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|  |  | **Validation** |  |  |
| 1 | dmeoriv | Was the patient enrolled in HBPC only for DME or IV therapy? | 1\*,2  **\*If 1, the record is excluded** | DME = durable medical equipment – provision of medical equipment and supplies for a home-bound patient, usually large equipment such as hospital bed, wheelchair, commode chair, etc.  **Exclusion Statement: The patient was enrolled in HBPC only for DME or IV therapy.** |
| 2 | enrol4lab | Was the patient enrolled in HBPC only for lab monitoring?  1. Yes  2. No | 1,2 | If the patient was enrolled in HBPC only for lab monitoring, select “1.” Lab monitoring may include monitoring of anticoagulant therapy (e.g., draw blood for INR) and/or labs to monitor other conditions/treatment such as blood draws to monitor levels of certain drugs. |
| 3 | visithbpc | Does the record document a HBPC encounter by any member of the HBPC team\* during the study interval? | 1,2\*  **\*If 2, the record is excluded** | **HBPC encounter** = **home visit, telephone visit, OR documentation by HBPC team member indicating HBPC was providing or managing the patient’s care such as HBPC treatment notes, interdisciplinary plan notes, referral notes, medication review notes**   * The HBPC encounter must have occurred during the study interval dates. * The patient may also have been an inpatient, been seen in an ambulatory care clinic, or had another encounter with VHA during the study interval period; however, at least one HBPC encounter must have occurred during the study interval. * Even if discharge from HBPC occurred during or prior to the last day of the study interval, answer “1” if the patient had at least one HBPC encounter during the study interval. * HBPC telephone visit by any member of the HBPC team is acceptable.   **Exclude: documentation that indicates the patient is no longer enrolled in HBPC such as bereavement note**  \*HBPC team = physician, PA, NP, Clinical Nurse Specialist (CNS), nurse, social worker, chaplain, pharmacy, dietician, or other discipline providing services to the HBPC patient. HBPC encounter by Dietary or a Home Health Aide is excluded.  **Exclusion Statement: The patient did not have a HBPC encounter during the study interval.** |
| 4 | hbpcdt | Enter the date of the most recent home care encounter for this patient, occurring within the study interval. | mm/dd/yyyy   |  | | --- | | > = stdybeg and <= stdyend | | Exact date must be entered. 01 to indicate unknown day or month may not be used. |
| 5 | justone | Was there only one home care encounter during the study interval? | 1,2\*  \*If 2, go to admisdt else go to evalvst | Only one home care encounter =   * the patient was seen only once in his/her home or via telephone visit by any member of the HBPC team or VHA staff (regardless of other VHA encounters that may have occurred) during the study interval, OR * the patient was not seen in his/her home or via telephone visit by HBPC during the study interval AND there is documentation of ONLY ONE note indicating that HBPC was managing or providing the patient’s care. |
| 6 | evalvst | Was this encounter only pre-admission screening for possible enrollment in the HBPC program? | 1\*,2  **\*If 1, the record is excluded** | Only to assess = the patient was not enrolled in HBPC at the time of the encounter and the encounter was a pre-admission screening to assess the patient’s need for HBPC services.  **Exclusion Statement: The only encounter during the study interval was pre-admission screening to assess the patient for enrollment in HBPC.** |
| 7 | admisdt | Enter the HBPC admission date. **Admission date is date of the note in which a full assessment of the patient is documented.** | mm/dd/yyyy   |  | | --- | | <= 20 years prior to or = stdybeg and < stdyend |   **If hbpcdt – admisdt < 30 days, the case is excluded**   |  | | --- | | If hbpcdt – admisdt > = 30 days and < = 1 yr from stdybeg, auto-fill hcstatus = 2  If hbpcdt – admisdt > 1 year, auto-fill  hcstatus = 3 | | Admission to HBPC – first note in record may be a pre-admission/screening assessment note. **Admission to HBPC is the visit in which a full assessment of the patient is initiated.** This may be the first or subsequent visit. The note may have many titles, such as initial assessment, admission assessment, etc. Date of the assessment note is used to calculate the enrollment time period.  If the patient had a previous enrollment in HBPC, but was discharged from home care, and then later readmitted, count as a new admission and use the most recent admission date.  If the patient was discharged from HBPC and re-admitted within 48 hours for administrative reasons, do not count as a new admission.  If an exact admission date cannot be determined, month and year must be entered at a minimum.  **Exclusion Statement**  **The patient was enrolled in HBPC for less than the 30 days initial assessment period.** |
| 8 | hcstatus | Counting from the most recent HBPC encounter within the study interval, enter the patient’s status in regard to HBPC admission:   1. HBPC admission greater than or equal to 30 days but less than or equal to 1 year 2. HBPC admission greater than one year (>365 days from the admission date) | 2,3  **Computer will auto-fill hcstatus = 2 if hbpcdt – admisdt > = 30 days AND < = 1 yr from stdybeg, OR auto-fill hstatus = 3**  **if hbpcdt – admisdt** > **1 year** | Enrollment in HBPC = admission. First note in record may be a pre-admission/screening assessment note. Admission to HBPC is the encounter in which a full assessment of the patient is initiated. This may be the first or subsequent encounter. The note may have many titles, such as initial assessment, admission assessment, etc. Date of the assessment note is used to calculate the admission time period.  Patients enrolled in HBPC less than 30 days from the most recent HBPC visit are excluded. The hierarchy for screening patients enrolled more than 30 days is as follows:  (1) Patients that have been enrolled less than one year should be screened within 30 days of admission.  (2) Patients enrolled in HBPC more than one year (>365 days) should be screened within the past 12 months.  **If the HBPC patient is admitted to an acute care hospital and has a length of stay greater than 15 days, the patient is discharged from home care and must be readmitted. The patient is considered a new enrollment and must be re-screened within 30 days of admission**. |

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| **If Hcstatus = 3, auto-fill admitmed as 95, and go to mednum** **If Hcstatus = 2 and hbpcdt – admisdt > 120 days, auto-fill admitmed as 95, and go to mednum; otherwise go to admitmed** | | | | |
|  |  | Medication Management |  |  |
| 9 | admitmed | At the time of admission to HBPC, was the patient on 9 or more medications from the VA?   1. Yes 2. No 3. Not applicable | 1, 2,95  If 1, auto-fill mednum as 95, prevmed as 95, premedt as 99/99/9999, and go to medrev  If 2, auto-fill mednum as 95, prevmed as 95, premedt as 99/99/9999, medrev as 95, and medrevdt as 99/99/9999, nomedrev as 95, admdate as 99/99/9999, dcdate as 99/99/9999, and go to clindt | VA medication profile= listing of current VA medications under the “medications” tab in CPRS  If there were **9 or more active medications** on the VA medication profile at the time of the most recent HBPC visit, select “1.”  Active medications include scheduled, prn medications, and topical medications that are listed as active, suspended, or pending in the VA medication profile. |
| 10 | mednum | At the most recent HBPC visit, was the patient on 9 or more medications from the VA?   1. Yes 2. No 3. Not applicable | 1,2,95 | VA medication profile= listing of current VA medications under the “medications” tab in CPRS  If there were **9 or more active medications** on the VA medication profile at the time of the most recent HBPC visit, select “1.”  Active medications include scheduled, prn medications, and topical medications that are listed as active, suspended, or pending in the VA medication profile. |
| 11 | prevmed | At least 3 months prior to the most recent visit, did documentation in the record indicate the patient was on 9 or more VA medications?   1. Yes 2. No 3. Not applicable | 1,2,95  If 2, auto-fill premedt as 99/99/9999, medrev as 95, medrevdt as 99/99/9999, nomedrev as 95, admdate as 99/99/9999, dcdate as 99/99/9999, and go to clindt | 3 months prior to the most recent HBPC visit= count back 3 months from the day of the most recent visit. For example, most recent HBPC visit occurred on 11/22/06. 3 months prior would be on or prior to 08/22/06.  Answer “1” if the record indicates the patient was on 9 or more VA medications at least 3 months prior to the most recent HBPC visit.  VA medication profile= listing of current VA medications under the “medications” tab in CPRS  Active medications include scheduled, prn medications, and topical medications that are listed as active, suspended, or pending in the VA medication profile. |
| 12 | premedt | Enter the most recent date at least 3 months prior to the most recent HBPC visit that the documentation in the record indicated the patient was on 9 or more VA medications. | mm/dd/yyyy  Will be auto-filled as 99/99/9999 if admitmed = 2 or prevmed=2   |  | | --- | | <= 1 year prior to stdybeg and >= 3 months prior to hbpcdt | | Enter the exact date. The use of 01 to indicate missing day or month is not acceptable. |
| **The question medrev will contain one of the following phrases that will appear on the computer screen in accordance with the patient’s length of stay.**  **Hcstatus=2 AND hbpcdt – admisdt <=120 days,** **computer to display (During the timeframe from admisdt to admisdt + 30 days)**  **Hcstatus=2 AND**  **hbpcdt – admisdt > 120 days, computer to display (During the timeframe from premedt to premedt + 110 days)**  **Hcstatus=3 computer to display (During the timeframe from premedt to premedt + 110 days)** | | | | |
| 13 | medrev | Did a pharmacist review the patient’s medication management plan?   1. Yes 2. No 3. Not applicable | 1,2,95  Will be auto-filled as 95 if admitmed = 2 or prevmed=2  If 1, auto-fill nomedrev as 95, admdate as 99/99/9999, and dcdate as 99/99/9999  If 2, auto-fill medrevdt as 99/99/9999, and go to nomedrev | A medication review of the patient’s medication management plan consists of a review by a pharmacist of all medications. All medications include prescribed, OTC, topical, and systemic medications from VA and non-VA providers as noted in the record. The pharmacist will review all medications for appropriateness, adverse reactions and interactions, and communicate concerns and recommendations to the HBPC provider and primary care provider.  **Acceptable documentation consists of:**   * the medication review note must be identified as a HBPC treatment plan, interdisciplinary team meeting note, admission note, quarterly review note, or pharmacy medication review note, **and** * the note must be signed by the pharmacist, **and** * notation that there were no pharmacy recommendations OR that recommendations were communicated to the HBPC provider and primary care provider. |

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| 14 | medrevdt | Enter the date of the medication management plan review. | mm/dd/yyyy  Will be auto-filled as 99/99/9999 if admitmed = 2, prevmed=2, or medrev=2   |  | | --- | | If hcstatus = 2 AND hbpcdt – admisdt <=120 days,  >= admisdt and  <= 30 days after admisdt  If hcstatus = 2 AND hbpcdt – admisdt  > 120 days **OR**  if hcstatus = 3,  < = 110 days after premedt and  < = stdyend | | Enter the exact date. The use of 01 to indicate missing day or month is not acceptable. |
| **The question nomedrev will contain one of the following phrases that will appear on the computer screen in accordance with the patient’s length of stay.**  **Hcstatus=2 AND hbpcdt – admisdt <=120 days,** **computer to display (During the timeframe from admisdt to admisdt + 30 days)**  **Hcstatus=2 AND**  **hbpcdt – admisdt > 120 days,**  **computer to display (During the timeframe from premedt to premedt + 110 days)**  **Hcstatus=3 computer to display (During the timeframe from premedt to premedt + 110 days)** | | | | |
| 15 | nomedrev | Did the record document the patient was hospitalized during the time the medication management plan was to be reviewed?  1. Yes  2. No  95. Not applicable | 1,2,95  Will be auto-filled as 95 if admitmed =2, prevmed = 2,  or medrev = 1  If 2, auto-fill admdate as 99/99/9999 and dcdate and 99/99/9999 and go to clindt | The intent of the question is to determine if the patient was hospitalized during the timeframe the medication management plan would have been reviewed. |

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| 16 | admdate | Enter the admission date. | mm/dd/yyyy  Will be auto-filled as 99/99/9999 if admitmed =2, prevmed = 2,  or medrev = 1   |  | | --- | | If hcstatus = 2 AND hbpcdt – admisdt <=120 days,  >= admisdt and  <= 30 days after admisdt  If hcstatus = 2 AND hbpcdt – admisdt  > 120 days **OR**  if hcstatus = 3,  > premedt and < = 110 days after premedt and  < = stdyend | |  |
| 17 | dcdate | Enter the discharge date. | mm/dd/yyyy  Will be auto-filled as 99/99/9999 if admitmed =2, prevmed = 2,  or medrev = 1   |  | | --- | | >= admdate and  <= pulldt | |  |
| 18 | clindt | Enter the date of the most recent HBPC face-to-face visit by a nurse (RN, LPN) or clinician (physician/NP/CNS/PA). | mm/dd/yyyy  Abstractor may enter 99/99/9999  If 99/99/9999, auto-fill medlist as 95, listdt as 99/99/9999, and go to alreddx   |  | | --- | | <= 1 year prior to or = stdybeg and  <= stdyend | | Nurse = RN or LPN  Clinician = Physician, NP, CNS, or PA  Enter the exact date. The use of 01 to indicate missing day or month is not acceptable.  If the patient did not have a face-to-face HBPC visit within the past year by a clinician or nurse, enter default 99/99/9999. |

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| 19 | medlist | | During the timeframe from (computer to display clindt – 1 day to clindt + 7 days) is there documentation in the record that a written current medication list was given to the patient or sent to the patient?   1. Yes 2. No 3. Most recent visit by a clinician occurred within 7 days prior to study end date   95. Not applicable | | 1,2,3,95  Will be auto-filled as 95 if clindt = 99/99/9999  If 2 or 3, auto-fill listdt as 99/99/9999, and go to alreddx   |  | | --- | | **Cannot enter 3 if stdyend – clindt > 7 days prior to stdyend** | | | **Current written medication profile**= a dated and reconciled list of all medications the patient is taking including name, dose, dosing schedule, any changes brought to the attention of the patient, the veteran’s name, a VA contact name and phone number for questions.  All medications= prescription, OTC, topical, and systemic medications from VA and non-VA sources  Nurse = RN or LPN  **Acceptable documentation:**  **The most recent nurse, NP, CNS, PA or physician face-to-face HBPC visit note documents that the Medication Profile was printed, reconciled, dated and provided to patient; OR**  **Signed note in CPRS that contains the current medication profile, dated with notation to be mailed or delivered to patient during the timeframe from 1 day prior to within 7 days after the most recent face-to-face home visit.** | |
| 20 | listdt | | Enter the date the current medication list was given to the patient or sent to the patient. | | mm/dd/yyyy  Will be auto-filled as 99/99/9999 if  Will be auto-filled as 95 if clindt = 99/99/9999  or medlist=2 or 3   |  | | --- | | < = 1 day prior to or = clindt and  <= stdyend | | | Enter the **earliest** date the patient either received the current medication list or the date of the signed note in CPRS indicating the medication list was mailed or delivered to the patient.  Enter the exact date. The use of 01 to indicate missing month or day is not acceptable. | |
| 21 | | alreddx | | Does the medical record document the patient has a known diagnosis of any of the following:   1. aphasia 2. dementia of Alzheimer’s disease or other dementia 3. delirium 4. comatose state   99. none of these diagnoses | | 1\*, 2\*,3\*,4\*, 99  \*If 1,2,3, or 4, go to ptreside, else  go to behvtrig | | Aphasia = defect or loss of the power of expression by speech, writing, or signs, or of comprehending spoken or written language, due to injury or disease of the brain.  Dementia = multiple cognitive deficits that include memory impairment. Etiology may include Alzheimer’s, vascular dementia, dementia due to HIV, head trauma, Parkinson’s, Huntington’s Disease, Creutzfeldt-Jakob Disease.  **Delirium = characterized by a disturbance of consciousness and a change in cognition that develop over a short period of time.**  Comatose state = a state of unconsciousness from which the patient cannot be aroused, even by powerful stimulation  Any of the above-listed diagnoses must be an actual diagnosis listed on a problem or diagnosis list. |
| **The question behvtrig will contain one of the following phrases that will appear on the computer screen in accordance with the patient’s length of stay.**  **If hcstatus=2: Within 30 days from the date of admission** **If hcstatus=3: Within the past year (within 365 days of the most recent admission to HBPC)** | | | | | | | | |
|  | |  | | **Behavioral Triggers** | |  | |  |
| 22 | | behvtrig | | Is there evidence that a clinician observed the patient for behavioral triggers suggestive of dementia?  1. Yes  2. No | | 1,2  If 2, auto-fill prestrig as 95, behavdt as 99/99/9999, and go to  cogdt, else go to prestrig | | **The reviewer will accept any documentation by the clinician stating the presence or absence of behavioral trigger (s). The intent is to determine that the clinician observed the patient for evidence of behavioral triggers suggestive of dementia and documented the presence or absence of behavioral triggers. For example, clinician notes, “Patient is poor historian. Nurse reported the patient missed last 2 appointments and is having difficulty with medication instructions. Behavior raises concern for dementia.” Select “1.”**  **Clinician = physician, PA, APN, Clinical Nurse Specialist (CNS), RN, LPN, social worker, psychologist**  If the clinician documents there are “no behavioral triggers” (or similar wording), select “1.” |
| 23 | | prestrig | | Did the clinician document the presence of behavioral triggers suggestive of dementia?  1. Yes  2. No  95. Not applicable | | 1,2,95  Will be auto-filled as 95 if behvtrig = 2 | | **In order to answer “1,” the clinician must document that behavioral triggers suggestive of dementia are present.** This could include a check box that indicates behavioral triggers are present or a description as noted below.  **Examples of behavioral triggers suggestive of dementia include, but are not limited to:**  The patient:   * Is a “poor historian” or “seems odd” * Is inattentive to appearance, inappropriately dressed for the weather, or dirty * Fails to appear for scheduled appointments or comes at the wrong time or on the wrong day * Repeatedly and apparently unintentionally fails to follow instructions (e.g., changing medications) * Has unexplained weight loss, “failure to thrive,” or vague symptoms (e.g., weakness or dizziness) * Seems unable to adapt or experiences functional difficulties under stress (e.g., the hospitalization, death, or illness of a spouse) * Defers to a caregiver—a family member answers questions directed to the patient |

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| 24 | behavdt | Enter the date of the documentation of the observation for behavioral triggers suggestive of dementia (either positive or negative).  (Documentation in HBPC note of behavioral triggers assessment within 30 days prior to admission to HBPC is acceptable.) | mm/dd/yyyy  Will be auto-filled as 99/99/9999 if  behvtrig = 2  If prestrig = 1, go to cogdt  If prestrig = 2, auto-fill cogdt as 99/99/9999,  scrncog as 95, screnout as 95, impair as 95,  addfolo as 95, and go to ptreside   |  | | --- | | If hcstatus = 2,  <= 30 days prior to or = admisdt and  <= 30 days after admisdt  If hcstatus = 3, < = 1 year prior to or = stdybeg and  < = stdyend | | If observation of behavioral triggers is documented more than once during the year, enter the most recent date of the documentation.  Enter the exact date. The use of 01 to indicate missing day or month is not acceptable. |
| **The question cogdt will contain one of the following phrases that will appear on the computer screen in accordance with the patient’s length of stay.**  **If hcstatus=2: Within 30 days from the date of admission**  **If hcstatus=3: Within the past year (within 365 days of the most recent admission to HBPC)** | | | | |

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| 25 | cogdt | Enter the date of the assessment of cognitive function using a standardized tool.  (Documentation of use of results of a standardized tool performed in another setting within 30 days prior to admission to HBPC is acceptable.) | mm/dd/yyyy  **Abstractor can enter default date 99/99/9999**  Will be auto-filled as 99/99/9999  if prestrig = 2  If 99/99/9999, auto-fill scrncog as 95,  screnout as 95,  impair as 95, addfolo as 95, and go to ptreside   |  | | --- | | If hcstatus = 2,  <= 30 days prior to or = admisdt and  <= 30 days after admisdt  If hcstatus = 3, < = 1 year prior to or = stdybeg and  < = stdyend | | **Assessment of cognitive function must be done using a standardized tool.**  **The standardized instrument used must be named, and the questions and scoring must be in accordance with the authentic assessment tool.**  **Standardized tool:** cognitive assessment tool that has been validated as identifying cognitive impairment.  Examples: the clock test, the Mini-Mental State Exam (MMSE), the Blessed Orientation-Memory-Concentration test (BOMC), Short Test of Mental Status (STMS), Mini-cog, St. Louis University Mental Status Exam (SLUMS), and the Short Portable Mental Status Questionnaire (SPMSQ)  **If an assessment of cognitive function was not done within the past year, enter 99/99/9999.** |

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| 26 | scrncog | What instrument was used to assess the patient’s cognitive function?   1. Clock test 2. Mini-Mental State Examination (MMSE) 3. The Blessed Orientation-Memory-Concentration Test (BMOC) 4. Short Test of Mental Status (STMS) 5. Mini-cog 6. St. Louis University Mental Status Exam (SLUMS) 7. Short Portable Mental Status Questionnaire (SPMSQ) 8. other standardized instrument   95. not applicable | 1,2,3,4,5,6,7,8,95  Will be auto-filled as 95 if prestrig = 2 or cogdt = 99/99/9999 | **Clock drawing test**= the patient is asked to draw a clock, put in all the numbers, and set the hands at ten past eleven  **Mini-Mental State Examination (MMSE)**= a series of questions to measure orientation to time and place, immediate recall, short-term verbal memory, calculation, language, and construct ability  **Blessed Orientation-Memory-Concentration Test (BMOC)**= six questions to assess orientation to time, recall of a short phrase, counting backward, and reciting the months in reverse order  **Short Test of Mental Status (STMS)** = assesses orientation, attention, recall, calculation, abstraction, clock drawing, and copying  **Mini-cog**= a combination of the clock drawing test with a three item recall screen  **St. Louis University Mental Status Exam (SLUMS**)= a series of eleven questions to assess cognition that factors the patient’s educational level into scoring of the exam  **Short Portable Mental Status Questionnaire (SPMSQ**)= series of ten questions to assess cognition that factors the patient’s educational level into scoring of the exam  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. |
| 27 | screnout | Is the outcome of the cognitive assessment documented in the medical record?   1. yes 2. no   95. not applicable | 1,2,95  Will be auto-filled as 95 if prestrig = 2 or cogdt=99/99/9999  If 2, auto-fill  impair as 95, addfolo as 95, and go to ptreside | It is not necessary for a copy of the cognitive assessment tool to be present in the record; however, administration of the exam and the outcome should be recorded.  The scoring of the cognitive assessment and therefore the outcome will be determined based upon which standardized assessment was utilized. |

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| 28 | | impair | | Did the assessment outcome indicate any degree of cognitive impairment for this patient?   1. yes 2. no   95. not applicable | | 1,2,95  Will be auto-filled as 95  if prestrig = 2  or cogdt =99/99/9999,  or screnout =2  If 2, auto-fill  addfolo as 95, and go to ptreside | | Symptoms of cognitive impairment: memory deficits, language impairment, affective changes, dementia-related behaviors (wandering, agitation, repetitive behaviors), loss of instrumental activities of daily living, incontinence, immobility  **Abstractor judgment may not be used. The record must document the findings of the cognitive assessment. Answer “1,” if the cognitive assessment is positive even if impairment is noted to be mild. Less than a perfect score does not indicate the patient has cognitive impairment.** |
| 29 | | addfolo | | Did the clinician document completion of follow-up for the positive cognitive assessment?   1. yes 2. no   95. not applicable | | 1,2,95  Will be auto-filled as 95 if prestrig = 2, cogdt=99/99/9999, screnout =2, or impair=2 | | Follow-up for cognitive impairment may include, but are not limited to: taking a medical history, performing a neurological exam, blood work, brain imaging, neuropsychological testing, or depression screening.  **There must be clinician documentation that the follow-up was done in relation to the patient’s cognitive impairment.** If there is documented completion of any follow-up related to the positive cognitive impairment screen, answer “1.” |
|  | |  | | **Caregiver Strain** | |  | |  |
| 30 | ptreside | | Was there documentation in the medical record of the patient’s place of residence?   1. Patient lives alone at home 2. Patient lives with another person at home 3. Patient lives in a Community Residential Care Facility, Assisted Living Facility, or nursing home 4. Patient lives in a VA medical foster home 5. Homeless   99. Unable to determine | | 1 ,2,\*3,4**,**5,99  **\*If 3, go to end**  If 1,2 or 5, go to caregivr; else if 4 or 99, auto-fill caregivr as 95, vetcargiv as 95, and go to caredt | | Review the admission assessment note, social services notes, and/or visit notes to determine where the patient resides.  If there is documentation that the patient lives with another person at home, answer “2” **unless** the person is a paid caregiver. If the only person living in the home with the patient is a paid caregiver, answer “1.”  Veterans enrolled in a medical foster home are not excluded from caregiver screening.  VA Medical foster home (MFH) = medically supervised foster home for patients with chronic medical problems who are unable to live with their family, in which the MFH caregiver resides in the home with the veteran and there are no more than 3 patients residing in the medical foster home.  CRC or ALF setting = patient lives in a CRC, assisted living facility, or other institution where the organization is responsible for caregiver activities. | |

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| 31 | caregivr | Does the record document that the HBPC patient has a caregiver?   1. Yes 2. No   95. Not applicable | 1,2,95  Will be auto-filled as 95 if ptreside = 4 or 99  If 1, auto-fill vetcargiv as 95, and go to caredt  If 2, go to vetcargiv | **Caregiver** = **One who provides ongoing support and care for a Veteran in the HBPC program.** The caregivers referred to are informal or unpaid caregivers—people who take on caregiver duties for other than employment or financial gain. Caregivers may assist the patient with activities of daily living, health care, financial matters, guidance, companionship and social interaction.  If the patient lives alone, lives with another person, or is homeless AND the record documents that the patient does NOT have a caregiver, answer “2.” If the record documents the HBPC patient is the caregiver for another person, answer “2.” |
| 32 | vetcargiv | Does the record document that the HBPC patient serves as a caregiver to another person?  1. Yes  2. No  95. Not applicable | 1,2,95  Will be auto-filled as 95 if ptreside = 4 or 99 or caregivr = 1  If 1, go to caredt; else if 2, go to end | **In order to answer “1,” there must be explicit documentation that the HBPC patient serves as the caregiver for the other person. For example, “Patient provides care to his wife who has dementia.”** |
| 33 | caredt | Enter the date within the past year, of the caregiver strain screen using the Zarit Burden Interview Screening scale.  (Documentation of caregiver strain screen using the Zarit Burden Interview Screening scale within 30 days prior to admission to HBPC is acceptable as being screened.) | mm/dd/yyyy  **Abstractor can enter default 99/99/9999 if no screen was done**  If 99/99/9999, go to end, else go to wichgivr   |  | | --- | | < =1 year prior or = stdybeg and  < = stdyend | | The Zarit Burden Interview Screening scale is a four question tool used to assess caregivers for caregiver strain. A caregiver is a person who provides ongoing support and care for a veteran in the HBPC program for other than employment or financial gain. A caregiver may include a spouse, other relative, friend, or neighbor. **The nurse has discretion in determining the appropriate caregiver to screen. The screen may be completed by the caregiver or administered by a member of the HBPC staff.**  **Telephone screening is acceptable.**  Enter the date the screen was documented in the record as completed.  **If caregiver strain screen was not done within the past year using the Zarit Burden Interview Screening scale, enter 99/99/9999.** |
| 34 | wichgivr | Which caregiver was screened for caregiver strain?   1. Spouse 2. Relative other than spouse 3. Friend 4. Neighbor 5. Other 6. VA Medical Foster Home Staff 7. HBPC patient | 1,2,3,4,5,6,7   |  | | --- | | **Warning: if <> 6 and ptreside = 4 OR if <> 7 and vetcargiv = 1** | | Caregiver= One who provides ongoing support and care for another person. The caregivers referred to are informal or unpaid caregivers—people who take on caregiver duties for other than employment or financial gain. |
| 35 | carescor | What was the outcome of the Zarit Burden screening scale documented in the record?  3. Outcome positive (score >=8)  6. Outcome negative (score <=7)  99. No score documented | 3,6, 99  If carescor = 6 or 99, go to end, else go to carefolo | A score of 8 or higher on the 4 question Zarit Burden Screening scale reflects high caregiver burden and requires follow-up. Documentation of the outcome of the Zarit Burden screen as positive or negative OR documentation of the score is acceptable. If the scores of the individual questions are documented in the record without the total score, the abstractor may add the scores of the individual questions to calculate the total score.  **Zarit Burden Screening Scale (4 question):**  1) DO YOU FEEL that because of the time you spend with your relative that you don’t have enough time for yourself?  2) DO YOU FEEL stressed between caring for your relative and trying to meet other responsibilities (work/family)?  3) DO YOU FEEL strained when you are around your relative? (listed as question 5 on 12 question survey)  4) DO YOU FEEL uncertain about what to do about your relative? (listed as question 10 on 12 question survey)  **Responses to questions are:**  0 🡪 Never  1 🡪 Rarely  2 🡪 Sometimes  3 🡪 Quite Frequently  4 🡪 Nearly Always  If the outcome or score of the Zarit Burden screen is not documented in the record or cannot be calculated, enter “99.” |
| 36 | carefolo | Did the medical record document follow-up for the positive caregiver strain screen?   1. Yes 2. No   98. Caregiver refused intervention | 1,2,98  If 2 or 98, go to end, else go to howfolo | Follow-up for a positive caregiver strain screen may include documentation of any of the following interventions:   * Caregiver education related to caregiver strain or concerns * Additional screening focused on the caregiver * Social work referral * Visit with social worker addressing caregiver strain * Offer of caregiver respite such as planned time away from the patient where someone else provides the care * Referral to caregiver support group * Mental Health referral * Other methods documented as caregiver support |
| 37 | howfolo1  howfolo2  howfolo3  howfolo4  howfolo5  howfolo5  howfolo6  howfolo7  howfolo8 | What follow-up intervention(s) are documented in the medical record?  **Indicate all that apply:**   1. Caregiver Education related to strain 2. Additional Screening focused on the caregiver 3. Social Work referral 4. Social Work visit for strain 5. Respite Offer 6. Refer to support group 7. MH referral 8. Other | 1,2,3,4,5,6,7,8 | Indicate each intervention documented in the record for follow-up of the positive caregiver strain screen. |