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| [**Link to Mnemonics and Questions**](https://secure.wvmi.org/QUESTIONS/Specifications/Mnemonics%20and%20Questions/fy2023q2/MnemonicQuestions2q23.xlsx) | | | | | | |
| 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).**  **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) Telehealth BP: A BP reading documented in a clinical video telehealth (CVT) or telephone visit note or in the vital signs package.**  **NOTE: Telehealth BP is not the same as Care Coordination (CC/H) electronic capture of BP. BP captured by CC/H will be entered in a subsequent question.**  **6) Self-reported** **BP readings by the patient/caregiver that are documented in the medical record.**  **7) BP readings taken on a day of low intensity or preventive procedures are acceptable to use. Low intensity/preventive procedures include but are not limited to vaccinations, allergy injections, lidocaine injections, eye exams with dilating agents, wart or mole removal.**  **8)** **A documented “average BP” (e.g., “average BP: 139/70”) is eligible for use**  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.  **Cont’d next page** | |
|  |  | |  |  | | **BP cont’d**  **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. * When excluding BP readings, the intent is to identify diagnostic or therapeutic procedures that require a medication regimen, a change in diet or a change in medication. * BPs taken during an outpatient visit which was for the **sole** purpose of having a diagnostic test or surgical procedure performed (e.g., sigmoidoscopy, stress test). * BPs obtained the same day as a major diagnostic or surgical procedure (e.g., administration of IV contrast for a radiology procedure; cardiac catheterization; endoscopy). * BPs obtained the same day as a therapeutic procedure (examples include but are not limited to dialysis, chemotherapy). * BP ranges and thresholds do not meet criteria   **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.**  Cerner suggested data sources: Ambulatory View/Vital Signs (adjust timeframe and confirm acceptable source in Documentation/Progress note |
| 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 | encarcor | | Is there documentation the patient was enrolled in Care Coordination (CC/H)?  1. Yes  2. No | 1,2  If 1, go to ccbps  If 2, auto-fill ccbps as zzz/zzz, ccbpdt as 99/99/9999, and go to weight as applicable | | **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. |
| 4 | 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 scibp as applicable**  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.  Cerner suggested data sources: Ambulatory View/Vital Signs (adjust timeframe and confirm acceptable source in Documentation/Progress note; CC/H vital signs should be marked |
| 5 | 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. |
|  |  | | **Weight** |  | |  |
| 6 | 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 and go to height | | **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.** |
| 7 | 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. |
| 8 | 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 entrbmi | | **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.** |
| 9 | htunit | | Unit of measure:   1. Inches 2. Centimeters    1. Not applicable | 1,2,95  If height z-filled, will be auto-filled as 95  If weight z-filled, 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. |

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|  |  | **MOVE! Weight Management Program** |  |  |
| 10 | 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**  **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.** |
| **If BMI or ENTRBMI >= 25, go to nowttx; else go to asesadl** | | | | |
| 11 | nowttx  nowttx3  nowttx4  nowttx5  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. Acute Inpatient Hospitalization for any reason in the 3 months prior to the most recent weight measurement 2. Physician/APN/PA documentation that patient was not a suitable candidate for weight management due to competing co-morbidities, frequent hospitalizations, and/or other health status reasons 3. Pregnancy or postpartum period 4. None of the above documented | 3,4,5,99  **Question nowttx is applicable to ALL patients**   |  | | --- | | Can only select 5 if sex = female |   **\*If nowttx = 3,4, or 5, auto-fill movetx as 95, movedate as 99/99/9999, and go to asesadl** | **The intent of this question is to exclude patients with certain health conditions from the MOVE indicators.**   * **Patients with 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 indicator.**   Notation of patient’s pregnancy or delivery of baby during the past year by a nurse or clinician is sufficient to select value 5.**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.” |
| 12 | 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 = 3,4, or 5  If movetx = 3, auto-fill movedate as 99/99/9999, and go to asesadl as applicable | **Look in progress notes for documentation that the patient participated in weight management treatment on at least one occasion.**  For the purposes of this question, clinician includes licensed health care professional (e.g., physician/APN/PA, RN, LPN, psychologist, registered dietitian, rehabilitation therapist, social worker) or health care professional who is under supervision of a licensed health care professional.  Acceptable documentation includes:  **1. VA Weight Management Treatment**   * Clinic notes specifying Veteran participation in any modality of the MOVE! Weight Management Program for Veterans: * Individual or group in-person, by telephone, or through video teleconferencing * Home telehealth (sometimes called TeleMOVE!). Participation in the Low Acuity, Low Intensity (L2) weight management protocol is also acceptable. * Use of the MOVE! Coach mobile application in conjunction with clinician support provided in-person, by phone, or via secure messaging. This is also known as MOVE! Coach with Care. * Use of Annie text messaging weight management protocol in conjunction with clinician support provided in-person, by phone, or via secure messaging. * Evidence that the clinician discussed the patient’s completed multifactorial assessment results (e.g., MOVE!11 questionnaire, or associated patient and/or healthcare provider reports) with the patient. * Clinic notes specifying Veteran participation in the VHA Telephone Lifestyle Coaching Program with a chosen focus on weight management. * Clinic notes specifying obesity as a reason for the encounter and documentation that weight management counseling was provided with ongoing follow up regarding weight management. Counseling must include more than one of the following elements of evidence-based weight management: diet, physical activity, and behavioral strategies.   **Cont’d next page** |
|  |  |  |  | Weight management treatment cont’d  2. **Non-VA Weight Management Treatment**   * Notation from the clinician that the patient is participating in a non-VA, clinically-supported (i.e., includes group or individual contact with a coach or clinical staff) weight management program that targets more than one aspect of weight management (e.g., diet, physical activity, and behavioral strategies). Examples of such programs include Weight Watchers, TOPS Club, HMR program, Optifast, Curves Complete, etc.). Clinically-supported web-based or mobile application weight loss programs are acceptable. * For the purposes of this measure, weight management treatment programs that target only one aspect of weight management (e.g. Nutrisytem, Curves Fitness, etc.) are NOT acceptable.   3**. Patient did not participate in weight management treatment**   * 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.” |
| 13 | 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 = 3,4, or 5OR if (BMI > 0 and < 25 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, 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. |

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| **If patient age 75 or >, go to asesadl; else go out of Module** | | | | |
|  |  | **Frail Elderly** |  |  |
| 14 | asesadl | Within the past 12 months, was an assessment of the patient’s ADLs performed using a standardized and published tool?  1. Yes  2. No | 1,2  If 2, auto-fill 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; Vulnerable Elders Survey Tool (VES):**   * 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).   * The VES is a 13 item, simple, function-based questionnaire that considers four factors: age, self-rated health, limitations in physical function and functional disability. The total score ranges from 0-10; the likelihood of future functional decline or death increases linearly as the score increases. A score of 3 or higher is often used to identify individuals as vulnerable to functional decline, but providers can elect to use higher scores if they want to narrow selection and identify persons at even greater risk.   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 the results must be documented. |
| 15 | 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. |
| 16 | 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. Yes  2. No | 1,2  If 2, auto-fill 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 tools:** **Instrumental Activities of Daily Living Scale (IADL) M.P. Lawton and E.M. Brody; Vulnerable Elders Survey Tool (VES):**   * 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). * The VES is a 13 item, simple, function-based questionnaire that considers four factors: age, self-rated health, limitations in physical function and functional disability. The total score ranges from 0-10; the likelihood of future functional decline or death increases linearly as the score increases. A score of 3 or higher is often used to identify individuals as vulnerable to functional decline, but providers can elect to use higher scores if they want to narrow selection and identify persons at even greater risk.   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 IADLs were assessed using a standardized and published tool and the results must be documented. |
| 17 | iadldt | Enter the date of the most recent assessment of IADLs using a standardized and published 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. |

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|  |  | **Falls** |  |  |
| 18 | askfalls | During the past twelve months, was the patient asked about the presence/absence of any falls during the preceding 12 months?  1. Yes  2. No | 1,2  If 2, go to fallscrn | 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.**  **Suggested Data Sources:** Inpatient or outpatient record. Inpatient Nursing Assessment is suggested as a likely source. |
| 19 | askfaldt | Enter the date the patient was most recently questioned about falls during the preceding 12 months. | mm/dd/yyyy  If valid date, go to uicode   |  | | --- | | < = 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. |
| 20 | fallscrn | During the past twelve months, was a falls screening completed using a standardized falls screening tool?   1. Yes 2. No | 1,2  If 2 go to uicode | **In order to answer “1,” documentation within the past 12 months must indicate a falls screening was completed using a standardized fall screening tool (e.g., MAHC-10 or Morse Fall Scale (MFS)).**  The MAHC-10 uses a 10 point scale. A score or 4 or more indicates fall risk.  The MFS assesses six areas of fall risk (history of falling, secondary diagnosis, ambulatory aid, IV therapy/heparin lock, gait, and mental status). The fall risk score can range from 0 to 125. A score of 25 to 45 indicates moderate risk and a score greater than 45 indicates high risk for fall.  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.  **Suggested Data Sources:** Inpatient or outpatient record. Inpatient Nursing Assessment is suggested as a likely source. |
| 21 | fallscrndt | Enter the most recent date a falls screening was completed using a standardized falls screening tool. | mm/dd/yyyy   |  | | --- | | < = 12 mos prior to or = stdybeg and < = stdyend | | Enter the most recent date a falls screening was completed using a standardized falls screening tool. |

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|  |  | **Urinary Incontinence** |  |  |
| 22 | uicode | Within the past 12 months, did the patient record contain a urinary incontinence  ICD-10-CM code R32, N3941, N393, N3946, N3942, N3943, N3944, N3945, N39490, N39498, or F980  1. Yes  2. No | \*1,2  \*If 1, go to end | ICD-10 R32, N3941, N393, N3946, N3942, N3943, N3944, N3945, N39490, N39498: Incontinence of urine codes  ICD-10 F980: enuresis of non-organic origin. Involuntary urination past age of normal control; also called bedwetting, no trace to biological problem; focus on psychological issues  ICD-10 N3644: detrusor sphincter dyssynergia  ICD-10 N3642: intrinsic (urethral) sphincter deficiency  ICD-10 N393: stress incontinence, female. Involuntary leakage of urine due to insufficient sphincter control; occurs upon sneezing, laughing, coughing, sudden movement, or lifting  ICD-10 R3981: Urinary incontinence, functional/urinary incontinence associated with cognitive impairment |
| 23 | 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.” |
| 24 | 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. |
| 25 | 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. |