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|  |  | **Validation** |  |  |
| 1 | visithbpc | Does the record document a HBPC encounter by any member of the HBPC team\* during the study interval?  Yes  No | 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.** |
| 2 | 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. |
| 3 | justone | Was there only one home care encounter during the study interval?  1. Yes  2. No | 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. |
| 4 | evalvst | Was this encounter only pre-admission screening for possible enrollment in the HBPC program?  1. Yes  2. No | 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.** |
| 5 | admisdt | Enter the HBPC admission date. **Admission date is date of the progress note documenting admission.** | mm/dd/yyyy   |  | | --- | | Warning if <= 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 prior to hbpcdt, auto-fill hcstatus = 2  If hbpcdt – admisdt > 1 year, auto-fill  hcstatus = 3 | | **Admission to HBPC is the note that states the patient is admitted to HBPC.**  **Note:** The first note in the record may be a pre-admission/screening assessment note and should not be considered as the admission date.  HBPC Admission Date guidelines:   * May be the first or subsequent visit. The note may have many titles, such as initial assessment, admission note, etc. Date of the admission 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. If day cannot be determined, enter 01 as default.   **Exclusion Statement**  **The patient was enrolled in HBPC for less than the 30 days initial assessment period.** |
| 6 | 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 prior to hbpcdt, OR auto-fill hcstatus = 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 **note that states the patient is admitted to HBPC.**  This may be the first or subsequent encounter. The note may have many titles, such as initial assessment, admission note, etc. Date of the admission 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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|  | |  | | **Medication Management** | |  | |  |
| **If Hcstatus = 2 and hbpcdt – admisdt <= 120 days, go to admmed; else if Hcstatus = 2, go to medone**  **If Hcstatus = 3, go to medone** | | | | | | | | |
| 7 | admmed | | At the time of HBPC admission, was the patient on at least one medication?  1. Yes  2. No | | 1,2  If 2, go to hospice; else go to medrev3 | | Medications include prescribed, OTC, topical, and systemic medications from VA and non-VA providers as noted in the record.  Suggested data sources: HBPC notes, medication profile | |
| 8 | medone | | During the timeframe from (computer to display stdybeg – 110 days to stdybeg – 90 days), was the patient on at least one medication?  1. Yes  2. No | | 1,2  If 2, go to hospice | | Medications include prescribed, OTC, topical, and systemic medications from VA and non-VA providers as noted in the record.  Suggested data sources: HBPC notes, medication profile | |
| **The question medrev3 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) OR Hcstatus=3, computer to display (During the timeframe from stdybeg – 110 days to stdyend)** | | | | | | | | |
| 9 | medrev3 | | Did the record document the patient’s HBPC medication management plan in a note signed by the pharmacist?   1. Yes 2. No | | 1,2  If 2, go to nomedrev | | **A medication review of the patient’s medication management plan consists of a review by a pharmacist of all medications.** **To meet the intent of this question, documentation of the patient’s HBPC medication management plan in a note signed by the pharmacist is acceptable.**  All medications include prescribed, OTC, topical, and systemic medications from VA and non-VA providers as noted in the record. The pharmacist should review all medications for appropriateness (e.g., indication for medications or medication is no longer indicated, dosage), adverse reactions and interactions, and communicate concerns and recommendations to the HBPC provider or primary care provider.  **Note:** The timeframe for review of the patient’s medication management plan is based on the number of days the patient has been admitted to HBPC.   * For patients admitted to HBPC less than or equal to 120 days prior to the most recent HBPC visit date, review is required within 30 days of HBPC admission date. * For patients admitted to HBPC greater than 120 days prior to the most recent HBPC visit date, review is required quarterly. For purpose of this measure, the quarterly timeframe is calculated based on the study begin date (count back 110 days prior to study begin date) and ends with last day of study interval (study end date). **Example:** Using March 2014 as the study month, the study begin date is 3/01/2014 and study end date is 3/31/2014. The calculated timeframe for quarterly review is 11/11/2013 through 3/31/2014. | |
| 10 | medrevdt | | Enter the date of the medication management plan review. | | mm/dd/yyyy   |  | | --- | | 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,  stdybeg – 110 days and <= stdyend | | | Enter the exact date. The use of 01 to indicate missing day or month is not acceptable. | |
| 11 | medchg | | Did the pharmacist make any recommendation for change in the patient’s medication regimen?  1. Yes  2. No | | 1,2  If 2, go to clindt | | If the pharmacist recommends a change to at least one medication (e.g., change in dose, frequency, discontinuation of medication), select “1”.  For example, pharmacist notes, “Patient’s BP consistently above 150/90; recommend increasing Lisinopril to 20 mg PO daily.” | |
| 12 | medcomm | | Did the pharmacist communicate any change in the patient’s medication regimen to the HBPC or primary care provider?  1. Yes  2. No | | 1,2  If 1 or 2, go to clindt | | Pharmacist communication of a change to the medication regimen may be completed by direct communication (e.g., pharmacist calls the provider) or by cosignature of the medication plan review note by the HBPC or primary care provider.  It is not necessary to see documentation of communication of all recommended changes in the medication regimen. | |
| **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 OR Hcstatus=3, computer to display (During the timeframe from stdybeg – 110 days to stdyend)** | | | | | | | | |
| 13 | nomedrev | | Did the record document the patient was hospitalized during the time the medication management plan was to be reviewed?  1. Yes  2. No | | 1,2  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. | |
| 14 | admdate | | Enter the admission date. | | mm/dd/yyyy  Will be auto-filled as 99/99/9999 if  nomedrev = 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,  stdybeg – 110 days and <= stdyend | | | Enter the exact date. | |
| 15 | dcdate | | Enter the discharge date. | | mm/dd/yyyy  Will be auto-filled as 99/99/9999 if nomedrev = 2   |  | | --- | | >= admdate and  <= pulldt | | | Enter the exact date. | |
| 16 | clindt | | Enter the date of the most recent HBPC face-to-face visit by a nurse (RN, LPN) or clinician (physician/NP/CNS/PA/Pharmacist). | | 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 hospice   |  | | --- | | <= 1 year prior to or = stdybeg and  <= stdyend | | | Nurse = RN or LPN  Clinician = Physician, NP, CNS, PA, or pharmacist  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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| 17 | 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 hospice   |  | | --- | | **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, pharmacist, 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.** |
| 18 | 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  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. |
| 19 | hospice | Is the patient receiving hospice care?  1. Yes  2. No | \*1,2  **\*If 1, go to ptreside** | **Hospice:** A Medicare or VA funded community-based service delivered at home, in a nursing home, or at a hospice facility at end of life.  **Exclude:** Palliative care |
| 20 | 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, current 4. comatose state 5. Traumatic Brain Injury   99. none of these diagnoses | 1\*, 2\*,3\*,4\*,\*5, 99  \*If 1,2,3, 4, or 5, go to ptreside; else  go to prestrig2 | NOTE: ICD-9 codes for the listed diagnoses are provided in Appendix A.  **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** = symptom complex characterized by intellectual deterioration (including disturbances in memory as well as language, spatial abilities, impulse control, judgment, or other areas of cognitive ability) severe enough to interfere with social or occupational functioning.  **Delirium** = characterized by a disturbance of consciousness and a change in cognition that develop over a short period of time. Exclude previous history of delirium that has resolved.  **Comatose state** = a state of unconsciousness from which the patient cannot be aroused, even by powerful stimulation  **Traumatic Brain Injury** = happens when something outside the body hits the head with significant force. Individuals who sustain a TBI may experience a variety of effects, such as an inability to concentrate, an alteration of the senses, difficulty speaking, and emotional and behavioral changes.  **Any of the above-listed diagnoses must be an actual diagnosis listed on the problem list.** |
| **The question prestrig2 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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| 21 | prestrig2 | Did the HBPC clinician document the presence or absence of behavioral triggers (i.e., warning signs) suggestive of dementia or other cognitive impairment?  (For patients admitted to HBPC less than or equal to 1 year, clinician documentation in HBPC pre-admission/admission note of behavioral triggers assessment within 30 days prior to HBPC admission is acceptable.)   1. Yes: **Presence** of behavioral triggers is documented.   4. Yes: **Absence** of behavioral triggers is documented.  99. No: **No documentation** of presence or absence of behavioral triggers or unable to determine from medical record documentation. | 3,4,99  If 99, go to ptreside | **The intent is to determine that the HBPC clinician observed the patient for evidence of behavioral triggers suggestive of dementia or other cognitive impairment and documented the presence or absence of behavioral triggers.**  **In order to answer “3” the HBPC clinician must document that behavioral triggers suggestive of dementia or other cognitive impairment are present.**  **It is not a requirement that the exact term “behavioral triggers” be found in the record.**  **Examples of behavioral triggers suggestive of dementia or other cognitive impairment include, but are not limited to:**  The patient:   * Is a “poor historian” or forgetful * Is inattentive to appearance or unkempt, inappropriately dressed for the weather, or disheveled * Fails to keep appointments or comes on the wrong day or wrong time * Repeatedly and apparently unintentionally fails to follow instructions (e.g., not following through with medication changes) * Has unexplained weight loss, “failure to thrive,” or vague symptoms (e.g., weakness or dizziness) * Defers to a caregiver or family member to answer questions   **If the HBPC clinician documents there are “no behavioral triggers” (or similar wording, such as “no evidence of cognitive impairment”, “no dementia warning signs”, “no signs or symptoms of dementia or other cognitive impairment”), select “4.”**  **If there is conflicting documentation regarding the presence or absence of behavioral triggers during the specified timeframe, use the most recent documentation of presence or absence of behavioral triggers to answer this question.**  **If there is no documentation of presence or absence of behavioral triggers suggestive of dementia or other cognitive impairment or unable to determine from medical record documentation, select “99”.** |
|  |  |  |  | **Behavioral Triggers cont’d**  HBPC Clinician = physician, PA, APN, Clinical Nurse Specialist (CNS), RN, LPN, social worker, psychologist, pharmacist  Suggested data sources: HBPC assessment/admission note, HBPC annual assessment, HBPC visit notes |
| 22 | behavdt | Enter the date of the most recent documentation by the HBPC clinician noting presence or absence of behavioral triggers suggestive of dementia.  (For patients admitted to HBPC less than or equal to 1 year, HBPC clinician documentation in HBPC pre-admission/admission note of behavioral triggers assessment within 30 days prior to HBPC admission is acceptable.) | mm/dd/yyyy  If prestrig2 = 3, go to asescog  If prestrig2 = 4, 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 specified timeframe, enter the most recent date of the documentation of presence or absence of behavioral triggers.  HBPC Clinician = physician, PA, APN, Clinical Nurse Specialist (CNS), RN, LPN, social worker, psychologist, pharmacist  Enter the exact date. The use of 01 to indicate missing day or month is not acceptable. |
| **The question asescog 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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| 23 | asescog | Was the patient’s cognitive function assessed using a standardized and published tool?  (For patients admitted to HBPC less than or equal to 1 year, HBPC clinician documentation in HBPC pre-admission/admission note of assessment of cognitive function within 30 days prior to HBPC admission is acceptable.)   1. Yes 2. No   98. Patient refused assessment of cognitive function | 1,2,98  If 2 or 98, go to ptreside | **The intent is to have an objective assessment of cognitive function, using a standardized and published tool, for the patient with documented behavioral trigger(s) suggestive of dementia or other cognitive impairment.**  **The tool must be named and the result of the assessment must be documented in accordance with the specific tool used (e.g., positive or negative, numeric value for total scale score, or other designation).**  **Examples of Brief Cognitive Tools:**  **Blessed Orientation-Memory-Concentration Test (BOMC) -** six questions to assess orientation to time, recall of a short phrase, counting backward, and reciting the months in reverse order  **Mini-Cog** – this test has minimal language requirements making it better for educational or cultural variations. The Mini-Cog combines a three item word recall with drawing the hands on a clock.  **General Practitioner Assessment of Cognition (GPCOG)** – This tool was developed for the primary care setting and is available in different languages. It includes a short patient assessment and follow up interview with the patient’s caregiver.  **Short Test of Mental Status (STMS) -** The evaluator provides a name and address, asks about the date and awareness of current news and ends with seeking patient recall of the name and address. A follow up interview with the caregiver seeks information about changes in patient memory and behavior.  **St. Louis University Mental Status Exam (SLUMS**) - This is a brief exam containing oral and written items. It includes recall, orientation to date and time, simple math, and recall of other general information. It is more sensitive than the MMSE.  **Montreal Cognitive Assessment (MoCA)** – This assessment is a one page, 30 point test and evaluates visual-spatial relationships, recall, language, attention, concentration, working memory and orientation. |
| 24 | cogdt | Enter the date of the most recent assessment of cognitive function using a standardized and published tool.  (For patients admitted to HBPC less than or equal to 1 year, HBPC clinician documentation in HBPC pre-admission/admission note of assessment of cognitive function within 30 days prior to HBPC admission is acceptable.) | mm/dd/yyyy   |  | | --- | | 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 | | **Enter the exact date of the most recent assessment of cognitive function using a standardized and published tool.** |
| 25 | cogout | Is the outcome of the cognitive assessment documented in the medical record?   1. Yes 2. No | 1,2  If 2, go to ptreside | The result of the cognitive assessment must be documented in the record in accordance with the specific tool used (e.g., positive or negative, numeric value for total scale score, or other designation).  Examples of other designation include, but are not limited to: “assessment of cognitive function indicates mild cognitive impairment”, “results not indicative of cognitive impairment”. |
| 26 | impair | Did the assessment outcome indicate any degree of cognitive impairment for this patient?   1. Yes 2. No | 1,2  If 2, go to ptreside | **The intent of the question is to determine if the outcome of the assessment indicated any degree of cognitive impairment or not.**  **Abstractor judgment may not be used. The record must document the clinician’s interpretation of the cognitive assessment outcome. Less than a perfect score does not indicate the patient has cognitive impairment.**  Answer “1,” if the cognitive assessment is interpreted as positive, even if impairment is noted to be mild. Look for language such as “impaired”, “positive”, or “suggestive of cognitive impairment”.  Answer “2,” if the cognitive assessment is interpreted as negative. Look for language such as “within normal limits”, or “results not indicative of cognitive impairment”. |
| 27 | addfolo | During the timeframe from (computer to display cogdt to cogdt + 30 days and < stdyend), did the HBPC clinician document a plan for follow-up of the positive cognitive assessment?   1. Yes 2. No | 1,2 | **The clinician performing and reporting the results of the cognitive assessment should document an initial plan for follow up.**  **Follow-up for positive cognitive assessment may include referral to the PCP for further evaluation, ordering a diagnostic workup, care planning, and/or treatment.**  **The follow-up plan must be related to the patient’s cognitive impairment and documented within 30 days after the cognitive assessment.**  **Examples may include, but are not limited to:** taking a medical history; performing or referring for blood work; depression screening; referring for psychology/psychiatry consult; referring for neuropsychological testing; referring for neurologic exam; referring for brain imaging; care planning with Veteran/family for dementia or other similar diagnosis; supportive counseling for patient, and caregiver education and/or support.  Note that follow-up could also include documentation by the clinician that cognitive impairment has remained stable over time (e.g., since last year’s assessment) and reinforcement of current treatment plan.  Follow up actions do not need to occur during a face-to-face visit; they may be documented in the medical record as part of the plan or, in the case of education and support, via telephone contact with Veteran/caregiver.  If there is documentation of a follow-up plan related to the positive cognitive impairment assessment, answer “1.”  **HBPC Clinician = physician, PA, APN, Clinical Nurse Specialist (CNS), social worker, psychologist** |

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|  | |  | | **Caregiver Strain** | |  | |  |
| 28 | 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 nuthyd as applicable**  If 1,2 or 5, go to caregivr; else if 4 or 99, auto-fill caregivr as 95, vetcargiv as 95, and go to scrncare | | 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”.  **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. MFH documentation should be found in MFH Coordinator notes.  **Veterans enrolled in a Medical Foster Home are not excluded from caregiver screening.**  CRC or ALF setting = patient lives in a CRC, assisted living facility, or other institution where the organization is responsible for caregiver activities. | |
| 29 | caregivr | | Is there HBPC medical record documentation that identifies a caregiver for the patient?   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 scrncare  If 2, go to vetcargiv | | **A caregiver provides substantive assistance, i.e., assistance with Activities of Daily Living (ADL) and/or with Instrumental Activities of Daily Living (IADL), on an ongoing basis for the Veteran in the Veteran’s place of residence. The assistance may involve, but is not limited to, direct personal care activities, such as bathing, dressing, grooming or other activities, such as laundry, shopping, meal preparation. The caregiver may be a family member, friend, or neighbor who lives with or lives separately from the Veteran.**   * Look for specific documentation by HBPC staff that identifies whether or not the patient has a caregiver. If HBPC documentation is conflicting (e.g., caregiver vs no caregiver), accept the most recent HBPC documentation. * Caregivers of Veterans enrolled in the VA Program of Comprehensive Assistance for Family Caregivers are paid a stipend and are included in caregiver screening; answer “1”. * If the caregiver is a paid caregiver (e.g., private caregiver, caregiver service, state agency), answer “2.” 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.”   Suggested data sources: HBPC assessment/admission note, HBPC annual assessment, HBPC Care Plan | |
| 30 | 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 scrncare; else if 2, go to nuthyd as applicable | | **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.”** | |
| 31 | scrncare | | During the past year, was the caregiver screened for caregiver strain using the Zarit Burden Interview Screening scale?  1. Yes  2. No  98. Caregiver refused screening for caregiver strain | | 1,2, 98  If 2 or 98, go to nuthyd as applicable | | The Zarit Burden Interview Screening scale is a four question tool used to assess caregivers for caregiver strain. Of note, there are longer versions of the Zarit Burden Interview (e.g., 12-item and 22-item), which include the 4 screening items. Enter the date of administration of any version of the Zarit Burden Interview.  **The screen may be administered during a face-to-face visit in the Veteran’s home (either HBPC staff interview of caregiver or self-administered by caregiver) or via telephone.**  Refusal = offered the opportunity to complete the Zarit Burden Interview during the past year and there is a documented refusal. | |
| 32 | caredt | | Enter the date within the past year, of the most recent 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   |  | | --- | | < =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. Of note, there are longer versions of the Zarit Burden Interview (e.g., 12-item and 22-item), which include the 4 screening items. Enter the date of administration of any version of the Zarit Burden Interview.  **The screen may be administered during a face-to-face visit (either HBPC staff interview of caregiver or self-administered by caregiver) or via telephone.** | |
| 33 | wichgivr | | Which caregiver was screened for caregiver strain?   1. Spouse/partner 2. Relative other than spouse/partner 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** | | | **A caregiver provides substantive assistance, i.e., assistance with Activities of Daily Living (ADL) and/or with Instrumental Activities of Daily Living (IADL), on an ongoing basis for the Veteran in the Veteran’s place of residence. The assistance may involve, but is not limited to, direct personal care activities, such as bathing, dressing, grooming or other activities, such as laundry, shopping, meal preparation. The caregiver may be a family member, friend, or neighbor who lives with or lives separately from the Veteran.** | |
| 34 | 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 nuthyd as applicable; else go to indther | | 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.”  **Note:** Some sites may choose to use longer forms of the Zarit Burden Interview (e.g., 12-item or 22-item). If a longer form is used, the site should document the total score on the 4-item screen. | |
| 35 | indther | | During the timeframe from (computer to display caredt to caredt + 14 days and < stdyend), was the caregiver offered **therapy** individualized to the caregiver situation?  1. Yes  2. No  98. Caregiver refused therapy | | 1,2,98 | | * An offer of caregiver therapy, **individualized to the caregiver situation,** is indicated by documentation that the caregiver was offered therapeutic intervention to address caregiver strain. * Therapeutic intervention provides support/services for the caregiver and might include counseling, psychoeducation (e.g. education about illness, behaviors and coping strategies), skills-training, stress-management, specific individual, couples, family, or group caregiver therapy (e.g., REACH-VA, Family-Caregiver Therapy), or other interventions that aim to help the caregiver cope with caregiver strain and/or improve self-care. * In contrast to other types of follow-up noted for the CAREFOLO question below, therapeutic intervention typically implies working with the caregiver for more than one encounter.   **Note:** The caregiver therapy does not need to be initiated within 14 days after the positive caregiver strain screen, but the offer for caregiver therapy must be made within that timeframe.  **Exclude:** Offer of or referral to community support group, respite care | |
| 36 | Carefolo  Hc22 | | During the timeframe from (computer to display caredt to caredt + 14 days and < stdyend), did the medical record document other types of follow-up for the positive caregiver strain screen?   1. Yes 2. No   98. Caregiver refused intervention | | 1,2,98 | | Follow-up for a positive caregiver strain screen must occur during the timeframe indicated and may include documentation of any of the following types of interventions:   * Caregiver education materials/resources related to caregiver strain or concerns * Completion of additional screening focused on the caregiver * Offer of caregiver respite such as planned time away from the patient where someone else provides the care * Referral to support group * Encourage caregiver to follow up with own physical/mental health care provider. * Physical/mental health referral for caregiver physical/mental health concerns. * Other methods documented as caregiver support   Follow-up during a face-to-face encounter or via telephone is acceptable.  In order to answer “98” there must be documentation that the caregiver refused offer of all interventions. | |
| **If Hcstatus=2, go to nuthyd; else go to end** | | | | | | | | |
|  |  | | **Nutrition/Hydration** | |  | |  | |
| 37 | nuthyd | | Within 30 days of HBPC admission date, does the record document assessment of the patient’s nutritional and hydration needs by a registered dietician during a face-to-face encounter?   1. Yes 2. No | | 1,2  If 2, go to envases | | **Initial nutritional and hydration assessment must be performed by a registered dietician during a face-to-face encounter in the Veteran’s home within 30 days of HBPC admission.**  The assessment may contain: biometrics, lab interpretation, nutrition risk/problem, and education.  Education and counseling regarding dietary management of disease, i.e., the need for CHF patient to restrict sodium and fluid intake, nutritional supplements to combat cachexia of cancer, etc., is evidence that assessment occurred.  Telephone or clinical video teleconference (CVT) encounter is not acceptable.  A dietician student/intern/trainee with appropriate co-signature by registered dietician is acceptable  Suggested data source: HBPC Nutrition (Assessment) note | |
| 38 | nuthydt | | Enter the date of the initial nutritional and hydration assessment by a registered dietician. | | mm/dd/yyyy   |  | | --- | | >= admisdt and <= 30 days after admisdt | | | Enter the exact date of the initial nutritional and hydration assessment by a registered dietician within 30 days of admission. | |
| 39 | nutintv | | Does the record document a plan of care or intervention by the registered dietician to address the patient’s nutritional and/or hydration needs?   1. Yes 2. No 3. Record documents intervention for nutritional/hydration status not required | | 3,4,5  If 4 or 5, go to envases | | The nutritional care plan may include recommendations and findings, interventions, education, follow-up visit frequency, and goals.  A dietician student/intern/trainee with appropriate co-signature by registered dietician is acceptable.  Suggested data sources: HBPC Nutrition Assessment note, HBPC Nutrition progress note | |
| 40 | nutresp | | Following documentation of the nutritional/hydration care plan/intervention, was the patient’s response to the nutritional/hydration care plan/intervention evaluated by the registered dietician?  3. Yes  4. No  5. No HBPC visit between nutritional/hydration care plan/intervention and study end date | | 3,4,5 | | Follow up assessments may be face to face, telephone, or clinical video teleconference (CVT) as appropriate to the patient’s needs.  A dietician student/intern/trainee with appropriate co-signature by registered dietician is acceptable.  Suggested data sources: HBPC Nutrition Assessment note, HBPC Nutrition progress note | |
|  |  | | **Environment Safety/Risk Assessment** | |  | |  | |
| 41 | envases | | Was a home environmental safety/ risk assessment documented by a rehabilitation therapist during a face-to-face encounter within 30 days of HBPC admission date?   1. Yes 2. No | | 1,2  If 2, go to end | | **A home environmental safety/ risk assessment must be performed by a rehabilitation therapist during a face-to-face encounter in the Veteran’s home. The home environmental safety/risk assessment may be found in an HBPC progress note and must include:**   * **overall assessment of the patient’s living environment;** * **identification any safety issues;** * **list any adaptive devices/equipment that are already in place;** * **recommendations and/or interventions provided; and** * **education provided to patient/caregiver.**   Home environment is the environment where the patient lives and includes patient’s own home, assisted living facility, personal care home and medical foster home.  Rehabilitation therapist = Occupational therapist (OT), Physical therapist (PT), and Kinesiotherapist (KT)  A rehabilitation therapist student/intern/trainee with appropriate co-signature by rehabilitation therapist is acceptable.  Suggested Data Sources: HBPC Home Environment Assessment note, Rehabilitation Therapy (KT,OT, PT) Assessment note | |
| 42 | envasedt | | Enter the date of the home environmental safety/risk assessment documented by a rehabilitation therapist. | | mm/dd/yyyy   |  | | --- | | >= admisdt and <= 30 days after admisdt | | | Enter the exact date of the home environmental safety/risk assessment completed by a rehabilitation therapist within 30 days of admission. | |
| 43 | envoxy | | Was the patient oxygen dependent?   1. Yes 2. No | | 1,2  If 2, go to envintv | | **Oxygen dependent = use of oxygen by the patient in the home.**  Suggested Data Sources: HBPC Environment Assessment, HBPC Rehabilitation Therapy (KT/OT/PT) Assessment, HBPC Nursing Admission Assessment, problem list | |
| 44 | asesoxy | | Was a home oxygen safety risk assessment documented by a HBPC team member during a face-to-face encounter within 30 days of HBPC admission date?   1. Yes 2. No | | 1,2 | | Home oxygen safety risk assessment may be part of the home environmental safety/risk assessment and may be documented under safety risks. The home oxygen safety risk assessment must be performed during a face-to-face encounter in the Veteran’s home by a member of HBPC team. Home oxygen safety may also be found in HBPC nursing notes.  Home oxygen safety risk assessment must include:   * documentation of whether smoking materials are in the home, * other fire safety risks in the home such as potential for open flames, and * whether or not the home has functioning smoke detectors.   Any HBPC team member may complete this assessment.  Suggested Data Sources: HBPC Environment Assessment note, HBPC Rehabilitation Therapy (KT/OT/PT) Assessment, Nursing Admission Assessment or notes | |
| 45 | envintv | | Does the record document a plan of care or intervention by the rehabilitation therapist to address the home environmental safety/risk assessment findings?   1. Yes 2. No 3. Record documents plan of care or intervention for home environmental safety/risk assessment not required | | 3,4,5  If 4 or 5, go to end | | The home environmental care plan or intervention may include recommendations and findings, interventions, education, follow-up visit frequency, and goals.  A rehabilitation therapist student/intern/trainee with appropriate co-signature by rehabilitation therapist is acceptable.  Suggested data sources: HBPC Environment Assessment note, HBPC Rehabilitation Therapy (KT/OT/PT) progress notes | |
| 46 | envresp | | Following documentation of the home environmental safety/risk care plan or intervention, was response to the care plan/ intervention evaluated by the rehabilitation therapist?  3. Yes  4. No  5. No HBPC visit between home environmental care plan/intervention and study end date | | 3,4,5 | | Follow up assessments may be face to face, telephone, clinical video teleconference (CVT) as appropriate to the patient’s needs.  Examples of response to environmental care plan/intervention may include, but are not limited to: patient is using ADL equipment properly (intervention was providing patient education on proper use), patient removed throw rugs (intervention was identifying throw rugs as safety hazard and recommending removal)  A rehabilitation therapist student/intern/trainee with appropriate co-signature by rehabilitation therapist is acceptable.  Suggested data sources: HBPC Environment Assessment note, HBPC Environment progress note, HBPC Rehabilitation Therapy (KT/OT/PT) progress notes | |