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|  |  | **Organizational Identifiers** |  |  |
|  | VAMC  CONTROL  QIC  BEGDTE  REVDTE | Facility ID Control Number  Abstractor ID  Abstraction Begin Date  Abstraction End Date | Pre-fill  QI pre-fill  Auto-fill  Auto-fill  Auto-fill |  |
|  |  | **Patient Identifiers** |  |  |
|  | SSN  FIN  PTNAMEF  PTNAMEL  BIRTHDT  SEX  RACE  ETHNICITY  COHORT  AGE | Patient SSN FIN  First Name  Last Name  Birth Date  Sex  Race  Ethnicity  Cohort  Age | Pre-fill: no change  Pre-fill: no change  Pre-fill: no change  Pre-fill: no change  Pre-fill: no change  Pre-fill: **can change**  Pre-fill: no change  Pre-fill: no change  Pre-fill: no change  If VALNEXUS = 1, calculate age at PNEXUSDT; else if SEENYR2 = 1, calculate age at NEXUSDT2 |  |
| [Link to Mnemonics and Questions](https://secure.wvmi.org/QUESTIONS/Specifications/Mnemonics%20and%20Questions/fy2024q2/MnemonicQuestions2q24.xlsx) | | | | |
| **#** | **Name** | **Question** | Field Format | Definitions/Decision Rules |
| 1 | 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. |
| **If PNEXUSDT = blank; go to SEENYR2** | | | | |
| 2 | pnexusdt | **Computer will prefill** 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  **Pre-fill from pull list**   |  | | --- | | < = 1 year prior or = stdybeg and < = stdyend |   **Cannot modify** | **Computer will pre-fill the most recent Nexus clinic visit date during the past year during which the patient was seen by a physician/NP/PA, psychologist or Clinical Nurse Specialist.** |
| 3 | valnexus | On (computer to display pnexusdt), is there documentation the patient was seen by a physician, NP, PA, Psychologist, or Clinical Nurse Specialist in one of the “Nexus clinics”?   1. Yes 2. No | 1,2  **If 2, go to seenyr2** | **To answer “yes” all of the following are required:**   * the visit must have occurred on the date displayed in the question; **and** * the patient must be seen by a physician/NP/PA, psychologist or Clinical Nurse Specialist; **and** * the visit must be a face to face OR clinical video telehealth (e.g., CVT, VA Video Connect (VVC)) encounter; **and** * the visit must be in one of the Nexus clinics   **Note:** “Nexus clinics” include primary care, specialty clinics and mental health clinics. Refer to Table 8 to view the Nexus clinics list to determine the patient was seen in a Nexus clinic.  If the Veteran is admitted to a VHA Residential Rehabilitation program or Domiciliary, consider applicable Nexus Clinic visits when answering this question.  **If any above requirement is NOT met, enter “2”.** |
| 4 | pcvt | **Computer prefill**: Was the Nexus clinic visit on (computer display pnexusdt) a clinical video telehealth (e.g., CVT, VA Video Connect (VVC)) encounter?  1. Yes  2. No | 1,2  **Pre-fill from pull list**  **Cannot modify**  If 1, go to valcvt; else go to pnxusloc | **Computer will pre-fill response value to indicate if the most recent Nexus clinic visit was/was not a CVT or VVC encounter.**  CVT or VVC is a real-time interactive video encounter between the physician, NP, PA, Psychologist, or Clinical Nurse Specialist (CNS) and the patient. |
| 5 | valcvt | On (computer to display pnexusdt), is there documentation the visit with a physician, NP, PA, Psychologist, or Clinical Nurse Specialist was a clinical video telehealth (e.g, CVT,VA Video Connect (VVC)) encounter?   1. Yes 2. No | 1,2 | **CVT or VVC is a real-time interactive video encounter between the physician, NP, PA, Psychologist, or Clinical Nurse Specialist (CNS) and the patient.**  **Note:** The clinic note title/description may not reflect CVT. Please read note to determine if visit was conducted via CVT.  CVT visit documentation may also describe method used such as VA Video Connect (VVC).   * If the visit with a physician, NP, PA, Psychologist, or Clinical Nurse Specialist on the date displayed was a CVT or VVC encounter, enter “1”. * If the visit was not a CVT or VVC encounter, enter “2”.   **Exclude**: telephone encounter |
| 6 | pnxusloc | **Computer will prefill** the name of the Nexus clinic location for the visit on (computer display pnexusdt) when the patient was seen by a physician, NP, PA, psychologist, or Clinical Nurse Specialist (CNS). | \_\_\_\_\_\_\_\_\_\_  pnxusloc  **Pre-fill from pull list**  **Cannot modify** | **Computer will prefill the name of the Nexus clinic location for the visit that occurred on PNEXUSDT when the patient was seen by a physician, NP, PA, psychologist, or Clinical Nurse Specialist (CNS).** |
| 7 | valnexloc | Does (computer to display pnxusloc), the Nexus clinic location name where the patient was seen by a physician, NP, PA, psychologist, or Clinical Nurse Specialist (CNS) on (computer to display pnexusdt), match the clinic location name documented in the record.  1. Yes  2. No | 1,2  **If 1 or 2, go to othrcare as applicable** | * **Look for documentation that the Nexus clinic location name displayed is the same Nexus clinic location name documented in the record for the visit on PNEXUSDT.** * The clinic location name displayed may include the clinic stop code (e.g., 323 ABC PACT TEAM 1); however if the clinic location name displayed matches the documentation in the medical record select “1”. The stop code does not need to be present in the medical record documentation to select value”1”.   + For example, clinic location name displayed is “502 MH OP1 PSY1” and the clinic location name in outpatient encounter information is “MH OP1 PSY1”; select value “1”.   **Suggested data sources**: outpatient encounter, patient care encounter (PCE), past clinic visits (CVP) |
| 8 | seenyr2 | During the timeframe from (computer display stdybeg – 1 year to stdyend),was the Veteran seen by a physician, NP, PA, Psychologist, or Clinical Nurse Specialist in one of the “Nexus clinics”?  1. Yes  2. No | 1,\*2  **\*If 2, the record is excluded**   |  | | --- | | **Warning if 2** | | For purposes of EPRP, Nexus refers to a designated group of clinics having a specific stop code (primary or secondary) as shown in Table 8.  **To answer “yes” all of the following are required:**   * the visit must have occurred during the timeframe displayed in the question; **and** * the patient must be seen by a physician/NP/PA, psychologist or Clinical Nurse Specialist; **and** * the visit must be a face to face OR clinical video telehealth (e.g., CVT, VA Video Connect (VVC)) encounter; **and** * the visit must be in one of the Nexus clinics   **Note:** “Nexus clinics” include primary care, specialty clinics and mental health clinics. Refer to Table 8 to view the Nexus clinics list to determine the patient was seen in a Nexus clinic.  If the Veteran is admitted to a VHA Residential Rehabilitation program or Domiciliary, consider applicable Nexus Clinic visits when answering this question.  **If any above requirement is NOT met, enter “2”.**  **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. |
| 9 | nexusdt2 | 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 | | Enter the exact 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. |
| 10 | nexuscvt2 | Was the Nexus clinic visit on (computer display nexusdt2) a clinical video telehealth (CVT, VA Video Connect (VVC)) encounter?   1. Yes 2. No | 1,2 | **CVT or VVC is a real-time interactive video encounter between the physician, NP, PA, Psychologist, or Clinical Nurse Specialist (CNS) and the patient.**  **Note:** The clinic note title/description may not reflect CVT. Please read note to determine if visit was conducted via CVT.  CVT visit documentation may also describe method used such as VA Video Connect (VVC).   * If the visit with a physician, NP, PA, Psychologist, or Clinical Nurse Specialist on the date displayed was a CVT or VVC encounter, enter “1”. * If the visit was not a CVT or VVC encounter, enter “2”.   **Exclude**: telephone encounter |
| 11 | nxusloc2 | For the NEXUS clinic visit with a physician, NP, PA, psychologist or Clinical Nurse Specialist (CNS) on (computer display NEXUSDT2), enter the NEXUS clinic location name.   |  | | --- | |  | | \_\_\_\_\_\_\_\_\_\_\_  Text field | **This question asks for entry of the name of the Nexus clinic location for the visit that occurred on the date entered in NEXUSDT2. Nexus clinic location names vary by facility.**  Some examples of clinic location names:   * PRO-VVC-OPS-M-GENPSYCH4 PRO * DEE VOD PACT PROV 2 * CO-PACT SILVER 3   Suggested data sources: outpatient encounter, patient care encounter (PCE), past clinic visits (CVP) |
| 12 | wichnxus2 | Computer will auto-fill the Nexus clinic location name.   |  | | --- | |  | | Computer auto-fill  If VALNEXUS = 1, auto-fill PNXUSLOC; if SEENYR2 = 1, auto-fill NXUSLOC2  **Cannot modify** | **Computer will auto-fill based on VALNEXUS response value.**  If VALNEXUS = 1, auto-fill PNXUSLOC; if VALNEXUS = 2 and SEENYR2 = 1, auto-fill NXUSLOC2. |
| If Mental Health flag = 1, go to othrcare; otherwise, go to hospice | | | | |
| 13 | othrcare | Is there evidence in the medical record that within the past two years, the patient refused VHA Primary Care and is receiving ONLY his/her primary care in a non-VHA setting?  1. Yes  2. No  **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 | There must be specific documentation of patient refusal of VHA Primary Care, and the refusal must have occurred within the past two years.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 during the past two years 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. |
| 14 | hospice | During the past year is there documentation in the medical record the patient is enrolled in a VHA or community-based hospice program? 1. Yes  2. No | 1,2  **If 1 and cohort = 50, 51 or 54, go to nexuspp; else if 1, the case is excluded** | **Hospice program – providing care that focuses on the quality of life for people and their caregivers who are experiencing an advanced, life-limiting illness. Care may be provided in a hospice facility, in the home, or other settings.**  **Acceptable:** Enrollment in a VHA or community-based hospice program  **Unacceptable:** Enrollment in a VHA Palliative Care or HBPC program  **Suggested Data sources:** Problems List,Consult notes, History and physical, Order summary, Clinic notes  **Exclusion statement:** Documentation of enrollment in hospice during the past year excludes the case from CGPI measures except medication reconciliation for cohorts 50, 51, and 54. |
| 15 | pallcare | During the past year is there documentation in the medical record the patient is enrolled in a VHA or community-based palliative care program? 1. Yes  2. No | 1,2  **If Cohort 54 and FEFLAG = 0, go to asesadl in Core Module** | Palliative Care is the identification, prevention, and treatment of suffering by assessment of physical, psychosocial, intellectual, and spiritual needs of the patient with a goal of supporting and optimizing the patient’s quality of life.  **Suggested Data sources:** Consult notes, History and physical, Order summary, Clinic notes |
| 16 | nonacadm | Is there documentation in the medical record the patient had a non-acute inpatient admission during the past year?  1. Yes 2. No | 1,2 | Examples of non-acute inpatient care include but are not limited to rehabilitation units, skilled nursing facilities, respite care, domiciliary, CLC. |
| **Age > = 66 go to inltcset; if age < 66, auto-fill inltcset as 95 and go to selectdx** | | | | |
| 17 | inltcset | Is there documentation in the medical record the patient lived long-term (greater than 60 consecutive days) in a VHA or community-based institutional setting anytime during the past year? 1. Yes 2. No 95. Not applicable | 1,2,95  If 1 and ILLFLAG = 1, go to frailty2 as applicable  Will be auto-filled as 95 if age < 66 | **The intent of this question is to determine if the patient lived long-term (greater than 60 days) in an institutional setting anytime during the past year.**  **Institutional settings may include, but are not limited to nursing homes, community living centers, long term care (LTC) facilities, assisted living facilities.**  **Exclude:** Residential Rehabilitation Treatment Programs (RRTP); Domiciliary facilities (DOM), group or personal care homes  **Suggested Data Sources:** Discharge summary, History and physical, other  admin/discharge reports |
| 18 | advillns | During the past two years, is there documentation in the medical record the patient has an advanced illness diagnosis? 1. Yes 2. No | 1,2  If 1, go to frailty2 as applicable | **The problem list or health factors may be used to perform an initial search for a diagnosis of an advanced illness; however, the documentation of the applicable ICD-10-CM code must be found in association with an inpatient or outpatient encounter during the past two years.**  **Each health factor should have an associated date that represents the date the health factor was recorded.**  **For the purposes of this question, acceptable advanced illness diagnosis codes are included in Table 5, Advanced Illness.**  Advanced illness includes:   * Malignancies * Parkinson’s disease * Alzheimer’s disease * Chronic Kidney Disease (CKD) and End Stage Renal Disease (ESRD) diagnoses * Heart Failure (HF) diagnoses   **Refer to Table 5, Advanced Illness, for specific diagnoses and ICD-10-CM codes.**  **Suggested Data Sources:** clinic/progress notes, discharge summary, history and physical, outpatient encounter diagnosis codes, admission/discharge diagnosis codes |
| 19 | demeds | During the past two years, is there physician, NP, PA, CNS or pharmacist documentation in the medical record the patient has a prescription for a dementia medication? 1. Yes  2. No | 1,2 | **An acceptable dementia medication must be documented as a prescription during the past two years.**  Acceptable dementia medications include:   * Donepezil * Galantamine * Rivastigmine * Memantine * Donepezil-memantine (combination)   **Suggested Data Sources:** Clinical pharmacy notes, EMLR note, Medication reconciliation notes, Progress notes (clinic notes) |
| **If FRAILFLAG = 1, go to selectdx; else go to frailty2** | | | | |
| 20 | frailty2 | During the past year, is there documentation in the medical record the patient has any condition/diagnosis consistent with frailty documented on two different dates? 1. Yes  2. No | 1,2  If 2, go to selectdx | Any provider (including nurses) can document frailty in any setting (including the home). A nurse may only document a medical diagnosis after a physician, NP, PA or CNS has documented the diagnosis.  In order to select value 1, a condition/diagnosis consistent with frailty must be documented on two different dates during the past year. Documentation of the same condition/diagnosis on both dates is acceptable.  **Frailty may include but is not limited to:**   * presence of pressure ulcers * abnormalities of gait and mobility * adult Failure To Thrive (FTT) * history of fall(s)   **Refer to Table 6 for other specific disorders.**  **Suggested Data Sources**: H&P, nursing assessments, progress notes, problem list |
| 21 | fraildt1 | Enter the most recent date a condition/diagnosis consistent with frailty was documented. | mm/dd/yyyy   |  | | --- | | <= 1 year prior to or = stdybeg and <= stdyend | | Enter the most recent date a condition/diagnosis consistent with frailty was documented. |
| 22 | fraildt2 | During the timeframe from (computer display stdybeg – 1 year to fraildt1 – 1 day), enter the most recent date a condition/diagnosis consistent with frailty was documented. | mm/dd/yyyy   |  | | --- | | <= 1 year prior to stdybeg and prior to fraildt1 | | During the specified timeframe, enter the most recent date a condition/diagnosis consistent with frailty was documented. |
| 23 | **selhtn**  **selmi**  **selpci**  **pcidt** | **SELECTDX: Did the patient have one or more of the following active diagnoses?**  **NOTE:** ICD-9-CM codes (prior to 10/01/2015) and ICD-10 codes (on or after 10/01/2015) 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**  ICD-9 code 401.x (ICD-10 code I10) - excludes elevated blood pressure without diagnosis of hypertension, pulmonary hypertension, that involve vessels of brain and eye  ICD-9 401.0 = malignant hypertension  ICD-9 401.1 = benign hypertension  ICD-9 401.9 = unspecified hypertension  **4 = Old Myocardial Infarction**  ICD-9-CM code 412 (ICD-10 code I252) = old myocardial infarction. The abstractor may determine the patient had a past AMI from clinician documentation, and presence of the code is not an absolute requirement  **5 = PCI in past two years**  **Abstractor must know approximate month and year of procedure**  ICD-10 02703ZZ, 02704ZZ, 02713ZZ, 02714ZZ, 02723ZZ, 02724ZZ, 02733ZZ, 02734ZZ  **Enter the date of the most recent PCI done anywhere in the past two years.** | 1,4,5,6,7,11,12,99   |  | | --- | | **pcidt, cabgdt, and revasdt**  **mm/dd/yyyy**  < = 2 years prior or = stdybeg and < = stdyend | | **‘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.   **Hypertension**  A diagnosis recorded as ‘borderline hypertension’ is hypertension if 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.  Mention of HTN on a problem list alone without documentation in the encounter note is not sufficient to select “yes.”  **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 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. If month and year cannot be known or extrapolated (e.g., “last fall”, “eighteen months ago”) from documentation, do not select these procedures as applicable to the case under review.  **Cont’d next page** |

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|  | **selcabg**  **cabgdt**  **selchf**  **selckd**  **selkidtx**  **kidtxdt**  **selneph**  **selrevas**  **revasdt** | **6 = CABG in past two years Abstractor must know approximate month and year of procedure**  **ICD-10** **PCS** 0210093, 0210493, 02100A3, 02100J3, 02100K3, 02100Z3, 02104A3, 02104J3, 02104K3, 02104Z3  **ICD-10** **PCS** 021K0Z8, 021K0Z9, 021K0ZC, 021K0ZW, 021K4Z8, 021K4Z9, 021K4ZC, 021K4ZW, 021L4Z8, 021L4Z9, 021L0ZC, 021L0Z8, 021L0Z9, 021L4ZC  **Enter the date of the most recent CABG done anywhere in the past two years.**  **7 = CHF (May also be noted as “systolic dysfunction”) See applicable codes in Definitions/Decision rules.**  **11 = Chronic Kidney (Renal) Disease, stage 5 or ESRD (end stage renal disease) or dialysis (hemodialysis or peritoneal dialysis) documented any time prior to the study end date**  **ICD-10 codes N185, N186, Z9115, Z992, 3E1M39Z, 5A1D00Z, 5A1D60Z, 5A1D70Z, 5A1D80Z, 5A1D90Z**  **12 = Kidney Transplant**  **ICD-10 codes Z94.0, 0TY00Z0, 0TY00Z1, 0TY00Z2, 0TY10Z0, 0TY10Z1, 0TY10Z2,**  **Enter the date of the most recent kidney transplant done any time prior to the study end date.**  **13 = Nephrectomy (kidney removal) documented any time prior to the study end date**  **ICD-10 PCS codes (0TB00ZZ, 0TB03ZZ, 0TB04ZZ, 0TB07ZZ, 0TB08ZZ, 0TB10ZZ, 0TB13ZZ, 0TB14ZZ, 0TB17ZZ, 0TB18ZZ, 0TT00ZZ, 0TT04ZZ, 0TT10ZZ, 0TT14ZZ, 0TT20ZZ, 0TT24ZZ**  **Cont’d next page**  **14 = Limb Revascularization in the past 2 years**  **CPT codes: 37220, 37221, 37224, 37225, 37226, 37227, 37228, 37229, 37230, 37231**  **Enter the date of the most recent limb revascularization procedure done anywhere in the past two years.**  **99 = Patient did not have any of these diagnoses** | |  | | --- | | **kidtxdt**  **mm/dd/yyyy**  > patient’s DOB and <= stdyend  Warning: If > 10 years prior to stdyend |   The Mental Health Cognitive Function will be enabled first  The Core, PI, Shared, and specific disease modules will be enabled if selhtn = T, dmflag = 1, selmi = true, PCI = true, CABG = true, or selchf = true.  If 99, the Core, PI, Shared, Mental Health Module (as applicable) will be enabled. | **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 CABG. If month and year cannot be known or extrapolated (e.g., “last fall”, “eighteen months ago”) 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 and ICD-10-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 (ICD-10 I110) = malignant hypertensive heart disease with congestive heart failure  402.11 (ICD-10 I110) = benign hypertensive heart disease with congestive heart failure  402.91(ICD-10- I110) = unspecified hypertensive heart disease with congestive heart failure  404.01 (ICD-10 I130 )= malignant hypertensive heart and renal disease with congestive heart failure  404.11 (ICD-10 I130) = benign hypertensive heart and renal disease with congestive heart failure  404.91 (ICD-10 I130) = unspecified hypertensive heart and renal disease with congestive heart failure  428.0 (ICD-10 I509) = congestive heart failure  (includes right heart failure, secondary to left heart failure)  428.1(ICD-10 I501) = left heart failure  428.9 (ICD-10 I509) = heart failure, unspecified  **The list of CHF codes should also include 398.91 (ICD-10 I0981), 428.2x (ICD-10 I5020 – I5023), and 428.4x (ICD-10 I5040 – I5043).**  **Cont’d next page**  **Limb revascularization procedure includes revascularization of the upper limb, whole arm, forearm, lower limb, and whole leg.** |
| **If selhtn = 1, go to htnenc1; else go to ivdenc1** | | | | |
| 24 | htnenc1 | During the timeframe (computer display stdybeg - 1 year to stdybeg - 6 months) is there documentation the patient had an outpatient encounter with a documented diagnosis of hypertension?  1. Yes  2. No | 1,2  If 2, auto-fill htnencdt1 as 99/99/9999 and go to ivdenc1   |  | | --- | | **Warning if 2 and selhtn = 1** | | **The intent of these questions (htnenc1 and htnenc2) is to determine if the patient had at least two outpatient encounters on different dates of service with a documented diagnosis of hypertension during the first six months of previous year or the year prior to the current year.**  **Hypertension diagnosis may be taken from clinical documentation in the outpatient setting and must include the ICD-10-CM code I10: Essential (primary) hypertension.**  **Visit type need not be the same for the two visits.** Review notes during the specified timeframe to determine if there was an outpatient encounter. An outpatient encounter includes any of the following:   * Face to face visit - includes any face to face encounter with a provider, e.g., clinic, PCP, specialty provider, etc. * Telephone visit - must be an actual communication with the patient, not an attempt or voice mail. * Telehealth visit - refers to real-time clinic based video encounter between patient and provider. * Online assessment - a medical evaluation done online * **Exclude:** Acute Inpatient and ED visits.   **Hypertension diagnosis must be recorded as the patient’s diagnosis by a physician, NP, PA, or CNS in the encounter note.**   * Mention of hypertension on a problem list alone without documentation in the encounter note is not sufficient to select “1.” * Documentation of hypertension on a problem list in the encounter note with evidence the hypertension was addressed (e.g., BP under control, documentation of current or new prescription of anti-hypertensive medication) is acceptable. * A diagnosis recorded as ‘borderline hypertension’ is hypertension if 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. |
| 25 | htnencdt1 | Enter the date of the most recent outpatient encounter with documented diagnosis of hypertension during the timeframe from (computer display stdybeg - 1 year to stdybeg - 6 months). | mm/dd/yyyy  Will be auto-filled as 99/99/9999 if htnenc1 = 2   |  | | --- | | < = 1 year prior to stdybeg and >=6 months prior to stdybeg | | Enter the exact date of the outpatient visit. The use of 01 to indicate missing day or month is not acceptable. |

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| 26 | htnenc2 | During the timeframe from (computer to display 2 years prior to stdybeg) to (computer to display htnencdt1-1 day) is there documentation the patient had an outpatient encounter with a documented diagnosis of hypertension?  1. Yes  2. No | 1,2  If 2, auto-fill htnencdt2 as 99/99/9999 | **Review notes during the specified timeframe to determine if the patient had an outpatient encounter with a documented diagnosis of hypertension.**  **Hypertension diagnosis may be taken from clinical documentation in the outpatient setting and must include the ICD-10-CM code I10: Essential (primary) hypertension.**  **An outpatient encounter includes any of the following:**   * Face to face visit - includes any face to face encounter with a provider, e.g., clinic, PCP, specialty provider, etc. * Telephone visit - must be an actual communication with the patient, not an attempt or voice mail. * Telehealth visit - refers to real-time clinic based video encounter between patient and provider. * Online assessment - a medical evaluation done online * **Exclude:** Acute Inpatient and ED visits.   **Hypertension diagnosis must be recorded as the patient’s diagnosis by a physician, NP, PA, or CNS in the encounter note.**   * Mention of hypertension on a problem list alone without documentation in the encounter note is not sufficient to select “1.” Documentation of hypertension on a problem list in the encounter note with evidence the hypertension was addressed (e.g., BP under control, documentation of current or new prescription of anti-hypertensive medication) is acceptable. * A diagnosis recorded as ‘borderline hypertension’ is hypertension if 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. |
| 27 | htnencdt2 | Enter the date of the most recent outpatient encounter with documented diagnosis of hypertension during the timeframe from (computer to display 2 years prior to stdybeg) to (computer to display htnencdt1- 1 day). | mm/dd/yyyy  Will be auto-filled as 99/99/9999 if htnenc2 = 2   |  | | --- | | < = 2 yrs prior to stdybeg and < htnencdt1 | | Enter the exact date of the most recent outpatient visit during the specified timeframe.. The use of 01 to indicate missing day or month is not acceptable. |
| 28 | ivdenc1 | Within the past year is there documentation the patient had an outpatient or acute inpatient encounter with a documented diagnosis of ischemic vascular disease (IVD)?  1. Yes  2. No | 1,2  If 2, go to cirrhosis as applicable   |  | | --- | | **Warning if 2 and selmi, selpci or selcabg = T** | | **The intent of this question is to determine if the patient had an outpatient or acute inpatient encounter with a documented diagnosis of ischemic vascular disease (IVD) during the past year.**  **Refer to Table 7 for a list of acceptable ICD-10-CM codes and diagnoses.**  Ischemic vascular disease diagnoses may be taken from clinical documentation in the acute inpatient or outpatient setting and must include one of the acceptable diagnosis codes.  **Outpatient or acute inpatient encounters include:**   * Face to face or telehealth outpatient encounter with an IVD diagnosis * A telephone visit with an IVD diagnosis * An online assessment with an IVD diagnosis * An acute inpatient encounter with an IVD diagnosis   **Examples of IVD include but are not limited to**:   * all forms of angina * ischemic heart disease * atherosclerosis or stenosis of native or grafted coronary arteries * cerebral infarction due to occlusion or stenosis of precerebral and cerebral arteries * atherosclerosis, stenosis or occlusion of native, stented or grafted peripheral arteries * atherosclerosis of renal artery   **Review all clinical notes during the past year to determine if there was an acute inpatient or outpatient encounter  with a documented diagnosis of IVD. For acute inpatient encounter, the discharge date must be within the past year.**  **Exclude:** Non-acute inpatient admissions. Examples of non-acute inpatient care include but are not limited to rehabilitation units, skilled nursing facilities, respite care. |
| 29 | ivdencdt1 | Enter the date of the most recent outpatient or acute inpatient encounter with documented diagnosis of ischemic vascular disease in the past year. | mm/dd/yyyy   |  | | --- | | <= 1 year prior or = stdybeg and <= stdyend | | Enter the exact date of the most recent outpatient or acute inpatient encounter with documented diagnosis of ischemic vascular disease during the past year. For acute inpatient encounter, enter the discharge date.  The use of 01 to indicate missing day or month is not acceptable. |
| 30 | ivdenc2 | During the timeframe from (computer to display 2 years prior to stdybeg to 1 year – 1 day prior to stdybeg) is there documentation the patient had an outpatient or acute inpatient encounter with a documented diagnosis of ischemic vascular disease?  1. Yes  2. No | 1,2  If 2, auto-fill ivdencdt2 as 99/99/9999 and go to cirrhosis as applicable   |  | | --- | | **Warning if 2 and selmi, selpci or selcabg = T** | | **The intent of this question is to determine if the patient had an outpatient or acute inpatient encounter with a documented diagnosis of ischemic vascular disease (IVD) during the year prior to the past year.**  **Refer to Table 7 for a list of acceptable ICD-10-CM codes and diagnoses.**  Ischemic vascular disease diagnoses may be taken from clinical documentation in the acute inpatient or outpatient setting and must include one of the acceptable diagnosis codes.  **Outpatient or acute inpatient encounters include:**   * Face to face or telehealth outpatient encounter with an IVD diagnosis * A telephone visit with an IVD diagnosis * An online assessment with an IVD diagnosis * An acute inpatient encounter with an IVD diagnosis   **Examples of IVD include but are not limited to**:   * all forms of angina * ischemic heart disease * atherosclerosis or stenosis of native or grafted coronary arteries * cerebral infarction due to occlusion or stenosis of precerebral and cerebral arteries * atherosclerosis, stenosis or occlusion of native, stented or grafted peripheral arteries * atherosclerosis of renal artery   **Review all clinical notes during the specified timeframe to determine if there was an acute inpatient or outpatient encounter  with a documented diagnosis of ischemic vascular disease (IVD).**  **Exclude:** Non-acute inpatient admissions. Examples of non-acute inpatient care include but are not limited to rehabilitation units, skilled nursing facilities, respite care. |
| 31 | ivdencdt2 | Enter the date of the most recent outpatient or acute inpatient encounter with documented diagnosis of ischemic vascular disease during the year prior to the past year. | mm/dd/yyyy  Will be auto-filled as 99/99/9999 if ivdenc2 = 2   |  | | --- | | < = 2 yrs prior to stdybeg and > 1 year prior to stdybeg | | Enter the exact date of the most recent outpatient or acute inpatient encounter with documented diagnosis of ischemic vascular disease during the year prior to the past yearpast year. For acute inpatient encounter, enter the discharge date.  The use of 01 to indicate missing day or month is not acceptable. |
| **If (dmflag = 1) OR (selmi = 1) OR (selcabg = 1) OR (selpci =1) OR (ivdenc1 and ivdenc2 = 1), go to cirrhosis; if (dmflag <> 1), (selmi <> 1), (selcabg <>1), (selpci <>1), and (ivdenc1 or ivdenc2 = 2) and  (sex = 2 and age < 51 years), go to ivfpreg; else go to end** | | | | |
| 32 | cirrhosis | Does the record document a diagnosis of cirrhosis during the past two years?   1. Yes 2. No | 1,2 | * Include diagnosis noted in clinic notes or progress notes. Diagnosis may be taken from the inpatient or outpatient setting. * Diagnoses documented on a problem list must be validated by a clinician diagnosis within the past 2 years. |
| 33 | muscledx | Does the record document a diagnosis of myalgia, myositis, myopathy, or rhabdomyolysis during the past year?   1. Yes 2. No | 1,2  If sex = 2 and age < 51 years, go to ivfpreg; else go to end | * Include documentation of myalgia (muscle pain), myositis, myopathy, or rhabdomyolysis noted in clinic notes or progress notes during the past year. Documentation may be taken from the inpatient or outpatient setting. * Diagnoses documented on a problem list must be validated by a clinician diagnosis within the past year. * Documentation of myalgia, myositis, myopathy, or rhabdomyolysis may also be accepted from the allergy/adverse reaction drug reaction package. The date of allergy/adverse drug reaction documentation may be greater than the past year. * If there is documentation of an allergy/adverse drug reaction to more than one statin medication, select value “1”.   **Myalgia** means muscle pain or aching.  **Myositis** means muscle inflammation.  Myopathy is a muscular disease in which the muscle fibers do not function for any one of many reasons, resulting in muscular weakness.  Rhabdomyolysis is the breakdown of muscle tissue that leads to the release of muscle fiber contents into the blood. These substances are harmful to the kidney and often cause kidney damage.  **NOTE: For the purposes of this question, fibromyalgia and cardiomyopathy are not acceptable to answer “yes”.**  **Suggested data sources:** Progress notes, problem list, allergy/adverse drug reaction package |
| 34 | ivfpreg | Does the record document any one of the following during the past two years:   1. Pregnancy 2. In vitro fertilization (IVF) 3. Both in vitro fertilization and pregnancy   99. None of the above | 1,2,3,99  If 99, go to clomiphen; else go to end  If 1 or 3, go to pregdt | **The question intent is to determine if there is medical record documentation the patient was pregnant or received in vitro fertilization during the past two years.**  **Evidence of pregnancy includes but is not limited to documentation of:**   * Positive pregnancy test * In vitro fertilization procedure * Intrauterine pregnancy * Abdominal, ectopic, molar, ovarian or tubal pregnancy * Missed, spontaneous or threatened abortion * Induced termination of pregnancy |
| 35 | pregdt | Enter the most recent date evidence of pregnancy was documented in the medical record during the past two years. | mm/dd/yyyy   |  | | --- | | <= 2 years prior or = stdybeg and <= stdyend |   **Go to end** | Enter the most recent date there is evidence of pregnancy documented in the medical record during the past two years.. |
| 36 | clomiphen | Does the record document the patient was prescribed clomiphene during the past two years?   1. Yes 2. No | 1,2 | Clomiphene is a non-steroidal fertility medicine. It causes the pituitary gland to release hormones needed to stimulate ovulation (the release of an egg from the ovary). |

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| **Nexus Clinics** |  |
| |  |  |  |  | | --- | --- | --- | --- | | **Code** | **Clinic Description** | **Code** | **Clinic Description** | | **303** | Cardiology | **550** | MH Clinic **Group** | | **305** | Endocrinology | **552** | Intensive Community Mental Health Recovery Services (ICMHR) **Individual** | | **306** | Diabetes Clinic | **560** | Substance Use Disorder **Group** | | **309** | Hypertension | **562** | PTSD Outpatient and Residential Specialty Program **Individual** | | **312** | Pulmonary/Chest | **565** | MH Intervention Biomedical Care **Group** (examples: chronic pain, essential hypertension, LBP, migraine HA, obesity…) | | **322** | Comprehensive Women’s Primary Care Clinic | **567** | Intensive Community Mental Health Recovery Services (ICMHR) **Group** | | **323** | Primary Care Medicine | **576** | Psychogeriatric Clinic **Individual** | | **348** | Primary Care Shared Appointment | **577** | Psychogeriatric Clinic **Group** | | **350** | GeriPACT | **582** | Psychosocial Rehabilitation Recovery Center (PRRC) **Individual** | | **502** | Mental Health Clinic **Individual** | **583** | Psychosocial Rehabilitation Recovery Center (PRRC) **Group** | | **509** | Psychiatry | **704** | Women’s Gender-Specific Preventive Care | | **510** | Psychology |  |  | | **513** | Substance Use Disorder **Individual** |  |  | | **516** | Post Traumatic Stress Disorder (PTSD) Outpatient and Residential Specialty Program **Group** |  |  | | **523** | Opioid Treatment Program |  |  | | **533** | Mental Health (MH) Intervention Biomedical Care **Individual** (for use by MH clinicians who provde individual…primary diagnosis is med rather than psych…examples: chronic pain, essential hypertension, LBP, migraine HA, obesity…) |  |  | | **534** | MH Integrated Care **Individual** |  |  | | **539** | MH Integrated Care **Group** |  |  | | **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, Primary Care clinic or Specialty clinic (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. |