VHA EXTERNAL PEER REVIEW PROGRAM
INSTRUMENT
Third Quarter FY2014

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
		Organizational Identifiers		
	VAMC	Facility ID	Auto-fill	
	CONTROL	Control Number	Auto-fill	
	QIC	Abstractor ID	Auto-fill	
	BEGDTE	Abstraction Begin Date	Auto-fill	
	REVDTE	Abstraction End Date	Auto-fill	
		Patient Identifiers		
	SSN	Patient SSN	Auto-fill: no change	
	PTNAMEF	First Name	Auto-fill: no change	
	PTNAMEL	Last Name	Auto-fill: no change	
	BIRTHDT	Birth Date	Auto-fill: no change	
	SEX	Sex	Auto-fill: can change	
	MARISTAT	Marital Status	Auto-fill: no change	
	RACE	Race	Auto-fill: no change	
		Validation		

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
1	visithbpc	Does the record document a HBPC encounter by any member of the HBPC team* during the study interval? 1. Yes 2. No	1, 2* ***If 2, the record is excluded**	**HBPC encounter = home visit, telephone visit, OR documentation by HBPC team member indicating HBPC was <u>providing or managing</u> 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. **<u>Exclusion Statement:</u> 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.

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
3	justone	Was there <u>only one</u> 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. **<u>Exclusion Statement:</u> 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. **<u>Exclusion Statement</u>** **The patient was enrolled in HBPC for less than the 30 days initial assessment period.**

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
6	hcstatus	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 year 3. 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.**
		If Hcstatus = 2 and hbpcdt - admisdt <= 120 days, go to admmed; else if Hcstatus = 2, go to medone **If Hcstatus = 3, go to medone**		
		Medication Management		
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 medrev2	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

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		The question medrev2 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 day, 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)		

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
9	medrev2	Did a pharmacist review the patient's medication management plan? 1. Yes 2. No	1, 2 If 2, auto-fill medrevdt as 99/99/9999, and go to nomedrev	A medication review of the patient's medication management plan consists of a review by a pharmacist of all medications. All medications include prescribed, OTC, topical, and systemic medications from VA and non-VA providers as noted in the record. The pharmacist will review all medications for appropriateness, adverse reactions and interactions, and communicate concerns and recommendations to the HBPC provider and primary care provider. **Acceptable documentation consists of:** • HBPC pharmacy medication review note, **and** • the note must be signed by the pharmacist, **and** • notation that there were no pharmacy recommendations OR that recommendations were communicated to the HBPC provider 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.

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
10	medrevdt	Enter the date of the medication management plan review.	mm/dd/yyyy Will be auto-filled as 99/99/9999 medrev2=2 If medrev2 = 1, go to clindt 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.
		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)**		
11	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.

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
12	admdate	Enter the admission date.	mm/dd/yyyy Will be auto-filled as 99/99/9999 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.
13	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.

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
14	clindt	Enter the date of the most recent HBPC face-to-face visit by a nurse (RN, LPN) or clinician (physician/NP/CNS/PA).	mm/dd/yyyy Abstractor may enter 99/99/9999 If 99/99/9999, auto-fill medlist as 95, listdt as 99/99/9999, and go to hospice <= 1 year prior to or = stdybeg and <= stdyend	Nurse = RN or LPN Clinician = Physician, NP, CNS, or PA Enter the exact date. The use of 01 to indicate missing day or month is not acceptable. If the patient did not have a face-to-face HBPC visit within the past year by a clinician or nurse, enter default 99/99/9999.
15	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 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.**

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
16	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.
17	hospice	Is the patient receiving hospice care? 1. Yes 2. No	*1, 2 ***If 1, go to end**	**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
		Behavioral Triggers		
18	alreddx	Does the medical record document the patient has a known diagnosis of any of the following: 1. aphasia 2. dementia of Alzheimer's disease or other dementia 3. delirium 4. comatose state 99. none of these diagnoses	1*, 2*, 3*, 4*, 99 *If 1, 2, 3, or 4, go to ptreside, else go to behvtrig	Aphasia = defect or loss of the power of expression by speech, writing, or signs, or of comprehending spoken or written language, due to injury or disease of the brain. Dementia = multiple cognitive deficits that include memory impairment. Etiology may include Alzheimer's, vascular dementia, dementia due to HIV, head trauma, Parkinson's, Huntington's Disease, Creutzfeldt-Jakob Disease. **Delirium = characterized by a disturbance of consciousness and a change in cognition that develop over a short period of time.** Comatose state = a state of unconsciousness from which the patient cannot be aroused, even by powerful stimulation Any of the above-listed diagnoses must be an actual diagnosis listed on a problem or diagnosis list.
		The question behvtrig will contain one of the following phrases that will appear on the computer screen in accordance with the patient's length of stay. **If hcstatus=2: Within 30 days from the date of admission** **If hcstatus=3: Within the past year (within 365 days of the most recent admission to HBPC)**		

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
19	behvtrig	Is there evidence that a clinician observed the patient for behavioral triggers suggestive of dementia? 1. Yes 2. No	1, 2 If 2, auto-fill prestrig as 95, behavdt as 99/99/9999, and go to ptreside, else go to prestrig	**NOTE: For HBPC admissions that occur on or after July 1, 2011, the ONLY ACCEPTABLE DATA SOURCE for this data element is an HBPC admission assessment note completed by a clinician during the specified time frame** **The reviewer will accept any documentation by the clinician stating the presence or absence of behavioral trigger (s) in an HBPC admission assessment note.** **The intent is to determine that the HBPC clinician observed the patient for evidence of behavioral triggers suggestive of dementia and documented the presence or absence of behavioral triggers.** **It is not a requirement that the exact term "behavioral triggers" be found in the HBPC record.** For example, clinician notes, "Patient is poor historian. Nurse reported the patient missed last 2 appointments and is having difficulty with medication instructions. Behavior raises concern for dementia." Select "1." If the clinician documents there are "no behavioral triggers" (or similar wording), select "1." **Clinician = physician, PA, APN, Clinical Nurse Specialist (CNS), RN, LPN, social worker, psychologist**

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20	prestrig	Did the clinician document the presence of behavioral triggers suggestive of dementia? 1. Yes 2. No 95. Not applicable	1, 2, 95 Will be auto-filled as 95 if behvtrig = 2	**In order to answer "1," the clinician must document that behavioral triggers suggestive of dementia are present.** This could include a check box that indicates behavioral triggers are present or a description as noted below. **Examples of behavioral triggers suggestive of dementia include, but are not limited to:** The patient: • Is a "poor historian" or "seems odd" • Is inattentive to appearance, inappropriately dressed for the weather, or dirty • Fails to appear for scheduled appointments or comes at the wrong time or on the wrong day • Repeatedly and apparently unintentionally fails to follow instructions (e.g., changing medications) • Has unexplained weight loss, "failure to thrive," or vague symptoms (e.g., weakness or dizziness) • Seems unable to adapt or experiences functional difficulties under stress (e.g., the hospitalization, death, or illness of a spouse) • Defers to a caregiver-a family member answers questions directed to the patient

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

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
22	cogdt	Enter the date of the most recent assessment of cognitive function using a standardized and published tool. (Documentation of use of results of a standardized tool performed in another setting within 30 days prior to admission to HBPC is acceptable.)	mm/dd/yyyy **Abstractor can enter default date 99/99/9999** Will be auto-filled as 99/99/9999 if prestrig = 2 If 99/99/9999, auto-fill cogases as 95, screnout as 95, impair as 95, addfolo as 95, and go to ptreside If hcstatus = 2, <= 30 days prior to or = admisdt and <= 30 days after admisdt If hcstatus = 3, < = 1 year prior to or = stdybeg and < = stdyend	**Assessment of cognitive function must be done using a standardized and published tool.** **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, or other designation).** **Examples of Brief Cognitive Tools:** Blessed Orientation-Memory-Concentration test (BOMC), Mini-Cog, General Practitioner Assessment of Cognition (GPCOG), Short Test of Mental Status (STMS), St. Louis University Mental Status Exam (SLUMS), Montreal Cognitive Assessment (MoCA) **If an assessment of cognitive function was not done within the past year, enter 99/99/9999.**

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
23	cogases	What standardized and published tool was used to assess the patient's cognitive function? 1. The Blessed Orientation-Memory-Concentration Test (BOMC) 2. Mini-cog 3. General Practitioner Assessment of Cognition (GPCOG) 4. Short Test of Mental Status (STMS) 5. St. Louis University Mental Status Exam (SLUMS) 6. Montreal Cognitive Assessment (MoCA) 7. other standardized and published tool 95. not applicable	1, 2, 3, 4, 5, 6, 7, 95 Will be auto-filled as 95 if prestrig = 2 or cogdt = 99/99/9999	**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 screen 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 visuo-spatial relationships, recall, language, attention, concentration, working memory and orientation. **If another standardized and published tool is used, 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, or other designation).**
24	screnout	Is the outcome of the cognitive assessment documented in the medical record? 1. Yes 2. No 95. Not applicable	1, 2, 95 Will be auto-filled as 95 if prestrig = 2 or cogdt=99/99/9999 If 2, auto-fill impair as 95, addfolo as 95, and go to ptreside	It is not necessary for a copy of the cognitive assessment tool to be present in the record; however, administration of the exam and the outcome should be recorded. The scoring of the cognitive assessment and therefore the outcome will be determined based upon which standardized assessment was utilized.

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25	impair	Did the assessment outcome indicate any degree of cognitive impairment for this patient? 1. Yes 2. No 95. Not applicable	1, 2, 95 Will be auto-filled as 95 if prestrig = 2 or cogdt =99/99/9999, or screnout =2 If 2, auto-fill addfolo as 95, and go to ptreside	Symptoms of cognitive impairment: memory deficits, language impairment, affective changes, dementia-related behaviors (wandering, agitation, repetitive behaviors), loss of instrumental activities of daily living, incontinence, immobility **Abstractor judgment may not be used. The record must document the findings of the cognitive assessment. Answer "1," if the cognitive assessment is positive even if impairment is noted to be mild. Less than a perfect score does not indicate the patient has cognitive impairment.**
26	addfolo	During the timeframe from (computer to display cogdt to cogdt + 30 days and ≤ stdyend), did the clinician document completion of follow-up for the positive cognitive assessment? 1. Yes 2. No 95. Not applicable	1, 2, 95 Will be auto-filled as 95 if prestrig = 2, cogdt=99/99/9999, screnout =2, or impair=2	**There must be clinician documentation that the follow-up was done in relation to the patient's cognitive impairment and occur within 30 days after the cognitive assessment or if the cognitive assessment occurred prior to admission, during the 30 days after admission.** Follow-up for cognitive impairment may include, but are not limited to: taking a medical history, performing or referring for blood work, depression screening, psychology/psychiatry consult, neuropsychological testing, neurologic exam, brain imaging, care planning for dementia or other similar diagnosis, supportive counseling, and caregiver education. If there is documented completion of any follow-up related to the positive cognitive impairment assessment, answer "1."
		Caregiver Strain		

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27	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 caredt	Review the admission assessment note, social services notes, and/or visit notes to determine where the patient resides. If there is documentation that the patient lives with another person at home, answer "2". **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.
28	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 caredt If 2, go to vetcargiv	**Caregiver = One who provides ongoing support and care for a Veteran in the HBPC program.** **A caregiver provides substantive assistance, i.e., assistance with Activities of Daily (ADL) and/or with Instrumental Activities of Daily Living (IADL), and may be a family member, friend, or neighbor who lives with or lives separately from the Veteran.** The caregivers referred to are informal or unpaid caregivers-people who take on caregiver duties for other than employment or financial gain. • 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". These caregivers should be identified in a Caregiver Support Coordinator note. • 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."

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29	vetcargiv	Does the record document that the HBPC patient serves as a caregiver to another person? 1. Yes 2. No 95. Not applicable	1, 2, 95 Will be auto-filled as 95 if ptreside = 4 or 99 or caregivr = 1 If 1, go to caredt; else if 2, go to 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."**
30	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 **Abstractor can enter default 99/99/9999 if no screen was done** **If 99/99/9999, go to nuthyd as applicable** < =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.** If caregiver strain screen was not done within the past year using the Zarit Burden Interview Screening scale, enter 99/99/9999.
31	wichgivr	Which caregiver was screened for caregiver strain? 1. Spouse/partner 2. Relative other than spouse 3. Friend 4. Neighbor 5. Other 6. VA Medical Foster Home Staff 7. HBPC patient	1, 2, 3, 4, 5, 6, 7 **Warning: if <> 6 and ptreside = 4 OR if <> 7 and vetcargiv = 1**	**A caregiver provides substantive assistance, i.e., assistance with Activities of Daily (ADL) and/or with Instrumental Activities of Daily Living (IADL), and may be a family member, friend, or neighbor who lives with or lives separately from the Veteran.**

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
32	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 **Note:** Some sites may choose to use longer forms of the Zarit Burden Interview (e.g., 12-item or 22-item). Regardless of which form is used, sites should calculate the score on the 4-item screen.

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
33	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 If 2 or 98, go to carefolo	• 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. • Intervention might include counseling, psychoeducation (e.g. education about illness, behaviors and coping strategies), skills-training, stress-management, specific caregiver therapy (e.g., REACH-VA), or other interventions that aim to help the caregiver cope with caregiver strain and/or improve self-care. **Note:** Caregiver therapy may occur with the individual caregiver, or with the veteran and/or other family members present. **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
34	therprov	Which discipline was requested to or provided the therapy to the caregiver? 3. Social worker 4. Psychologist 5. Other	3, 4, 5	If there is documentation the caregiver was seen by the social worker or psychologist prior to the positive caregiver strain screen and the social worker or psychologist provided therapy to the caregiver, select "3" or "4" as applicable. Select option "5" for any discipline other than social work or psychologist.

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
35	carefolo	During the timeframe from (computer to display caredt to caredt + 14 days and ≤ stdyend), did the medical record document other follow-up for the positive caregiver strain screen? 1. Yes 2. No 98. Caregiver refused intervention	1, 2, 98 If 2 or 98, go to nuthyd as applicable, else go to howfolo1	Follow-up for a positive caregiver strain screen must occur during the timeframe indicated and may include documentation of any of the following interventions: • Caregiver education 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.**
36	howfolo1 howfolo2 howfolo5 howfolo6 howfolo8 howfolo9 howfolo10	What follow-up intervention(s) are documented in the medical record? **Indicate all that apply:** 1. Provided caregiver education related to strain 2. Completed additional screening focused on the caregiver 5. Offered respite care 6. Referred to support group 8. Other 9. Encourage caregiver to follow up with own physical/mental health care provider 10. Physical/mental health referral for caregiver medical/mental health concerns	1, 2, 5, 6, 8, 9, 10	Indicate each intervention documented in the record for follow-up of the positive caregiver strain screen.
		Nutrition/Hydration		
		If Hcstatus = 2, go to nuthyd; else go to end		

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
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 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 computer 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 to address the patient's nutritional and/or hydration needs? 3. Yes 4. No 5. 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. Suggested data sources: HBPC Nutrition Assessment note, HBPC Nutrition progress note
40	nutresp	Is there evidence in the record that the patient's response to the nutritional/hydration care plan/intervention was evaluated? 3. Yes 4. No 5. No HBPC visit between nutrional/hydration care plan/intervention and study end date	3, 4, 5	Follow up assessments may be face to face, telephone, or computer video teleconference (CVT) as appropriate to the patient's needs. Suggested data sources: HBPC Nutrition Assessment note, HBPC Nutrition progress note
		Environment Safety/Risk Assessment		

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
41	envases	Was a home environmental safety/ risk assessment completed 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 may be found in a 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 completed 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 Home Environment Assessment, Rehabilitation Therapy (KT,OT, PT) Assessment, HBPC Nursing Admission Assessment, problem list

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
44	asesoxy	Was a home oxygen safety risk assessment completed 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 documented under safety risks. Home oxygen safety may also be found in HBPC nursing notes.** Home oxygen safety risk assessment may 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, HBPC Nursing Admission Assessment or notes
45	envintv	Does the record document a plan of care or intervention to address the home environmental safety/risk assessment findings? 3. Yes 4. No 5. 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. Suggested data sources: HBPC Environment Assessment note, HBPC Rehabilitation Therapy (KT/OT/PT) progress notes
46	envresp	Is there evidence in the record that the home environmental safety/risk plan of care or intervention was evaluated? 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, computer video teleconference (CVT) as appropriate to the patient's needs. Suggested data sources: HBPC Environment Assessment note, HBPC Environment progress note, HBPC Rehabilitation Therapy (KT/OT/PT) progress notes