VHA EXTERNAL PEER REVIEW PROGRAM
VALIDATION MODULE
Third Quarter FY2014

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
		Organizational Identifiers		
	VAMC	Facility ID	**Auto-fill**	
	CONTROL	Control Number	**Auto-fill**	
	QIC	Abstractor ID	**Auto-fill**	
	BEGDTE	Abstraction Begin Date	**Auto-fill**	
	REVDTE	Abstraction End Date	**Auto-fill**	
		Patient Identifiers		
	SSN	Patient SSN	**Auto-fill: no change**	
	PTNAMEF	First Name	**Auto-fill: no change**	
	PTNAMEL	Last Name	**Auto-fill: no change**	
	BIRTHDT	Birth Date	**Auto-fill: no change**	
	SEX	Sex	**Auto-fill: can change**	
	MARISTAT	Marital Status	**Auto-fill: no change**	
	RACE	Race	**Auto-fill: no change**	
1	dxexcld	Does the patient have one of the following diagnoses: 1. Multiple Sclerosis (MS), <u>without</u> primary problem of paraplegia 2. Amyotrophic Lateral Sclerosis (ALS) 3. Guillain-Barre Syndrome 4. malignant tumor of the spinal cord 95. not applicable 99. patient has none of these diagnoses	1*, 2, *3*, 4*, 95, 99 If catnum <> 36 or 61 will be auto-filled as 95 **Abstractor cannot enter 95** *If 1, 2, 3, or 4, and catnum = 36 or 61, exclude the record. If 99 and catnum = 61, go to ipadm, else go to nonvet	**Excluded:** ALS (commonly known as Lou Gherig's disease), Guillain-Barre Syndrome, malignant tumor of the spinal cord, and MS in which patient does not have primary problem of paraplegia. **Included:** Benign tumors of the spinal cord**,** MS in which patient does have primary problem of paraplegia (paralysis of the legs and lower part of the body) associated with the disease process. **Abstractor cannot enter 95.** **<u>Exclusion Statement</u>:** **The patient's diagnosis does not meet inclusion criteria for the spinal cord injury and disorders cohort.**
2	ipadm	Did the patient with a diagnosis of spinal cord injury have an inpatient admission at this VA within the past year?	1, *2 *If 2, go to nonvet	The inpatient admission does not have to be related to the spinal cord injury. If the only admission at this VA in the past year is for the patient's annual SCI evaluation, answer "1."

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3	admdt	Enter the date of admission to inpatient care.	mm/dd/yyyy **Can be modified** < = 1 year prior or = stdybeg and < = stdyend	**May be auto-filled from OABI pull list; can be modified.** A patient of a hospital is considered an inpatient upon issuance of written doctor's orders to that effect.
4	admtm	Enter the time of admission to inpatient care.	____ UMT	Do not use ER discharge time or patient transfer time. Enter time in Universal Military Time.
5	dcdate	Enter the date of discharge.	mm/dd/yyyy >=admdt and warning if > 6 months after admdt	May be auto-filled from the OABI pull list. If the discharge date is not auto-filled, enter the exact date.
6	dctime	Enter the time of discharge.	____ UMT >admdt/admtm	Enter time in Universal Military Time.
7	dcdispo	What was the patient's discharge disposition on the day of discharge? 1. Home • Assisted Living Facilities (ALFs) - includes assisted living care at nursing home/facility • Court/Law Enforcement - includes detention facilities, jails, and prison • Home - includes board and care, domiciliary, foster or residential care, group or personal care homes, retirement communities, and homeless shelters • Home with Home Health Services • Outpatient Services including outpatient procedures at another hospital, outpatient Chemical Dependency Programs and Partial Hospitalization	1, 2, 3, 4, 5, 6, 7, 99	**Discharge disposition: The final place or setting to which the patient was discharged on the day of discharge.** • **Only use documentation from the day of or the day before discharge when abstracting this data element.** For example: Discharge planning notes on 04-01-20xx document the patient will be discharged back home. On 04-06-20xx, the nursing discharge notes on the day of discharge indicate the patient was being transferred to skilled care. Enter "5". • **Consider discharge disposition documentation in the discharge summary, post-discharge addendum, or a late entry as day of discharge documentation, regardless of when it was dictated/written.** • **If there is documentation that further clarifies the level of care that documentation should be used to determine the correct value to abstract. If documentation is contradictory, use the latest documentation.** For example: Discharge planner note from day before

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		2. Hospice - Home (or other home setting as listed in #1 above) 3. Hospice - Health Care Facility • General Inpatient and Respite, Residential and Skilled Facilities, and Other Health Care Facilities 4. Acute Care Facility • Acute Short Term General and Critical Access Hospitals • Cancer and Children's Hospitals • Department of Defense and Veteran's Administration Hospitals 5. Other Health Care Facility • Extended or Immediate Care Facility (ECF/ICF) • Long Term Acute Care Hospital (LTACH) • Nursing Home or Facility including Veteran's Administration Nursing Facility • Psychiatric Hospital or Psychiatric Unit of a Hospital • Rehabilitation Facility including Inpatient Rehabilitation Facility/Hospital or Rehabilitation Unit of a Hospital • Skilled Nursing Facility (SNF), Sub-Acute Care or Swing Bed • Transitional Care Unit (TCU) 6. Expired 7. Left Against Medical Advice/AMA 99. Not documented or unable to determine		discharge states "XYZ Nursing Home". Nursing discharge note on day of discharge states "Discharged: Home." Select "1". • If documentation is contradictory, and you are unable to determine the latest documentation, select the disposition ranked highest (top to bottom) in the following list. ◦ Acute Care Facility ◦ Hospice - Health Care Facility ◦ Hospice - Home ◦ Other Health Care Facility ◦ Home • Values "2" and "3" hospice includes discharges with hospice referrals and evaluations • If the medical record states only that the patient is being discharged to another hospital and does not reflect the level of care that the patient will be receiving, select "4". • If the medical record identifies the facility the patient is being discharged to by name only (e.g., Park Meadows) and does not reflect the type of facility of level of care, select "5". • If the medical record states only that the patient is being discharged and does not address the place or setting to which the patient was discharged, select "1". • Selection of option "7" (left AMA): ◦ Explicit "left against medical advice" documentation is not required (e.g., "Patient is refusing to stay for continued care"- select "7"). **For the purposes of this data element, a signed AMA form is not required.** ◦ If any source states the patient left against medical advice, select value "7", regardless of whether the AMA documentation was written last. ◦ Documentation suggesting that the patient left before discharge instructions could be given without "left AMA" documentation does not count. **Excluded Data Sources:** Any documentation prior to the last two days of

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				hospitalization, coding documents **Suggested Data Sources:** Discharge instruction sheet, discharge planning notes, discharge summary, nursing discharge notes, physician orders, progress notes, social service notes, transfer record
8	nonvet	Did the record document the patient was a non-veteran? 1. Yes 2. No	1*, 2 *If 1, the record is excluded	In order to answer "1," there must be documentation that the patient is not a veteran. Examples: non-veteran female patient who is married to a veteran, active duty military personnel receiving care at this VA **Exclusion Statement:** Non-veteran cases are excluded from outpatient review.
9	seenyr	Was the **veteran** seen within the last twelve months by a physician, NP, PA, Psychologist, or Clinical Nurse Specialist in one of the "Nexus clinics"? **Within the last 12 months = twelve months from the first day of the study interval to the end of the study interval** "Nexus clinics" include primary care and specialty clinics as defined in past years plus mental health clinics added in FY05. The abstractor can scroll through the drop box to view the clinic listing to ensure the patient was seen in a Nexus clinic.	1, 2* If 1, go to nexusdt ***If 2 and catnum <> 61, the record is excluded If 2 and ipadm = 2, the record is excluded, else if ipadm = 1, go to selectdx**	All the following must be true to answer "yes:" • the patient was a veteran • the clinic visit occurred within 12 months from the first day of the study interval to the end of the study interval; • the visit occurred at one of the Nexus clinics; • during the visit, the patient was seen face-to-face (includes televideo encounter) by a physician, NP, PA, Psychologist, or Clinical Nurse Specialist. The qualifying visit may NOT be a telephone call. Subsequent visits during the year may be phone calls. **Exclusion Statement:** **Although the stop code indicated a visit to a Nexus clinic, the veteran was not seen by a physician, NP, PA, Psychologist, or Clinical Nurse Specialist in an applicable outpatient clinic within the study year.**
10	nexusdt	Enter the date of the most recent visit to a Nexus clinic during which the patient was seen by a physician, NP, PA, Psychologist, or Clinical Nurse Specialist.	mm/dd/yyyy < = 1 year prior or = stdybeg and < = stdyend	Most recent visit = the visit in which the patient was seen most immediately prior to the end of the study interval Enter the exact date of the visit to the Nexus clinic. The use of 01 to indicate missing day or month is not acceptable.

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11	wichnxus	For the most recent NEXUS clinic visit when the patient was seen by a physician, APN, PA, or psychologist, enter the name of the NEXUS clinic. **(Abstractor will select name from a drop down box of NEXUS Clinics.)**	_____ wichnxus	This question asks for the name of the NEXUS clinic for the visit that occurred on the date entered in NEXUSDT. Do not enter a NEXUS clinic name for a visit that occurred after the study end date.
12	onlyone	Was this visit the patient's only encounter with this VAMC within the last twelve months?	1, 2 **If 2, auto-fill specvst as 95**	Within the last 12 months = twelve months from the first day of the study interval**.** **Pharmacy visits for prescriptions, and laboratory visits are not considered encounters for purposes of CGPI data collection.**
13	specvst	Was the one visit limited to unscheduled urgent care, a specialist appointment, or post-hospitalization follow-up at a tertiary center (that was not to an SCI Center or SCI support clinic for catnums 36 and 61)? 1. yes 2. no 95. not applicable	1*, 2, 95 If onlyone = 2, will be auto-filled as 95 ***If 1 and catnum <> 61, the record is excluded** **If 1 and catnum = 61, go to selectdx** If 2 and mental health flag = 1; go to othrcare; else if 2, go to selectdx	**Examples:** 1. Patient presents as a "walk-in" to General Medicine clinic and asks to be seen for a severe respiratory infection. The patient is treated only for the acute illness. 2. Patient is followed routinely at a CBOC near his home. A suspected heart valve problem is identified, and the patient is referred to a cardiologist at the Boston VAMC. The only record available to the abstractor is the specialist visit to the cardiologist in Boston. 3. Patient with schizophrenia is initially admitted to his local VAMC, but severity of his symptoms requires discharge to a tertiary center for acute inpatient psychiatric care. Following discharge, he returns in three weeks to the tertiary center for a scheduled post-discharge follow-up visit. The visit selected for review is the post-discharge visit to the tertiary center. **Exclusion Statement:** Only limited care could be provided at the patient's one encounter with this VAMC.
		If Mental Health flag = 1, go to othrcare; otherwise, go to selectdx		

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14	othrcare	Is there evidence in the medical record that <u>within the past two years</u>, the patient refused VHA Primary Care and is receiving ONLY his/her primary care in a non-VHA setting? **To answer "1," both evidence of refusal of VHA Primary Care and documentation of primary care received outside VHA must be present in the record.**	1, 2 **If FEFLAG = 0, go to asesadl in Core Module**	**There must be specific documentation of patient refusal of VHA Primary Care, <u>and the refusal must have occurred within the past two years</u>.** (Examples: record documents that patient does not wish to be seen in VHA Primary Care clinics, prefers to seek care elsewhere, or does not wish to receive care at all unless under emergency circumstances. Documentation of patient statements such as "I only signed up for VA for my MH service-connected condition." or "My private physician does all my primary care" represent refusal of VHA Primary Care.) **Receiving primary care ONLY in a non-VHA setting:** The patient may be receiving mental health or other specialty care at the VAMC, but his/her primary care <u>during the past two years</u> was received outside VHA. (Examples: patient's medical care is being provided by a primary care provider who does not practice in the VHA system; patient under care of non-VHA specialist who provides his/her primary care; patient receives care from other sources such as free clinics.)
15	selcabg selchf selckd selcopd selpci selhtn selmi selnone seldm	**Did the patient have one or more of the following active diagnoses?** **NOTE:** ICD-9-CM codes are used only as examples to guide the abstractor and are not all-inclusive. Diagnoses are determined by clinician documentation, not by the presence or absence of codes. **Indicate all that apply:** **1 = Hypertension** 401 (excludes elevated blood pressure without diagnosis of hypertension, pulmonary hypertension, that involving vessels of brain and eye) 401.0 = malignant hypertension 401.1 = benign hypertension 401.9 = unspecified hypertension **2 = COPD, chronic bronchitis, emphysema, or bronchiectasis**	1, 2, 3, 4, 5, 6, 7, 11, 99 **If selcopd = T, auto-fill fluhirsk2 and pnuhirsk4** **If dmflag = 1, auto-fill fluhirsk3 and pnuhirsk2** **If selmi = T, auto-fill pnuhirsk3 and vascdis1**	'Active' diagnosis = the condition was ever diagnosed and there is no subsequent statement, prior to the most recent outpatient visit, indicating the condition was resolved or is inactive. **Medical diagnoses must be recorded as the patient's diagnosis by a physician, NP, PA, or CNS in clinic notes or discharge summary.** **Diagnoses documented on a problem list must be validated by a clinician diagnosis.** **Because a problem list may not be all-inclusive, it is expected that reviewer will read all progress notes for the Nexus clinics for a year to identify all diagnoses.** **<u>Hypertension</u>** A diagnosis recorded as 'borderline hypertension' is hypertension <u>if</u> it is coded as hypertension and being treated as hypertension, by recommended weight loss and/or recommended increase in physical activity, and/or prescription for medication such as a diuretic, beta-blocker, ACE, ARB, or calcium channel blocker. **<u>COPD</u>** Acute or chronic asthma is not applicable to the COPD diagnosis. ICD-9-CM

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		496 = chronic airway obstruction, NEC (includes chronic nonspecific lung disease, chronic obstructive lung disease, chronic obstructive pulmonary disease) (Note: does not include pneumoconioses and other lung diseases due to external agents, **3 = Diabetes Mellitus** 250 (excludes gestational diabetes, hyperglycemia NOS, neonatal DM, nonclinical diabetes) **4 = Old Myocardial Infarction** ICD-9-CM code 412 = old myocardial infarction. The abstractor may determine the patient had a past AMI from clinician documentation, and presence of the 412 code is not an absolute requirement **5 = PCI in past two years (Enable IHD Module)** **Abstractor must know approximate month and year of px** ICD-9-CM Code: 00.66 **6 = CABG in past two years (Enable IHD Module)** **Abstractor must know approximate month and year of px** ICD-9-CM Codes: 36.1, 36.2 **7 = CHF (May also be noted as "systolic dysfunction")** **See applicable codes in Definitions/Decision rules** **11 = Chronic Kidney Disease or ESRD (end stage renal disease)** **Codes: 585.1, 585.2, 585.3, 585.4 585.5, 585.6, 585.9** Chronic kidney may also be documented as chronic renal disease, chronic renal insufficiency, or chronic uremia. **99 = patient did not have any of these diagnoses**		codes 500-508. Does not include "restrictive airway disease" or COPD/asthma) 491 = chronic bronchitis (491.0 - 491.9) 492 = emphysema (492-0 = emphysematous bleb; 492.8 = other emphysema 494 = bronchiectasis **Diabetes Mellitus** Applicable for insulin-dependent, oral hypoglycemic medication, or diet control alone. **'Borderline diabetes' is not considered DM** 250.0 - 250.8 (with 5th digit classification) **Old Myocardial Infarction** The past AMI must have occurred more than eight weeks prior to the date of the most recent NEXUS visit, with treatment at any VHA or community acute care hospital. Do not presume AMI if record states CAD, ASHD, CABG, PTCA, angina, or IHD. Previous MI must be documented by a clinician. Patient self-report is not acceptable. **PCI or CABG in past two years:** from the first day of the study interval to the first day of the same month two years previously **The abstractor must be able to determine the month and year the procedure was performed for PCI and/or CABG. If month and year cannot be known or extrapolated from documentation, do not select these procedures as applicable to the case under review.** CHF (May also be noted as "systolic dysfunction") Codes include both heart failure directly attributable to hypertension and heart failure characterized only as myocardial failure. CHF must be listed as a patient diagnosis in the outpatient clinic setting, and not merely referring to a one-time acute episode of CHF. Not acceptable: cardiomyopathy with no reference to CHF ICD-9-CM codes: (Codes are used only as examples to guide the abstractor and are not all-inclusive. Diagnoses are determined by clinician documentation, not by the presence or absence of codes.) 402.01 = malignant hypertensive heart disease with congestive heart failure 402.11 = benign hypertensive heart disease with congestive heart failure 402.91= unspecified hypertensive heart disease with congestive heart failure 404.01 = malignant hypertensive heart and renal disease with congestive heart

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				failure 404.11 = benign hypertensive heart and renal disease with congestive heart failure 404.91 = unspecified hypertensive heart and renal disease with congestive heart failure 428.0 = congestive heart failure (includes right heart failure, secondary to left heart failure) 428.1 = left heart failure 428.9 = heart failure, unspecified **The list of CHF codes should also include 398.91, 428.2x, and 428.4x.**
		Nexus Clinics 303 - Cardiology 305 - Endocrinology/Metabolism 306 - Diabetes 309 - Hypertension 312 - Pulmonary/Chest 322 - Womens Clinic 323 - Primary Care/Medicine 350 - Geriatric Primary Care 348 - Primary Care - Group 310/323 - Chronic Infectious Disease Primary Care 323/531 - Mental Health Primary Care 509 - Psych MD Individual 510 - Psychology Individual 512 - Psych Consultation 557 - Psych MD Group 558 - Psychology Group 502 - MH Clinic Individual 550 - MH Clinic Group 533 - **MH Intervention Biomed care individual** (for use by MH clinicians who provide individual.....primary dx is med rather than psych.....examples; chronic pain, essential hypertension, LBP, migraine HA, obesity....) 565 - **MH, Intervention Biomed Group** - group examples.....chronic pain, essential hypertension, LBP,		In determining whether the patient was seen in a Nexus clinic, the abstractor should be guided by whether the clinic is a Mental Health clinic or a Primary Care clinic (or Cardiology, Endocrinology, etc.) If unable to make a definitive decision, consult with the facility Liaison for help in determining the clinic Stop Code. Stop codes can be found in VISTA in the Patient Care Encounter (PCE) program.

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		migraine HA, obesity....) 560 - Substance Use Disorder Group 513 - Substance Use Disorder Individual 523 - Opioid Substitution 540 - PCT - PTSD individual 561 - PCT - PTSD Group 577 - Psychogeriatric group 576 - Psychogeriatric clinic - individual 559 - Psychosocial Rehab Group 532 - Psychosocial Rehab Individual 516 - Post Traumatic Stress Disorder (PTSD) Group 562 - PTSD Individual In determining whether the patient was seen in a Nexus clinic, the abstractor should be guided by whether the clinic is a Mental Health clinic or a Primary Care clinic (or Cardiology, Endocrinology, etc.) If unable to make a definitive decision, consult with the facility Liaison for help in determining the clinic Stop Code. Stop codes can be found in VISTA in the Patient Care Encounter (PCE) program. 519 - SUD/PTSD Teams 503 - MH Residential Care 552 - MHICM - Individual 567 - MHICM - Group 524 - Active Duty Sexual Trauma 534 - MH Integrated Care Day Programs • 505 - Day Treatment Individual • 506 - Day Hospital Individual • 547 - Intensive SUD Group • 553 - Day Treatment Group • 554 - Day Hospital Group • 580 - PTSD Day Hospital		

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		Clinics applicable <u>only</u> to SCI patients: 210 - SCI 215 - SCI Home Care Program 315 - Neurology 414 - Urology 201 - Rehabilitation **DO NOT INCLUDE**: 117 - Nurse Only Visit 160 - Pharmacy Consult 450 - Compensation & Pension Exam 529 - Health Care for Homeless Vet 591 - Incarcerated Veterans Re-entry 535 - MH Vocational Assist Individual 573 - MH Incentive Therapy Group 574 - MH Compensated Work Tx Group 575 - MH Vocational Group 566 - MH Risk Factor - reduction education group 654 - Non-VA Residential Care Days 655 - Commmunity non-VA 656 - DoD Non-VA care 670 - Assisted Living VHA-paid, staff anything paired with 707 Smoking Cessation anything paired with 713 Gambling Addiction any of the telephone (527, 528, 530, 536, 537....) Off Station MH (residential SUD home, ICCM Homeless) 691 - Pre-employ physical-military 710 - Flu clinics 717 - PPD only		