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| --- | --- | --- | --- | --- | --- |
| 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 12/22/08. Two BP measurements were noted - 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.) 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** 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)   **If blood pressure was not taken at an accepted VHA encounter or documented in the VHA medical record within the past year, enter default zzz/zzz.** |
| 2 | bp1dt | Enter the date this blood pressure was measure. | 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 | bpdocvs | Was the most recent blood pressure entered in VHABPS/VHABPD documented in the Vital Signs package? | 1,2 | Only answer “1” if the most recent BP value entered in VHABPS and VHABPS was documented in the vital signs package in CPRS. If even one component (e.g. systolic or diastolic value) of the most recent BP was documented in a progress note, answer “2.” For example, the most recent BP documented in VS package is 144/86. APN retakes BP on the same date and documents in clinic note, “BP - 136/86.” Answer “2.” |
| 4 | seehtnpt | On (display BP1DT), was the patient seen by a physician/APN/PA? | 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). |
| 5 | 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. |
| 6 | ccbps  ccbpd | 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. |
| 7 | 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. |
| 8 | 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, go to weight, else go to postbps1** | **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 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) |
| 9 | cpostbpdt | Computer to enter the date POSTBP question was answered. | mm/dd/yyyy |  |
| 10 | postbps1  postbpd1 | 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 12/22/08. 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) |
| 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. |
| 12 | postbpvs | Was the blood pressure entered in POSTBPS/POSTBPD documented in the Vital Signs package? | 1,2 | Only answer “1” if the most recent BP value entered in POSTBPS and POSTBPS was documented in the vital signs package in CPRS. If even one component (e.g. systolic or diastolic value) of the most recent BP was documented in a progress note, answer “2.” For example, the most recent BP documented in VS package is 144/86. APN retakes BP on the same date and notes “BP - 136/86.” Answer “2.” |
|  |  | **Weight** |  |  |
| 13 | 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.** |
| 14 | wtunit | Unit of measure:   1. Pounds 2. Kilograms    1. 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. |
| 15 | 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. |
| 16 | height | Enter the patient’s height. | \_\_\_\_\_ **Abstractor can enter default zz if no height available**  If z-filled, auto-fill htunit as 95. | **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 zz if no height can be found in the record.** |
| 17 | htunit | Unit of measure:   1. Inches 2. Centimeters    1. Not applicable | 1,2,95  If height z-filled, will be auto-filled as 95   |  | | --- | | Warning window: when htunit = 1, and height < = 56 or > = 77  when htunit = 2, and height < = 156 or > = 191 |   **If BMI cannot be calculated, go to entrbmi, else auto-fill entrbmi as zz.z and bmidocdt as 99/99/9999, and go to nowttx** | 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. |
| **If patient age 70 or >, go to asesadl; else go to entrbmi** | | | | |

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|  |  | **MOVE! Weight Management Program** |  |  |
| 18 | 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** | 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.** |
| 19 | 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. |

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| 20 | | nowttx  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 5. None of the above documented | 1,2,3,4,99  **Question nowttx is applicable to ALL patients age < 70**  **\*If nowttx = 1,2,3, or 4 auto-fill permnotx 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.  \*Pregnancy is an exclusion for this indicator and may be documented by a nurse or clinician.  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.”  **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.”  “Obesity patient with advanced Alzheimer’s dementia, unable to fully participate in a behaviorally-based weight management program at this time.”  **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.” |
| 21 | | permnotx | | During the year prior to the past year, is there 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 7/01/10; one year previous to past year would be 7/01/08 to 6/30/09).  **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 conditions 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, or moderate-severe chronic, progressive neurologic conditions, ALS, Parkinson’s, dementia, etc.) |
| 22 | | waistcir | | 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. |
| 23 | | obesdx  obesdx1  obesdx2  obesdx3  obesdx4  obesdx5  obesdx7 | | 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   1. 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 asesadl, 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. |
| 24 | 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 4. 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. * Copy of either the MOVE!23 Patient or Staff Report in the progress notes. * Evidence that the patient is participating in a home telehealth version of MOVE (sometimes called TeleMOVE). * A notation from the clinician that patient is participating in a weight management program outside of the VA facility. |
| 25 | 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   |  | | --- | | < = 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 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. |
| 26 | 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 | **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. |
| **If patient age 75 or >, go to asesadl; else go out of Module** | | | | | | |

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|  |  | | **Frail Elderly** |  |  |
| 27 | asesadl | | Within the past 12 months, was an assessment of the patient’s ADLs performed using a standardized 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 Tools: Katz Index of Independence in Activities of Daily Living;**  Other tools are acceptable but must be standardized and published.  If another standardized tool is used, the standardized instrument 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 tool and interpretation of the results must be documented. |
| 28 | adltool | | What standardized 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 = 95 | 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 tool is used, the standardized instrument must be named, and the questions and scoring must be in accordance with the authentic screening tool. |
| 29 | adldt | | Enter the date of the most recent assessment of ADLs using a standardized 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. |
| 30 | asesiadl | | Within the past 12 months, was an assessment of the patient’s instrumental activities of daily living (IADLs) performed using a standardized 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 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 tool and the interpretation of the results must be documented. |
| 31 | iadltool | | What standardized 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 tool is used, the standardized instrument must be named, and the questions and scoring must be in accordance with the authentic screening tool. |
| 32 | iadldt | | Enter the date of the most recent assessment of IADLs using a standardized tool. | mm/dd/yyyy   |  | | --- | | < = 12 mos prior to or = stdybeg and < = 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** |  |  |
| 33 | askfalls | | Within the past twelve months, was the patient asked about the presence/absence of any falls within the preceding 12 months? | 1,2  If 2, auto-fill askfaldt as 99/99/9999 | 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 within the preceding 12 months.**  **Sources: Inpatient or outpatient record**. Inpatient Nursing Assessment is suggested as a likely source. |
| 34 | askfaldt | | Enter the date the patient was most recently questioned about falls within the past 12 months. | mm/dd/yyyy  Will be auto-filled as 99/99/9999 if askfalls = 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. |
| 35 | reptfall | | During the past twelve months, did the patient report a fall(s)?  1. One fall with no injury  2. Two or more falls  3. At least one fall with injury requiring treatment  4. No falls within the past year | 1,2,3,\*4  **\*If 4, go to uicode** | Patient report does not have to be in response to questioning by the PCC staff. Patient may self-report a fall without being questioned about a fall history. (Example: during a regularly scheduled clinic visit for hypertension, the patient mentions and the clinician records the patient had a fall since the last visit.)  **Injury Requiring Treatment**: any fall for which a patient seeks medical attention, i.e., a visit (usually to clinic or ED.) The degree of treatment (cold pack vs band aid) is not an issue. |
| 36 | falldt | | Enter the date of the most recent fall reported by the patient. | mm/dd/yyyy  If reptfall = 1 OR stdyend - falldt < 90 days, go to uicode; else if reptfall = 2 or 3 AND stdyend - falldt >= 90 days, go to falleval2   |  | | --- | | < = 12 mos prior to or = stdybeg and < = stdyend | | **If the patient reported a fall without injury OR two or more falls, enter the date the patient reported the fall (s).**  **If the patient reported at least one fall with injury and received treatment for the fall at any VAMC, enter the date of the actual fall. If the patient was not treated at a VAMC, enter the date the fall was reported.**  For example, patient was asked about falls during the past 12 months on 02/07/2011 and reported he fell 4 months ago and went to ED at this VAMC. Enter the date the fall occurred.  Month and year should be known and entered accurately. If the exact day is not known, 01 may be entered. |
| 37 | | falleval2 | On the day of or during the 3 months after the most recent fall or report of fall, was a basic fall evaluation, documenting all of the following five components completed?   * Circumstances of the fall * Medications patient is taking * Relevant chronic conditions * Diagnostic plans/therapeutic recommendations * Documentation of action taken as appropriate  1. Yes 2. No | 1,2 | **The basic fall evaluation must address all five components. The individual components may be accepted from different progress notes on the day that the most recent fall or report of fall was evaluated. If even one component is not included in the basic fall evaluation, the abstractor must answer “2.”**  **If there is documentation on the day of or during the 3 months after the most recent fall or report of fall that the patient was referred to a falls clinic, answer “1.”**  **Circumstances of the fall**: how fall(s) occurred; patient injury sustained, treatment required for injury  **Medications patient is taking**: review of medications which may have contributed to patient fall or mobility disorder (Example: “addition of beta blocker may have caused orthostatic hypotension resulting in patient fall”)  **Relevant chronic conditions**: diseases/disorders likely to contribute to patient fall risk (Example: “DJD in both hips with severe stiffness and pain is contributing to fall risk.”)  **Diagnostic plans/therapeutic recommendations**: changes in patient medications, use of adaptive/assistive equipment, restriction in environment for cognitively impaired patients, adaptation of living conditions to decrease fall risk, i.e., installation of hand rails  **Documentation of action taken**: medication changes, treatment for chronic conditions, recommendations and referrals |
| 38 | | faleyex | On the day of or during the 3 months after the most recent fall or report of fall, does the record document an eye exam was performed?  1. Yes  2. No | 1,2  If 2, auto-fill eyexamdt as 99/99/9999 and go to orthobp | **An eye exam may be performed by an optometrist or ophthalmologist. Documentation in a clinic note that visual acuity was checked using a Snellen or other eye chart is sufficient to answer “yes” to this question.** |
| 39 | | eyexamdt | Enter the date of the eye exam performed closest to the date of the most recent fall or report of fall. | mm/dd/yyyy  Will be auto-filled as 99/99/9999 if  faleyex = 2   |  | | --- | | < = 3 months after or = falldt and < = stdyend | | Month and year should be known and entered accurately. If the exact day is not known, 01 may be entered. |
| 40 | | orthobp | On the day of or during the 3 months after the most recent fall, does the record document assessment of orthostatic blood pressure?  1. Yes  2. No | 1,2  If 2, auto-fill orthbpdt as 99/99/9999 and go to gaiteval | **Orthostatic BP check (lying, sitting, standing) may be performed by a nurse.** |
| 41 | | orthbpdt | Enter the date of the orthostatic BP assessment closest to the date of the most recent fall or report of fall. | mm/dd/yyyy  Will be auto-filled as 99/99/9999 if  orthobp = 2   |  | | --- | | < = 3 months after or = falldt and < = stdyend | | Month and year should be known and entered accurately. If the exact day is not known, 01 may be entered. |
| 42 | | gaiteval | On the day of or during the 3 months after the most recent fall, does the record document a basic gait evaluation was completed?  1. Yes  2. No | 1,2  If 2, auto-fill gaitdt as 99/99/9999 and go to baleval | **A basic gait evaluation may be performed by a physician/APN/PA or physical therapy in an inpatient or outpatient setting.**  A gait exam that includes any of the following elements is acceptable: side by side/semi-/full tandem, pick up penny from floor, resistance to nudge/Romberg, turning, reference to stability when sitting, walking or rising.  **Note:** A combined “gait and balance” exam, such as Tinetti or “get up and go” exam passes this question.  Physician/APN/PA or physical therapy documentation that “gait is normal” (or other similar wording) is acceptable.  Suggested data sources: clinic notes, ED notes, physical therapy/occupational health notes, home health notes |
| 43 | | gaitdt | Enter the date of the basic gait evaluation completed closest to the date of the most recent fall or report of fall. | mm/dd/yyyy  Will be auto-filled as 99/99/9999 if  gaiteval = 2   |  | | --- | | < = 3 months after or = falldt and < = stdyend | | Month and year should be known and entered accurately. If the exact day is not known, 01 may be entered. |
| 44 | | baleval | On the day of or during the 3 months after the most recent fall, does the record document a balance evaluation was completed?  1. Yes  2. No | 1,2  If 2, auto-fill balevldt as 99/99/9999, and go to neuroevl | **A balance evaluation may be performed by a physician/APN/PA or physical therapy in an inpatient or outpatient setting.**  **Note:** A combined “gait and balance” exam, such as Tinetti or “get up and go” exam passes this question.  Physician/APN/PA or physical therapy documentation such as “balance is normal” (or other similar wording) is acceptable. |
| 45 | | balevldt | Enter the date of the balance evaluation completed closest to the date of the most recent fall or report of fall. | mm/dd/yyyy  Will be auto-filled as 99/99/9999 if  baleval = 2   |  | | --- | | < = 3 months after or = falldt and < = stdyend | | Month and year should be known and entered accurately. If the exact day is not known, 01 may be entered. |
| 46 | | neuroevl | On the day of or during the 3 months after the most recent fall, does the record document a neurologic exam was completed?  1. Yes  2. No | 1,2  If 2, auto-fill neurodt as 99/99/9999 and go to aseshaz | **Neurologic exam must be completed by physician/APN/PA. The neurologic exam must include two or more of the following evaluation components: cranial nerves, motor, sensory, vestibular screen, reflexes, cerebellar function/coordination and tone.**  **A generalized statement by the physician/APN/PA, such as “neuro exam – no focal findings” is acceptable only if at least two of the above components are documented in the note.** |
| 47 | | neurodt | Enter the date of the neurologic exam completed closest to the date of the most recent fall or report of fall. | mm/dd/yyyy  Will be auto-filled as 99/99/9999 if  neuroevl = 2   |  | | --- | | < = 3 months after or = falldt and < = stdyend | | Month and year should be known and entered accurately. If the exact day is not known, 01 may be entered. |
| 48 | | aseshaz | On the day of or during the 3 months after the most recent fall or report of fall, does the record document an assessment of home hazards?  1. Yes  2. No | 1,2  If 2, auto-fill idhazard as 95, hazdt as 99/99/9999, hazmod as 95, hazmodt as 99/99/9999, and go to uicode | **Assessment of home hazards includes, but is not limited to: questioning the patient/caregiver regarding layout of the home, steps, rugs, hand rails, lighting.**  **If the record documents an order for an in-home safety evaluation was given to the patient, enter “1.”**  Suggested data sources: clinic notes, nursing notes, physical therapy/occupational health notes, social work notes, home health notes |
| 49 | | hazdt | Enter the date the assessment of home hazards was completed. | mm/dd/yyyy  Will be auto-filled as 99/99/9999 if  aseshaz = 2   |  | | --- | | < = 3 months after or = falldt and < = stdyend | | **If assessment for home hazards occurred on more than one date during the time frame, enter the date of the assessment closest to the date that the fall was reported.**  Month and year should be known and entered accurately. If the exact day is not known, 01 may be entered. |
| 50 | | idhazard | Were any home hazards identified? | 1,2,95  If 2, auto-fill hazmod as 95, hazmodt as 99/99/9999, and go to uicode | Home hazards include, but are not limited to: lack of hand rails, steps, throw rugs, poor lighting  Suggested data sources: clinic notes, in-home safety evaluation note, nursing notes, physical therapy/occupational health notes, social work notes, home health notes |
| 51 | | hazmod | On the day of or during the 3 months after the most recent fall or report of fall, does the record document modification of home hazards was recommended to the patient/caregiver?  1. Yes  2. No  95. Not applicable | 1,2, 95  Will be auto-filled as 95 if aseshaz = 2 or idhazard = 2  If 2, auto-fill hazmodt as 99/99/9999 and go to uicode | **The intent of the question is to determine if recommendations were made or that education was provided to the patient/caregiver regarding home hazard modifications. It is not necessary to confirm that the home hazards were modified.**  **Modification/education of home hazards includes, but is not limited to: advising the patient/caregiver to remove throw rugs, install hand rail in bathroom, use of night lights, use of bedside commode, avoiding rapid position changes.**  Suggested data sources: clinic notes, nursing notes, physical therapy/occupational health notes, social work notes, home health notes |
| 52 | | hazmodt | Enter the date that modification of home hazards was recommended to the patient/caregiver. | mm/dd/yyyy  Will be auto-filled as 99/99/9999 if  aseshaz = 2,  idhazard = 2, or  hazmod = 2   |  | | --- | | < = 3 months after or = falldt and < = stdyend | | **If recommendations for modification of home hazards occurred on more than one date during the time frame, enter the date closest to the date that the fall was reported.**  Month and year should be known and entered accurately. If the exact day is not known, 01 may be entered. |
|  | |  | **Urinary Incontinence** |  |  |
| 53 | | 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, auto-fill uiscrapp as 2, uiscreen as 95, uiscrndt as 99/99/9999, uinewcon as 95, uievalnd as 95, uiworkup  as 95, and 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 |
| 54 | | 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  Will be autofilled as 2 if uicode = 1  If 2 or 3, auto-fill uiscreen as 95, uiscrndt as 99/99/9999, uinewcon as 95, uievalnd as 95, uiworkup as 95, and 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.” |
| 55 | | uiscreen | Within the past 12 months, was the patient screened for urinary incontinence?     1. Yes 2. No   95. Not applicable | 1, 2, 95  Will be autofilled as 95 if uicode is 1 or uiscrapp is 2 or 3  If 2, auto-fill uiscrndt as 99/99/9999, uinewcon as 95, uievalnd as 95, and uiworkup  as 95, and 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. |
| 56 | | 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. |
| 57 | | uinewcon | Was urinary incontinence a new condition identified for this patient?   1. Yes 2. No 3. Not applicable | 1,2,95  Will be auto-filled as 95 if uicode = 1, or uiscrapp = 2 or 3, or uiscreen = 2  If 2, auto-fill uievalnd as 95, and uiworkup  as 95, and go to end | Urinary incontinence should be marked as being present if any of the following synonyms are present: mild, moderate, or severe stress incontinence; inability to control bladder function; involuntary loss of urine during coughing, sneezing, laughing; involuntary loss of urine; inability to hold urine; involuntary loss of urine associated with over-distension of the bladder. |
| 58 | | uievalnd | Did the record document that additional evaluation of urinary incontinence was needed?   1. Yes 2. No, patient satisfied with current status 3. No, patient declines further evaluation of urinary incontinence 4. No, in the overall clinical picture for this patient, UI evaluation is not indicated   95. Not applicable  99. None of the above or unable to determine | 1,2,3,4,95,99  Will be auto-filled as 95 if uicode = 1, or uiscrapp = 2 or 3, or uiscreen = 2, or uinewcon = 2  If 2,3, or 4, auto-fill uiworkup as 95, and go to end | Urinary incontinence first identified at a new evaluation requires completion of a targeted history that documents all factors described in question UIWORKUP.  In order to answer “2,” there should be documentation that the patient is satisfied with current (wet) condition as evidenced by completion of a standardized questionnaire with an outcome consistent with satisfaction of current status. An example of an appropriate tool would be the AUA-SI 8 question on global satisfaction: **“If you were to spend the rest of your life with your urinary problem the way it is now, how would you feel about that?** Acceptable responses include: **Delighted/Pleased/Mostly satisfied**.  For option 3, there must be documentation that the patient identified as having incontinence was informed about treatment options and declined further evaluation.  For option 4, there must be documentation that the overall clinical picture for this patient is such that UI evaluation is not indicated. Documentation of clinical factors such as the patient’s limited life expectancy is acceptable. |
| 59 | | uiworkup | Was a targeted incontinence history, documenting all of the following five factors obtained?   * Type of urinary incontinence and quantification * Prior treatment for urinary incontinence * Mobility and cognition assessment * Physical examination * Laboratory assessment   1. Yes   2. No   95. Not applicable | 1,2,95  Will be auto-filled as 95 if uicode = 1, or uiscrapp = 2 or 3, or uiscreen = 2, or uinewcon = 2, or  uievalnd = 2,3, or 4 | **The targeted incontinence history must address all five factors. The individual factors may be accepted from different progress notes.**  **If even one factor is not included in the incontinence history, the abstractor must answer “2.”**  1) **Type of UI and quantification**: Comment on characteristics of urine loss must be made. This can be listed as: urge, stress, mixed, functional, or overflow; or symptoms suggestive of any one of the above. Degree of urine loss should be quantified by any of the following: patient estimate as to the amount of urine lost (number of pads or undergarments, volume of urine lost, degree to which clothes are damp); patient estimate as to the frequency of urine loss; or any measure of the bother experienced by the patient.  (2) **Prior treatment for urinary incontinence:** Documentation of any prior treatments attempted and success/failure of previous efforts.  (3) **Mobility and cognition assessment**: Ability to get to toilet and cognition should be assessed as either “intact with respect to continence”, or “barrier to gaining continence”.  (4) **Physical examination**: An abdominal, genital, and rectal examination must be performed. The physical exam must be done as part of the urinary incontinence history, or make reference to a prior visit for UI in the past 3 months when an abdominal, genital, and rectal physical exam was performed.  (5) **Laboratory assessment:** There should be a laboratory examination of a urine specimen which may be a formal urinalysis, urine culture, or urine dipstick. |
| **If FEFLAG = 0, go to Frail Elderly Instrument** | | | | | |