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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? YesNo  | 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 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

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| > = 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. Yes2. 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. Yes2. 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 | admisdthc34 | Enter the HBPC admission date. **Admission date is date of the progress note documenting admission.**   | mm/dd/yyyy

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| Warning if <= 20 years prior to or = stdybeg and < stdyend |

**If hbpcdt – admisdt < 30 days, the case is excluded**

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| --- |
| If hbpcdt – admisdt > = 30 days and < = 1 yr prior to hbpcdt, auto-fill hcstatus = 2If 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:* **Review the record carefully to determine the most recent HBPC admission date.**
* May be the first or subsequent visit. The note may have many titles, such as initial assessment, admission note, etc. Review the content of the note to verify documentation of HBPC admission date. 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 | hcstatushc26,hc27,hc29, hc34, hc35, hc36 | Counting from the most recent HBPC encounter within the study interval, enter the patient’s status in regard to HBPC admission:2. HBPC admission greater than or equal to 30 days but less than or equal to 1 year3. 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****If 2, go to inptadm; else go to admmed as applicable** | **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**. |
| 7 | inptadmhc26, hc29,hc34, hc35, hc36 | During the time frame from (computer display admisdt to admisdt + 30 days), did the record document the patient was hospitalized? 1. Yes2. No | 1,2If 2, auto-fill admdate2 as 99/99/9999 and go admmed as applicable  | The intent of the question is to determine if the patient was hospitalized during the 30 days following HBPC admission. If the patient was hospitalized at a non-VHA facility, the dates must be documented in order to determine admission within the specified time frame. |
| 8 | admdate2 | Enter the admission date. | mm/dd/yyyyIf valid date, go to medrecdtWill be auto-filled as 99/99/9999 if inptadm = 2

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| >= admisdt and <= 30 days after admisdt  |

 | Enter the exact date. |

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|  |  | **Medication Management** |  |  |
| **If Hcstatus = 2 and hbpcdt – admisdt <= 120 days, go to admmed; else go to medrecdt** |
| 9 | admmedhc34 | At the time of HBPC admission, was the patient on at least one medication?1. Yes2. No | 1,2If 2, go to medrecdt; 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 |
| 10 | medrev3hc34 | During the time frame from (computer to display admisdt to admisdt + 30 days), did the record document the patient’s HBPC medication management plan in a note signed by the pharmacist? 1. Yes
2. No
 | 1,2If 2, go to medrecdt | **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.
 |
| 11 | medrevdthc34 | Enter the date of the most recent medication management plan review. | mm/dd/yyyy

|  |
| --- |
| If hcstatus = 2 AND hbpcdt – admisdt <=120 days, >= admisdt and <= 30 days after admisdt  |

 | Enter the exact date. The use of 01 to indicate missing day or month is not acceptable. |
| 12 | medchghc34 | Did the pharmacist make any recommendation for change in the patient’s medication regimen?1. Yes2. No | 1,2If 2, go to medrecdt | 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.”  |
| 13 | medcommhc34 | Did the pharmacist communicate any change in the patient’s medication regimen to the HBPC or primary care provider?1. Yes2. No | 1,2 | 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 or documentation of the direct communication..It is not necessary to see documentation of communication of all recommended changes in the medication regimen. |

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|  |  | Medication Education |  |  |
| 14 | medrecdthc37 | Enter the date of the most recent HBPC face to face or telephone encounter when medication reconciliation was performed by a physician/APN/PA, pharmacist, RN, or LPN during the past 90 days | mm/dd/yyyyAbstractor may enter 99/99/9999If 99/99/9999, go to ptreside

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| --- |
| <= 90 days prior to or = stdybeg and <= stdyend |
| Warning if 99/99/9999 |

 | Enter the exact date of the **most recent HBPC face to face or telephone encounter when medication reconciliation was performed by a physician/APN/PA, pharmacist, RN, or LPN during the past 90 days.**The Medication Reconciliation process seeks to maintain and communicate accurate patient medication information. It entails identifying, addressing, and documenting medication discrepancies found in the VA electronic medical record as compared with the medication information supplied by the patient. This information, along with any changes made during the episode of care, is communicated to the patient, caregiver or family member, and appropriate members of the health care team.Medication reconciliation is not the same process as medication management plan review by a pharmacist.If there is no documentation of a HBPC face to face or telephone encounter when medication reconciliation was performed by a physician/APN/PA, pharmacist, RN, or LPN during the past 90 days, enter 99/99/9999. |
| 15 | newmedrxhc37 | During the HBPC encounter on (computer to display medrecdt) when medication reconciliation was performed, was a new medication prescribed, added or identified during the medication reconciliation process?1. Yes 2. No  | 1,2If 2, go to ptreside | **A new medication is defined as any VA prescription, non-VA prescription, OTC or herbal/nutritional supplement and PRN medications that have been prescribed by a VA or non-VA provider (or started by the patient/caregiver) at this visit or during the time period between this visit and the next most previous HBPC visit where medication reconciliation was performed by a HBPC physician/APN/PA, pharmacist, RN, or LPN.**The reviewer should only look at the most recent HBPC med reconciliation in the past 90 days (encounter entered in MEDRECDT). If unable to determine whether a medication is a ‘new medication,’ it may be necessary to compare the medication list from the next most previous HBPC visit when medication reconciliation was performed to the medication list for the most recent HBPC visit (MEDRECDT). A new medication is defined as one that has not been on the patient’s medication list (active or expired) within the past 90 days. A renewal of a medication previously prescribed in the 90 days prior to this encounter does not count as a new medication. For example, MEDRECDT is 6/15/2016 and furosemide is on the medication list. On 5/15/2016, furosemide was noted as expired and reordered the same date.For the purpose of this question, exclude medical and diagnostic test supplies (e.g., glucometer strips, gauze, syringes, etc.). |
| 16 | mededcon1mededcon2mededcon3mededcon4hc37 | During the time frame (computer to display medrecdt – 10 days to medrecdt + 10 days), did a physician/APN/PA, pharmacist, RN, or LPN provide education on the new medication(s) prescribed/added to the patient/caregiver to include:

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| --- | --- |
| 16a. Medication name, type and reason for use | 1. Yes2. No |
| 16b. How to administer the medication (include process, time, frequency, route, and dose) | 1. Yes2. No |
| 16c. Anticipated actions and potential side effects | 1. Yes2. No |
| 16d. How to monitor effects of the medication | 1. Yes2. No |

 | 1,2If any mededcon1, mededcon2, mededcon3, or mededcon4 = 2, go to noedpln | * **Medication education can be provided by the physician/APN/PA, pharmacist, RN, or LPN.**
* **The education may be provided in person or by telephone.**
* **If patient was ordered a new medication by a non-HBPC provider---it would show up on the new medication list—and be recognized as such during medication reconciliation.** The patient/caregiver should then receive education from the HBPC physician/APN/PA, pharmacist, RN, or LPN within 10 days prior to or after the home visit when the new medication was documented.
* The listed components must be documented for each new medication prescribed or added to the patient’s medication list.

**For example:** Lisinopril was newly prescribed for the patient. RN documents, “Medication education and handout on Lisinopril provided to patient. Reviewed all of the following:* Medication name, type, and reason for use
* How to administer the medication (include process, time, frequency, route, and dose)
* Anticipated actions and potential side effects
* How to monitor effects of the medication

**Acceptable documentation:**A medication handout may be given to the patient as long as the physician/APN/PA, RN, LPN, or pharmacist documents the education (or counseling) provided included the required components in the note.If multiple medications were prescribed/added, use of a checklist to cover the components for all new medications is acceptable.  |
| 17 | mededevalhc37 | Did the physician/APN/PA, pharmacist, RN, or LPN document an evaluation of the patient/caregiver’s understanding of the medication education?3. Yes, documented evaluation indicated patient/caregiver understanding of medication education provided4. Yes, documented evaluation indicated patient/caregiver did **NOT** understand medication education provided5. No, physician/APN/PA, pharmacist, RN, or LPN did not document an evaluation of patient/caregiver’s understanding of the medication education | 3,4,5If 4, go to medevpln; else go to ptreside | **For example, after providing medication education to patient/caregiver, provider notes, “Patient indicated understanding of material covered. Patient repeated medication administration instructions accurately.”** Examples include but are not limited to: returned demonstration of insulin injection accurately.  **If documentation indicated the patient did not understand the medication instruction completely, answer “4.”**  |
| 18 | medevplnhc37 | Did the physician/APN/PA, pharmacist, RN, or LPN document a plan to address the patient/caregiver’s lack of understanding of the medication education?1. Yes2. No | 1,2If 1 or 2, go to ptreside | **A plan to address patient/caregiver’s lack of understanding of medication education may include but is not limited to:** Instruction of caregiver, placing medication in medication boxes, contacting provider for discontinuation of medication, contacting family member for assistance, additional home care visits for reinforcement provided medication delivery system, home health agency to fill med boxes. |
| 19 | noedpln | During the time frame (computer to display medrecdt – 10 days to medrecdt + 10 days), did the physician/APN/PA, pharmacist, RN, or LPN document a plan to address medication education that was not provided to the patient/caregiver?1. Yes
2. No
 | 1,2 | **If medication education was not provided by the physician/APN/PA, pharmacist, RN, or LPN during the specified time frame, the provider may document a plan to address the required medication education.** **Examples include, but are not limited to:** Patient lives in assisted living facility (ALF) and ALF staff are administering medications; patient has new diagnosis of moderate cognitive impairment and HBPC social worker is working to locate next of kin or caregiver to assist; going to contact the healthcare POA to assist in managing their meds; patient is hard of hearing and plan to mail written material and follow-up. |

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|  |  | **Caregiver Strain** |  |  |
| 20 | ptresidehc22,hc25 | 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. |
| 21 | caregivrhc22,hc25 | Is there HBPC medical record documentation that identifies a caregiver for the patient? 1. Yes
2. No

95. Not applicable | 1,2,95Will be auto-filled as 95 if ptreside = 4 or 99If 1, auto-fill vetcargiv as 95, and go to scrncareIf 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 |
| 22 | vetcargivhc22,hc25 | Does the record document that the HBPC patient serves as a caregiver to another person?1. Yes2. No95. Not applicable | 1,2,95Will be auto-filled as 95 if ptreside = 4 or 99 or caregivr = 1If 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.”**  |
| 23 | scrncarehc22,hc25 | During the past year, was the caregiver screened for caregiver strain using the Zarit Burden Interview Screening scale?1. Yes2. No98. Caregiver refused screening for caregiver strain | 1,2, 98If 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.  |
| 24 | 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

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| --- |
| < =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.**  |
| 25 | carescorhc22 | 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, 99If carescor = 6 or 99, go to nuthyd as applicable | 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 🡪 Never1 🡪 Rarely2 🡪 Sometimes3 🡪 Quite Frequently4 🡪 Nearly AlwaysIf 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. |
| 26 | carefolohc22 | During the time frame from (computer to display caredt to caredt + 14 days and < stdyend), did the medical record document follow-up for the positive caregiver strain screen?1. Yes2. No98. 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:* Offer of individualized therapy which may 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.

**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 time frame.* 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 and inptadm = 2, go to nuthyd; else go to dochospce** |
|  |  | **Nutrition/Hydration** |  |  |
| 27 | nuthydhc29 | During the time frame from (computer to display admisdt – 30 days to admisdt + 30 days), does the record document assessment of the patient’s nutritional and hydration needs by a registered or clinical dietician during a face-to-face encounter?1. Yes2. No | 1,2If 2, go to envases | **Initial nutritional and hydration assessment must be performed by a registered or clinical dietician during a face-to-face encounter in the Veteran’s home within the time frame of 30 days prior to or after HBPC admission date.** 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 acceptableSuggested data source: HBPC Nutrition (Assessment) note |
| 28 | nuthydt | Enter the date of the initial nutritional and hydration assessment by a registered or clinical dietician. | mm/dd/yyyy

|  |
| --- |
| <= 30 days prior to or = admisdt and <= 30 days after admisdt  |

 | Enter the exact date of the initial nutritional and hydration assessment by a registered or clinical dietician within 30 days of admission. |
|  |  | **Environment Safety/Risk Assessment** |  |  |
| 29 | envaseshc35 | During the time frame from (computer to display admisdt – 30 days to admisdt + 30 days), was a home environmental safety/ risk assessment documented by a rehabilitation therapist during a face-to-face encounter? 1. Yes
2. No
 | 1,2If 2, go to envoxy | **A home environmental safety/ risk assessment must be performed by a rehabilitation therapist during a face-to-face encounter in the Veteran’s home within the time frame of 30 days prior to or after HBPC admission date. 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 |
| 30 | envasedt | Enter the date of the home environmental safety/risk assessment documented by a rehabilitation therapist. | mm/dd/yyyy

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| --- |
| <= 30 days prior to or = 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. |
| 31 | envoxyhc36 | Was the patient oxygen dependent?1. Yes
2. No
 | 1,2If 2, go to dochospce | **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, Oxygen consult, problem list |
| 32 | asesoxyhc36 | During the time frame from (computer to display admisdt – 30 days to admisdt + 30 days) at a face-to-face encounter, was a home oxygen safety risk assessment documented by a HBPC team member to include all of the following components?* Whether there are smoking materials in the home,
* Whether or not the home has functioning smoke detectors, and
* Whether there are other fire safety risks in the home, such as the potential for open flames
1. Yes
2. No
 | 1,2If 2, go to dochospce | Home oxygen safety risk assessment may be part of the home environmental safety/risk assessment or another assessment, such as the Nursing Initial/Admission Assessment. Any HBPC team member may complete and document the Home Oxygen Safety Risk Assessment. The risk assessment must be performed during a face-to-face encounter in the Veteran’s place of residence by a member of HBPC team. **Home oxygen safety risk assessment must include documentation of:** * whether there are smoking materials in the home,
* whether or not the home has functioning smoke detectors, and
* whether there are other fire safety risks in the home such as the potential for open flames

Suggested Data Sources: HBPC Environment Assessment note, HBPC Home Oxygen Checklist, HBPC Rehabilitation Therapy (KT/OT/PT) Assessment, Nursing Admission Assessment or notes, HBPC Respiratory Therapy notes |
| 33 | oxyedu1oxyedu2oxyedu3oxyedu4hc36 | Did the HBPC team member inform and educate the patient/caregiver on home oxygen safety to include:

|  |  |
| --- | --- |
| 33a. The findings of the oxygen safety risk assessment | 1. Yes2. No |
| 33b. The causes of fire | 1. Yes2. No |
| 33c. Fire risks for neighboring residences and buildings | 1. Yes2. No |
| 33d. Precautions that can prevent fire-related injuries | 1. Yes2. No |

 | 1,2If any oxyedu1, oxyedu2,oxyedu3, or oxyedu4 = 2, go to dochospce | Home oxygen safety risk assessment education may be part of the home environmental safety/risk assessment or another assessment, such as the Nursing Initial/Admission Assessment. Any member of the HBPC team may inform and educate the patient/caregiver regarding home oxygen safety. **The HBPC team member must inform and educate the patient/caregiver about the following:** * The findings of the oxygen safety risk assessment,
* The causes of fire,
* Fire risks for neighboring residences and buildings, and
* Precautions that can prevent fire-related injuries

Suggested Data Sources: HBPC Environment Assessment note, HBPC Home Oxygen Checklist, HBPC Rehabilitation Therapy (KT/OT/PT) Assessment, Nursing Admission Assessment or notes, HBPC Respiratory Therapy notes |
| 34 | oxyrechc36 | Did a HBPC team member document recommendations to address identified oxygen safety risk(s)?3. Yes4. No5. HBPC team member documented that NO oxygen safety risks were identified | 3,4,5If 4 or 5, go to dochospce | Any member of the HBPC team may document recommendations to address identified oxygen safety risks. Examples of recommended interventions (intervention documentation) to address identified oxygen safety risk(s) include, but are not limited to: Example 1:* Safety Risk Assessment:  Existing smoke detector is non-functioning
* **Intervention documentation:  Replace non-functioning smoke detector**
* Response to intervention:   Smoke detector is now functioning

Example 2:* Safety Risk Assessment:  “No smoking” signs are not posted on the exterior of the house.
* **Intervention documentation:  Family to post “no smoking” signs on the front exterior door.**
* Response to intervention: “No smoking” signs are posted on front exterior door.

Example 3:* Safety Risk Assessment:  Burning candles observed near where patient is using oxygen.
* **Intervention documentation:   Veteran educated to not use oxygen near open flames.**
* Response to intervention:  No further evidence of candle usage observed at follow up visit.

If HBPC team member documented NO oxygen safety risks were identified, select 5.Suggested Data Sources: HBPC Environment Assessment note, HBPC Home Oxygen Checklist, HBPC Rehabilitation Therapy (KT/OT/PT) Assessment, Nursing Admission Assessment or notes, HBPC Respiratory Therapy notes |
| 35 | oxyrecreshc36 | Following documentation of the home oxygen safety/risk care plan or intervention, was response to the care plan/ intervention evaluated by a HBPC team member?3. Yes4. No5. No HBPC visit between home oxygen care plan/intervention and study end date | 3,4,5 | Follow up assessment may be face to face, telephone, clinical video teleconference (CVT) as appropriate to the patient’s needs.  Any member of the HBPC team may document response to care plan/intervention. Examples of response to oxygen safety care plan/intervention include, but are not limited to: Example 1:* Safety Risk Assessment:  Existing smoke detector is non-functioning
* Intervention documentation:  Replace non-functioning smoke detector
* **Response to intervention:   Smoke detector is now functioning**

Example 2:* Safety Risk Assessment:  “No smoking” signs are not posted on the exterior of the house.
* Intervention documentation:  Family to post “no smoking” signs on the front exterior door.
* **Response to intervention: “No smoking” signs are posted at front exterior door.**

Example 3:* Safety Risk Assessment:  Burning candles observed near where patient is using oxygen.
* Intervention documentation:   Veteran educated to not use oxygen near open flames.
* **Response to intervention:  No further evidence of candle usage observed at follow up visit.**

Suggested Data Sources: HBPC Environment Assessment note, HBPC Home Oxygen Checklist, HBPC Rehabilitation Therapy (KT/OT/PT) Assessment, Nursing Admission Assessment or notes, HBPC Respiratory Therapy notes |

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|  |  | **Depression Screening** |  |  |
| 36 | dochospcehc?? | Is one of the following documented in the medical record?The patient is enrolled in a VHA or community-based Hospice programThe patient has a diagnosis of cancer of the liver, pancreas, or esophagusOn the problem list it is documented the patient’s life expectancy is less than 6 months?1. Yes2. No | \*1,2\*If 1, go to end | A “yes” answer to this question will exclude the case from the Mental Health and Immunization measures.Although all noted conditions may be applicable to the case, only one is necessary for exclusion from the Mental Health and Immunization measures.The stage of cancer of the liver, esophagus, or pancreas is not applicable. Even if the patient is newly diagnosed, the case is excluded.Patient’s life expectancy of less than six months must be documented on the problem list or in the computer field “health factors,” without exception.**Acceptable:** Enrollment in a VHA or community-based Hospice**Unacceptable:** Enrollment in a VHA Palliative Care program or HBPC. |
| 37 | dementdx2hc38, hc39, hc40, hc?? | During the past year, does the record document a diagnosis of dementia/neurocognitive disorder as evidenced by one of the following ICD-10-CM diagnosis codes:**A8100, A8101, A8109, A812, A8189, A819, Primary I60xx – I69xx + Secondary F0150 or F0151, F0390, F0391, any Primary xxx.xx + Secondary F0280 or F0281, F0390. F0391, F1027, F1997, G231, G300, G301, G308, G309, G3101, G3109, G3183, G903**1. Yes2. No | 1,2If 2, go to modsevci  | **The diagnosis of dementia or other condition associated with dementia may be found on a problem list or in health factors, but must be verified by physician/APN/PA documentation in the record. Dementia/neurocognitive disorder diagnosis recorded during an outpatient or inpatient encounter is acceptable.****Each health factor should have an associated date that represents the date the health factor was recorded.** **For the purposes of this question, acceptable dementia diagnosis codes are included in the table on the next page.** Suggested data sources: HBPC notes, clinic/progress notes (e.g. primary care, neurology, geriatrics, psychiatry), history and physical, discharge summary, outpatient encounter diagnosis codes, admission/discharge codes |
| **ICD-10-CM Code Dementia/neurocognitive Disorder Code Table**

|  |  |  |  |
| --- | --- | --- | --- |
| **ICD-10-CM Code** | **ICD-10-CM Description** | **ICD-10-CM Code** | **ICD-10-CM Description** |
| A81.00 | Creutzfeldt-Jakob disease, unspecified | G30.9 | Alzheimer's Disease, Unspecified |
| A81.01 | Variant Creutzfeldt-Jakob disease | G31.01 | Pick's Disease |
| A81.09 | Creutzfeldt-Jakob disease, other | G31.09 | Other Frontotemporal Dementia |
| A81.2 | Progressive multifocal leukoencephalopathy | G31.83 | Dementia with Lewy Bodies |
| A81.89 | Other atypical virus infections of central nervous system [included for Prion disease of the CNS NEC] | G90.3 | Multi-system atrophy |
| A81.9 | Atypical virus infection of central nervous system, unspecified [Prion diseases of the central nervous system NOS] | B20 + F02.80 | Human Immunodeficiency Virus [HIV] disease, with dementia without behavioral disturbances |
| Primary (I60.XX-I69.XX) + F01.50 (secondary only) | Vascular dementia without behavioral disturbance | B20 + F02.81 | Human Immunodeficiency Virus [HIV] disease, with dementia with behavioral disturbances |
| Primary (I60.XX-I69.XX) + F01.51 (secondary only) | Vascular dementia with behavioral disturbance | G10 + F02.80 | Huntington's disease, with dementia without behavioral disturbances |
| F03.90 | Unspecified dementia without behavioral disturbance | G10 + F02.81 | Huntington's disease, with dementia with behavioral disturbances |
| F03.91 | Unspecified dementia with behavioral disturbance | G20 + F02.80 | Parkinson's disease, with dementia without behavioral disturbances |
| F10.27 | Alcohol dependence with alcohol-induced persisting dementia | G20 + F02.81 | Parkinson's disease, with dementia with behavioral disturbances |
| F19.97 | Other psychoactive substance use, unspecified with psychoactive substance-induced persisting dementia | G91.2 + F02.80 | Normal pressure hydrocephalus (NPH), with dementia without behavioral disturbances |
| G23.1 | Progressive supranuclear palsy | G91.2 + F02.81 | Normal pressure hydrocephalus (NPH), with dementia with behavioral disturbances |
| G30.0 | Alzheimer's disease with early onset | ANY primary diagnosis + F02.80 (secondary only) | Dementia in other diseases classified elsewhere without behavioral disturbance |
| G30.1 | Alzheimer's disease with late onset |  ANY primary diagnosis + F02.81 (secondary only) | Dementia in other diseases classified elsewhere with behavioral disturbance |
| G30.8 | Other Alzheimer's disease |  |  |

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| 38 | demsevhc38, hc39, hc40, hc?? | Was the severity of dementia assessed during the past year using one of the following standardized tools?1. Clinical Dementia Rating Scale (CDR)
2. Functional Assessment Staging Tool (FAST)
3. Global Deterioration Scale (GDS)

99. Severity of dementia was not assessed during the past year using one of the specified tools | 1,2,3,99If 99, go to modsevci | **Clinical Dementia Rating Scale** (CDR) = 5-point scale used to characterize six domains of cognitive and functional performance (memory, orientation, judgment & problem-solving, community affairs, home & hobbies, personal care)**Functional Assessment Staging Tool (FAST)** = charts decline of patients with Alzheimer’s Disease and is broken down into 7 stages.**Global Deterioration Scale (GDS)** = provides an overview of the stages of cognitive function and is broken down into 7 stages. |
| 39 | cogscor2hc38, hc39, hc40, hc?? | What was the outcome of the assessment of the severity of dementia assessment?4. Score indicated mild dementia5. Score indicated moderate to severe dementia6. Score indicated no dementia99. No score documented in the record or unable to determine outcome | 4,5,6,99If 4 or 6, go to deptxyr; else if 99, go to modsevci**If 5, go to fluvac16** | **Abstractor judgment may be used. The record must document the score of the assessment and the abstractor must be able to determine whether the score indicates no dementia, mild dementia, or moderate to severe dementia.** The scoring of the dementia assessment and therefore the outcome will be determined based upon which standardized tool was utilized. In order to answer “4” or “5,” the abstractor must be able to determine whether the score indicated mild dementia or moderate to severe dementia. For example, patient is assessed with CDR and documented score = 2, select “5.” **Clinical Dementia Rating Scale:** Score may range from 0 (normal) to 3 (severe dementia)**Functional Assessment Staging Tool (FAST):** Score may range from 1 (normal) to 7 (severe dementia)**Global Deterioration Scale (GDS)** : Score (stage) may range from 1 (no cognitive impairment) to 7 (very severe cognitive decline)For the above tools, scores indicating at least moderate degree of dementia are:* **FAST >= 5**
* **GDS >= 5**
* **CDR >= 2**

**If documentation of the outcome of the assessment or the score of the standardized tool does not indicate the severity of dementia, enter “99.”**  |
| 40 | modsevcihc38, hc39, hc40, hc?? | During the past year, did the clinician document in the record that the patient has moderate or severe cognitive impairment? 1. Yes
2. No

  | 1,2If 2, auto-fill cogimpdt as 99/99/9999 and go to deptxyr | Clinician = physician, APN, PA**In order to answer “1,” there must be clinician documentation in the record that the patient has moderate, moderate to severe, or severe cognitive impairment OR a clinician notation that the patient is too cognitively impaired to be screened.** In addition, the Clinical Reminder for mental health screening allows providers to establish this exclusion by checking the box to indicate **“Unable to screen due to Chronic, Severe Cognitive Impairment.” This is acceptable documentation of chronic, severe cognitive impairment.** If the clinician documentation notes “mild cognitive impairment” or “cognitive impairment” without specifying severity, answer “2.”Sources: HBPC notes, Clinical Reminder for mental health screening, clinician notes. |
| 41 | cogimpdt | Enter the date of the most recent clinician documentation of moderate or severe cognitive impairment. | mm/dd/yyyy**If modsevci = 1, go to fluvac16**

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| < = 1 year prior to or = stdybeg and < = stdyend  |

 | Enter the exact date. The use of 01 to indicate missing month or day is not acceptable. |

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| 42 | deptxyrhc38, hc39, hc40 | Within the past year, did the patient have at least one clinical encounter where depression was identified as a reason for the clinical encounter as evidenced by one of the following ICD-10-CM diagnosis codes: **F32, F320 - F325, F328, F329, F33, F330, F331, F332, F333, F334, F3340, F3341, F3342, F339, F341, F338, F0631, F0632**1. Yes2. No | 1,2If 2, auto-fill recdepdt as 99/99/9999, and go to bpdxyr | Depression does not have to be listed as the only reason for the clinical encounter, but identified as one of the reasons for the clinical encounter as evidenced by any of the following ICD-10-CM diagnosis codes: * **F32, F320 - F325, F328, F329, F33, F330, F331, F332, F333, F334, F3340, F3341, F3342, F339, F341, F338, F0631, F0632**

The diagnosis of depression may have been made prior to the past year, but if the patient has at least one clinical encounter within the past year for depression as evidenced by documentation of one of the above ICD-10 diagnosis codes, answer “1.” Clinical encounter includes HBPC visits, outpatient visits, ED visits, and inpatient admission.  |
| 43 | recdepdt | Enter the date within the past year of the most recent clinical encounter where depression was identified as a reason for the clinical encounter. | mm/dd/yyyyWill be auto-filled as 99/99/9999 if deptxyr = 2If deptxyr = 1, go to leavduty

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| < = 1 year prior to or = stdybeg and < = stdyend |

 | Depression does not have to be listed as the only reason for the clinical encounter, but identified as one of the reasons for the clinical encounter as evidenced by documentation of the specified ICD-10 diagnosis code. Enter the most recent date within the past year documented in the record when the patient was seen for depression.If the most recent clinical encounter for depression within the past year was an inpatient admission, enter the date of discharge.Enter the exact date. The use of 01 to indicate missing month or day is not acceptable. |
| 44 | bpdxyrhc38, hc39, hc40 | Within the past year, did the patient have at least one clinical encounter where bipolar disorder was identified as a reason for the clinical encounter as evidenced by one of the following ICD-10-CM diagnosis codes: **F30, F301, F3010 – F3013, F302 – F304, F308, F309, F31, F310, F311, F3110 – F3113, F312, F313, F3130 – F3132, F314 – F316, F3160 – F3164, F317, F3170 – F3178, F318, F3181, F3189, F319**1. Yes2. No | 1,2 If 2 and deptxyr = 2, go to phq2dt; else if 2, go to leavduty | Bipolar disorder does not have to be listed as the only reason for the clinical encounter, but identified as one of the reasons for the clinical encounter as evidenced by any of the following ICD-10 diagnosis codes: * **F30, F301, F3010 – F3013, F302 – F304, F308, F309, F31, F310, F311, F3110 – F3113, F312, F313, F3130 – F3132, F314 – F316, F3160 – F3164, F317, F3170 – F3178, F318, F3181, F3189, F319**

The diagnosis of bipolar disorder may have been made prior to the past year, but if the patient has at least one clinical encounter within the past year for bipolar disorder as evidenced by documentation of one of the above ICD-10 diagnosis codes, answer “1.” Clinical encounter includes HBPC visits, outpatient visits, ED visits, and inpatient admission.  |
| 45 | recbpdt | Enter the date within the past year of the most recent clinical encounter where bipolar disorder was identified as a reason for the clinical encounter. | mm/dd/yyyyIf bpdxyr = 1, go to leavduty

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| < = 1 year prior to or = stdybeg and < = stdyend |

 | Bipolar disorder does not have to be listed as the only reason for the clinical encounter, but identified as one of the reasons for the clinical encounter as evidenced by one of the specified ICD-10 diagnosis codes. Enter the date within the past year of the most recent clinical encounter when the patient was seen for bipolar disorder. If the most recent clinical encounter for bipolar disorder within the past year was an inpatient admission, enter the date of discharge.Enter the exact date. The use of 01 to indicate missing month or day is not acceptable. |

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| 46 | phq2dthc38, hc39, hc40 | Enter the date within the past year of the most recent screening for depression by the PHQ-2 or PHQ-9.  | mm/dd/yyyyAbstractor can enter 99/99/9999**If 99/99/9999, go to leavduty**

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| < = 1 year prior to or = stdybeg and < = stdyend |

 | **NOTE: For depression screening completed on or after 10/01/2016, the VHA will only accept screening completed with the PHQ-2.** **Prior to 10/01/2016, enter the most recent date within the past year of completion of the PHQ-2 or PHQ-9 depression screen documented in the record. If the patient was not screened for depression in the past year by the PHQ-2 or PHQ-9, enter 99/99/9999.****If the most recent depression screen was completed on or after 10/01/2016 using the PHQ-9, enter 99/99/9999.** **Acceptable setting for depression screening:** HBPC encounter, outpatient encounter, inpatient hospitalization, screening by telephone, and televideo (real time) with face-to-face encounter between the provider and patient Enter the exact date. The use of 01 to indicate missing month or day is not acceptable. |
| 47 | scrnphqhc38, hc39, hc40 | On the date of the most recent screening for depression, was the patient screened by the PHQ-2 or the PHQ-9?2. Screened by PHQ-23. Screened by PHQ-94. Screened by PHQ-2 AND PHQ-9 on the same date | 2,3,4

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| **Hard Edit: Cannot enter 3 or 4 if phq2dt >= 10/01/2016** |

 | **NOTE: For depression screening completed on or after 10/01/2016, the VHA will only accept screening completed with the PHQ-2.****If the patient was screened for depression by the PHQ-2 AND PHQ-9 on the same date (date of most recent screening for depression entered in PHQ2DT), select “4.”****Acceptable setting for depression screening:** outpatient encounter, inpatient hospitalization, screening by telephone, and televideo (real time) with face-to-face encounter between the provider and patient**PHQ-2 = Patient Health Questionnaire (2 questions - scaled)** Question 1: “Over the past two weeks, have you often been bothered by little interest or pleasure in doing things?”Question 2: “Over the past two weeks, have you often been bothered by feeling down, depressed, or hopeless?”Answers to PHQ-2 are scaled, ranging from “not at all” to “nearly every day.”**Patient Health Questionnaire (PHQ-9) asks:**Over the last 2 weeks, how often have you been bothered by any of the following problems?1. Little interest or pleasure in doing things
2. Feeling down, depressed, or hopeless
3. Trouble falling asleep or staying asleep, or sleeping too much
4. Feeling tired or having little energy
5. Poor appetite or overeating
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down
7. Trouble concentrating on things, such as reading the newspaper or watching television
8. Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual
9. Thought that you would be better off dead, or of hurting yourself in some way

10. If you checked off *any* problems, how *difficult* have these problems made it for you to do work, take care of things at home, or get along with other people? |
| 48 | ph1scorhc38, hc39, hc40 | Enter the score for PHQ-2 Question 1 documented in the record:**(**Question #1 of the PHQ-9 is PHQ-2 question #1 and should be used if available). **Over the past 2 weeks, have you been bothered by little interest or pleasure in doing things?**0. Not at all → 01. Several days → 12. More than half the days → 23. Nearly every day → 399. No answer documented | 0,1,2,3,99 | **If the PHQ-2 and the PHQ-9 were administered on the same date, enter the response or score documented for the PHQ-2 question 1:**Over the past 2 weeks, have you been bothered by little interest or pleasure in doing things?Not at all → 0Several days → 1More than half the days → 2Nearly every day → 3**If the patient’s answers are documented in the record, the abstractor may assign the score in accordance with the patient’s response. If the score of Question #1 is documented without the question, the abstractor may enter that score. If neither the question response nor the score of the individual question is documented, enter 99.** |
| 49 | ph2scorhc38, hc39, hc40 | Enter the score for PHQ-2 Question 2 documented in the record:**(**Question #2 of the PHQ-9 is PHQ-2 question #2 and should be used if available). **Over the past 2 weeks, have you been bothered by feeling down, depressed, or hopeless?**0. Not at all → 01. Several days → 12. More than half the days → 23. Nearly every day → 399. No answer documented | 0,1,2,3,99If scrnphq = 3, go to phq9ques, else go to phqtotal | **If the PHQ-2 and the PHQ-9 were administered on the same date, enter the response or score documented for the PHQ-2 question 2:** Over the past 2 weeks, have you been bothered by feeling down, depressed, or hopeless?Not at all → 0Several days → 1More than half the days → 2Nearly every day → 3**If the patient’s answers are documented in the record, the abstractor may assign the score in accordance with the patient’s response. If the score of Question #2 is documented without the question, the abstractor may enter that score. If neither the question response nor the score of the individual question is documented, enter 99.** |
| 50 | phqtotalhc38, hc39, hc40 | Enter the total score for the **PHQ-2** documented in the medical record. | \_\_\_\_\_**Abstractor may enter default z if no PHQ-2 total score for either question is documented in the record****Valid values = 0-6, z** | **The total score for PHQ-2 questions 1 and 2 must be documented in the medical record. The abstractor may NOT enter the total score if it is not documented in the record, even if both questions have been answered and the total is evident. If there is a score for only one question, and it is called the “total,” enter that score.****If no total score is documented in the record, enter default z.** |
| 51 | outcome3hc38, hc39, hc40 | What was the outcome of the PHQ-2 documented in the record?1. Outcome positive (suggestive of depression)2. Outcome negative (no indication of depression)99. Outcome not documented | 1,2,99**If scrnphq = 2 AND** (phqtotal = > 3 OR ph1scor = 3 OR ph2scor = 3), OR[sum (exclude values >3) of ph1scor and ph2scor] = > 3, OR outcome3 = 1, go to deprisk, else if scrnphq = 2, go to leavduty | **The interpretation of the PHQ-2 score (positive or negative) must be documented in the record. If the outcome of the PHQ-2 is not documented in the record, enter “99.”****NOTE for VHA field: A score of greater than or equal to 3 is considered a positive screen.** |
| 52 | phq9queshc38 | Did the record document the patient’s responses to all 9 questions of the PHQ-9?1. Yes2. No | 1,2 | **Answer key to each of the nine questions on the PHQ-9 is as follows:**Not at all → 0Several days → 1More than half the days → 2Nearly every day → 3**In order to answer “1,” the record must document the patient’s responses to all 9 questions on the PHQ-9.** |
| 53 | ph9totalhc38, hc39, hc40 | Enter the total score of the PHQ-9 documented in the record. | \_\_\_ \_\_\_Whole numbers only 0 to 27Abstractor can enter zz

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| Warning if 0 AND ph1scor or ph2scor = 1, 2, or 3 OR if < sum of [ph1scor and ph2scor] |

 | The total score for PHQ-9 questions must be documented in the medical record. The abstractor may NOT enter the total score if it is not documented in the record, even if all 9 questions have been answered and the total is evident. The total score may range from 0 to 27.

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| --- | --- |
| Total Score | Depression Severity |
| 1-4 | Minimal depression |
| 5-9 | Mild depression |
| 10-14 | Moderate depression |
| 15-19 | Moderately severe depression |
| 20-27 | Severe depression |

**If no total score is documented in the record, enter default zz.** |
| 54 | ph9scorhc39, hc40 | Enter the score for PHQ-9 Question 9 documented in the record:**Over the last 2 weeks, how often have you been bothered by thoughts that you would be better off dead, or of hurting yourself in some way?**0. Not at all → 01. Several days → 12. More than half the days → 23. Nearly every day → 399. No answer documented | 0,1,2,3,99 | The answer key for PHQ-9 question 9 is as follows:Not at all → 0Several days → 1More than half the days → 2Nearly every day → 3**If the patient’s answers are documented in the record, the abstractor may assign the score in accordance with the patient’s response. If the score of Question #9 is documented without the question, the abstractor may enter that score. If neither the question response nor the score of the individual question is documented, enter 99.**  |
| 55 | phq9outhc38, hc39, hc40 | Was the outcome of the PHQ-9 documented in the medical record?1. Outcome positive 3. Score suggestive of no depression4. Score suggestive of mild depression5. Score suggestive of moderate depression6. Score suggestive of moderately severe depression7. Score suggestive of severe depression99. No documentation of outcome | 1,3,4,5,6,7,99If ph9total > 10, or (ph9scor = 1,2, or 3), or (phq9out = 1,5,6, or 7), **OR****If scrnphq = 4 AND** ph1scor = 3 or ph2scor = 3, or [sum (exclude values >3) of ph1scor and ph2scor] = > 3, or phqtotal > 3 or outcome3 = 1, go to deprisk, else go to leavduty | **The interpretation of the PHQ-9 score must be documented in the record. Documentation of “PHQ-9 negative” or “PHQ-9 positive” without patient response to the questions or total score is not acceptable, and “99” should be entered.** **If the Clinical Reminder for the PHQ-9 is in use, the outcome may be documented by notation of the score and the suggested severity of depression.** **Documentation of PHQ-9 outcome by suggested severity of depression takes precedence over outcome documented as positive/negative. Select the applicable option for documentation of no depression, mild, moderate, moderately severe, or severe depression.** If the outcome of the PHQ-9 is documented as “negative,” select “3.” |
| 56 | depriskhc39 | On the day of or the day after the positive PHQ-2 (or PHQ-9depression screen or affirmative answer to PHQ-9 question 9 completed prior to 10/01/2016), did the provider document a suicide ideation/behavior evaluation?1. Yes2. No | 1,2If 2, auto-fill deprskdt as 99/99/9999, and go to deplan | A standardized instrument is NOT required for suicide risk evaluation.  Suicide evaluation includes an appraisal of the patient’s subjective experience (suicide ideation, wish, plan, and intent) and behaviors (warning signs). **Acceptable Provider Documentation of Suicide Risk Evaluation:**  * A clinical reminder is available from Patient Care Services (PCS) and is acceptable if all required elements (feelings of hopelessness, suicidal thoughts, suicide plans if having suicidal thoughts, and history of suicide attempts) of the reminder are completed by the provider and contained in the medical record; **OR**
* If the PCS Clinical Reminder is **NOT** used, there must be at a minimum, a notation by the provider that the suicide risk evaluation was completed.  The provider notation is an attestation that hopelessness, suicidal thoughts, suicide plan if having suicidal thoughts, and history of suicide attempts were addressed with the patient.

Suicide ideation/behavior evaluation can be performed face-to-face, by telemedicine, or by telephone as long as the provider – patient exchange is documented in the medical record and accurately reflects the encounter.* **Acceptable Provider**: For a “provider” to be deemed acceptable for suicide risk evaluation he/she must be an MD, DO, PhD or PsyD Psychologist, LCSW, LCSW-C, LMSW, LISW, MFT, LPMHC, APN, PA, RN, or clinical pharmacist (RPH/PharmD). Trainee in ANY of these categories may complete a suicide risk evaluation with appropriate co-signature.

**Suggested sources**: HBPC notes, progress notes, ED notes, H&P, consultation, Clinical Reminder  |
| 57 | deprskdthc39 | Enter the date the suicide ideation/behavior evaluation was completed. | mm/dd/yyyy

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| < = 1 day after or = phq2dt and < = 1 day after stdyend |

 | Enter the exact date. The use of 01 to indicate missing month or day is not acceptable. |
| 58 | deplanhc40 | During the time frame from (computer to display phq2dt to phq2dt + 14 days), did a HBPC team member (physician/APN/PA, RN, Pharmacist, Psychologist, Social Worker) document a follow-up evaluation and/or plan for treatment?1. Yes2. No98. Veteran refused follow-up intervention for positive depression screen | 1,2,98 | **Follow-up evaluation and/or plan for treatment:** The intent of this question is that a positive depression screen, in addition to flagging the need for a suicide risk evaluation, should always lead to further evaluation for possible depression or other medical/psychological conditions that could lead to a positive screening result.  Documentation may include indication of any of the following:* Discussion of positive depression screen with the HBPC interdisciplinary team with plan for follow-up evaluation by the PCP, psychologist, psychiatrist, or licensed clinical social worker
* Further depression evaluation documented by the professional who completed the screen
* Further depression evaluation documented by the PCP or mental health professional
* Provision of patient and/or family psychoeducation regarding depression and options for treatment
* Discussion with Veteran regarding interest in referral for consultation/treatment (e.g., for consideration for antidepressant medication and/or participation in a psychotherapy intervention, bereavement support, or other psychosocial or behavioral intervention as indicated
* Documentation of follow-up lab work or additional medical evaluation for potential physiologic cause for depression
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|  |  | **Screening for PTSD** |  |  |
| 59 | leavdutyhc?? | Enter the patient’s most recent date of separation from active military duty.  | mm/dd/yyyy**Abstractor can enter 99/99/9999 if no date of separation can be found**

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| --- |
| > = 01/01/1930 and <= stdyend  |

 | If the facility has installed the latest clinical reminder, the date should come forward from the administration files.  If you click on the reminder from the cover sheet or on the clinical maintenance button, it will show the most recent last service separation date. This date is critical in determining the frequency of PTSD screening. **If the veteran has more than one tour of duty, enter the most recent date of separation (only the most recently entered last service separation date shows).****Annual screening is required if no separation date is found; therefore, it is critical that the date of separation be located. Ask the Liaison to retrieve the date from the administrative file if it is not present in the Clinical Reminder.** As a last resort, if no date can be found, the abstractor can enter default 99/99/9999 |
| 60 | ptsdxhc?? | Within the past year, did the patient have at least one clinical encounter where PTSD was identified as a reason for the clinical encounter as evidenced by one of the following ICD-10-CM diagnosis codes: **F431, F4310 - F4312** 1. Yes2. No | 1,2**If 2, go to ptsrnpc** | PTSD does not have to be listed as the only reason for the clinical encounter, but identified as one of the reasons for the clinical encounter as evidenced by one of the following ICD-10-CM diagnosis codes: * + **F431, F4310 - F4312**

The diagnosis of PTSD may have been made prior to the past year, but if the patient has at least one clinical encounter within the past year for PTSD as evidenced by documentation of the specified ICD-10 diagnosis code, answer “1.” Clinical encounter includes outpatient visits, ED visits, and inpatient admission.  |
| 61 | recptsdthc?? | Enter the date within the past year of the most recent clinical encounter where PTSD was identified as a reason for the clinical encounter.  | mm/dd/yyyy**\*If ptsdx = 1, go to fluvac16**

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| < = 1 year prior to or = stdybeg and < = stdyend |

 | Enter the date of the most recent clinical encounter within the past year where PTSD was identified as a reason for the clinical encounter by evidence of the specified ICD-10 diagnosis code. If the most recent clinical encounter for PTSD within the past year was an inpatient admission, enter the date of discharge.Enter the exact date. The use of 01 to indicate missing month or day is not acceptable. |
| 62 | ptsrnpchc?? | Within the past five years, was the patient screened for PTSD using the Primary Care PTSD Screen (PC-PTSD)? 1. Yes2. No | 1,\*2**\*If 2, go to fluvac16** | The **Primary Care PTSD Screen** is a standardized tool consisting of four questions. **In order to answer “1”, the abstractor must see the exact wording of questions 1 through 4 below.** Documentation of the stem question (text prior to question #1) is not required. Have you ever had any experience that was so frightening, horrible, or upsetting that, **IN THE PAST MONTH**, you:1. Have had any nightmares about it or thought about it when you did not want to?
2. Tried hard not to think about it or went out of your way to avoid situations that remind you of it?
3. Were constantly on guard, watchful, or easily startled?
4. Felt numb or detached from others, activities, or your surroundings?

**Acceptable setting for PTSD screening:** outpatient encounter, inpatient hospitalization, screening by telephone, and televideo (real time) with face-to-face encounter between the provider and patient  |
| 63 | pcptsdthc?? | Enter the date of the most recent screen for PTSD using the PC-PTSD. | mm/dd/yyyy

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| < = 5 years prior or = stdybeg and < = stdyend |

 | Enter the exact date. The use of 01 to indicate missing month or day is not acceptable. |
| 64 | pcptsdhc??pcptsd1pcptsd2pcptsd3pcptsd4 | Enter the patient’s answers to each of the Primary Care PTSD Screen questions:Have you ever had any experience that was so frightening, horrible, or upsetting that, **IN THE PAST MONTH**, you:1. Have had any nightmares about it or thought about it when you did not want to?2. Tried hard not to think about it or went out of your way to avoid situations that remind you of it? 3. Were constantly on guard, watchful, or easily startled? 4. Felt numb or detached from others, activities, or your surroundings?1. Yes2. No 99. No answer documented | 1,2,99 | **If more than one PC-PTSD screen was performed on the date of the most recent screening AND any PC-PTSD screen was positive, enter the responses for the positive PC-PTSD screen.**A positive Primary Care PTSD screen is a score of 3 or greater.**The PC-PTSD screen must be documented in a clinic note.****For each question, enter the veteran’s “yes” or “no” answer to the question. If the question was not asked or the answer not recorded, enter “99.”**  |
| 65 | ptsdscorhc?? | Enter the total score for the PC-PTSD screen documented in the record. | \_\_\_**Abstractor can enter default z if no total score is documented**

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| Whole numbers 0 – 4 |

 | **If more than one PC-PTSD screen was performed on the date of the most recent screening AND any PC-PTSD screen was positive, enter the total score for the positive PC-PTSD screen.**A positive Primary Care PTSD screen is a score of 3 or greater.**The total score must be documented in a clinic note. The abstractor may NOT enter total score if it is not documented in the record, even if all the questions have been answered and the total is evident.** **If the total score is NOT documented in the record, enter default z.** |
| 66 | scorintrphc?? | Enter the interpretation of the PC-PTSD score, as documented in the medical record.1. Positive
2. Negative

99. No interpretation documented | 1,2,99\*If (pcptsdt <= 1 year prior to stdybeg and <= stdyend) AND (ptsdscor > 3) or[sum (exclude values > 1) of pcptsd1 andpcptsd2 and pcptsd3 and pcptsd4 > 3] or (scorintrp = 1), go to ptsdrisk; else go to fluvac16

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| Warning window if ptsrnpc = 1, ptsdscor 3 or > and scorintrp = 2; or if ptsrnpc = 1, ptsdscor < 3 and scorintrp = 1 |

 | **If more than one PC-PTSD screen was performed on the date of the most recent screening AND any PC-PTSD screen was positive, enter the outcome for the positive PC-PTSD screen.****If the record contains both a total score and an interpretation of positive or negative, enter “positive” or “negative” as documented in the record, even if the interpretation conflicts with the score.****If there was no interpretation of the screening outcome, enter “99.”** |
| 67 | ptsdriskhc?? | On the day of or the day after the positive PC-PTSD screen, did the provider document a suicide ideation/behavior evaluation?1. Yes2. No | 1,2If 2, go to fluvac16 | If the patient has a positive PC-PTSD screen or positive PHQ-2 (or PHQ-9 or affirmative answer to PHQ-9 question 9 completed prior to 10/01/2016 on the same date), only one suicide ideation/behavior evaluation is required on that date. In this situation, the suicide ideation/behavior evaluation may precede either the PTSD screen or the depression screen. A standardized instrument is NOT required for suicide risk evaluation.  Suicide evaluation includes an appraisal of the patient’s subjective experience (suicide ideation, wish, plan, and intent) and behaviors (warning signs). **Acceptable Provider Documentation of Suicide Risk Evaluation:**  * A clinical reminder is available from Patient Care Services (PCS) and is acceptable if all required elements (feelings of hopelessness, suicidal thoughts, suicide plans if having suicidal thoughts, and history of suicide attempts) of the reminder are completed by the provider and contained in the medical record; **OR**
* If the PCS Clinical Reminder is **NOT** used, there must be at a minimum, a notation by the provider that the suicide risk evaluation was completed.  The provider notation is an attestation that hopelessness, suicidal thoughts, suicide plan if having suicidal thoughts, and history of suicide attempts were addressed with the patient.

Suicide ideation/behavior evaluation can be performed face-to-face, by telemedicine, or by telephone as long as the provider – patient exchange is documented in the medical record and accurately reflects the encounter.* **Acceptable Provider**: For a “provider” to be deemed acceptable for suicide risk evaluation he/she must be an MD, DO, PhD or PsyD Psychologist, LCSW, LCSW-C, LMSW, LISW, MFT, LPMHC, APN, PA, RN, or clinical pharmacist (RPH/PharmD) . Trainee in ANY of these categories may complete a suicide risk evaluation with appropriate co-signature.

**Suggested sources**: progress notes, ED notes, H&P, consultation, Clinical Reminder  |

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| 68 | rskptsdthc?? | Enter the date the suicide ideation/behavior evaluation was completed. | mm/dd/yyyy

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| < = 1 day after or = pcptsdt and < = 1 day after stdyend |

 | Enter the exact date. The use of 01 to indicate missing month or day is not acceptable. |
|  |  | **Immunizations** |  |  |
| 69 | fluvac16hc?? | During the period 7/01/2016 to 3/31/2017, did the patient receive influenza vaccination?1. received vaccination from VHA1. received vaccination from private sector provider
2. patient’s only visit during immunization period preceded availability of vaccine

98. patient refused vaccination 99. no documentation patient received vaccination | 1,3,4,98,99**If 4, go to pnumovac****If 98 or 99, go to allerflu**  | **Acceptable documentation of influenza immunization:** 1. Notation of “flu shot given” entered in paper or electronic record. The month and year (or the fact it was flu vaccination season) when the patient received the vaccine must be known.
2. Influenza vaccine given in another setting, i.e., acute care, NHCU, etc., and the month and year are known
3. Patient self-report of flu shot at community facility if month and year are known and documented.
4. Checkmark on a checklist, if there is a month and year, and the checkmark is accompanied by the clinician’s signature or initials. The patient must have had a clinic visit or visit to a vaccination clinic on the date indicated on the checklist.
5. Historical information obtained by telephone by a member of the healthcare team and entered in a CPRS progress note is acceptable.
6. Documentation in the Immunization Health Summary (under the reports tab in CPRS) that the vaccine was provided by Walgreens, which will be noted as the facility. The month and year must be known.

**Unacceptable documentation:** 1. Patient is told to return later for flu vaccine.
2. “Shortfall” of flu vaccine, unless nationally publicized shortage
3. Documented assumption “patient gets annual flu shot or vaccination”
4. Documentation of the vaccine in the Immunization Health Summary, **WITHOUT** verification in a progress note that the vaccine was actually given (with the only exception of Walgreens as noted above).

**Cont next page** |
|  |  |  |  | **Cont from previous page****Additional guidelines:****Value 4** = The abstractor must see the pharmacy record stating the date the vaccine arrived on station (shipping slip, inventory record, etc.). **The patient’s only visit during the immunization period must have occurred prior to receipt of the facility’s flu vaccine.** (Example: patient’s only visit during immunization season of 7/01/16 – 3/31/17 was on 8/26/16. Facility did not receive vaccine until 9/05/16. Enter response #4.) **Value 98 (Patient refusal) = during the vaccination season, when flu shot was offered, patient stated he did not wish to receive flu vaccination****Value 99 = For patients who had no visits at all during immunization season and did not receive vaccine at this VAMC or elsewhere, answer “99.”**  |
| 70 | fluvacdthc?? | Enter the date influenza vaccination was given. | mm/dd/yyyy

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| > = 7/01/2016 and < = 3/31/2017 and (< = pulldt or < = stdyend if > pulldt) |

 | Although the day may be entered as day = 01, if the specific date is unknown, the exact month and year must be entered accurately.**If the exact month is unknown, but there is documentation the patient received the flu vaccine in fall or winter, enter “10” as the default month.** |
| 71 | allerfluhc?? | Does the patient have known allergy to eggs or other flu vaccine components, a history of Guillain-Barre Syndrome, a bone marrow transplant within the past 12 months?1. Yes2. No | 1,2 | “Inactivated influenza vaccine should not be administered to persons known to have anaphylactic hypersensitivity to eggs or other components of the influenza vaccine.”**Allergy to eggs or other flu vaccine component must be documented in the paper or electronic record. Notation does not have to state “anaphylactic.” If the facility is using single dose syringes and the veteran has a documented latex allergy, answer “yes.”**  |
| 72 | pnumovachc?? | At any time, not later than the study end date, did the veteran receive pneumococcal vaccination, either as an inpatient or outpatient?1. received pneumococcal vaccination from VHA
2. received pneumococcal vaccination from private sector provider

98. patient refused pneumococcal vaccination99. no documentation patient received pneumococcal vaccination | 1,3,98,99If 98 or 99, auto-fill pnuvacdt as 99/99/9999, and go to allerpnu | Documentation of either PPSV23 or PCV13 is acceptable.Acceptable documentation: * At a minimum the year of pneumococcal vaccination must be documented.
* Historical information obtained by telephone by a member of the healthcare team and entered in a CPRS progress note is acceptable.

Unacceptable: Notation in the record that patient has had pneumococcal vaccination if year of administration is not documented. **Patient refusal** = each time it was offered, patient stated he/she states he does not want pneumococcal vaccination  |
| 73 | pnuvacdthc?? | Enter the date of the most recent pneumococcal vaccination. | mm/dd/yyyyIf pnumovac = 98 or 99, will be auto-filled as 99/99/9999 If valid date, go to end

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| Warning if > 15 years prior to stdybeg and < = stdyend |

 | Notation in the record that patient has had pneumococcal vaccination is not acceptable unless, at a minimum, year is documented. If more than one pneumococcal vaccination, use the most recent date.Enter the year if that is the only information known, with 01 for month and day. |
| 74 | allerpnuhc?? | Is there documentation that the patient had a severe allergic reaction (e.g., anaphylaxis) to a pneumococcal (PPSV23 or PCV13) vaccine component?1. Yes2. No  | 1,2 | **Severe allergic reaction (e.g., anaphylaxis) to pneumococcal (PPSV23 or PCV13) vaccine component must be documented in the paper or electronic record.**  |