#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
1	vhabps vhabpd	Enter the patient's most recent blood pressure documented in the VHA medical record within the past year. (Exclude BP taken in ED, Ambulatory Surgery, Urgent Care visit, or during an inpatient admission)	__ __ __ /__ __ __ **Abstractor can enter *zzz/zzz* if no blood pressure was taken at any applicable VHA outpatient encounter within the past year** **If vhabp z-filled, auto-fill bp1dt as 99/99/9999, and go to encarcor** Warning if vhabps <= 80 or > = 250 Warning if vhabpd < = 44 or > = 135 Hard edit: vhabps and vhabpd must be > 0 Hard edit: vhabps must be > than vhabpd	**Acceptable for BP measurement:** **1) BP taken by ancillary personnel. The individual taking the BP does not have to be one of the designated clinicians.** **2) BP measurement report documented in the VHA medical record (scanned report) from an outside provider or professional entities (e.g, Health Departments) is acceptable.** **3) BP measurement obtained from outside provider or professional entity documented in a clinic note by a licensed member of the healthcare team with the date the BP was measured.** **4) BP recorded by HBPC** If there are multiple BPs recorded for a single date at acceptable VHA outpatient encounters, use the lowest systolic and lowest diastolic BP on that date as the representative BP. The systolic and diastolic results do not need to be from the same reading. For example, patient was seen in primary care clinic and cardiology clinic on 12/22/20XX. Two BP measurements were noted - 148/82 and 138/92. Enter 138/82 as the lowest BP recorded for that date. **NOTE: Do not enter electronic capture of BP documented by Care Coordination (CC/H) as it will be entered in a subsequent question.** **EXCLUDE the following BP readings:** • Blood pressure taken in the Emergency Department, Ambulatory Surgery, Urgent Care visit, or during an inpatient admission. An Urgent Care clinic is not to be confused with a walk-in, non-urgent clinic (same day care clinic available at some facilities.) If the blood pressure taken in the ED or at an Urgent Care clinic is the patient's only BP taken within the past year, enter *zzz/zzz*. • Patient self-report of BP in person or via phone conversation is not acceptable (e.g., nurse documents, "Patient called. BP today 120/78). • BPs taken during an outpatient visit which was for the <u>**sole** purpose of having a diagnostic test or surgical procedure performed</u> (e.g., sigmoidoscopy, removal of a mole) • BPs obtained the same day as a major diagnostic or surgical procedure (e.g., stress test, administration of IV contrast for a radiology procedure,

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
				endoscopy) **If blood pressure was not taken at an accepted VHA encounter or documented in the VHA medical record within the past year, enter default ⚏⚏/⚏⚏.**
2	bp1dt	Enter the date this blood pressure was measured.	mm/dd/yyyy Will be auto-filled as 99/99/9999 if vhabp z-filled < = 1 year prior or = stdybeg and < = stdyend	Enter the exact date. The use of 01 to indicate missing day or month is not acceptable. If VHABPS and VHABPD were z-filled, the date will auto-fill as 99/99/9999. The abstractor cannot enter the 99/99/9999 default date if valid BP numbers were entered in VHABPS and VHABPD.
3	seehtnpt	On (display BP1DT), was the patient seen by a physician/APN/PA, pharmacist or RN case manager?	1, 2	This question refers to the outpatient encounter when the most recent BP was documented in the record (the BP entered in VHABPS/VHABPD). If the patient was seen by a pharmacist or RN case manager only on BP1DT, there must be documentation that the encounter was related to management of the patient's blood pressure.
4	prebpd prebps	During the year prior to (computer to display bp1dt), enter the BP recorded most immediately prior to the BP recorded on (computer to display bp1dt). (Exclude BP taken in ED, Ambulatory Surgery, Urgent Care visit, or during an inpatient admission)	__ __ __ /__ __ __ **Abstractor can enter ⚏⚏/⚏⚏ if no blood pressure was taken at any applicable VHA outpatient encounter during the year prior to bp1dt** **If prebps and prebpd z-filled, auto-fill prebpdt as 99/99/9999, and go to encarcor** Warning if prebps <=	**Acceptable for BP measurement:** **1) BP taken by ancillary personnel. The individual taking the BP does not have to be one of the designated clinicians.** **2) BP measurement report documented in the VHA medical record (scanned report) from an outside provider or professional entities (e.g, Health Departments) is acceptable.** **3) BP measurement obtained from outside provider or professional entity documented in a clinic note by a licensed member of the healthcare team with the date the BP was measured.** **4) BP recorded by HBPC** If there are multiple BPs recorded for a single date at acceptable VHA outpatient encounters, use the lowest systolic and lowest diastolic BP on that date as the representative BP. The systolic and diastolic results do not need to be from the same reading. For example, patient was seen in primary care clinic and cardiology clinic on 12/22/20XX. Two BP measurements were noted - 148/82 and 138/92.

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
			80 or > = 250 Warning if prebpd < = 44 or > = 135 Hard edit: prebps and prebpd must be > 0 Hard edit: prebps must be > than prebpd	Enter 138/82 as the lowest BP recorded for that date. **NOTE: Do not enter electronic capture of BP documented by Care Coordination (CC/H) as it will be entered in a subsequent question.** **EXCLUDE the following BP readings:** • Blood pressure taken in the Emergency Department, Ambulatory Surgery, Urgent Care visit, or during an inpatient admission. An Urgent Care clinic is not to be confused with a walk-in, non-urgent clinic (same day care clinic available at some facilities.) If the blood pressure taken in the ED or at an Urgent Care clinic is the patient's only BP taken within the past year, enter *zzz/zzz*. • Patient self-report of BP in person or via phone conversation is not acceptable (e.g., nurse documents, "patient called. BP today 120/78). • BPs taken during an outpatient visit which was for the **sole** <u>purpose of having a diagnostic test or surgical procedure performed</u> (e.g., sigmoidoscopy, removal of a mole) • BPs obtained the same day as a major diagnostic or surgical procedure (e.g., stress test, administration of IV contrast for a radiology procedure, endoscopy) **If blood pressure was not taken at an accepted VHA encounter or documented in the VHA medical record during the year prior to BP entered on BP1DT, enter default *zzz/zzz*.**
5	prebpdt	Enter the date this blood pressure was measured.	mm/dd/yyyy Will be auto-filled as 99/99/9999 if prebps/prebpd z-filled < = 1 year prior to bp1dt and < bp1dt	Enter the exact date. The use of 01 to indicate missing day or month is not acceptable. If PREBPS and PREBPD were z-filled, the date will auto-fill as 99/99/9999. The abstractor cannot enter the 99/99/9999 default date if valid BP numbers were entered in PREBPS and PREBPD.

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
6	encarcor	Is there documentation the patient was enrolled in Care Coordination (CC/H)?	1, 2 If 1, go to ccbps If 2, auto-fill ccbps as *zzz/zzz*, ccbpdt as 99/99/9999, and go to postbp	**Care Coordination (CC/H) electronic capture of BP**: Patient measures his BP and the readings are electronically transmitted to Care Coordination. This BP reading **cannot** be changed by the patient and does not involve patient interpretation. The BP readings are entered into the legal medical record by Care Coordination and are acceptable if they are clearly identified in the progress note as Care Coordination/Home Telehealth and electronically captured.
7	ccbpd ccbps	Enter the most recent blood pressure documented in the record by Care Coordination (CC/H).	__ __ __ /__ __ __ **Abstractor can enter** *zzz/zzz* **If valid, go to ccbpdt** **If z-filled, auto-fill ccbpdt as 99/99/9999 and go to postbp** Will be auto-filled as *zzz/zzz* if encarcor = 2 Warning if ccbps <= 80 or >= 250 Warning if ccbpd <= 44 or >= 135 Hard edit: ccbps and ccbpd must be > 0 Hard edit: ccbps must be > than ccbpd	**Care Coordination (CC/H) electronic capture of BP:** patient measures his BP and the readings are electronically transmitted to Care Coordination. This BP reading cannot be changed by the patient and does not involve patient interpretation. The BP readings are entered into the legal medical record by Care Coordination and are acceptable if they are clearly identified in the progress note as Care Coordination/Home Telehealth and electronically captured. If BP was not recorded by Care Coordination within the past year, enter default *zzz/zzz*. **Unacceptable:** BP taken by patient or caregiver at home and result phoned to VHA provider.
8	ccbpdt	Enter the date this blood pressure was measured.	mm/dd/yyyy Will be auto-filled as 99/99/9999 if encarcor or ccbps is z-filled < = 1 year prior or = stdybeg and < = stdyend	Enter the exact date. The use of 01 to indicate missing day or month is not acceptable.

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
9	postbp	After the study end date and up to and including the review date, was a blood pressure < 140/90 documented? **(Exclude BP taken in ED, Ambulatory Surgery, Urgent Care visit, or during an inpatient admission)**	1, 2 **If 2 and catnum = 61, go to scibps; else if 2, go to weight**	**Acceptable BP measurement:** 1) BP taken by ancillary personnel. The individual taking the BP does not have to be one of the designated clinicians. 2) BP measurement report documented in the VHA medical record (scanned report) from an outside provider or professional entities (e.g, Health Departments) is acceptable. 3) BP measurement obtained from outside provider or professional entity documented in a clinic note by a licensed member of the healthcare team with the date the BP was measured. 4) BP recorded by HBPC 5) BP recorded by Care Coordination **Exclude the following BP readings:** • Blood pressure taken in the Emergency Department, Ambulatory Surgery, Urgent Care visit, or during an inpatient admission. An Urgent Care clinic is not to be confused with a walk-in, non-urgent clinic (same day care clinic available at some facilities.) • Patient self-report of BP in person or via phone conversation is not acceptable (e.g., nurse documents, "patient called. BP today 120/78). • BPs taken during an outpatient visit which was for the <u>sole purpose of having a diagnostic test or surgical procedure performed</u> (e.g., sigmoidoscopy, removal of a mole) • BPs obtained the same day as a major diagnostic or surgical procedure (e.g., stress test, administration of IV contrast for a radiology procedure, endoscopy)

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
10	postbpd1 postbps1	Enter the first blood pressure < 140/90 documented in the record after the study end date and up to and including the review date.	__ __ __ /__ __ __ Hard edit: postbps1 must be > 0 and cannot be > 139 AND postbpd1 must be > 0 and cannot be > 89 Hard edit: postbps1 must be > than postbpd1 Warning if postbps1 <= 80 Warning if postbpd1 <= 44	If there is more than one acceptable BP < 140/90 after the study end date and up to the review date, enter the first acceptable BP that is less than 140/90. **Acceptable BP measurement:** 1) BP taken by ancillary personnel. The individual taking the BP does not have to be one of the designated clinicians. 2) BP measurement report documented in the VHA medical record (scanned report) from an outside provider or professional entities (e.g, Health Departments) is acceptable. 3) BP measurement obtained from outside provider or professional entity documented in a clinic note by a licensed member of the healthcare team with the date the BP was measured. 4) BP recorded by HBPC 5) BP recorded by Care Coordination If there are multiple BPs recorded for a single date at acceptable VHA outpatient encounters, use the lowest systolic and lowest diastolic BP on that date as the representative BP. The systolic and diastolic results do not need to be from the same reading. For example, patient was seen in primary care clinic and cardiology clinic on 12/22/20XX. Two BP measurements were noted as 148/82 and 138/92. Enter 138/82 as the lowest BP recorded for that date. **Exclude the following BP readings:** • Blood pressure taken in the Emergency Department, Ambulatory Surgery, Urgent Care visit, or during an inpatient admission. An Urgent Care clinic is not to be confused with a walk-in, non-urgent clinic (same day care clinic available at some facilities.) • Patient self-report of BP in person or via phone conversation is not acceptable (e.g., nurse documents, "patient called. BP today 120/78). • BPs taken during an outpatient visit which was for the sole purpose of having a diagnostic test or surgical procedure performed (e.g., sigmoidoscopy, removal of a mole) • BPs obtained the same day as a major diagnostic or surgical procedure (e.g., stress test, administration of IV contrast for a radiology procedure, endoscopy)

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
11	pstbpdt1	Enter the date the first BP < 140/90 was documented after the study end date.	mm/dd/yyyy > stdyend and <= revdte	If more than one acceptable BP of < 140/90 is documented after the study end date and up to the review date, enter the date of the first acceptable BP that is < 140/90.
		If catnum = 61, go to scibps; else go weight		
12	scibps scibpd	Enter the patient's last blood pressure measured prior to discharge during the patient's most recent inpatient admission.	__ __ __ /__ __ __ Abstractor can enter *zzz/zzz* If z-filled, auto-fill scibpdt as 99/99/9999 and go to weight Warning if scibps <= 80 or > = 250 Warning if scibpd < = 44 or > = 135 Hard edit: scibps and scibpd must be > 0 Hard edit: scibps must be > than scibpd	Enter the last BP recorded on the day of discharge OR if a BP was not recorded on the day of discharge, enter the last BP recorded prior to the day of discharge. If a blood pressure was not documented during the most recent inpatient admission, enter default zzz/zzz.
13	scibpdt	Enter the date this blood pressure was measured.	mm/dd/yyyy Will be auto-filled as 99/99/9999 if scibp z-filled >= admdt and <=dcdate	Enter the exact date. The use of 01 to indicate missing day or month is not acceptable. If SCIBPS and SCIBPD were z-filled, the date will be auto-filled as 99/99/9999. The abstractor cannot enter the 99/99/9999 default date if valid BP numbers were entered in SCIBPS and SCIBPD.
		Weight		

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
14	weight	Enter the patient's weight measured most recently within the past year.	_____ **Abstractor can enter default zzz if weight not measured within past year** If z-filled, auto-fill wtunit as 95	**Source:** May be taken from either the inpatient or outpatient record **Rules:** Use the most recent weight recorded in the medical record within the study parameters. If more than one weight is recorded during the most recent encounter, and the weights differ, use the lowest weight. **Enter default zzz if patient's weight was not measured within the past year.**
15	wtunit	Unit of measure: 1. Pounds 2. Kilograms 95. Not applicable	1, 2, 95 If weight z-filled, will be auto-filled as 95 Warning window: when wtunit = 1 and weight < = 98 or > = 278 When wtunit = 2, and weight < = 44 or > = 126	BMI is calculated in kilograms. If pounds are entered, the computer will convert pounds to kilograms in making the calculation. The resulting BMI is displayed on the computer screen. Abstractor cannot enter 95 if valid weight was entered in WEIGHT.
16	wtdt	Date the most recent weight was measured:	mm/dd/yyyy **If weight z-filled, auto-fill as 99/99/9999** < = 1 year prior or = stdybeg and < = stdyend	Day may be entered as 01, if exact date is unknown. At a minimum, the month and year must be entered accurately. If WEIGHT was z-filled, the date will be auto-filled as 99/99/9999. The abstractor cannot enter the 99/99/9999 default date if a valid weight is entered in question WEIGHT.
17	height	Enter the patient's height.	_____ **Abstractor can enter default zzz if no height available** If z-filled, auto-fill htunit as 95 and go to erefbmi	**No time period applies to this element.** If more than one height is recorded, use the most recent. Height must be entered wholly in inches or centimeters. If pt. is 5 feet 8 inches, enter 68. 5ft = 60 in. 6ft = 72in. **Enter default zzz if no height can be found in the record.**

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
18	htunit	Unit of measure: 1. Inches 2. Centimeters 95. Not applicable	1, 2, 95 If height z-filled, will be auto-filled as 95 If weight z-filled, go to erefbmi; else go to entrbmi Warning window: when htunit = 1, and height < = 56 or > = 77 when htunit = 2, and height < = 156 or > = 191	Body Mass Index = Wt (kg)/ Ht*Ht (M). If BMI is 25 -29.9, the patient is defined as overweight. If BMI is 30 or >, the patient is defined as obese. BMI will be displayed on computer screen once the height unit is entered, if the weight, weight unit, and height have also been entered. HTUNIT will be auto-filled as 95 if no valid height was entered. Abstractor cannot enter 95 if valid value was entered in question HEIGHT.
19	erefbmi	During the past year, is there documentation the patient refused measurement of weight or height? 1. Yes 2. No	1, 2	This question is informational only and does not impact current MOVE measures. Documentation from the inpatient or outpatient record during the past year that the patient refused measurement of weight or height is acceptable.
		MOVE! Weight Management Program		
20	entrbmi	Enter the patient's most recent BMI documented in the record within the past year.	__ __.__ **Abstractor can enter zz.z if no BMI documented in record** **If entrbmi z-filled, auto-fill bmidocdt as 99/99/9999** Only display entrbmi in software if BMI could not be calculated	Enter the most recent BMI documented in the record with the past year by facility personnel. BMI may sometimes be found documented with other vital signs within progress notes. **If no BMI is documented in the record within the past year, enter zz.z.**

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
21	bmidocdt	Enter the date this BMI was documented in the record.	mm/dd/yyyy Will be auto-filled as 99/99/9999 if BMI was calculated or if entrbmi = zz.z < = 1 yr prior to or = stdybeg and < = stdyend	Enter the exact date. The use of 01 to indicate missing day or month is not acceptable.

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
22	nowttx1 nowttx2 nowttx3 nowttx4 nowttx99	Within the past year, does the record document any of the following indicators that weight management treatment was not appropriate? **Indicate all that apply:** 1. Documented life expectancy of < 6 months 2. Patient enrolled in Hospice Care 3. Hospitalization for any reason in the 3 months prior to the most recent weight measurement 4. Physician/APN/PA documentation that patient was not a suitable candidate for weight management due to competing co-morbidities, *pregnancy, frequent hospitalizations, and/or other health status reasons 99. None of the above documented	1, 2, 3, 4, 99 **Question nowttx is applicable to ALL patients *If nowttx = 1, 2, 3, or 4 auto-fill permnotx as 95, epalcare as 95, waistcir as 95, obesdx as 95, movetx as 95, movedate as 99/99/9999, and moveoffr as 95, and go to asesadl**	The intent of this question is to exclude patients with certain health conditions from the MOVE indicators. Patients with limited life expectancy or other health conditions that would limit the benefit of any weight management treatment or would severely limit the patient's ability to participate in weight management treatment are excluded from the MOVE indicators. • Patient's life expectancy of less than six months must be documented by a physician, APN, or PA in the problem list, in the computer field "health factors," or in the progress notes. • Notation of patient enrollment in Hospice is sufficient to enter "2." • Pregnancy is an exclusion for this indicator and may be documented by a nurse or clinician. Examples of health conditions that may limit patient's ability to participate in weight management treatment include (but are not limited to): acutely exacerbated substance abuse or mental health conditions, acutely exacerbated chronic medical conditions (e.g., congestive heart failure, COPD, musculoskeletal illness/injury, acute moderate-serious infections or injuries). **Examples of physician/APN/PA documentation that patient was not a suitable candidate for weight management:** "Patient with BMI 32 but weight management treatment not appropriate at this time due to acute exacerbation of COPD." "Patient is obese based on BMI, but is experiencing mental status changes which make weight management treatment difficult at this time. Will defer discussion for when patient's mental status has improved." **Note:** Clinician documentation that weight management treatment is not appropriate because the patient has a normal BMI or a BMI 25- 29.9 without obesity associated conditions does not meet the intent of this question. Enter "99."

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
23	epalcare	During the past year, is there physician/APN/PA documentation that the patient received palliative care? 1. Yes 2. No 95. Not applicable	1, 2, 95 Will be auto-filled as 95 if nowttx = 1, 2, 3, or 4	This question is informational only and does not impact current MOVE measures. Palliative care is specialized medical care for people with serious illnesses. It is focused on providing patients with relief from the symptoms, pain, and stress of a serious illness-whatever the diagnosis. The goal is to improve quality of life for both the patient and the family. Palliative care treats people suffering from serious and chronic illnesses including, but not limited to, cancer, cardiac disease such as Congestive Heart Failure (CHF), Chronic Obstructive Pulmonary Disease (COPD), kidney failure, Alzheimer's, HIV/AIDS and Amyotrophic Lateral Sclerosis (ALS). Suggested data sources: Consultation, palliative care notes, progress notes
24	permnotx	During the year <u>prior</u> to the past year, is there one physician/APN/PA documentation of a permanent contraindication to weight management treatment? 1. Yes 2. No 95. Not applicable	1, 2, 95 Will be auto-filled as 95 if nowttx = 1, 2, 3, or 4 **If 1, auto-fill waistcir as 95, obesdx as 95, movetx as 95, movedate as 99/99/9999, and moveoffr as 95, and go to asesadl; else if 2, go to waistcir**	**Year prior to the past year** = Determine "the past year" by counting back one year to the first day of the month of the first date of the study interval (as is calculated for "within the past year.") Look for a permanent contraindication to weight management treatment documented during the year prior to this date. (Example: The study begin date is 11/01/12; one year previous to past year would be 11/01/10 to 10/31/11). **Look in the computer field "health factors" for documentation of a permanent contraindication to weight management treatment. The health factor must be verified by physician/APN/PA documentation in the medical record. Each health factor should have an associated date that represents the date the health factor was recorded.** Examples of permanent contraindications to weight management may include (but are not limited to): terminal or end stage disease (e.g., ESRD, end-stage COPD), progressive neurologic condition (e.g., ALS, Dementia, Parkinson's disease)
25	waistcir	During the past year, is the patient's waist circumference above 40 inches (102cm) if male or above 35 inches (88 cm) if female? 1. Yes (WC is above threshold) 2. No (WC is at or below threshold) 95. Not applicable 99. No waist circumference documented	1, 2, 95, 99 Will be auto-filled as 95 if nowttx = 1, 2, 3, or 4, or if permnotx = 1	Waist circumference may be referred to as abdominal girth (AG) and is sometimes recorded with other vital signs or noted in provider progress notes. A high waist circumference is associated with an increased risk for type 2 diabetes, dyslipidemia, hypertension, and CVD.

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
26	obesdx5 obesdx1 obesdx7 obesdx3 obesdx4 obesdx2	Within the past year, does the record document a diagnosis of any of the following obesity-related comorbidities? 1. Diabetes 2. Obstructive sleep apnea 3. Hypertension 4. Hyperlipidemia/dyslipidemia 5. Degenerative Joint Disease 7. Metabolic syndrome 1. Yes 2. No 95. Not applicable	1, 2, 95 Will be auto-filled as 95 if nowttx = 1, 2, 3, or 4, or if permnotx = 1 **If seldm = -1, auto-fill obesdx1 as 1** **If selhtn = -1, auto-fill obesdx3 as 1** **If obesdx1 = 1, auto-fill seldm as 1** **If obesdx3 = 1, auto-fill selhtn as 1** **If (BMI > 0 and < 25 and waistcir = 2 or 99), OR if (BMI >= 25 and < 30 AND ALL obesdx = 2 AND waistcir = 2 or 99), auto-fill movetx as 95, movedate as 99/99/9999 and moveoffr as 95, and go to efolplan as applicable, else go to movetx**	Documentation of medical diagnoses: • Medical diagnoses must be documented in the clinic notes, problem list, or health factors by a physician, APN, or PA • Diagnoses documented in a clinical reminder by a RN, LPN, or KT (kinesiotherapist) must be confirmed in the medical record by clinician documentation. Diabetes and hypertension will be auto-filled if selected in the Validation Module. **Obstructive sleep apnea:** look in progress notes and problem list for this diagnosis. Codes 780.57 and 786.03 may be indicative of obstructive sleep apnea, although 786.03 lists sleep apnea as an exclusion. **Do not select hyperlipidemia/dyslipidemia based on lipid profile results. There must be a specific diagnosis of hyperlipidemia or dyslipidemia documented by a designated clinician.** **Degenerative joint disease may be selected if a diagnosis of osteoarthritis is documented by a designated clinician.** Look for codes 715.00-715.98. Do not select metabolic syndrome based on an elevated fasting glucose and/or elevated triglycerides. There must be a specific diagnosis of metabolic syndrome documented by a designated clinician. Look in problem list or clinic notes. Code 277.7 may be indicative of metabolic syndrome. **Source:** Diagnoses may be taken from either the inpatient or outpatient record.

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
27	movetx	Within the past year, did the patient participate in weight management treatment on at least one occasion? 1. Patient participated in VA weight management treatment 2. Patient participated in non-VA weight management treatment 3. Patient did not participate in any weight management treatment 95. Not applicable	1, 2, 3, 95 Will be auto-filled as 95 if nowttx = 1, 2, 3, or 4, OR if permnotx = 1, OR if (BMI > 0 and < 25 and waistcir = 2 or 99), OR if (BMI >= 25 and < 30 AND ALL obesdx = 2 AND waistcir = 2 or 99) If movetx = 1 or 2, auto=fill moveoffr as 1 If movetx = 3, auto-fill movedate as 99/99/9999, and go to moveoffr	Look in progress notes for documentation that the patient participated in weight management treatment on at least one occasion. Acceptable documentation could include: • Clinic notes documenting the provision of weight management treatment, such as progress notes from phone calls or clinic visits (group or individual) related to weight management counseling or treatment. Weight management treatment encounters could be face-to-face visits, phone calls, or clinical video teleconferencing. • Copy of either the MOVE!23 or MOVE!11 Patient or Staff Report in the progress notes. • Evidence that the patient is participating in a home telehealth version of MOVE (sometimes called TeleMOVE) or MOVE!Telephone Lifestyle Coaching (MOVE TLC). • A notation from the clinician that patient is participating in a weight management program outside of the VA facility (e.g., Weight Watchers, TOPS, HMR, Optifast, etc.). Unacceptable documentation: • For the purposes of this question, weight management treatment programs that target only one aspect of weight management (e.g. Nutrisytem, Curves) are not acceptable. Web based or mobile application weight loss programs that do not include group or individual sessions with a coach or clinical staff are not acceptable. If the patient did not participate in weight management treatment or there is documentation the patient refused weight management within the past year, enter "3."

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
28	movedate	Enter the date of the most recent weight management treatment visit or telephone contact.	mm/dd/yyyy Will be auto-filled as 99/99/9999 if nowttx = 1, 2, 3, or 4, OR if permnotx = 1, OR if (BMI > 0 and < 25 and waistcir = 2 or 99), OR if (BMI >= 25 and < 30 AND ALL obesdx = 2 AND waistcir = 2 or 99), or if movetx = 3 If movetx = 1 or 2, go to asesadl as applicable < = 1 year prior to or = stdybeg and < = stdyend	Look in the progress notes for documentation of the date of the most recent visit or phone contact related to MOVE!23, MOVE!11, or other VA weight management treatment. If patient is receiving weight management treatment outside of the VA, look for documentation/confirmation by a VA clinician of the patient's continued participation in the non-VA program. Enter the date of the most recent note that confirms/documents continued participation in a non-VA program. Enter the exact date. The use of 01 to indicate missing month or year is not acceptable.

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
29	moveoffr	Within the past year, was the patient provided information on the risks of overweight or obesity AND provided information about available weight management treatment? 1. Yes 2. No 95. Not applicable	1, 2, 95 Will be auto-filled as 95 if nowttx = 1, 2, 3, or 4, OR if permnotx = 1, OR if (BMI > 0 and < 25 and waistcir = 2 or 99), OR if (BMI >= 25 and < 30 AND ALL obesdx = 2 AND waistcir = 2 or 99) Will be auto-filled as 1 if movetx = 1 or 2 If (age < 65 AND BMI < 18.5 or >= 25) OR (age >= 65 years AND BMI < 23 or >= 30), go to efolplan; else go to asesadl as applicable	**Look in progress notes or in health factors for documentation that the health care professional provided information to the patient on the health risks of the patient's overweight or obesity problem AND documentation that weight management treatment, such as the MOVE! Program, was discussed and offered to the patient.** Brief advice from a health care professional to lose weight, eat right, or be physically active **does not** qualify as offering treatment. While physicians, nurses, and mid-level providers are the clinicians most likely to provide this information and offer treatment, any qualified health care professional can discuss the health risks of obesity with the patient and provide information about treatment that is available and document this conversation with the patient. This includes health care professionals such as Pharmacists, Registered Dietitians, Rehabilitation Specialists (PT, OT, KT, RT), Psychologists, and Social Workers. While a variety of health professional staff can provide information about treatment that is available to patients, the suitability, timing, and parameters of treatment for an individual patient should be determined by clinical staff credentialed and privileged to make these determinations. Weight management treatment is identified as a specific, on-going clinical activity (such as MOVE! Weight Management Program) either within the facility or in the community. Some MOVE! Programs are carried out by referral to a specific clinic, others are embedded within primary care clinics and do not require a referral.

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
30	efolplan1 efolplan2 efolplan3 efolplan4 efolplan5 efolplan6 efolplan7 efolplan8 efolplan99	During the past year, did a physician/APN/PA, or pharmacist document a follow-up plan for a BMI outside of normal parameters? **Select all that apply:** 1. Schedule future appointment to follow-up on BMI 2. Provide education related to abnormal BMI 3. Referral such as registered dietician, nutritionist, occupational therapy, physical therapy, exercise physiologist, mental health professional, bariatric surgery 4. Pharmacological interventions such as prescribing orlistat (BMI above normal) or megestrol acetate (BMI below normal) 5. Recommend or prescribe dietary supplements 6. Discuss exercise 7. Provide nutrition counseling 8. Other 99. None of the above	1, 2, 3, 4, 5, 6, 7, 8, 99	This question is informational only and does not impact current MOVE measures. **BMI outside of normal parameters:** • Age 65 years and older BMI < 23 or >= 30 • Age 18 to 64 years BMI < 18.5 or > 25 **Documentation of follow-up interventions must be related to the BMI outside of normal parameters. Example:** "Patient referred to nutrition counseling for BMI > 30". **Follow-up intervention for BMI outside of normal parameters may include, but is not limited to:** • Schedule future appointment to follow-up on BMI • Provide education • Referral such as registered dietician, nutritionist, occupational therapy, physical therapy, exercise physiologist, mental health professional, bariatric surgery • Pharmacological interventions such as prescribing orlistat (BMI above normal), megestrol acetate (BMI below normal) • Dietary supplements • Exercise and/or nutrition counseling **Discussion or offer of an intervention is sufficient to select the intervention. Example:** Primary care provider offers referral to nutritionist and patient says she will think about it. Select "3".
		If (age < 65 AND BMI < 18.5 or >= 25) OR (age >= 65 years AND BMI < 23 or >= 30), go to efolplan; else go to asesadl as applicable		
		If patient age 75 or >, go to asesadl; else go out of Module		
		Frail Elderly		

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
31	asesadl	Within the past 12 months, was an assessment of the patient's ADLs performed using a standardized and published tool?	1, 2 If 2, auto-fill adltool as 95, adldt as 99/99/9999, and go to asesiadl	Activities of daily living include bathing, dressing, toileting, transferring, continence, and feeding. **Standardized and published Tools: Katz Index of Independence in Activities of Daily Living;** Other tools are acceptable but must be standardized and published. If another standardized and published tool is used, the tool must be named, and the questions and scoring must be in accordance with the authentic screening tool. In order to answer "1," the documentation must clearly indicate that ADLs were assessed using a standardized and published tool and interpretation of the results must be documented.
32	adltool	What standardized and published tool was used to assess ADLs? 1. Katz Index of Independence in Activities of Daily Living Scale 2. Other 95. Not applicable	1, 2, 95 Will be auto-filled as 95 if asesadl = 2	Katz Index of Independence in Activities of Daily Living assesses the patient's independence or dependence in six areas: bathing, dressing, toileting, transferring, continence, and feeding. The total points range from 0 (patient very dependent) to 6 (patient independent). If another standardized and published tool is used, the tool must be named, and the questions and scoring must be in accordance with the authentic screening tool.
33	adldt	Enter the date of the most recent assessment of ADLs using a standardized and published tool.	mm/dd/yyyy Will be auto-filled as 99/99/9999 if asesadl = 2 < = 12 mos prior to or = stdybeg and < = stdyend	Exact date should be available in the record. The use of 01 to indicate missing day or month is not acceptable.

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
34	asesiadl	Within the past 12 months, was an assessment of the patient's instrumental activities of daily living (IADLs) performed using a standardized and published tool?	1, 2 If 2, auto-fill iadltool as 95, iadldt as 99/99/9999 and go to askfalls	**Instrumental activities of daily living includes ability to use telephone, shopping, food preparation, housekeeping, laundry, mode of transportation, responsibility for own medications, and ability to handle finances.** **IADL standardized and published tool: Instrumental Activities of Daily Living Scale (IADL) M.P. Lawton and E.M. Brody** Other tools are acceptable but must be standardized and published. In order to answer "1," the documentation must clearly indicate that IADLs were assessed using a standardized and published tool and the interpretation of the results must be documented.
35	iadltool	What standardized and published tool was used to assess IADLs? 1. Lawton Instrumental Activities of Daily Living Scale 2. Other 95. Not applicable	1, 2, 95 Will be auto-filled as 95 if asesiadl = 2	**Lawton Instrumental Activities of Daily Living Scale assesses eight domains of independent living skills: ability to use telephone, shopping, food preparation, housekeeping, laundry, mode of transportation, responsibility for own medications, and ability to handle finances.** **A summary score ranges from 0 (low function, dependent) to 8 (high function, independent).** If another standardized and published tool is used, the tool must be named, and the questions and scoring must be in accordance with the authentic screening tool.
36	iadldt	Enter the date of the most recent assessment of IADLs using a standardized and published tool.	mm/dd/yyyy $\leq$ 12 mos prior to or = stdybeg and $\leq$ stdyend Will be auto-filled as 99/99/9999 if asesiadl = 2	Exact date should be available in the record. The use of 01 to indicate missing day or month is not acceptable.
		Falls		
37	askfalls	During the past twelve months, was the patient asked about the presence/absence of any falls <u>during the preceding 12 months</u>?	1, 2 If 2, go to uicode	For persons age 75 or older, a falls history should be obtained on annual basis. **In order to answer "1," documentation within the past 12 months must indicate the patient was asked about the presence/absence of any falls during the preceding 12 months. Sources: Inpatient or outpatient record.** Inpatient Nursing Assessment is suggested as a likely source.

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
38	askfaldt	Enter the date the patient was most recently questioned about falls during the preceding 12 months.	mm/dd/yyyy Will be auto-filled as 99/99/9999 if askfalls = 2 $\leq$ = 12 mos prior to or = stdybeg and $\leq$ = stdyend	Exact date should be available in the record. The use of 01 to indicate missing day or month is not acceptable.
		Urinary Incontinence		
39	uicode	Within the past 12 months, did the patient record contain a urinary incontinence ICD-9-CM code of 788.3 (all decimals included) or 307.6, 596.55, 599.82, or 625.6	*1, 2 *If 1, go to end	788.3 - 788.39 Incontinence of urine codes 307.6: enuresis of non-organic origin. Involuntary urination past age of normal control; also called bedwetting, no trace to biological problem; focus on psychological issues 625.6: stress incontinence, female. Involuntary leakage of urine due to insufficient sphincter control; occurs upon sneezing, laughing, coughing, sudden movement, or lifting 596.55: detrusor sphincter dyssynergia 599.82: intrinsic (urethral) sphincter deficiency
40	uiscrapp	Did the record document that screening for the presence of urinary incontinence is appropriate for this patient? 1. Yes 2. No, patient already known to have urinary incontinence 3. No, patient has a urinary ostomy appliance, supra-pubic catheter, or Foley catheter in place	1, 2, 3 If 2 or 3, go to end	**Appropriate for UI screening** = Patients without known problem of urinary incontinence If there is documentation of pre-existing urinary incontinence, enuresis, intrinsic (urethral) sphincter deficiency, or detrusor sphincter dyssynergia, select "2." If there is documentation the patient has a urinary ostomy appliance, supra-pubic catheter, or Foley catheter in place, answer "3."

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
41	uiscreen	Within the past 12 months, was the patient screened for urinary incontinence? 1. Yes 2. No	1, 2 If 2, go to end	**Acceptable as screening for urinary incontinence (UI):** • UI observed (urine odor or stained garments, direct observation of urine loss during examination) • UI reported spontaneously • UI reported in response to specific questioning. There must be mention of questioning on "leakage", "urine loss", "incontinence", or "urinary incontinence." A generic review of systems listed as "negative for renal disease" or "no bowel or bladder problems" without mention of questioning for UI would not be acceptable. Documentation of "genitourinary system review of symptoms negative" is acceptable.
42	uiscrndt	Enter the most recent date the patient was screened for urinary incontinence.	mm/dd/yyyy < = 12 mos prior to or = stdybeg and < = stdyend	Exact date should be available in the record. The use of 01 to indicate missing day or month is not acceptable.