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

DCDATE
Discharge date from hospital:

ADMDT
Date of admission to inpatient care:

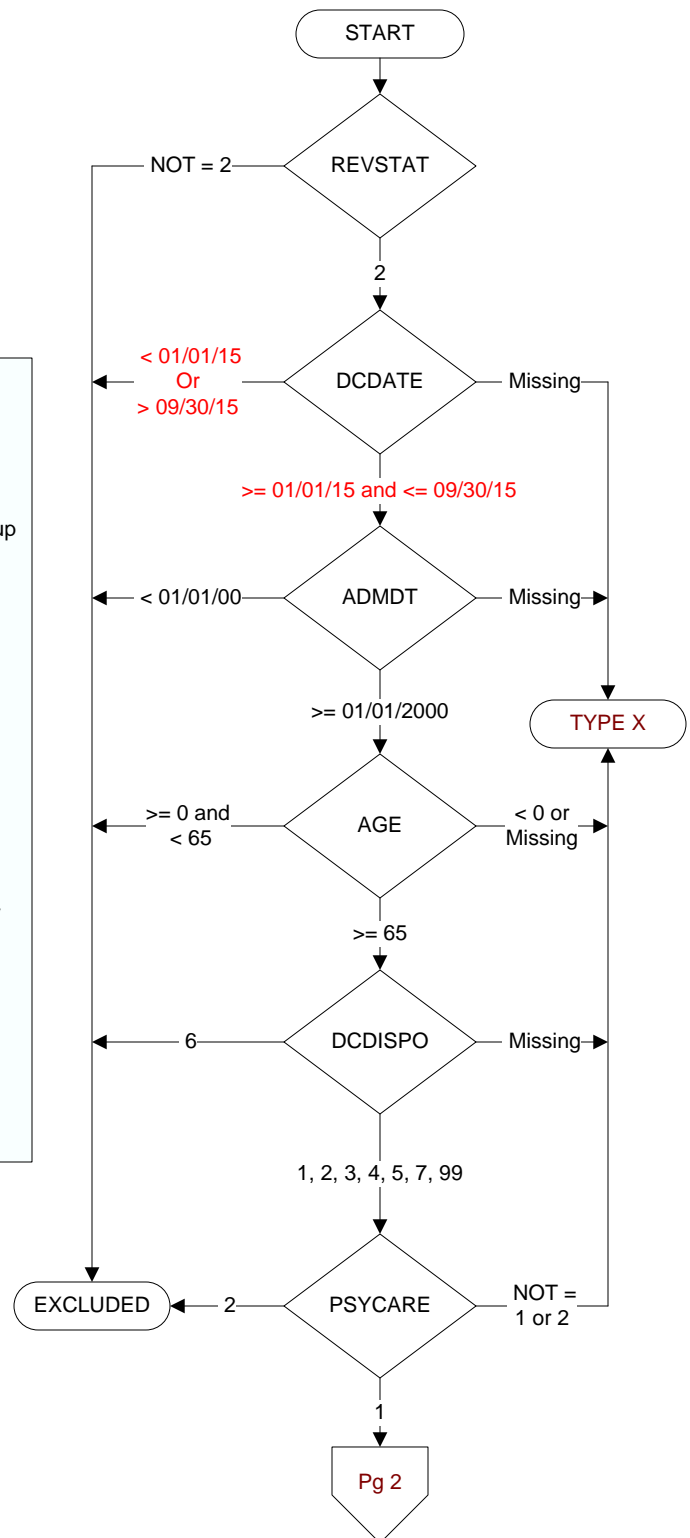**AGE** (calculated field)
ADMDT - BIRTHDT

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

PSYCARE
Did the patient receive care in an inpatient psychiatric care setting?
1. Yes
2. No

START

REVSTAT — NOT = 2

2

DCDATE — < 01/01/15 Or > 09/30/15 — Missing

>= 01/01/15 and <= 09/30/15

ADMDT — < 01/01/00 — Missing

>= 01/01/2000

TYPE X

AGE — >= 0 and < 65 — < 0 or Missing

>= 65

DCDISPO — 6 — Missing

1, 2, 3, 4, 5, 7, 99

PSYCARE — 2 — NOT = 1 or 2

EXCLUDED

1

Pg 2

Pg 2

REFRNEXT — 2, 3 →

REFRNEXT — NOT = 1, 2, 3, 4, 5 →

1, 4, 5

CARPLNDX — 2 →

CARPLNDX — NOT = 1 or 2 →

1

CAREASON — 2 →

CAREASON — NOT = 1 or 2 →

1

PLNDCMED — 2 →

PLNDCMED — NOT = 1 or 2 →

1

PLANEXT — 2 → In Denominator only (**fails** indicator)

PLANEXT — NOT = 1 or 2 → TYPE X

1

In Denominator and Numerator (**passes** indicator)

REFRNEXT
Is there documentation in the medical record that the patient was referred to the next level of care provider upon discharge from a hospital based inpatient psychiatric setting?
Select one option:
1. The medical record contains documentation that the patient was referred to the next level of care provider upon discharge from the hospital based inpatient psychiatric setting
2. The medical record contains documentation that the patient or guardian refused the next level of care provider upon discharge from a hospital based inpatient psychiatric setting **OR** refused to authorize release of information.
3. The medical record contains documentation that the patient:
   -- eloped **OR**
   -- failed to return from leave and was discharged **OR**
   -- was discharged from the hospital **from a setting other than a *Psychiatric Care Setting*** to another level of care outside of the hospital system.
4. The medical record contains documentation that the patient was **NOT** referred to the next level of care provider upon discharge from a hospital based inpatient psychiatric setting for a reason other than options 1 – 3.
5. The medical record does not contain documentation that the patient was referred to the next level of care provider upon discharge from a hospital based inpatient psychiatric setting OR unable to determine from the medical record

CARPLNDX
Is there documentation in the medical record of a continuing care plan which includes the principal discharge diagnosis?
1. The medical record contains a continuing care plan which includes the principal discharge diagnosis
2. The medical record does not contain a continuing care plan which includes the principal discharge diagnosis or unable to determine from medical record documentation

CAREASON
Is there documentation in the medical record of a continuing care plan which contains the reason for hospitalization?
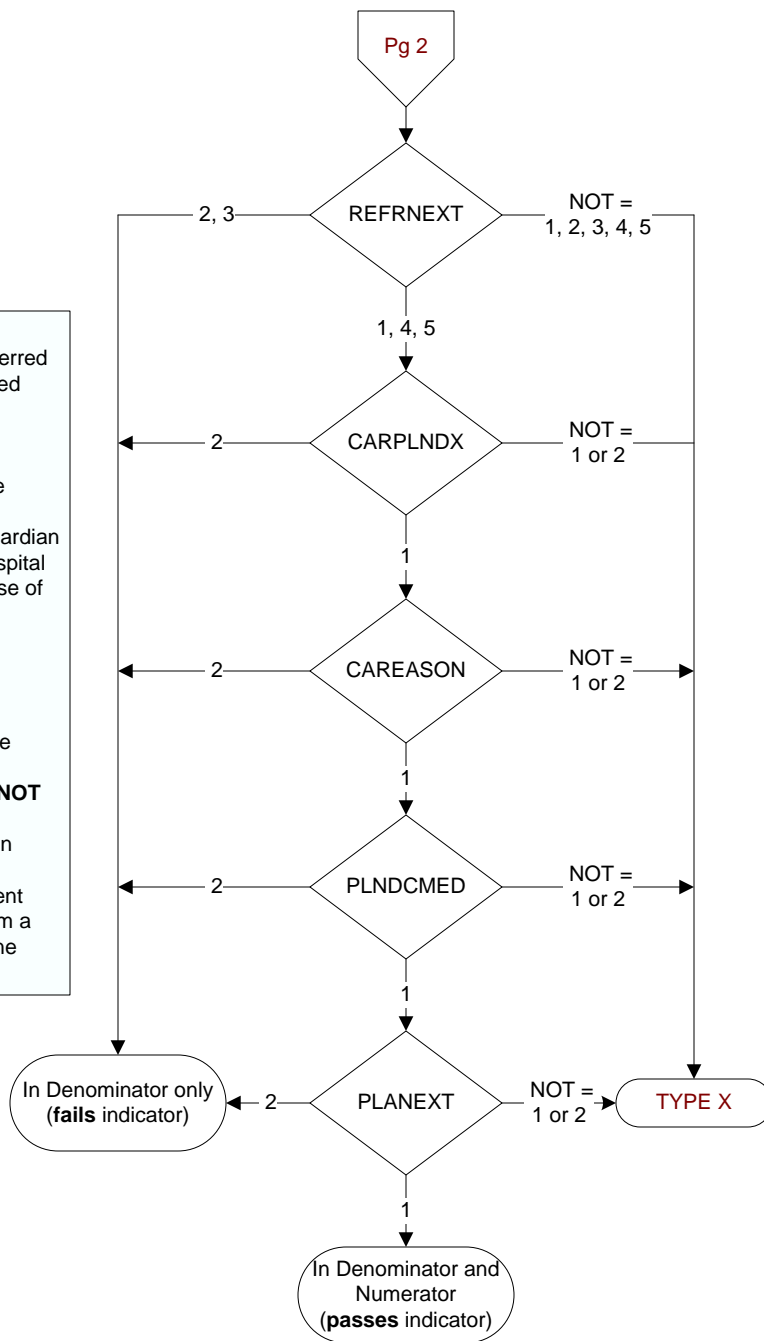1. The medical record contains a continuing care plan which includes the reason for hospitalization
2. The medical record does not contain a continuing care plan which includes the reason for hospitalization or unable to determine from medical record documentation

PLNDCMED
Is there documentation in the medical record the continuing care plan contained:
-- the discharge medications, and
-- dosage and indication for use, OR
-- states no medications prescribed at discharge
1. Yes
2. No

PLANEXT
Is there documentation in the medical record the continuing care plan contained next level of care recommendations?
1. The medical record contains a continuing care plan which includes next level of care recommendations
2. The medical record does not contain a continuing care plan which included next level of care recommendations OR unable to determine from medical record documentation