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| **Indicator** | **Description** | **Cohort(s)** | Denominator | **Numerator** |
| **CANCER SCREENING** |  |  |
| P32h | **Breast Screen age 50-74 (includes 3D mammogram)** | **50, ( 16, 48, 51, 60 and****othrcare not =1), cohort 54 with FE flag and othrcare not=1** | **Includes all cases except:*** **Males or gender unknown**
* **Age<52 or >74**
* **The patient is enrolled in a VHA or community hospice**
* **The patient is enrolled in a VHA or community based palliative care program**
* **The patient is age >=66 and there is documentation the patient is living long term in a VHA or community-based institutional setting**
* **The patient is age >=66 and**
	+ **the case is flagged for frailty OR during the past year there is documentation of a condition/diagnosis consistent with frailty AND**
	+ **The case is flagged for advanced illness OR there is documentation that the patient has an active condition/diagnosis considered an advanced illness OR the patient has an active prescription for a dementia medication**
* **The patient did not have a mammogram or refused a mammogram and had a bilateral mastectomy or gender alteration in the past**
* **The patient did not have a mammogram and there is documentation by the patient’s PCP that he/she does not believe the patient will experience a net benefit from cancer screening because of one or both of the specified reasons (life expectancy < 5 years or patient couldn’t tolerate further workup or treatment)**
 | **Cases included in the denominator will pass if:** * **The medical record contains a report of a mammogram (screening, digital or tomosynthesis (3D mammogram) performed for the patient during the past 27 months**
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| **Indicator** | **Description** | **Cohort(s)** | Denominator | **Numerator** |
| p33 | Breast Screen age 45-74 timely per ACS guidelines | 50, (16, 48, 51, 60 andothrcare not =1) 54 with FE flag and othrcare not=1 | Includes all cases except:* Males or gender unknown
* Age<45 or >74
* The patient is enrolled in a VHA or community hospice
* The patient is enrolled in A VHA or community based palliative care program
* Patients age >=66 who were living long term in a VHA or community-based institutional setting
* The patient is age >=66 and
	+ the case is flagged for frailty OR during the past year there is documentation of a condition/diagnosis consistent with frailty AND
	+ The case is flagged for advanced illness OR there is documentation that the patient has an active condition/diagnosis considered an advanced illnessOR the patient has an active prescription for a dementia medication
* Those who did not have or refused to have a mammogram and
	+ The patient had a bilateral mastectomy or gender alteration in the past
	+ There is documentation by the patient’s PCP that he/she does not believe the patient will experience a net benefit from cancer screening because of one or both of the specified reasons (life expectancy < 5 years or patient couldn’t tolerate further workup or treatment
 | Cases included in the denominator will pass if:* The medical record contains a report of a mammogram (screening, digital or tomosynthesis (3D mammogram))

And* The date of screening is within the past 15 months or
* If the patient is age >=55 and <=74 and screening was done >15 months and <=27months in the past
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| Indicator | **Description** | **Cohort(s)** | **Denominator** | **Numerator** |
| p42 | Cervical Screen age 21-29 | 50, (16, 48, 51, 60 andothrcare not =1) ), cohort 54 with FE flag and othrcare not=1 | Includes all cases except:* The patient is enrolled in a VHA or community hospice
* The patient is enrolled in A VHA or community based palliative care program
* Males or gender unknown
* Age<21 or >29
* The patient had a hysterectomy or congenital absence of the cervix
* All Pap test reports within the past five years note sample was inadequate or that "no cervical cells were present"
* The patient did not have cervical screening and there is documentation by the patient’s PCP that he/she does not believe the patient will experience a net benefit from cancer screening because of one or both of the specified reasons (life expectancy < 5 yrs or patient couldn’t tolerate further workup or treatment)
 | Cases included in the denominator will pass if: * The collection date of the most recent Pap test performed at this or another VAMC or by a private sector provider is within the past 36 months
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| P44h | **Cervical Screen age 21-64 (includes hrHPV test age 30 and greater)** | **50, (16, 48, 51, 60 and****othrcare not =1) ), cohort 54 with FE flag and othrcare not=1** | **Includes all cases except:*** **The patient is enrolled in a VHA or community hospice**
* **The patient is enrolled in A VHA or community based palliative care program**
* **Males or gender unknown**
* **Age <21 or >=65 years**
* **The patient had a hysterectomy or congenital absence of the cervix**
* **All Pap test reports within the past five years note sample was inadequate or that "no cervical cells were present"**
* **The patient did not have cervical screening and there is documentation by the patient’s PCP that he/she does not believe the patient will experience a net benefit from cancer screening because of one or both of the specified reasons (life expectancy < 5 yrs or patient couldn’t tolerate further workup or treatment)**
 | **Cases included in the denominator will pass if:** * **The collection date of the most recent Pap test performed at this or another VAMC or by a private sector provider is within the past 36 months**

**OR*** **The collection date of the most recent Pap test is > 36 months or a Pap test was not done or was refused in the past 5 years and the patient’s age is >=30 and**
	+ **An hrHPV/HPV test was done at a VAMC or by a private sector provider within the past 5 years**
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| Indicator | **Description** | **Cohort(s)** | **Denominator** | **Numerator** |
| p45h | Cervical Screen age 30-64 | 50, (16, 48, 51, 60 andothrcare not =1) ), cohort 54 with FE flag and othrcare not=1 | Includes all cases except:* The patient is enrolled in a VHA or community hospice
* The patient is enrolled in A VHA or community based palliative care program
* Males or gender unknown
* Age<30 or >64
* The patient had a hysterectomy or congenital absence of the cervix
* All Pap test reports within the past five years note sample was inadequate or that "no cervical cells were present"
* The patient did not have cervical screening and there is documentation by the patient’s PCP that he/she does not believe the patient will experience a net benefit from cancer screening because of one or both of the specified reasons (life expectancy < 5 years or patient couldn’t tolerate further workup or treatment)
 | Cases included in the denominator will pass if: * The collection date of the most recent Pap test performed at this or another VAMC or by a private sector provider is within the past 36 months

OR* The collection date of the most recent Pap test is > 36 months or a Pap test was not done or was refused in the past 5 years and
	+ An hrHPV/HPV test was done at a VAMC or by a private sector provider within the past 5 years and
	+ The patient’s age at the time of the test is >= 30 years
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| **Indicator** | **Description** | **Cohort(s)** | Denominator | **Numerator** |
| P61h | **Colorectal Screen age 51-75** | **50, (16, 48, 51, 60 and****othrcare not =1)** **, cohort 54 with FE flag and othrcare not=1** | **Includes all cases except:*** **Age<=50 or >=76**
* **The patient is enrolled in a VHA or community hospice**
* **The patient is enrolled in A VHA or community based palliative care program**
* **The patient is age >=66 and there is documentation the patient is living long term in a VHA or community-based institutional setting**
* **The patient is age >=66 and**
	+ **the case is flagged for frailty OR during the past year there is documentation of a condition/diagnosis consistent with frailty AND**
	+ **The case is flagged for advanced illness OR there is documentation that the patient has an active condition/diagnosis considered an advanced illness OR the patient has an active prescription for a dementia medication**
* **The patient has a diagnosis of cancer of the colon or had a total colectomy**
* **The patient did not have or refused sigmoidoscopy or colonoscopy or did not have FOBT testing in the required timeframe but did have a colon CT or stool based DNA test**
* **The patient did not have colorectal screening and there is documentation by the patient’s PCP that he/she does not believe the patient will experience a net benefit from cancer screening because of one or both of the specified reasons (life expectancy < 5 yrs or patient couldn’t tolerate further workup or treatment)**
 | **Cases included in the denominator will pass if:** * **There is documentation of one of the following at this or another VAMC or by a private sector provider:**
	+ **a colonoscopy within the past 10 years**
	+ **guaiac fecal occult blood test x 3 within the past year**
	+ **iFOBT/FIT testing within the past year**
	+ **a sigmoidoscopy within the past 5 years;**
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| **Indicator** | **Description** | **Cohort(s)** | **Denominator** | **Numerator** |
| **Female** |  |  |  |
| chl1 | Chlamydia screen age 16-24 | 50, (16, 48, 51, 60 andothrcare not =1) 54 with FE flag and othrcare not=1 | Includes all cases except:* The patient is enrolled in a VHA or community hospice
* Males or gender unknown
* Age<18 or >24
* Patients who did not have documentation of one of the following in the past year:
	+ Prescription for contraceptives
	+ Pregnancy
	+ Documentation the patient is sexually active
	+ Pregnancy test performed
* Chlamydia testing was refused or not done in the past year and
	+ - There was no documentation that the patient was sexually active or of a prescription for contraceptives or pregnancy
		- A pregnancy test was done
		- AND

 one of the following* + - * there is documentation of a prescription for a retinoid medication within 6 days after the date of a pregnancy test OR
			* there is documentation of a diagnostic x-ray within 6 days after the date of a pregnancy test
 | Cases are included in the numerator if:* There is documentation the patient had one of the following in the past year:
	+ Prescription for contraceptives
	+ Pregnancy
	+ Documentation the patient is sexually active
	+ Pregnancy test performed

And* The medical record contains the report of a chlamydia test for the patient performed by VHA or by a private sector provider within the past year
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| **CARDIOVASCULAR** |  |  |
| **HEART FAILURE DIAGNOSIS** |  |  |
| Indicator | Description | Cohort(s) | Denominator | Numerator |
|  | Heart Failure DiagnosisNumber of cases reviewed | 50, (16, 48, 51, 60 andothrcare not =1), cohort 54 with FE flagand othrcare not=1 | * Number of cases with an active outpatient diagnosis of CHF (selchf = -1)
* The patient is not enrolled in a VHA or community hospice
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| chf14 | LVSF <40 on ACEI or ARB | 50, (16, 48, 51, 60 andothrcare not =1) , cohort 54 with FE flagand othrcare not=1 | Includes all cases except:* The patient is enrolled in a VHA or community hospice
* Selchf is not selected
* Those with LVSF documented as 40% or greater or the narrative description is not moderately or severely impaired
* Those with a reason for not prescribing both ACEI and ARBs
 | Cases included in the denominator will pass if::* There isdocumentation of one of the following:
	+ Patient is on an ACEI at the most recent OP visit or
	+ Patient is on an ARB at the most recent OP visit
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| **Indicator** | **Description** | **Cohort(s)** | **Denominator** | **Numerator** |
| **HYPERTENSION DIAGNOSIS** |  |  |
|  | Hypertension Diagnosis- Number of cases reviewed  | 50, (16, 48, 51, 60 andothrcare not =1), cohort 54 with FE flagand othrcare not=1 | * Number of cases with an active outpatient diagnosis of hypertension
* The patient is not enrolled in a VHA or community hospice
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| Ihd53h | HTN: BP <140/90 age 18-85 | 50, (16, 48, 51, 60 andothrcare not =1) , cohort 54 with FE flag and othrcare not=1 | Includes all cases except:* There is no Cerner flag
* Age <18 or >85
* The patient is enrolled in a VHA or community hospice
* The patient is enrolled in A VHA or community based palliative care program
* The patient does not have a diagnosis of HTN
* The patient did not have an outpatient encounter with a documented diagnosis of HTN during the applicable timeframe.
* The patient did not have an outpatient encounter with a documented diagnosis of HTN in the two years prior to the study begin date and up to one day prior to the date of the most recent OP encounter with a diagnosis of HTN
* The patient had any of the following during the past year
	+ a non-acute inpatient admission
	+ female age <51 and was pregnant
* The patient had a kidney transplant any time prior to the study end date
* The patient has a diagnosis of CKD stage 5 or ESRD or was on dialysis documented any time prior to the study end date
* The patient had a nephrectomy documented any time prior to the study end date
* The patient is age >=66 and there is documentation the patient is living long term in a VHA or community-based institutional setting
* The patient is age >=66 and < 81 and
	+ the case is flagged for frailty OR during the past year there is documentation of a condition/diagnosis consistent with frailty AND
	+ The case is flagged for advanced illness OR there is documentation that the patient has an active condition/diagnosis considered an advanced illness OR the patient had an active prescription for a dementia medication
* The patient is age>=81 and one of the following:
	+ the case is flagged for frailty or
	+ during the past year there is documentation of a condition/diagnosis consistent with frailty
 | Cases included in the denominator will pass if:* the most recent blood pressure\* is recorded as <140 systolic and < 90 diastolic

Please note:\*The most recent BP may be one obtained by Care Coordination\* If the most recent readings are for a Care Coordination blood pressure and for a blood pressure obtained in another acceptable setting on the same date, the lowest systolic reading and the lowest diastolic reading will be used to score the measure\*If the date of the most recent blood pressure is not >= to the date of the most recent outpatient encounter with a documented diagnosis of HTN, the case will fail |

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| **Indicator** | **Description** | **Cohort(s)** | **Denominator** | **Numerator** |
| **CHRONIC VASCULAR DISEASE** |  |  |
| cvrm2 | Statin therapy for patients with cardiovascular disease | 50, (16, 48, 51, 60 andothrcare not =1), cohort 54 with FE flag and othrcare not=1 | Includes all cases except:* There is no Cerner flag
* Age <21 or >75
* Females age < 40
* The patient is enrolled in a VHA or community hospice
* The patient is enrolled in A VHA or community based palliative care program
* Patients without at least one of the following:
	+ an AMI, CABG, or PCI in the past two years
	+ an outpatient or acute inpatient encounter with a documented diagnosis of ischemic vascular disease within the past year or there is an IVD diagnosis in the past year but no diagnosis in the year prior to the past year
* Patients with a diagnosis of CKD Stage 5 or ESRD in the past two years
* Patients with a diagnosis of cirrhosis in the past 2 years
* Patients with a diagnosis of myalgia, myositis, myopathy, or rhabdomyolysis during the past year
* Females age <51 with pregnancy, in vitro fertilization or both during the past 2 years
* Females age <51who were prescribed clomiphene in the past 2 years
* The patient is age >=66 and there is documentation the patient is living long term in a VHA or community-based institutional setting
* The patient is age >=66 and
	+ the case is flagged for frailty OR during the past year there is documentation of a condition/diagnosis consistent with frailty AND
	+ The case is flagged for advanced illness OR there is documentation that the patient has an active condition/diagnosis considered an advanced illness OR the patient has an active prescription for a dementia medication
 | Cases included in the denominator will pass if:* + - The patient was prescribed a statin medication in the past year and the statin was
			* atorvastatin and the most recent daily dose was >=10 mgs or
			* lovastatin or pravastatin and the most recent daily dose was >= 40 mgs or
			* rosuvastatin and the most recent daily dose was >= 5 mgs or
			* fluvastatin and the most recent daily dose was >= 80 mgs or
			* simvastatin and the most recent daily dose was >= 20 mgs or
			* pitavastatin and the most recent daily dose was >=2 mgs
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| **Indicator** | **Description** | **Cohort(s)** | **Denominator** | **Numerator** |
| **DIAGNOSIS OF OLD MI (AMI > 8 weeks)** |  |  |
|  | Diagnosis of Past AMI (AMI > 8 weeks) | 50, (16, 48, 51, 60 andothrcare not =1) , 54 with FE flag and othrcare not=1 | * + - Number of cases with a diagnosis of past AMI and the AMI occurred more than eight weeks prior to the date of the qualifying visit (selmi = true
* The patient is not enrolled in a VHA or community hospice
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| **Indicator** | **Description** | **Cohort(s)** | **Denominator** | **Numerator** |
| **ihd20h** | **AMI-Received persistent beta blocker treatment for 6 months post AMI discharge** | **50, (16, 48, 51, 60 and****othrcare not =1) , 54 with FE flag and othrcare not=1** | **Includes all cases except:*** **The patient is enrolled in a VHA or community hospice**
* **The patient has no diagnosis of past AMI**
* **Age <18 or >85**
* **The patient is age >=66 and there is documentation the patient is living long term in a VHA or community-based institutional setting**
* **The patient is age >=66 and**
	+ **the case is flagged for frailty OR during the past year there is documentation of a condition/diagnosis consistent with frailty AND**
	+ **The case is flagged for advanced illness OR there is documentation that the patient has an active condition/diagnosis considered an advanced illness OR there is documentation the patient has an active prescription for a dementia medication**
* **The patient is age>=81 and**
	+ **the case is flagged for frailty or**
	+ **during the past year there is documentation of a condition/diagnosis consistent with frailty**
* **The patient had more than one AMI in the 18 months prior to study begin date and the first date of discharge is < 180 days Or**
	+ **the patient had only one episode of AMI and the date of discharge from the most recent hospitalization for AMI in the past 2 years is <180 or > 730 days from study begin date**
* **There was a documented reason for not prescribing a beta blocker**
	+ **Beta blocker allergy**
	+ **Bradycardia**
	+ **Other reason documented by a physician/APN/PA**
	+ **Patient refusal**
 | **Cases included in the denominator will pass if:*** **The patient was on a beta blocker continuously during the 6 month period immediately following the AMI discharge**
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| **Indicator** | **Description** | **Cohort(s)** | **Denominator** | **Numerator** |
| ihd6 | AMI-Outpt LVEF <40 on ACEI or ARB at most recent visit | 50, (16, 48, 51, 60 andothrcare not =1) , 54 with FE flag and othrcare not=1 | Includes all cases except:* The patient is enrolled in a VHA or community hospice
* The patient had no diagnosis of past AMI
* There is no documentation of left ventricular function
* LVSF was not documented as <40% or moderate to severe systolic dysfunction
* Patients with documented reasons for not prescribing both ACEIs and ARBs or patient refusal
 | Cases included in the denominator will pass if:* The patient was taking an ACEI at the most recent outpatient visit OR
* The patient was taking an ARB at the most recent outpatient visit
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| **Indicator** | **Description** | **Cohort(s)** | **Denominator** | **Numerator** |
| **ENDOCRINE** |  |  |
| **DIAGNOSIS OF DIABETES** |  |  |
|  | Diabetes Mellitus Diagnosis –Number of cases reviewed | 50, (16, 48, 51, 60 andothrcare not =1) , 54 with FE flag and othrcare not=1 | * Number of cases with active diagnosis of diabetes mellitus (seldm =-1)
* The patient is not enrolled in a VHA or community hospice
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| **dmg23h** | **HgbA1c > 9 or not done in the past year****(low score is better)** | **50, (16, 48, 51, 60 and****othrcare not =1) , cohort 54 with FE flag and othrcare not=1** | **Includes all cases except:*** **The patient is enrolled in a VHA or community hospice**
* **The patient is enrolled in A VHA or community based palliative care program**
* **The case is not flagged for DM**
* **Age <18 or >75**
* **The patient is age >=66 and there is documentation the patient is living long term in a VHA or community-based institutional setting**
* **The patient is age >=66 and**
	+ **the case is flagged for frailty OR during the past year there is documentation of a condition/diagnosis consistent with frailty AND**
	+ **The case is flagged for advanced illness OR there is documentation that the patient has an active condition/diagnosis considered an advanced illness OR the patient has an active prescription for a dementia medication**
 | **Cases included in the denominator will also be included in the numerator if:*** **An HgbA1c was done in the past year and**
* **the value of the HgbA1c was >9**

 **OR*** **An HbA1c was not done in the past year or the patient refused a HgbA1c**
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| **Indicator** | **Description** | **Cohort(s)** | **Denominator** | **Numerator** |
| **dmg27h** | **BP <140/90** | **50, (16, 48, 51, 60 and****othrcare not =1) , cohort 54 with FE flag and othrcare not=1** | **Includes all cases except:*** There is no Cerner flag
* **The patient is enrolled in a VHA or community hospice**
* **The patient is enrolled in A VHA or community based palliative care program**
* **The case is not flagged for DM**
* **Age <18 or >75**
* **The patient is age >=66 and there is documentation the patient is living long term in a VHA or community-based institutional setting**
* **The patient is age >=66 and**
	+ **the case is flagged for frailty OR during the past year there is documentation of a condition/diagnosis consistent with frailty AND**
	+ **The case is flagged for advanced illness OR there is documentation that the patient has an active condition/diagnosis considered an advanced illness OR the patient has an active prescription for a dementia medication**
 | Cases included in the denominator will pass if:* **The most recent blood pressure recorded\* was <140 systolic and < 90 diastolic**

**Please note:****\*Most recent BP may be one obtained by Care Coordination****\*If the most recent readings are for a Care Coordination blood pressure and for a blood pressure obtained in another acceptable setting on the same date, the lowest systolic reading and the lowest diastolic reading will be used to score the measure** |

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| **Indicator** | **Description** | **Cohort(s)** | **Denominator** | **Numerator** |
| **dmg31h** | **Retinal exam, timely by disease** | **50, (16, 48, 51, 60 and****othrcare not =1) , cohort 54 with FE flag and othrcare not=1** | **Includes all cases except:*** **The patient is enrolled in a VHA or community hospice**
* **The patient is enrolled in A VHA or community based palliative care program**
* **The case is not flagged for DM**
* **Age <18 or >75**
* **The patient is age >=66 and there is documentation the patient is living long term in a VHA or community-based institutional setting**
* **The patient is age >=66 and**
	+ **the case is flagged for frailty OR during the past year there is documentation of a condition/diagnosis consistent with frailty AND**
* **The case is flagged for advanced illness OR there is documentation that the patient has an active condition/diagnosis considered an advanced illness OR the patient has an active prescription for a dementia medication**
* **There is explicit documentation by an ophthalmologist or optometrist that the patient is blind and no longer needs a retinal exam.**
 | **Cases included in the denominator will pass if:*** **A funduscopic/retinal exam was done within the past year at this or another VAMC or by a private sector provider and**
	+ **the retinal exam was performed by an ophthalmologist or an optometrist**

**or** * + **a digital image/retinal photo (dilated or non-dilated)was sent to be read by an ophthalmologist or optometrist**

**OR*** **A funduscopic/retinal exam as described above was not performed in the past year, and**
	+ **In the year previous to the past year, a retinal exam was performed by an ophthalmologist or an optometrist or automated digital image/retinal photo (dilated or non-dilated) was sent to be read by an ophthalmologist or optometrist**

 **and*** + **The report of the eye exam showed no retinopathy**
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| **Indicator** | **Description** | **Cohort(s)** | **Denominator** | **Numerator** |
| ked1h | Kidney health evaluation for patients with diabetes | 50, (16, 48, 51, 60 andothrcare not =1) , cohort 54 with FE flag and othrcare not=1 | Includes all cases except:* The patient is enrolled in a VHA or community hospice
* The patient is enrolled in A VHA or community based palliative care program
* The case is not flagged for DM
* Age <18 or >85
* The patient is age >=66 and there is documentation the patient is living long term in a VHA or community-based institutional setting
* The patient is age >=66 and
	+ the case is flagged for frailty OR during the past year there is documentation of a condition/diagnosis consistent with frailty AND
	+ The case is flagged for advanced illness OR there is documentation that the patient has an active condition/diagnosis considered an advanced illness OR the patient has an active prescription for a dementia medication
* The patient is age>=81 and flagged for frailty OR during the past year there is documentation of a condition/diagnosis consistent with frailty

At any time prior to or on the study end date there is documentation of ESRD or the patient is on dialysis  | Cases included in the denominator will pass if:* A urine albumin or microalbumin was performed within the past year and
* A urine creatinine was done within 4 days prior to or after the urine albumin or microalbumin or
	+ If no urine albumin/microalbumin and no urine creatinine, a urine albumin-creatinine ratio was documented in the past year

and* An eGFR was done within the past year
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| **Indicator** | **Description** | **Cohort(s)** | **Denominator** | **Numerator** |
| cvrm1 | Statin therapy for patients with diabetes | 50, (16, 48, 51, 60 andothrcare not =1) , cohort 54 with FE flag and othrcare not=1 | Includes all cases except:* There is no Cerner flag
* The case was not flagged for diabetes
* The patient is enrolled in a VHA or community hospice
* The patient is enrolled in A VHA or community based palliative care program
* The patient had an AMI in the past 2 years
* Age is <40 or >75
* The patient is age >=66 and there is documentation the patient is living long term in a VHA or community-based institutional setting
* The patient is age >=66 and
	+ the case is flagged for frailty OR during the past year there is documentation of a condition/diagnosis consistent with frailty AND
	+ The case is flagged for advanced illness OR there is documentation that the patient has an active condition/diagnosis considered an advanced illness OR the patient has an active prescription for a dementia medication
* The patient had any of the following within the past two years
	+ a CABG,or PCI
	+ an outpatient or acute inpatient encounter with a documented diagnosis of ischemic vascular disease within the past year and in the year prior to the past year
	+ CKD stage 5 or ESRD
	+ a diagnosis of cirrhosis
* Patients with a diagnosis of myalgia, myosititis, myopathy, or rhabdomyolysis during the past year
* Females age <51 with pregnancy, in vitro fertilization or both during the past 2 years
* Females age <51who were prescribed clomiphene in the past 2 years
 | Cased included in the denominator will pass if:* The patient was prescribed a statin medication in the past year and the statin was
	+ - * atorvastatin or
			* fluvastatin or
			* lovastatin or
			* pravastatin or
			* rosuvastatin or
			* simvastatin or
			* pitavastatin and
			* the most recent daily dose was >=1 mg
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| **Indicator** | **Description** | **Cohort(s)** | **Denominator** | **Numerator** |
| **C5**  | **Foot inspection** | **50, (16, 48, 51, 60 and****othrcare not =1) , 54 with FE flag and othrcare not=1** | **Includes all cases except:*** **The patient is enrolled in a VHA or community hospice**
* **The patient is enrolled in a VHA or community based palliative care program**
* **The case is not flagged for DM**
* **The patient is a bilateral amputee**
 | **Cases included in the denominator will pass if:*** **A visual inspection of the patient’s feet was performed in the past year**
 |
| c6 | Pedal pulses checked | 50, (16, 48, 51, 60 andothrcare not =1) , 54 with FE flag and othrcare not=1 | Includes all cases except:* The patient is enrolled in a VHA or community hospice
* The patient is enrolled in a VHA or community based palliative care program
* The case is not flagged for DM
* The patient is a bilateral amputee
 | Cases included in the denominator will pass if:* A check for pulses in the feet was performed in the past year
 |
| c7n | Foot Sensory exam using monofilament | 50, (16, 48, 51, 60 andothrcare not =1) , 54 with FE flag and othrcare not=1 | Includes all cases except:* The patient is enrolled in a VHA or community hospice
* The patient is enrolled in a VHA or community based palliative care program
* The case is not flagged for DM
* The patient is quadriplegic or paraplegic
* The patient had a past stroke resulting in bilateral

 sensory loss in the feet* The patient is a bilateral amputee
 | Cases included in the denominator will pass if:* A test for foot sensation using monofilament was performed in the past year
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| **Indicator** | **Description** | **Cohort(s)** | **Denominator** | **Numerator** |
| **MENTAL HEALTH** |  |  |
| **sa7** | **Screened annually for alcohol misuse** | **50, 16, 48, 51, 60, 54 with FE flag** | **Includes all cases except:*** **The patient is enrolled in a VHA or community hospice**
* **Patients with a diagnosis of dementia/neurocognitive disorder as evidenced by one of the applicable codes AND**
	+ **During the past year, there is documentation by a physician/APN/PA using a Clinical Reminder that the patient has probable permanent cognitive impairment or**
		- **The severity of dementia was assessed during the past year by one of the specified tools and the score of the assessment indicated moderate to severe cognitive impairment (cogscor2=5) or**
		- **The score indicated mild dementia, no dementia or outcome was not documented and there is clinician documentation  the patient has  moderate or severe cognitive impairment or**
		- **The severity of dementia was not assessed using one of the specified tool and there is clinician documentation in the past year the patient has moderate or severe cognitive impairment (modsevci=1)**
 | **Cases included in the denominator will pass if**:* **The patient was screened with the AUDIT-C within the past year**
* **The score of question 1 is 0 or all three questions have a valid score documented in the past year and**
* **The total score of screening within the past year is documented**
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| **Indicator** | **Description** | **Cohort(s)** | **Denominator** | **Numerator** |
| **sa17** | **Screened for alcohol misuse with score 5 or greater with timely brief intervention** | **50, 16, 48, 51, 60, 54 with FE flag** | **Includes all cases except:*** **The patient is enrolled in a VHA or community hospice**
* **Patients with a diagnosis of dementia/neurocognitive disorder as evidenced by one of the applicable codes AND**
	+ **During the past year, there is documentation by a physician/APN/PA using a Clinical Reminder that the patient has probable permanent cognitive impairment or**
		- **The severity of dementia was assessed during the past year by one of the specified tools and the score of the assessment indicated moderate to severe cognitive impairment (cogscor2=5) or**
		- **The score indicated mild dementia, no dementia or outcome was not documented and there is clinician documentation  the patient has  moderate or severe cognitive impairment or**
		- **The severity of dementia was not assessed using one of the specified tool and there is clinician documentation in the past year the patient has moderate or severe cognitive impairment (modsevci=1)**
	+ **The patient was not screened by AUDIT-C in the past year**
* **The score of the AUDIT-C is <5 or**
* **If the total score is not documented, the total**

**of the scores for questions 1, 2, and 3 is calculated by the computer and is <5*** **No brief intervention and the date of the most recent alcohol screening is <14 days prior to the study end date**
 | **Cases included in the denominator will pass if**:* The patient was advised to abstain OR the patient was advised to drink within recommended limits (alcbai3=1)

AND* The patient was provided personalized counseling regarding relationship of alcohol to the patient’s specific health issues OR

the patient was provided general alcohol related counseling (alcbai4=1)And* + The date of counseling was <=14 days after the positive alcohol screen
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| **Indicator** | **Description** | **Cohort(s)** | **Denominator** | **Numerator** |
| **cssrs1** | **Annual suicide risk screening using C-SSRS or CSRE** | **50, 16, 48, 51, 60, 54 with FE flag** | **Includes all cases except:*** **Nexus date is <01/01/21**
* **During the past year the patient was enrolled in a VHA or community-based hospice program**
* **Patients with a diagnosis of dementia/neurocognitive disorder as evidenced by one of the applicable codes AND**
	+ **During the past year, there is documentation by a physician/APN/PA using a Clinical Reminder that the patient has probable permanent cognitive impairment or**
		- **The severity of dementia was assessed during the past year by one of the specified tools and the score of the assessment indicated moderate to severe cognitive impairment (cogscor2=5) or**
		- **The score indicated mild dementia, no dementia or outcome was not documented and there is clinician documentation  the patient has  moderate or severe cognitive impairment or**
		- **The severity of dementia was not assessed using one of the specified tool and there is clinician documentation in the past year the patient has moderate or severe cognitive impairment (modsevci=1)**
 | **Cases included in the denominator will pass if:*** **The C-SSRS was completed (all applicable questions complete) within the past year and the outcome was documented**

**OR*** **The C-SSRS was not completed within the past year or the patient refused to be screened and**
	+ **There is evidence of a signed CSRE in the record and**
		- **The clinical impression of acute risk was documented and**
		- **The clinical impression of chronic risk was documented and**
		- **At least one of the general strategies for managing risk in any setting was documented**
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| **Indicator** | **Description** | **Cohort(s)** | **Denominator** | **Numerator** |
| csre1 | Timely VA Comprehensive Suicide Risk Evaluation (CSRE) | 50, 16, 48, 51, 60, 54 with FE flag | Includes all cases except:* Nexus date is <01/01/21
* During the past year the patient was enrolled in a VHA or community-based hospice program
* Patients with a diagnosis of dementia/neurocognitive disorder as evidenced by one of the applicable codes AND
	+ During the past year, there is documentation by a physician/APN/PA using a Clinical Reminder that the patient has probable permanent cognitive impairment or
		- The severity of dementia was assessed during the past year by one of the specified tools and the score of the assessment indicated moderate to severe cognitive impairment (cogscor2=5) or
		- The score indicated mild dementia, no dementia or outcome was not documented and there is clinician documentation  the patient has  moderate or severe cognitive impairmentor
		- The severity of dementia was not assessed using one of the specified tool and there is clinician documentation in the past year the patient has moderate or severe cognitive impairment (modsevci=1)
* The C-SSRS (Columbia) screener was not completed or the patient refused it in the past year
* The score of questions 3, 4, 5, and 8 of the CSSR-S was no or not documented and the interpretation of the C-SSRS was negative or not documented
* The score of questions 3, 4, 5, and 8 of the CSSR-S was yes and the interpretation of the C-SSRS was positive and the patient was admitted to inpatient or residential treatment for mental health care on the same calendar day as the positive C-SSRS
 | Cases included in the denominator will pass if:* There is evidence of a signed CSRE in the record and
	+ - The clinical impression of acute risk was documented and
		- The clinical impression of chronic risk was documented and
* At least one of the general strategies for managing risk in any setting was documented
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| **Indicator** | **Description** | **Cohort(s)** | **Denominator** | **Numerator** |
| **mdd40** | **Screened annually for depression**  | **50, 16, 48, 51, 60, 54 with FE flag** | **Includes all cases except:*** **During the past year the patient was enrolled in a VHA or community-based hospice program**
* **Patients with a diagnosis of dementia/neurocognitive disorder as evidenced by one of the applicable codes AND**
	+ **During the past year, there is documentation by a physician/APN/PA using a Clinical Reminder that the patient has probable permanent cognitive impairment or**
		- **The severity of dementia was assessed during the past year by one of the specified tools and the score of the assessment indicated moderate to severe cognitive impairment (cogscor2=5) or**
		- **The score indicated mild dementia, no dementia or outcome was not documented and there is clinician documentation  the patient has  moderate or severe cognitive impairment or**
		- **The severity of dementia was not assessed using one of the specified tool and there is clinician documentation in the past year the patient has moderate or severe cognitive impairment (modsevci=1)**
* **The patient had a clinical encounter within the past year with depression or bipolar disorder identified as a reason for the visit as evidenced by an applicable ICD-10 CM code**
 | **Cases included in the denominator will pass if:*** **The patient was screened using the PHQ-2 within the past year and**
	+ **The answers to questions 1 and 2 are documented and**
	+ **The total score is documented**
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| **Indicator** | **Description** | **Cohort(s)** | **Denominator** | **Numerator** |
| **ptsd51** | **PTSD Screening** | **50, 16, 48, 51, 60, 54 with FE flag** | **Includes all cases except:*** **The patient is enrolled in a VHA or community hospice**
* **Patients with a diagnosis of dementia/neurocognitive disorder as evidenced by one of the applicable codes AND**
	+ **During the past year, there is documentation by a physician/APN/PA using a Clinical Reminder that the patient has probable permanent cognitive impairment or**
		- **The severity of dementia was assessed during the past year by one of the specified tools and the score of the assessment indicated moderate to severe cognitive impairment (cogscor2=5) or**
		- **The score indicated mild dementia, no dementia or outcome was not documented and there is clinician documentation  the patient has  moderate or severe cognitive impairment or**
		- **The severity of dementia was not assessed using one of the specified tool and there is clinician documentation in the past year the patient has moderate or severe cognitive impairment (modsevci=1)**

The patient had a clinical encounter within the past year with PTSD identified as a reason for the visit by the specified ICD-10 CM codes | **Cases included in the denominator will pass if:****One of the following:*** **Screening was done using the PC-PTSD5+I9 or the PC-PTSD5>=9/1/2018 and**
	+ **The most recent date of separation is < 5 years ago and screening was done in the past year**
	+ **The veteran has not experienced exposure to traumatic events (traumevet=2) or**
	+ **The veteran has experienced exposure to traumatic events (traumevet=1 ) and**
		- **The patient’s response to all 5 questions is documented and**
		- **The total score is documented**

**OR*** **Screening was done using the PC-PTSD screen <10/1/2018 and**
	+ **The most recent date of separation is more than 5 years ago and screening was done in the past 5 years**
	+ **The answer to each question is documented and**
	+ **The total score is documented**
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| **IMMUNIZATIONS** |  |  |
| **Indicator** | **Description** | **Cohort(s)** | **Denominator** | **Numerator** |
| **pvc12** | **Pneumococcal immunization age 66 or greater** | **50, (16, 48, 51, 60 and****othrcare not =1) 54 with FE flag and othrcare not=1** | **Includes all cases except:*** **The patient is enrolled in a VHA or community hospice**
* **The patient had a bone marrow transplant during the past year**
* **The patient received chemotherapy during the past year**
* **The patient’s age as of 01/01/2021 is <66**
* **At any time in the patient’s history up to the study end date there is documentation of one of the following:**
	+ **Immunocompromising conditions**
	+ **Anatomic or functional asplenia**
	+ **Sickle cell disease and HB-S disease**
	+ **Cerebrospinal fluid leak(s)**
	+ **Cochlear implant(s)**
 | **Cases included in the denominator will pass if:*** **The patient received the PPSV23 pneumococcal vaccination from VHA or in the private sector as an inpatient or outpatient and the patient was age >=60 at the time the immunization was given**

**OR*** **The patient received the PCV20™ pneumococcal vaccination on or after 6/8/2021 and not later than the study end date from VHA or in the private sector as an inpatient or outpatient and the patient was age >=60 at the time the immunization was given**

**OR*** **The patient refused or did not receive the PPSV23 and the PCV20™ and received an unspecified pneumococcal vaccination prior to 10/01/2012** **and the patient was age >=60 at the time the immunization was given**

**\*\*If the patient received the PPSV23 or the PCV20**™ **or an unspecified pneumococcal vaccination < age 60 and there is documentation of a prior anaphylactic reaction to a pneumococcal vaccine the case will be excluded****OR** **If the patient refused or did not receive the PPSV23, the PCV20™ or an unspecified pneumococcal vaccination and there is documentation of a prior anaphylactic reaction to a pneumococcal vaccine, the case is excluded** |

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| **Indicator** | **Description** | **Cohort(s)** | **Denominator** | **Numerator** |
| p24 | Pneumococcal immunization refused(low score is better) | 50, (16, 48, 51, 60 andothrcare not =1) 54 with FE flag and othrcare not=1 | Includes all cases except:* The patient is enrolled in a VHA or community hospice
* The patient had a bone marrow transplant during the past year
* The patient received chemotherapy during the past year
* The patient’s age as of 01/01/2021 is <66
* At any time in the patient’s history up to the study end date there is documentation of one of the following:
	+ Immunocompromising conditions
	+ Anatomic or functional asplenia
	+ Sickle cell disease and HB-S disease
	+ Cerebrospinal fluid leak(s)
	+ Cochlear implant(s)
 | Cases included in the denominator will also be included in the numerator if:* The patient did not receive an unspecified pneumococcal vaccination prior to 10/1/2012 and there is no documentation of a prior anaphylactic reaction and
* The patient refused the PPSV23

OR* The patient did not receive an unspecified pneumococcal vaccination prior to 10/1/2012 and there is no documentation of a prior anaphylactic reaction and
* The patient did not receive the PPSV23 and
* The patient refused the PCV20™

**\*\***If the patient refused or did not receive the PPSV23 and the PCV20™ and did not receive an unspecified pneumococcal vaccination prior to 10/1/2012 and there is documentation of a prior anaphylactic reaction to a pneumococcal vaccine, the case is excluded |

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| **Indicator** | **Description** | **Cohort(s)** | **Denominator** | **Numerator** |
| p25h | Influenza immunization age 65 or greater | 50, (16, 48, 51, 60 andothrcare not =1) 54 with FE flag and othrcare not=1 | Includes all cases except:* There is no Cerner flag
* The patient is enrolled in a VHA or community hospice
* The patient’s age as of 07/01/2021 is <65
 | Cases included in the denominator will pass if:* influenza immunization was given at this VAMC, another VAMC, or in the private sector during the period from 7/1/2021 to the pull list date or study end date, whichever is greater

\*\*If there is documentation of previous allergic reaction to any component of the influenza vaccine or a history of Guillain-Barre Syndrome, or a bone marrow transplant during the past year, the case will be excluded if the patient refused or did not receive the influenza immunization during the current immunization season |
| p26h | Influenza immunization age 18 to 64 | 50, (16, 48, 51, 60 andothrcare not =1) 54 with FE flag and othrcare not=1 | Includes all cases except:* There is no Cerner flag
* The patient is enrolled in a VHA or community hospice
* The patient’s age as of 07/01/2021 is <18 or >64
 | Cases included in the denominator will pass if:* influenza immunization was given at this VAMC, another VAMC, or in the private sector during the period from 7/1/2021 to the pull list date or study end date, whichever is greater

\*\* If there is documentation of previous allergic reaction to any component of the influenza vaccine or a history of Guillain-Barre Syndrome, or a bone marrow transplant during the past year, the case will be excluded if the patient refused or did not receive the influenza immunization during the current immunization season |

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| **Indicator** | **Description** | **Cohort(s)** | **Denominator** | **Numerator** |
| p27 | Influenza immunization refused(low score is better) | 50, (16, 48, 51, 60 andothrcare not =1) 54 with FE flag and othrcare not=1 | Includes all cases except:* The patient is enrolled in a VHA or community hospice
* The patient’s age as of 07/01/2021 is <18
 | Cases included in the denominator will also be included in the numerator if:* influenza immunization was refused by the patient

\*\* If there is documentation of previous allergic reaction to any component of the influenza vaccine or a history of Guillain-Barre Syndrome, or a bone marrow transplant during the past year, the case will be excluded if the patient refused or did not receive the influenza immunization during the current immunization season |

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| **OSTEOPOROSIS** |  |  |
| **Indicator** | **Description** | **Cohort(s)** | **Denominator** | **Numerator** |
| Osw1h | Female 66-75 years of age who received osteoporosis screening | 50, (16, 48, 51, 60 andothrcare not =1) 54 with FE flag and othrcare not=1 | Includes all cases except:* Age is <66 or >75
* The patient is enrolled in a VHA or community hospice during the past year
* The patient is enrolled in a VHA or community-based palliative care program during the past year
* male or gender unknown
* There is documentation the patient is living long term in a VHA or community-based institutional setting
* The case is flagged for frailty OR during the past year there is documentation of a condition/diagnosis consistent with frailty AND
	+ The case is flagged for advanced illness OR there is documentation that the patient has an active condition/diagnosis considered an advanced illness OR there is documentation the patient has an active prescription for a dementia medication
* In the year prior to the study end date, there is documentation the patient received any of the following treatments for osteoporosis
	+ denosumab, 1mg injection
	+ ivandronate sodium, 1 mg injection
	+ teriparatide, 10 mcg injection
	+ zoledronic acid, 1 mg
* The patient received a dispensed prescription for one of the medications listed in the question ostmed during the specified timeframe
 | Cases included in the denominator will pass if:* **During the timeframe from the patient’s 63th birthday up to the study end date, there is documentation the patient was screened for osteoporosis by one of the following tests:**
	+ Ultrasound bone density (radial, wrist and/or heel)
	+ Computed Tomography (hips, pelvis, and/or spine)
	+ DEXA scan (hips, pelvis, and/or spine)
	+ DEXA scan (peripheral - radius, wrist and/or heel)
	+ Dual energy X-ray absorptiometry (DXA), (hips, pelvis, and/or spine)
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| **TOBACCO** |  |  |
| **Indicator** | **Description** | **Cohort(s)** | **Denominator** | **Numerator** |
| **smg8** | **Tobacco Use Cessation-Advised to Quit (outpt)**  | **50, (16, 48, 51, 60 and****othrcare not =1) 54 with FE flag and othrcare not=1** | **Includes all cases except:*** **The patient is enrolled in a VHA or community hospice**
* **Patients with a diagnosis of dementia/neurocognitive disorder as evidenced by one of the applicable codes AND**
	+ **During the past year, there is documentation by a physician/APN/PA using a Clinical Reminder that the patient has probable permanent cognitive impairment or**
		- **The severity of dementia was assessed during the past year by one of the specified tools and the score of the assessment indicated moderate to severe cognitive impairment (cogscor2=5) or**
		- **The score indicated mild dementia, no dementia or outcome was not documented and there is clinician documentation  the patient has  moderate or severe cognitive impairment or**
		- **The severity of dementia was not assessed using one of the specified tool and there is clinician documentation in the past year the patient has moderate or severe cognitive impairment (modsevci=1)**
* **During the past year, the patient was not screened or declined to answer National Clinical Reminder for Tobacco Screening questions or**
	+ **The patient was screened using the National Clinical Reminder and did not use tobacco at all**

**If the facility is using the Cerner EHR:*** **The patient was not screened by an acceptable provider, or refused to be screened or**
* **The tobacco screen was not positive**
 | Cases included in the denominator will pass if:* **During the past year, the patient was screened by an acceptable provider using the National Clinical Reminder and used tobacco every day or some days and**
	+ **The patient was advised to quit smoking or stop using tobacco using the National Clinical reminder**

**OR*** **The facility is using the Cerner EHR and during the past year the patient was advised to quit smoking or stop using tobacco**

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| **Indicator** | **Description** | **Cohort(s)** | **Denominator** | **Numerator** |
| **smg10** | **Tobacco Use Cessation-Discussed Cessation Medications (outpt)**  | **50, (16, 48, 51, 60 and****othrcare not =1) 54 with FE flag and othrcare not=1** | **Includes all cases except:*** **The patient is enrolled in a VHA or community hospice**
* **Patients with a diagnosis of dementia/neurocognitive disorder as evidenced by one of the applicable codes AND**
	+ **During the past year, there is documentation by a physician/APN/PA using a Clinical Reminder that the patient has probable permanent cognitive impairment or**
		- **The severity of dementia was assessed during the past year by one of the specified tools and the score of the assessment indicated moderate to severe cognitive impairment (cogscor2=5) or**
		- **The score indicated mild dementia, no dementia or outcome was not documented and there is clinician documentation  the patient has  moderate or severe cognitive impairment or**
		- **The severity of dementia was not assessed using one of the specified tool and there is clinician documentation in the past year the patient has moderate or severe cognitive impairment (modsevci=1)**
* **During the past year, the patient was not screened or the patient declined to answer National Clinical Reminder for Tobacco Screening questions or**
	+ **The patient was screened using the National Clinical Reminder and did not use tobacco at all**

**OR****If the facility is using the Cerner EHR:*** **The patient was not screened by an acceptable provider, or refused to be screened or**
* **The tobacco screen was not positive**
 | **Cases included in the denominator will pass if:*** **During the past year, the patient was screened by an acceptable provider using the National Clinical Reminder and used tobacco every day or some days and**
	+ **The patient was offered FDA approved medications by a provider to assist in tobacco use cessation using the National Clinical Reminder**

**OR*** **The facility is using the Cerner EHR and during the past year the patient was offered FDA approved medications by a provider to assist in tobacco use cessation**
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| **Indicator** | **Description** | **Cohort(s)** | Denominator | **Numerator** |
| **smg9** | **Tobacco Use Cessation-Discussed Cessation Strategies (outpt)** | **50, (16, 48, 51, 60 and****othrcare not =1) 54 with FE flag and othrcare not=1** | **Includes all cases except:*** **The patient is enrolled in a VHA or community hospice**
* **Patients with a diagnosis of dementia/neurocognitive disorder as evidenced by one of the applicable codes AND**
	+ **During the past year, there is documentation by a physician/APN/PA using a Clinical Reminder that the patient has probable permanent cognitive impairment or**
		- **The severity of dementia was assessed during the past year by one of the specified tools and the score of the assessment indicated moderate to severe cognitive impairment (cogscor2=5) or**
		- **The score indicated mild dementia, no dementia or outcome was not documented and there is clinician documentation  the patient has  moderate or severe cognitive impairment or**
		- **The severity of dementia was not assessed using one of the specified tool and there is clinician documentation in the past year the patient has moderate or severe cognitive impairment (modsevci=1)**
* **During the past year, the patient was not screened or the patient declined to answer National Clinical Reminder for Tobacco Screening questions or**
	+ **The patient was screened using the National Clinical Reminder and did not use tobacco at all**

**OR****If the facility is using the Cerner EHR:*** **The patient was not screened by an acceptable provider, or refused to be screened or**
* **The tobacco screen was not positive**
 | **Cases included in the denominator will pass if:*** **During the past year, the patient was screened by an acceptable provider using the National Clinical Reminder and used tobacco every day or some days and**
	+ **The provider provided information about behavioral counseling or treatment options other than medication to assist patient with quitting smoking or using tobacco using the National Clinical Reminder for Tobacco Use**

**OR*** **The facility is using the Cerner EHR and during the past year the provider provided information about behavioral counseling or treatment options other than medication to assist the patient with quitting smoking or using tobacco**
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| **Indicator** | **Description** | **Cohort(s)** | **Denominator** | **Numerator** |
| smg19mn | Tobacco Use-Current MHLow score is better | 51 and othrcare not=1 | Includes all cases except:* The patient is enrolled in a VHA or community hospice
* Patients with a diagnosis of dementia/neurocognitive disorder as evidenced by one of the applicable codes AND
	+ During the past year, there is documentation by a physician/APN/PA using a Clinical Reminder that the patient has probable permanent cognitive impairment or
		- The severity of dementia was assessed during the past year by one of the specified tools and the score of the assessment indicated moderate to severe cognitive impairment (cogscor2=5) or
		- The score indicated mild dementia, no dementia or outcome was not documented and there is clinician documentation the patient has moderate or severe cognitive impairment or
		- The severity of dementia was not assessed using one of the specified tool and there is clinician documentation in the past year the patient has moderate or severe cognitive impairment (modsevci=1)
* The patient declined to answer National Clinical Reminder for Tobacco Use questions
* The patient was not screened for tobacco use using the National Clinical Reminder for Tobacco Use

ORIf the facility is using the Cerner EHR:The patient was not screened by an acceptable provider, or refused to be screened | Cases included in the denominator will also be included in the numerator if:* During the past year, the patient was screened for tobacco use by an acceptable provider using the National Clinical Reminder for Tobacco Use

 AND* + Smokes cigarettes or uses tobacco every day or
	+ Smokes cigarettes or uses tobacco some days

OR* The facility is using the Cerner EHR and during the past year, the patient was screened for tobacco use by an acceptable provider and the screen was positive

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| **Indicator** | **Description** | **Cohort(s)** | **Denominator** | **Numerator** |
| smg19n | Tobacco Use-Current-non MHLow score is better  | 50 | Includes all cases except:* The patient is enrolled in a VHA or community hospice
* Patients with a diagnosis of dementia/neurocognitive disorder as evidenced by one of the applicable codes AND
	+ During the past year, there is documentation by a physician/APN/PA using a Clinical Reminder that the patient has probable permanent cognitive impairment or
		- The severity of dementia was assessed during the past year by one of the specified tools and the score of the assessment indicated moderate to severe cognitive impairment (cogscor2=5) or
		- The score indicated mild dementia, no dementia or outcome was not documented and there is clinician documentation the patient has moderate or severe cognitive impairment or
		- The severity of dementia was not assessed using one of the specified tool and there is clinician documentation in the past year the patient has moderate or severe cognitive impairment (modsevci=1)
* The patient declined to answer National Clinical Reminder for Tobacco Use questions
* The patient was not screened for tobacco use using the National Clinical Reminder for Tobacco Use

ORIf the facility is using the Cerner EHR:* The patient was not screened by an acceptable provider, or refused to be screened
 | Cases included in the denominator will also be included in the numerator if:* During the past year, the patient was screened for tobacco use by an acceptable provider using the National Clinical Reminder for Tobacco Use

AND* + Smokes cigarettes or uses tobacco every day or
	+ Smokes cigarettes or uses tobacco some days

OR* The facility is using the Cerner EHR and during the past year, the patient was screened for tobacco use by an acceptable provider and the screen was positive
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| **Indicator** | **Description** | **Cohort(s)** | **Denominator** | **Numerator** |
| **p7** | **Screened for tobacco use Nexus clinics** | **50, (16, 48, 51, 60 and****othrcare not =1) 54 with FE flag and othrcare not=1** | **Includes all cases except:*** **The patient is enrolled in a VHA or community hospice**
* **Patients with a diagnosis of dementia/neurocognitive disorder as evidenced by one of the applicable codes AND**
	+ **During the past year, there is documentation by a physician/APN/PA using a Clinical Reminder that the patient has probable permanent cognitive impairment or**
		- **The severity of dementia was assessed during the past year by one of the specified tools and the score of the assessment indicated moderate to severe cognitive impairment (cogscor2=5) or**
		- **The score indicated mild dementia, no dementia or outcome was not documented and there is clinician documentation  the patient has  moderate or severe cognitive impairment or**
		- **The severity of dementia was not assessed using one of the specified tool and there is clinician documentation in the past year the patient has moderate or severe cognitive impairment (modsevci=1)**
 | **Cases included in the denominator will pass if:*** **During the past year, the patient was screened for tobacco use by an acceptable provider using the National Clinical Reminder for Tobacco Use**

**OR*** **If the facility is using the Cerner EHR, the patient was screened for tobacco use by an acceptable provider**
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| **MOVE!** |  |  |
| **Indicator** | **Description** | **Cohort(s)** | **Denominator** | **Numerator** |
| mov6 | Participation in MOVE!/Weight Management treatment | 50, (16, 48, 51, 60 andothrcare not =1), 54 with FE flag and othrcare=1 | Includes all cases except:* The patient is enrolled in a VHA or community hospice
* Age <=17 or >=70
* BMI is <25 or there is no BMI documented or calculated
* There is documentation within the past year of an indicator that weight management treatment is not appropriate
 | Cases included in the denominator will pass if:* Within the past year the patient participated in VA or non-VA weight management treatment on at least one occasion
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| **MEDICATION RECONCILIATION** |  |  |
| **Indicator** | **Description** | **Cohort(s)** | **Denominator** | **Numerator** |
| mrec43 | Reconciled medication list provided to patient | 50 or 51 and othrcare not=1, 54 and FE flag =1 and othrcare not=1 | Includes all cases except:* The most recent Nexus encounter was NOT with a physician/APN/PA in a non-group setting
* No medication list was given to the patient/caregiver **and** documented that patient maintains own medication list
* The patient refused a list of the reconciled medications
 | Cases included in the denominator will pass if: * When the visit is face to face, there is documentation that a written list of the reconciled discharge medications was provided to the patient/caregiver the same day or the day following the visit (opmedlst=3)
* When the visit is conducted by CVT, VVC, or telephone, there is documentation the medication list was sent by secure messaging or traditional mail on the same day or the day following the visit (opmedlst2=3)
 |
| mrec54 | Essential medication list for review with all components in note | 50 or 51 and othrcare not=1, 54 and FE flag =1 and othrcare not=1 | Includes all cases except:* The most recent Nexus encounter was NOT with a physician/APN/PA in a non-group setting
 | Cases included in the denominator will pass if: * During the most recent NEXUS encounter there is evidence in the medical record that a medication list for review included all of the Essential Medication List components
	+ Active VA Prescriptions
	+ Remote Active VA Prescriptions
	+ Non-VA Prescriptions
	+ Expired VA Prescriptions within the last 90 days( and may include those expired within the past 180 days)
	+ Discontinued VA Prescriptions within the last 90 days (and may include those discontinued within the past 180 days)
* Any Pending Medication Orders
* Patient Allergies (Remote facility and Local facility)
 |
| mrec61 | Essential medication list reviewed with patient/caregiver  | 50 or 51 and othrcare not=1, 54 and FE flag =1 and othrcare not=1 | Includes all cases except:* The most recent Nexus encounter was NOT with a physician/APN/PA in a non-group setting
* There is documentation the patient/caregiver is unable or unwilling to participate in review of essential medication list components
 | Cases included in the denominator will pass if:* During the most recent NEXUS encounter there is evidence in the medical record the available essential medication list components were reviewed with the patient/caregiver
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| **Indicator** | **Description** | **Cohort(s)** | **Denominator** | **Numerator** |
| **ACOVE (age 75 years and older)** |  |  |
| fe1 | Assessed for urinary incontinence in the last 12 months | 54 and othrcare not=1 | Includes all cases except:* The patient is enrolled in a VHA or community hospice

Age <75* Cases with a code for urinary incontinence within the last 12 months
* The patient is already known to have urinary incontinence
* The patient has a urinary ostomy appliance, supra-pubic catheter or Foley catheter in place
 | Cases included in the denominator will pass if:The patient was screened for urinary incontinence in the past 12 months |
| fe3 | Fall history documented in the past 12 months | 54 and othrcare not=1 | Includes all cases except:* The patient is enrolled in a VHA or community hospice

Age <75 | Cases included in the denominator will pass if:The patient was asked about the presence/absence of any falls within the preceding 12 months |
| fe9 | Assessed functional status (ADL and IADL) in the past 12 months | 54 and othrcare not=1 | Includes all cases except:* The patient is enrolled in a VHA or community hospice

Age <75 | Cases included in the denominator will pass if:An assessment of the patient’s ADLs was performed in the last 12 months using a standardized toolANDAn assessment of the patient’s instrumental activities of daily living (IADLs) was performed in the last 12 months using a standardized tool |