Document Links:

[Hospital Outpatient Instrument](#)

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
5. Administrative exclusion from all measures

CATNUM (rcvd on pull list)
Sample category number
72 = HOP – AMI
73 = HOP – Chest Pain
74 = HOP – ED
75 = HOP – Pain Management
76 = HOP - Stroke

EMCODE (HOP)
Enter the E/M code documented for this outpatient encounter.
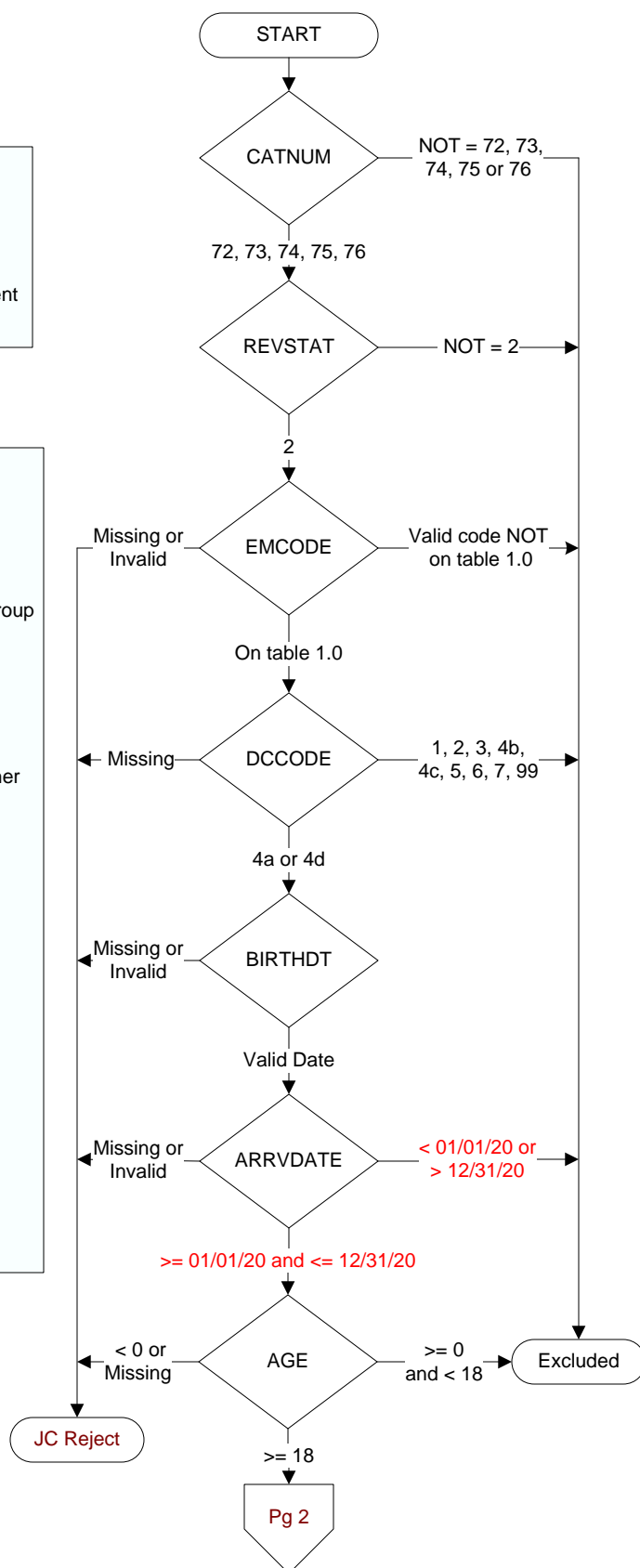
DCCODE (HOP)
What was the patient's discharge disposition from the outpatient setting?
1. Home
   - Assisted Living Facilities (ALFs) – includes assisted living care at nursing home/facility
   - Court/Law Enforcement – includes detention facilities, jails, and prison
   - Home – includes board and care, 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
4a. Non-VA Acute Care Facility – General Inpatient Care
4b. Acute Care Facility – Critical Access Hospital
4c. Acute Care Facility - Cancer or Children's Hospitals
4d. Acute Care Facility - Department of Defense or 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

BIRTHDT (rcvd on pull list)
Patients date of birth.

ARRVDATE (HOP)
Enter the **earliest** documented date the patient arrived in the hospital outpatient setting at this VAMC.

AGE
calculated field:
ARRVDATE - BIRTHDT

START

CATNUM — NOT = 72, 73, 74, 75 or 76 →

72, 73, 74, 75, 76

REVSTAT — NOT = 2 →

2

EMCODE — Missing or Invalid ← | Valid code NOT on table 1.0 →

On table 1.0

DCCODE — Missing ← | 1, 2, 3, 4b, 4c, 5, 6, 7, 99 →

4a or 4d

BIRTHDT — Missing or Invalid ←

Valid Date

ARRVDATE — Missing or Invalid ← | < 01/01/20 or > 12/31/20 →

>= 01/01/20 and <= 12/31/20

AGE — < 0 or Missing ← | >= 0 and < 18 → Excluded

JC Reject

>= 18

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PRINCODE (HOP)
Enter the ICD-10-CM principal diagnosis code.

ECG (HOP)
Was an electrocardiogram (ECG) performed within one hour prior to emergency department arrival or in the ED prior to transfer?
1. Yes
2. No

ECGINTER (HOP)
Is there documentation of ST-segment elevation on the ECG performed closest to emergency department arrival?
1. Yes
2. No

FIBRINTX (HOP)
Did the patient receive fibrinolytic therapy at this emergency department?
1. Yes
2. No

TRANACI (HOP)
Was there documentation the patient was transferred from this facility's emergency department to another facility for acute coronary intervention?
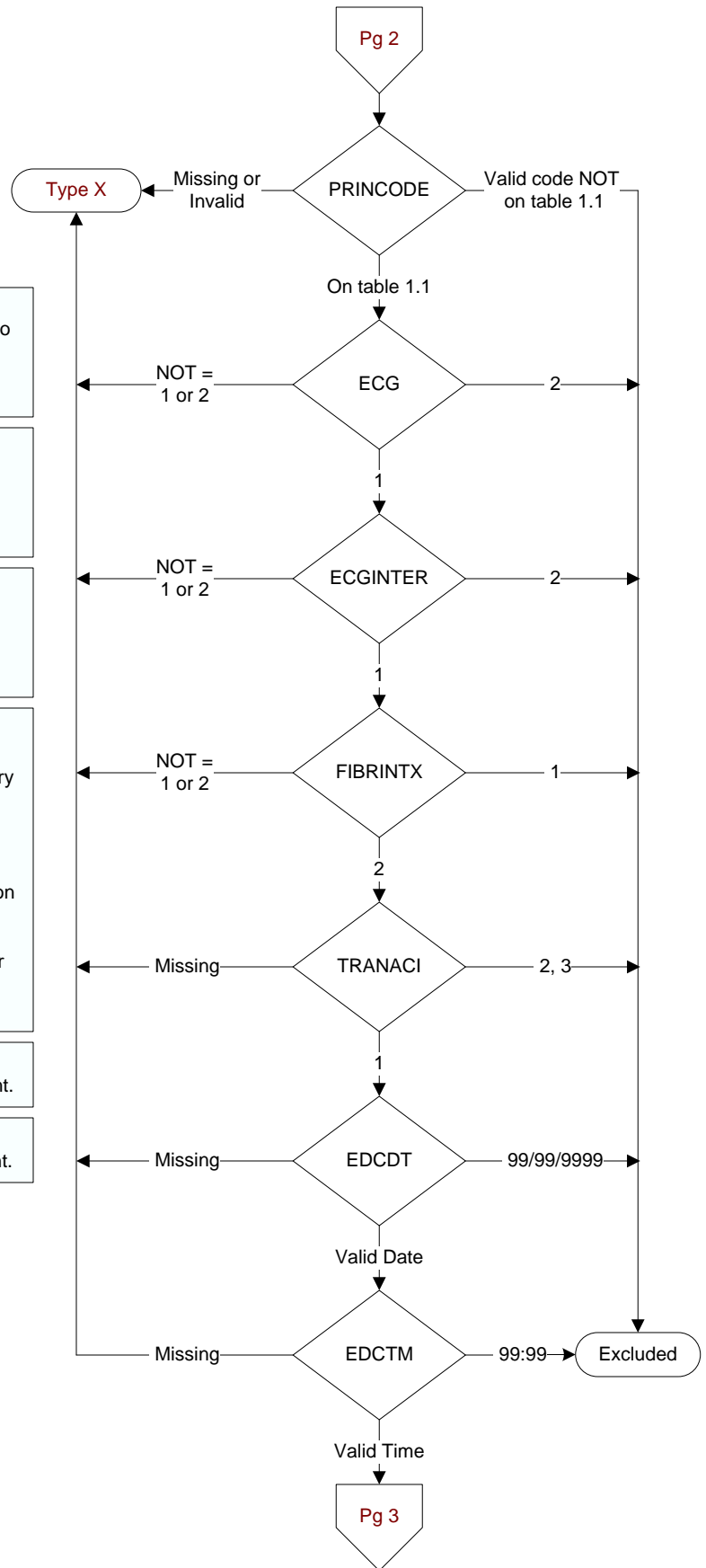1. There was documentation the patient was transferred from this facility's emergency department to another facility specifically for acute coronary intervention
2. There was documentation the patient was admitted to observation status prior to transfer
3. There was documentation the patient was transferred from this facility's emergency department to another facility for reasons other than acute coronary intervention or unable to determine reason for transfer from medical record
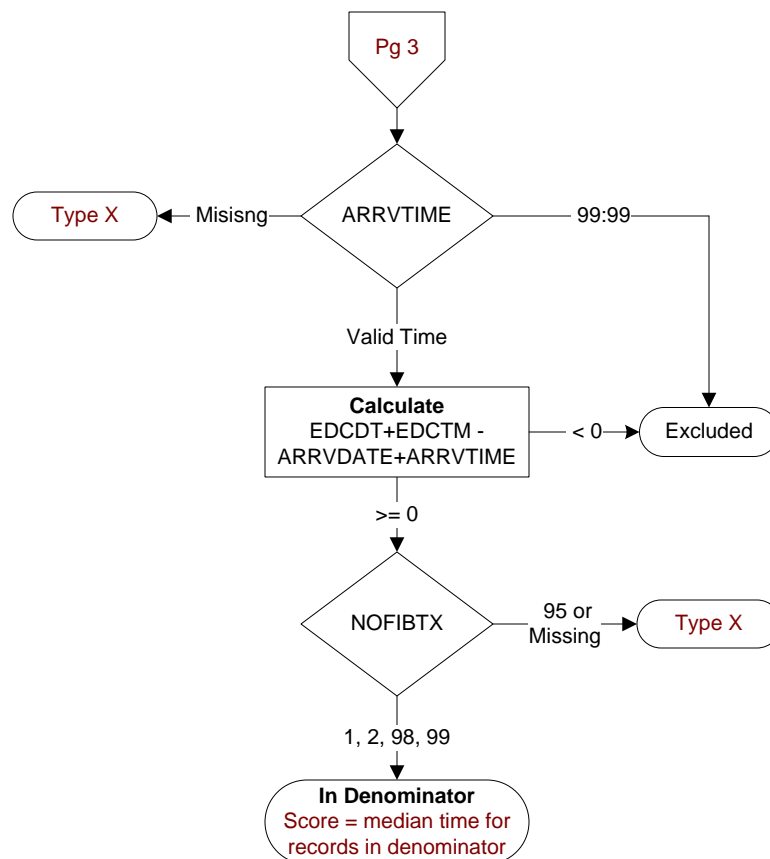
EDCDT (Validation)
Enter the date the patient departed from the emergency department.

EDCTM (HOP)
Enter the time the patient departed from the emergency department.

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Type X

PRINCODE
— Missing or Invalid → Type X
— Valid code NOT on table 1.1 → Excluded
— On table 1.1 ↓

ECG
— NOT = 1 or 2 →
— 2 →
— 1 ↓

ECGINTER
— NOT = 1 or 2 →
— 2 →
— 1 ↓

FIBRINTX
— NOT = 1 or 2 →
— 1 →
— 2 ↓

TRANACI
— Missing →
— 2, 3 →
— 1 ↓

EDCDT
— Missing →
— 99/99/9999 →
— Valid Date ↓

EDCTM
— Missing →
— 99:99 → Excluded
— Valid Time ↓

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Pg 3

Type X ← Misisng ← **ARRVTIME** — 99:99 →

Valid Time

Calculate
EDCDT+EDCTM -
ARRVDATE+ARRVTIME — < 0 → Excluded

>= 0

NOFIBTX — 95 or Missing → Type X

1, 2, 98, 99

In Denominator
Score = median time for
records in denominator

ARRVTIME (HOP)
Enter the **earliest** documented time the patient arrived at
the outpatient or emergency department at this VAMC.

NOFIBTX (HOP)
Is there physician/APN/PA or pharmacist documentation of a
contraindication or reason for not administering fibrinolytic therapy?
1. Yes, physician/APN/PA or pharmacist documented reason for
not administering fibrinolytic therapy
2. Yes, physician/APN/PA documented the patient has a diagnosis
of cardiogenic shock
95. Not applicable
98. Patient/caregiver refused fibrinolytic therapy
99. No documentation of reason for not administering fibrinolytic
therapy or unable to determine