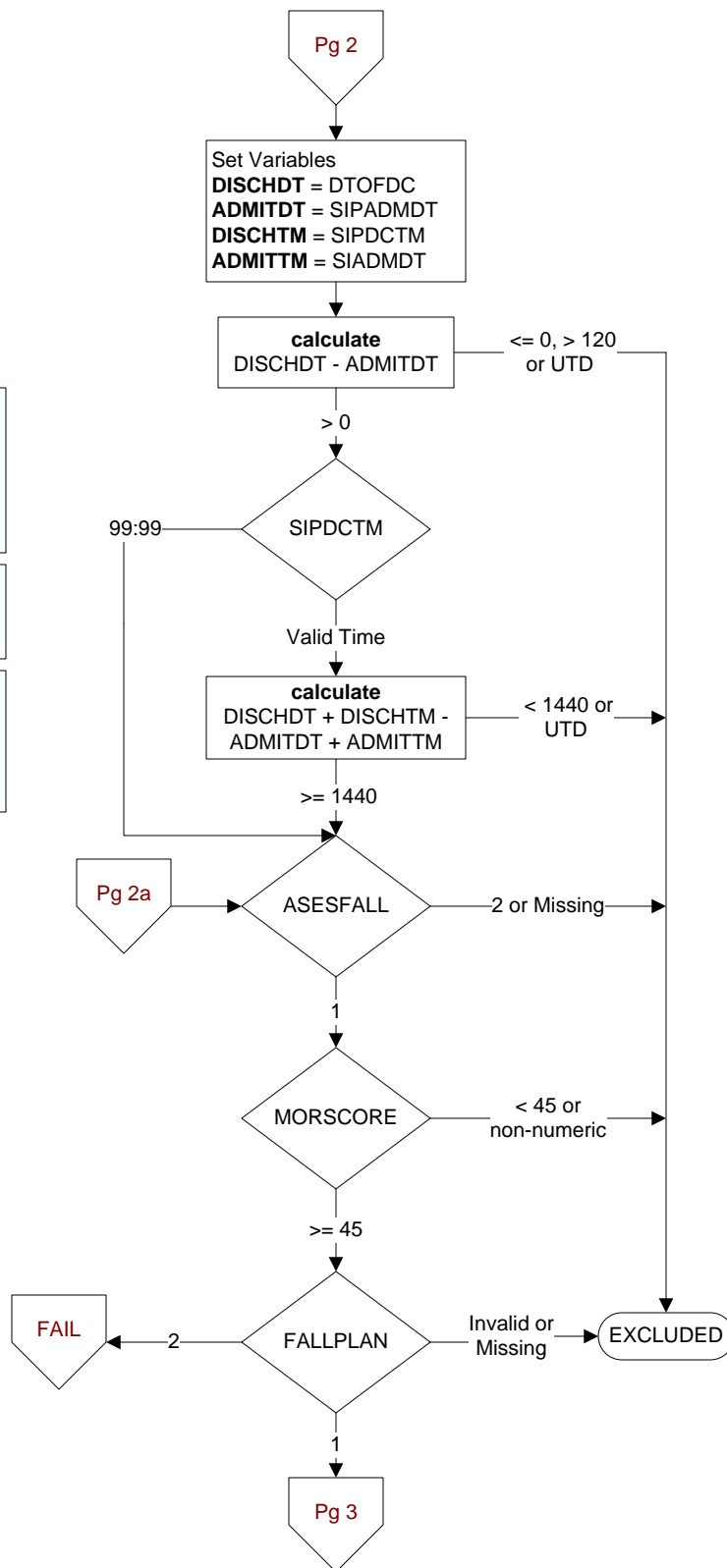
**ASESFALL** (Fall)  
Does the medical record document the patient was assessed for risk of falls using the Morse Fall Scale during this hospital stay?  
1. Yes  
2. No

**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.

