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|  |  | **Organizational Identifiers** |  |  |
|  | VAMC  CONTROL  QIC  BEGDTE  REVDTE | Facility ID  Control Number  Abstractor ID  Abstraction Begin Date  Abstraction End Date | Pre-fill  QI pre-fill  Auto-fill  Auto-fill  Auto-fill |  |
|  |  | **Patient Identifiers** |  |  |
|  | SSN  FIN  PTNAMEF  PTNAMEL  BIRTHDT  SEX  RACE  ETHNICITY  COHORT  AGE | Patient SSN  FIN  First Name  Last Name  Birth Date  Sex  Race  Ethnicity  Cohort  Age | Pre-fill: no change  Pre-fill: no change  Pre-fill: no change  Pre-fill: no change  Pre-fill: no change  Pre-fill: **can change**  Pre-fill: no change  Pre-fill: no change  Pre-fill: no change  Calculate age at HBPCDT |  |
|  |  | **Validation** |  |  |
| 1 | visithbpc | Does the record document a HBPC encounter by any member of the HBPC team\* during the study interval?  Yes  No | 1,2\*  **\*If 2, the record is excluded** | **Study interval = the study dates displayed in the software.**  **HBPC encounter** = **home visit, clinical video telehealth (CVT) encounter,** **telephone encounter, 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 CVT or telephone encounter 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   |  | | --- | | > = stdybeg and  <= stdyend | | **HBPC encounter** = **home visit, clinical video telehealth (CVT) encounter,** **telephone encounter 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**  Enter the date of the most recent HBPC encounter with a member of the HBPC team during the study interval.  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 time frame from (computer display stdybeg to stdyend)?  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 encounter 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 encounter by HBPC during the study interval AND there is documentation of ONLY ONE note indicating that HBPC was managing or providing the patient’s care. |
| 4 | evalvst | Was this encounter only pre-admission screening for possible enrollment in the HBPC program?  1. Yes  2. No | 1\*,2  **\*If 1, the record is excluded** | Only to assess = the patient was not enrolled in HBPC at the time of the encounter and the encounter was a pre-admission screening to assess the patient’s need for HBPC services.  **Exclusion Statement: The only encounter during the study interval was pre-admission screening to assess the patient for enrollment in HBPC.** |
| 5 | admisdt | Enter the HBPC admission date. **Admission date is date of the progress note documenting admission.** | mm/dd/yyyy  **If pre-filled, abstractor can modify; if not pre-filled, abstractor to enter date**   |  | | --- | | 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:   * **Review the record carefully to determine the most recent HBPC admission date.** * May be the first or subsequent HBPC encounter. 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 was discharged from HBPC VISTA package for administrative reasons (i.e., was hospitalized and/or placed in short term skilled nursing facility), do not count as a new admission when the Veteran returns home and HBPC plan of care is resumed. Note: HBPC VISTA package is not part of CPRS and the facility point of contact will need to supply any pertinent information. * 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. * If the admission date is prefilled, please verify the date in the medical record and if incorrect, enter the correct date.   **Exclusion Statement**  **The patient was enrolled in HBPC for less than the 30 days initial assessment period.**  **Suggested Data Sources:** HBPC admission note, HBPC consultation, HBPC care plan |
| 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 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.** The 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 encounter 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 should be screened within the past year.  If the patient was discharged from HBPC VISTA package for administrative reasons (i.e., was hospitalized and/or placed in short- term skilled nursing facility), do not count as a new admission when the Veteran returns home and HBPC plan of care is resumed. **Note**: HBPC VISTA package is not part of CPRS and the facility point of contact will need to supply any pertinent information. |
| 7 | inptadm | During the time frame from (computer display admisdt to admisdt + 30 days), did the record document the patient was admitted to an acute or non-acute inpatient facility?  1. Yes  2. No | 1,2  If 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 admitted to an acute or non-acute inpatient facility during the 30 days following HBPC admission.  Non-acute inpatient facility includes skilled nursing facility and rehabilitation facility.  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.  **Exclude:** Observation stay |
| 8 | admdate2 | Enter the admission date. | mm/dd/yyyy  If valid date, go to hospice  Will be auto-filled as 99/99/9999 if  inptadm = 2   |  | | --- | | >= admisdt and  <= 30 days after admisdt | | Enter the exact date. |
|  |  | **Medication Management** |  |  |
| **If Hcstatus = 2 and hbpcdt – admisdt <= 120 days, go to admmed; else go to swedacp1 as applicable** | | | | |
| 9 | 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 swedacp1 as applicable; else go to medrev3 | Medications include prescribed, OTC, and dietary supplement (such as a vitamin, mineral, herb or other botanical, amino acid, concentrate, metabolite, constituent, and/or extract), topical and systemic medications from VA and non-VA providers as noted in the record.  Suggested data sources: HBPC notes, medication profile |
| 10 | medrev3 | 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 | 1,2  If 2, go to swedacp1 as applicable | **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 or co-signed by the pharmacist is acceptable.**  All medications include prescribed, OTC, and dietary supplement (such as a vitamin, mineral, herb or other botanical, amino acid, concentrate, metabolite, constituent, and/or extract), 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 time frame 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 encounter date, review is required within 30 days of HBPC admission date. |
| 11 | medrevdt | 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 | medchg | Did the pharmacist make any recommendation for change in the patient’s medication regimen?  1. Yes  2. No | 1,2  If 2, go to medfalrisk | **If the pharmacist recommends a change to at least one medication (e.g., change in dose, frequency, discontinuation of medication), select “1”.**  **For the purposes of this question, medication includes prescription medications, over the counter medications and supplements.**  Acceptable documentation example, pharmacist notes, “Patient’s BP consistently above 150/90; recommend increasing Lisinopril to 20 mg PO daily;” select value 1.  **Pharmacist documentation of a clarification is NOT considered a recommendation for change in the patient’s medication regimen.** For example, “Last BP was 160/70. Will discuss with interdisciplinary team that patient is on furosemide, lisinopril and nifedipine and clarify if home BPs are similar;” select value 2. |
| 13 | medcomm | Did the pharmacist communicate any change in the patient’s medication regimen to the HBPC or primary care provider?  1. Yes  2. No | 1,2 | Pharmacist communication of a change to the medication regimen may be completed by any of the following:   * direct communication (e.g., pharmacist calls the provider) * co-signature of the medication plan review note by the HBPC or primary care provider * documentation of a medication change in the interdisciplinary team conference that included the HBPC or primary care provider   It is not necessary to see documentation of communication of all recommended changes in the medication regimen. |
| 14 | medfalrisk | During the time frame from (computer to display admisdt to admisdt + 30 days), did the pharmacist assess the patient’s medication regimen for fall risk potential?   1. Yes 2. No | 1, 2  If 1, go to swedacp1 | * **To meet the intent of this question, the pharmacist must document the medication regimen was assessed for fall risk potential or reviewed medications that may increase fall risk.** * **Example of acceptable documentation include but are not limited to:** * Clinical Pharmacy Note in specified time frame documents “Medication reviewed by pharmacist for fall risk potential, increased fall risk, medications that are associated with increased risk of falls, or medication fall risk screening with a score.”   **Review the following: HBPC Pharmacy – Medication Notes, HBPC Geriatric Pharm Chart Review, HBPC Initial Pharmacy Assessment, HBPC Pharmacy Quarterly Review, Pharm D HBPC Chart Review Note, Home Care Pharmacy Note, or any other note associated with pharmacist review.** |
| 15 | medfalases | During the time frame (computer to display admisdt to admisdt + 30 days), did the pharmacist document why fall risk potential was not assessed?   1. Yes 2. No | 1, 2 | If the pharmacist did not document the medication regimen was assessed for fall risk potential or reviewed medication that may increase fall risk, review the pharmacist note for documentation of a reason the assessment was not performed within the specified time frame. |
| **If hcstatus = 2, go to swedacp1; else go to nuthyd as applicable** | | | | |
| 16 | swedacp1  swedacp2  swedacp3  swedacp99 | During the time frame from (computer to display admisdt – 30 days to admisdt + 30 days), did a HBPC social worker document education about alternative caregiving/placement plans was provided to the patient/caregiver/guardian on any of the following components?  **Select all that apply:**   1. Education on potential VA resources (e.g., Respite, Homemaker and Home Health Aide (H/HHA) Care, adult day care, Long Term Care placement, Medical Foster Home (MFH)) 2. Education on potential VA limitations that may impact alternative caregiving/placement plans (e.g. Veterans who are SC less than 70% would not have placement in a contract nursing home (CNH), own long term care insurance, potential placement based on personal preferences and availability in state/out of state) 3. Education on potential non-VA and community resources (Medicaid eligibility, private insurance, personal preferences, Medicaid waivers, other state benefits etc.) that may impact alternative caregiving/placement plan   99. None of the above | 1,2,3,99  If 99, auto-fill edacpdt as 99/99/9999 and go to noedrsn | * **Look for documentation on the educational components regarding alternative caregiving/placement plans in the initial psychosocial assessment in the social worker note.** * Education about options for alternative caregiving/placement plans should be provided to all HBPC patients and/or caregiver/guardian. * **Please select all components that are documented.** * **Example of Acceptable Documentation:** HBPC social work screen/psychosocial assessment note documents: * VA Resources (Placement/LTC): Education provided on VA Homemaker/Home Health Aide program, in home respite, community adult day health center and hospice. Select value 1. * Barriers to VA Resources: Veteran is not eligible for long-term VA CNH benefit; veteran does not meet criteria based on level of independence. Select value 2. * Non-VA Community Resources: Education provided on State Veteran’s Homes, ALF/PCH/NH placement and Medicaid/Medicare/Private Insurance/LTC insurances resources. Select value 3. * **Education on alternative caregiving/placement plans should be tailored to the patient’s needs; however, documentation that education was provided for a component as stated is acceptable to select that value.** For example, HBPC social worker documents “Alternative caregiving/placement planning education provided: Education on potential VA resources (e.g., Respite, Homemaker and Home Health Aide (H/HHA) Care, adult day care, Long Term Care placement, Medical Foster Home (MFH)); select value 1. * Documentation a resource was declined without documentation that education was provided is not acceptable. For example, “Declined nursing home” is not acceptable to select value 1.   Suggested data sources: HBPC social work assessment, HBPC psychosocial admission assessment, social work section inter-disciplinary treatment plan (IDTP) or care plan |
| 17 | edacpdt | Enter the date that the HBPC social worker documented the education about alternative caregiving/placement plans with the patient/caregiver/guardian. | mm/dd/yyyy   |  | | --- | | <= 30 days prior to or = admisdt and <= admisdt + 30 days |   If valid date and admisdt >= 125 days prior to stdyend, go to  ptstplan; else go to nuthyd as applicable  Will be auto-filled as 99/99/9999 if  swedacp99 = -1 | Enter the date within 30 days of HBPC admission that the HBPC social worker documented a discussion about alternative caregiving/placement plans with the patient/caregiver/guardian. |
| 18 | noedrsn | During the time frame from (computer to display admisdt – 30 days to admisdt + 30 days), is there documentation by a HBPC social worker of a reason why the education about alternative caregiving/placement plans did not take place?  1. Yes  2. No  98. Patient/caregiver/guardian refused | 1,2,98  If 98 OR if [(1 or 2) and (admisdt < 125 days prior to stdyend)] go to nuthyd as applicable | **Examples of reasons may include, but are not limited to**:  Lack of decision making capacity; no caregiver/guardian available, Veteran hospitalized 16 days+.  If there is documentation the patient/caregiver/guardian refused education about alternative caregiving/placement, select 98.  Suggested data sources: HBPC social work assessment, HBPC psychosocial admission assessment, HBPC psychosocial periodic assessment, social work section inter-disciplinary treatment plan (IDTP) |
| 19 | ptstplan | During the time frame from (computer to display admisdt – 30 days to admisdt + 125 days), did the HBPC social worker document the plan for urgent/emergent care by either documenting the plan or documenting the patient/caregiver/guardian’s choice to decline making a plan?  1. Yes, HBPC social worker documented the plan for urgent/emergent care  2. No, HBPC social worker did not document the plan for urgent/emergent care  98. Patient/caregiver/guardian refused/declined to make a plan for urgent/emergent care | 1,2,98 | * **Urgent/emergent care planning pertains to plan for care in the event of the unplanned absence of the caregiver.** * Urgent/emergent care planning does NOT pertain to plans related to cardiopulmonary resuscitation (CPR), do not resuscitate (DNR), or life sustaining treatment (LST) such as feeding tube placement. * Look for documentation of the plan for urgent/emergent care in the initial psychosocial assessment or any other Social Worker follow-up documentation within 125 days of the initial assessment (telephone or home visit contacts). * Example of acceptable documentation:   + Social worker documents, “Wife currently providing care for the patient. In the event she is not available, daughter Jane Doe, phone number123-456-7890, would be able to provide care; select “1.” * Examples of unacceptable documentation:   + Social worker notes, “Discussed Veteran’s values, goals and preferences” or “Patient is not interested in SNF” or “Local emergency room”; select “2.” * If there is documentation the patient/caregiver/guardian refused to make a plan for urgent/emergent care, select 98.   Suggested data sources: HBPC social work assessment; HBPC social work note; social work section inter-disciplinary treatment plan (IDTP) |
| 20 | ptltplan | During the time frame from (computer to display admisdt – 30 days to admisdt + 125 days), did the HBPC social worker document the plan for long term care planning by either documenting the plan or documenting the patient/caregiver/guardian’s choice to decline making a plan?   1. Yes, HBPC social worker documented the plan for long term care 2. No, HBPC social worker did not document the plan for long term care   98. Patient/caregiver/guardian refused/declined to make a plan for long term care | 1,2,98 | * **Note: Long term care planning is defined as planning care for the Veteran if their condition changes or declines and the Veteran needs further care and/or assistance either in their home (i.e., friends, family, caregiver, paid caregiver) or to transition to a higher level of care (i.e., Assisted Living Facility or Memory Care Facility, Vet Center or State Veteran’s Home, Community Nursing Home (CNH), Medicaid Nursing Home, Medical Foster Home (MFH)).** * **Long term care (LTC) planning for increased level of care is applicable to Veterans currently living at home, in an assisted living facility (ALF), or medical foster home (MFH).** * Long term care options may include but are not limited to: assisted living facility (ALF) placement, VA or community nursing home (CNH), VA or community skilled nursing facility (SNF), medical foster home (MFH), care by family or friend other than current caregiver. * Look for documentation of the plan for long term care planning with the patient/caregiver/guardian in the initial psychosocial assessment or any other Social Worker follow-up documentation within 125 days of the initial assessment (telephone or home visit contacts). * **Examples of acceptable documentation for Value “1”**:   **Social worker notes:**   * “Discussed patient’s values, goals and preferences and options for long term care. Patient does not have family to care for him. He would be agreeable to assisted living facility or nursing home.” * “Discussed patient’s values, goals and preferences and options for long term care. Patient/caregiver/family states veteran will remain in the home.Practicality of staying in an unsafe environment was discussed. Will continue to work with patient/caregiver/family to discuss safe and realistic options for care.”   **Cont’d next page**   * **Example of unacceptable documentation**: Social worker documents, “Values and goals of care: Family wants patient to stay at home; select “2.” While goal is documented, social worker needs to work with patient/family to identify if staying at home is feasible and caregiving plan. If not feasible, other options should be discussed such as LTC placement options or alternate caregiver options reviewed and documented. Documentation that the Veteran will remain at home or in current situation without indicating feasibility and discussion of other options is not acceptable. * If there is documentation the patient/caregiver/guardian refused to make a plan for long term care or requests more time to discuss options to care, select 98. For example, Social worker notes, “Discussed patient’s values, goals, and preferences and options for long term care. Patient/caregiver/family needs more time to discuss options to care.”   Suggested data sources: HBPC social work assessment; HBPC social work note; social work section inter-disciplinary treatment plan (IDTP) |
| **If Hcstatus=2, go to nuthyd; else go to hospice** | | | | |

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|  |  | **Nutrition/Hydration** |  |  |
| 21 | nuthyd | 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 HBPC Registered Dietician (RD) or Registered Dietician Nutritionist (RDN) during a face-to-face encounter in the veteran’s home OR a clinical video telehealth (CVT) encounter prior to 7/01/2023?  3. Yes, assessment of patient’s nutritional and hydration needs by a HBPC RD or RDN was documented during a **face-to-face encounter.**  4. Yes, assessment of patient’s nutritional and hydration needs by a HBPC RD or RDN was documented during a **CVT encounter prior to 7/01/2023.**  5. No assessment of the patient’s nutritional and hydration needs was documented by a HBPC RD or RDN during a face-to-face or CVT encounter | 3,4,5  If 5, go to assesmal2 | * **Note: Effective July 1, 2023, assessment of nutritional and hydration needs must be completed during a face-to-face encounter.** * Initial nutritional and hydration assessment must be performed by a HBPC RD or RDN 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 OR a CVT encounter prior to 7/01/2023 and within specified time frame. * 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 encounter is not acceptable.** * A dietician student/intern/trainee with appropriate co-signature by registered dietician is acceptable.   Suggested data sources: HBPC RD or RDN Initial Nutrition Assessment note |
| 22 | nuthydt | Enter the date of the initial nutritional and hydration assessment by a HBPC RD or RDN. | mm/dd/yyyy   |  | | --- | | <= 30 days prior to or = admisdt and <= 30 days after admisdt | | If nuthyd = 4, cannot be >= 07/01/2023 | | Enter the exact date of the initial nutritional and hydration assessment by a HBPC RD or RDN within 30 days of admission. |

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| 23 | assesmal2 | During the time frame from (if nuthyd = 5, computer display (admisdt – 30 days to admisdt + 30 days); else display (On nuthydt), was an assessment for malnutrition completed by a HBPC Registered Dietitian (RD) or Registered Dietician Nutritionist (RDN) during the initial face-to-face encounter in the veteran’s home OR a clinical video telehealth (CVT) encounter prior to 7/01/2023?   1. Yes, the HBPC RD or RDN initial nutrition assessment contains an assessment for malnutrition that was completed by a RD or RDN during the initial **face-to-face** encounter 2. Yes, the HBPC RD or RDN initial nutrition assessment contains an assessment for malnutrition that was completed by a RD or RDN during the initial **CVT** encounter prior to 7/01/2023 3. No, the HBPC RD or RDN initial nutrition assessment does not contain an assessment for malnutrition completed by a RD or RDN during a face-to-face OR a CVT encounter 4. No, an assessment for malnutrition was not completed by the HBPC RD or RDN and the initial nutrition assessment contains documentation that the patient/caregiver/guardian refused or declined to participate in the assessment for malnutrition | 3,4,5,98  If 5 or 98 auto-fill asesmaldt as 99/99/9999, and go to envases | * **Note: Effective July 1, 2023, assessment for malnutrition must be completed during a face-to-face encounter.** * **The HBPC RD or RDN Initial Nutrition Assessment must contain a malnutrition assessment performed by a Registered Dietician (RD) or Registered Dietician Nutritionist (RDN) during the initial face-to-face encounter in the Veteran’s home within the time frame of 30 days prior to or after HBPC admission date OR a CVT encounter prior to 07/01/2023 and within the specified time frame.** * Malnutrition assessment completed by a dietician student/intern/trainee with appropriate co-signature by RD or RDN is acceptable. * **Malnutrition assessment by telephone is NOT acceptable.** * **With exception of hand grip (refer to hand grip rules below), RD or RDN documentation that a component is unable to be assessed is not acceptable.**   **In order to select value 3 (face-to-face encounter) or 4 (CVT encounter prior to 7/01/2023):**   * The malnutrition assessment must be completed by a HBPC RD or RDN during the initial face-to-face or CVT encounter; AND * **The malnutrition assessment must contain the**   **ASPEN/AND Malnutrition Diagnosis Guide AND/OR the malnutrition assessment must include all of the following:**   * evaluation of energy intake (such as RD/RDN may obtain or review the food and nutrition history, estimate optimum energy needs, compare them with estimates of energy consumed and report inadequate intake as a % of estimated energy requirements over time); * interpretation of weight loss (such as RD/RDN may evaluate the weight in light of other clinical findings including the presence of under or over hydration and/or assess weight change over time reported as a % of weight lost from baseline); * body fat loss (based on RD/RDN nutrition focused physical exam, such as loss of subcutaneous fat (e.g., orbital, triceps, fat overlying the ribs));   **Cont’d next page**  **Malnutrition Assessment cont’d**   * muscle mass loss (based on RD/RDN nutrition focused physical exam, such as muscle loss (e.g., wasting of the temples, clavicles, shoulders, interosseous muscles, scapula, thigh and calf)); * fluid accumulation (such as RD/RDN may evaluate generalized or localized fluid accumulation evident on exam (extremities, vulvar/scrotal edema or ascites); **AND** * reduced grip strength (**NOTES):**   + Assessment of hand grip strength of both hands (bilateral) using a dynamometer can be conducted by a trained member of the HBPC team other than the RD/RDN and may include: physician/ APN/PA, registered nurse (RN), licensed practical nurse (LPN), therapist (PT/OT/KT).   + The bilateral Hand Grip Strength measurement must have completed results documented in the RD Initial Nutrition Assessment as part of the assessment or as an addendum within the required time frame to meet the EPRP requirement.   + **For assessment completed on or after 4/01/2021, the numeric results of bilateral hand grip strength must be documented. If bilateral results are not documented, there must be documentation of unilateral (one) hand results with a reason why grip strength of both hands was not assessed. Example:**   **Hand grip assessment:**  **--**Patient seated upright at a 90 degree angle, feet on floor  --Reference ranges for camry device:  Male Age 70 -99 21..3 – 35.1 kg  --Left hand, June 7, 2022, 33, 31, 35 (x = 33)  --Right hand, 29, 31, 28 (x = 29)  [X] Normal grip strength  [ ] Measurably reduced grip strength  **Cont’d next page**   * + RD/RDN documentation of a reason (e.g., hand contracture, rheumatoid arthritis, etc.) the grip strength (bilateral or unilateral if one hand assessed) cannot be assessed is acceptable.   + Due to COVID-19 pandemic, documentation of deferral of hand grip strength assessment for a malnutrition assessment completed during a CVT encounter is acceptable.   Suggested data sources: HBPC RD or RDN Initial Nutrition Assessment |
| 24 | asesmaldt | Enter the date the assessment for malnutrition was completed by the HBPC RD or RDN. | mm/dd/yyyy  Will be auto-filled as 99/99/9999 if  asesmal2 = 5 or 98   |  | | --- | | If nuthyd = 5, <= 30 days prior to or = admisdt and <= 30 days after admisdt; else = nuthydt | | If assesmal2 = 4, cannot be >= 07/01/2023 | | Enter the exact date of the malnutrition assessment completed by a RD or RDN within 30 days of admission. |

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|  |  | **Environment Safety/Risk Assessment** |  |  |
| 25 | envases | 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 OR a clinical video telehealth (CVT) encounter prior to 7/01/2023?  3. Yes, a home environmental safety/ risk assessment was documented by a rehabilitation therapist during a **face-to-face encounter** in the patient’s home  4. Yes, a home environmental safety/ risk assessment was documented by a rehabilitation therapist during a **CVT encounter prior to 7/01/2023**.  5. No home environmental safety/ risk assessment was documented by a rehabilitation therapist during a face-to-face or CVT encounter | 3,4,5  If 5, go to envoxy | * **Note: Effective July 1, 2023, assessment of environment safety and risk assessment needs must be completed during a face-to-face encounter.** * **A home environmental safety/ risk assessment must be performed by a rehabilitation therapist during a face-to-face in the Veteran’s home within the time frame of 30 days prior to or after HBPC admission date OR CVT** **encounter prior to 7/01/2023 and within the specified time frame.**   **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 |
| 26 | envasedt | Enter the date of the home environmental safety/risk assessment documented by a rehabilitation therapist. | mm/dd/yyyy   |  | | --- | | <= 30 days prior to or = admisdt and <= 30 days after admisdt | | If envases= 4, cannot be >= 07/01/2023 | | Enter the exact date of the home environmental safety/risk assessment completed by a rehabilitation therapist within 30 days of admission. |
| 27 | envoxy | Was the patient oxygen dependent?   1. Yes 2. No | 1,2  If 2, go to hospice | **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 |
| 28 | asesoxy2 | During the time frame from (computer to display admisdt – 30 days to admisdt + 30 days) at a face-to-face encounter OR a CVT encounter prior to 7/01/2023, 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   3. Yes, a home oxygen safety risk assessment including all components above was documented by a HBPC team member during a **face-to-face encounter** in the patient’s home  4. Yes, a home oxygen safety risk assessment including all components above was documented by a HBPC team member during a **CVT encounter prior to 7/01/2023.**  5. No home oxygen safety risk assessment was documented by a HBPC team member during a face-to-face or CVT encounter | 3,4,5  If 5, go to hospice | * **Note: Effective July 1, 2023, a home oxygen safety risk assessment must be performed by a HBPC team member during a face-to-face encounter.** * **A home oxygen safety risk assessment must be performed by a HBPC team member 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 OR a CVT encounter prior to 7/01/2023 and within the specified time frame.**   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.  **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 |
| 29 | asesoxydt | Enter the date of the most recent home oxygen safety risk assessment documented by a HBPC team member . | mm/dd/yyyy   |  | | --- | | <= 30 days prior to or = admisdt and <= 30 days after admisdt | | If asesoxy2 = 4, cannot be >= 07/01/2023 | | Enter the date of the most recent home oxygen safety risk assessment documented by a HBPC team member.  **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 |
| 30 | oxyedu1  oxyedu2  oxyedu3  oxyedu4 | During the HBPC team face-to-face or CVT encounter on (computer to display asesoxydt), did the HBPC team member inform and educate the patient/caregiver on home oxygen safety to include:   |  |  | | --- | --- | | 1. The findings of the oxygen safety risk assessment | 1. Yes  2. No | | 2. The causes of fire | 1. Yes  2. No | | 3. Fire risks for neighboring residences and buildings | 1. Yes  2. No | | 4. Precautions that can prevent fire-related injuries | 1. Yes  2. No | | 1,2  If any oxyedu1, oxyedu2,oxyedu3, or oxyedu4 = 2, go to hospice | 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 |
| 31 | oxyrec | Did a HBPC team member document recommended interventions to address identified oxygen safety risk(s)?  Examples include, but are not limited to:   * Replace non-functioning smoke detector * Family to post “no smoking” signs on the front exterior door * Veteran educated to not use oxygen near open flames   3. Yes  4. No  5. HBPC team member documented that NO oxygen safety risks were identified | 3,4,5  If 4 or 5, go to hospice | Any member of the HBPC team may document recommendations to address identified oxygen safety risks. Examples of recommended interventions (**intervention documentation is bolded**) 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 |
| 32 | oxyrecres | 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?  Examples include, but are not limited to:   * Smoke detector is now functioning * “No smoking” signs are posted at front exterior door * No further evidence of candle usage observed at follow-up visit   3. Yes  4. No  5. 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 telehealth (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 (response to intervention is bolded)** 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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| 33 | hospice | During the past year, is there documentation in the medical record the patient is enrolled in a VHA or community-based hospice program? 1. Yes 2. No | 1,2  **If 1, go to end** | **Hospice program – providing care that focuses on the quality of life for people and their caregivers who are experiencing an advanced, life-limiting illness. Care may be provided in a hospice facility, in the home, or other settings.**  A “Yes” answer to this question will exclude the case from the mental health and immunization measures.  **Acceptable:** Enrollment in a VHA or community-based hospice program  **Unacceptable:** Enrollment in a VHA Palliative Care or HBPC program  **Suggested Data sources:** Consult notes, History and physical, Order summary, Clinic notes |
| 34 | pallcare | During the past year, is there documentation in the medical record the patient is enrolled in a VHA or community-based palliative care program? 1. Yes 2. No | 1,2 | **Palliative Care is the identification, prevention, and treatment of suffering by assessment of physical, psychosocial, intellectual, and spiritual needs of the patient with a goal of supporting and optimizing the patient’s quality of life.**  **Suggested Data sources:** Consult notes, history and physical, order summary, clinic notes |
|  |  | **Assessment of Cognitive Function** |  |  |
| 35 | dementdx2 | 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:  **A81.00, A81.01, A81.09, A81.2, A81.82, A81.89, A81.9, F01.50, F01.511, F01.518, F01.52 – F01.54, F01.A0, F01.A11, F01.A18, F01.A2 – F01.A4, F01.B0, F01.B11, F01.B18, F01.B2 – F01.B4, F01.C0, F01.C11, F01.C18, F01.C2 – F01.C4, F02.80, F02.811, F02.818, F02.82 – F02.84, F02.A0, F02.A11, F02.A18, F02.A2 – F02.A4, F02.B0, F02.B11, F02.B18, F02.B2 – F02.B4, F02.C0, F02.C11, F02.C18, F02.C2 – F02.C4, F03.90, F03.911, F03.918, F03.92 – F03.94, F03.A0, F03.A11, F03.A18, F03.A2 – F03.A4, F03.B0, F03.B11, F03.B18, F03.B2 – F03.B4, F03.C0, F03.C11, F03.C18, F03.C2 – F03.C4, F10.27, F10.97, F13.27, F13.97, F18.17, F18.27, F18.97, F19.17, F19.27, F19.97, G23.1, G30.0, G30.1, G30.8, G30.9, G31.01, G31.09, G31.83, G90.3**  1. Yes  2. No | 1,2  **If 2, go to scrnaudc** | * **The problem list or health factors may be used to perform an initial search for the diagnosis of dementia or other condition associated with dementia; however, the documentation of the applicable ICD-10 code must be found in association with an inpatient or outpatient encounter during the past year.** * **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 VHA ICD-10-CM Dementia Codes, Table 10.**   **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  **Cerner suggested data sources:** Diagnoses and problems/documentation – search diagnoses and problems for applicable code and verify use during the past year in Coding Summary found in Documentation |

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| 36 | permci | During the past year, did a physician/APN/PA or psychologist document that the patient has probable permanent cognitive impairment using a Clinical Reminder?   1. Yes 2. No | 1,2  If 2, auto-fill permcidt as 99/99/9999 and go to demsev | **Note:** A VHA Clinical Reminder for capture of probable permanent cognitive impairment is scheduled for release in June 2021.  **In order to answer “1,” there must be physician/APN/PA or psychologist documentation of the Clinical Reminder in the progress note that the veteran has probable permanent cognitive impairment and should be excluded from future mental health screening or other applicable clinical reminders.**  **Acceptable Source**: Clinical Reminder taxonomy which may be present in a Mental Health Screening note or other applicable templates or Clinical Reminders |
| 37 | permcidt | Enter the date of the most recent physician/APN/PA or psychologist documentation that the patient has probable permanent cognitive impairment. | mm/dd/yyyy  Will be auto-filled as 99/99/9999 if  permci = 2  **\*If permci = 1, go to bnmrtrns**   |  | | --- | | < = 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. |
| 38 | demsev | 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 | 1,2,3,99  If 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.  In order to answer “1,” the documentation must clearly indicate the severity of dementia was assessed using one of the specified tools, the date the assessment was completed, and the results of the assessment.  **If the severity of dementia was not assessed during the past year using one of the specified tools, enter 99.** |
| 39 | demsevdt | Enter the most recent date the assessment of severity of dementia using a specified tool was completed. | mm/dd/yyyy   |  | | --- | | < = 1 year prior to  or = stdybeg and  < = stdyend | | Enter the most recent date the assessment of the severity of dementia using a specified tool was completed.  **Acceptable tools:** Clinical Dementia Rating Scale (CDR), Functional Assessment Staging Tool (FAST), Global Deterioration Scale (GDS) |
| 40 | cogscor2 | What was the outcome of the assessment of the severity of dementia assessment?  4. Score indicated mild dementia  5. Score indicated moderate to severe dementia  6. Score indicated no dementia  99. No score documented in the record or unable to determine outcome | 4,\*5,6,99  **\*If 5, go to bnmrtrns** | **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.”** |
| 41 | incsevci | During the time frame from (computer display demsevdt + 1 day to stdyend), did a physician/APN/PA or psychologist document in the record that the patient has moderate or severe cognitive impairment?   1. Yes 2. No | 1,2  **If 2, go to scrnaudc** | * **In order to answer “1,” there must be physician/APN/PA or psychologist documentation in the record that the patient has moderate, moderate to severe, or severe cognitive impairment OR physician/APN/PA or psychologist notation that the patient is too cognitively impaired for mental health screening.** * Other acceptable documentation includes:   + The Clinical Reminder for mental health screening allows providers to establish this exclusion by checking the box to indicate **“Unable to screen due to Moderate or Severe Cognitive Impairment.”**   + The Form Browser for mental health screening in Oracle Cerner allows providers to establish this exclusion by checking the box to indicate **“Unable to Screen Due to Permanent, Major Neurodegenerative Disorder.”** * If the physician/APN/PA or psychologist documentation notes “mild cognitive impairment” or “cognitive impairment” without specifying severity, answer “2.” * Although a diagnosis of major neurocognitive disorder may indicate dementia, it does not specify the severity of the dementia. If this is the only documentation related to cognitive impairment, answer “2”.   **Sources**: Clinical Reminder for mental health screening, clinician notes. |
| 42 | incsevcidt | Enter the date of the most recent physician/APN/PA or psychologist documentation of moderate or severe cognitive impairment. | mm/dd/yyyy  **If incsevci = 1, go to bnmrtrns**   |  | | --- | | > demsevdt and  < = stdyend | | Enter the exact date. The use of 01 to indicate missing month or day is not acceptable. |
| 43 | modsevci | During the past year, did a **physician/APN/PA or psychologist** document in the record that the patient has moderate or severe cognitive impairment?  1. Yes  2. No | 1,2  If 2, auto-fill cogimpdt as 99/99/9999 and go to scrnaudc | * **In order to answer “1,” there must be physician/APN/PA or psychologist documentation in the record that the patient has moderate, moderate to severe, or severe cognitive impairment OR a physician/APN/PA or psychologist notation that the patient is too cognitively impaired for mental health screening.** * Other acceptable documentation includes: * The Clinical Reminder for mental health screening allows providers to establish this exclusion by checking the box to indicate **“Unable to screen due to Moderate or Severe Cognitive Impairment.”** * The form Browserfor mental health screening in Oracle Cerner allows providers to establish this exclusion by checking the box to indicate **“Unable to Screen Due to Permanent, Major Neurodegenerative Disorder.”** * If the physician/APN/PA or psychologist documentation notes “mild cognitive impairment” or “cognitive impairment” without specifying severity, answer “2.” * Although a diagnosis of major neurocognitive disorder may indicate dementia, it does not specify the severity of the dementia. If this is the only documentation related to cognitive impairment, answer “2”.   **Sources:** HBPC notes, Clinical Reminder for mental health screening, clinician notes. |
| 44 | cogimpdt | Enter the date of the most recent physician/APN/PA or psychologist documentation of moderate or severe cognitive impairment. | mm/dd/yyyy   |  | | --- | | < = 1 year prior to or = stdybeg and  < = stdyend |   Will be auto-filled as 99/99/9999 if modsevci = 2  **If modsevci = 1, go to bnmrtrns** | Enter the exact date. The use of 01 to indicate missing month or day is not acceptable. |

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|  |  | **Screening for Alcohol Misuse** |  |  |
| 45 | scrnaudc | During the past year, was the patient screened for alcohol misuse with the AUDIT-C?  1. Yes  2. No | 1,\*2  \*If 2, go to deptxyr | **Screening for alcohol misuse = the patient was screened during the specified time frame using AUDIT-C questions OR AUDIT-C question # 1 alone if answer was “never” (audc1=0).**  **AUDIT-C:**  **Question #1** = “How often did you have a drink containing alcohol in the past year?”  **Question #2** = “How many drinks containing alcohol did you have on a typical day when you were drinking in the past year?”  **Question #3** = “How often did you have six or more drinks on one occasion in the past year?”  **Acceptable setting for alcohol screening:** outpatient encounter, screening by telephone, and clinical video telehealth (CVT), inpatient hospitalization  **Cerner suggested data sources:** Form browser and select social history |
| 46 | dtalscrn | Enter the most recent date of screening for alcohol misuse with the AUDIT-C. | mm/dd/yyyy   |  | | --- | | <= 1 year prior to stdybeg and  < = stdyend | | Most recent date patient was screened for alcohol misuse = the most recent date the AUDIT-C was documented in the record. The date refers to the date of the signature on the encounter note.  Enter the exact date. The use of 01 to indicate missing month or day is not acceptable.  **Cerner suggested data sources:** Form browser and select social history |
| 47 | audc1 | Enter the score documented for AUDIT –C Question # 1 in the past year.  “How often did you have a drink containing alcohol in the past year?   1. Never 2. Monthly or less 3. Two to four times a month 4. Two to three times a week 5. Four or more times a week   99. Not documented | 0,1,2,3,4,99  If 0, auto-fill audc2 and audc3 as 95 | AUDIT-C Question #1 = “How often did you have a drink containing alcohol in the past year?” Each answer is associated with the following scores:   * Never 🡪 0 * Monthly or less🡪 1 * Two to four times a month 🡪 2 * Two to three times a week 🡪 3 * Four or more times a week 🡪 4 * Not documented 🡪 99   Answers to Question #1 of the AUDIT-C are scored as indicated. 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. |
| 48 | audc2 | Enter the score documented for AUDIT-C Question #2 in the past year.  “How many drinks containing alcohol did you have on a typical day when you were drinking in the past year?”   1. 0, 1 or 2 drinks 2. 3 or 4 3. 5 or 6 4. 7 to 9 5. 10 or more   95. Not applicable  99. Not documented | 0,1,2,3,4,95,99  Will be auto-filled as 95 if audc1 = 0 | AUDIT-C Question #2 = “How many drinks containing alcohol did you have on a typical day when you were drinking in the past year?” Each answer is associated with the following scores:   * 0 drinks 🡪 0 * 1 or 2 drinks 🡪 0 * 3 or 4 drinks 🡪 1 * 5 or 6 drinks 🡪 2 * 7 to 9 drinks 🡪 3 * 10 or more drinks 🡪 4 * Not documented 🡪 99   Answers to Question #2 of the AUDIT-C are scored as indicated. 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. |
| 49 | audc3 | Enter the score documented for AUDIT-C Question #3 in the past year.  “How often did you have six or more drinks on one occasion in the past year?”   1. Never 2. Less than monthly 3. Monthly 4. Weekly 5. Daily or almost daily   95. Not applicable  99. Not documented | 0,1,2,3,4,95,99  Will be auto-filled as 95 if audc1 = 0 | AUDIT-C Question #3 = “How often did you have six or more drinks on one occasion in the past year  Each answer is associated with the following scores:   * Never 🡪 0 * Less than monthly 🡪 1 * Monthly 🡪 2 * Weekly 🡪 3 * Daily or almost daily 🡪 4 * Not documented 🡪 99   Answers to Question #3 of the AUDIT-C are scored as indicated. 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 #3 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 | alcscor | Enter the total AUDIT-C score documented within the past year in the medical record. | \_\_ \_\_  Abstractor may enter default zz if the total score of the AUDIT-C is not documented in the record.  If scrnaudc = 1 valid values = 0-12. | **The abstractor may not enter the total AUDIT-C score calculated from the questions if it is NOT documented in the record.**  If the total score is not documented in the record, enter default zz.  If scrnaudc =2, the computer will auto-fill alcscor as zz. |
| **If alcscor or [sum of values in AUDC1 + AUDC2 + AUDC3 (excluding values of 95 and 99)] is >= 5, go to alcbai; else go to deptxyr** | | | | |
| 51 | alcbai  alcbai3  albai3dt  alcbai4  albai4dt  alcbai99 | During the time frame from (Computer to display DTALSCRN to DTALSCRN +14 days), does the record document any of the following components of brief alcohol intervention/counseling for past-year drinkers?  **Indicate all that apply and the date brief alcohol intervention/counseling was noted in the record:**  3. Advised/informed patient to abstain **OR** explicitly advised/informed patient to drink within recommended limits  4. Provided personalized feedback regarding relationship of alcohol to the patient’s specific health issues **OR**  general alcohol-related intervention/counseling (not linked to patient’s issues)  99. No alcohol intervention/counseling documented | 3,4,99  alcbai3 -1 or <>  mm/dd/yyyy    alcbai4 -1 or <>  mm/dd/yyyy   |  | | --- | | >= dtalscrn and  < = dtalscrn + 14 days | | **Assess the medical record for documentation of the following components of brief alcohol intervention/counseling. The intervention/counseling must have occurred within 14 days since the alcohol screening referenced in question SCRNAUDC.**   * **Alcbai3** – **Advised/informed patient to abstain from alcohol OR explicitly advised patient to drink within specified recommended limits.** Recommended limits are: < 14 drinks a week and < 4 drinks per occasion for men, and < 7 drinks a week and < 3 drinks per occasion for women. * **Alcbai4** – **Provided personalized alcohol feedback to patient on relationship of alcohol use to his/her health OR provided general intervention/counseling on alcohol use and health risks.**   + Personalized feedback: This can include the relation or interaction of alcohol use with any of the patient’s: (1) medical problems (hypertension, CHF, cirrhosis, hepatitis, etc.); (2) medications; (3) mental health diagnoses or concerns (for example depression or PTSD), (4) current life problems explicitly linked to alcohol use (e.g. a note that patient was counseled that alcohol use was impacting his relationship or legal problems), and/or (5) patient’s health worries/concerns: breast cancer, dementia, falls; **OR** * General intervention/counseling: Documentation indicates a general handout or information about alcohol use and health risks was given to the patient.   **Acceptable provider:** For a “provider” to be deemed acceptable to perform brief alcohol intervention/counseling, he/she must be a MD/DO, Licensed Psychologist (PhD/PsyD), LCSW, LCSW-C, LMSW, LISW, LMFT, LPC, LPMHC, APRN (NP/CNS), RN, PA, MS Level counselor, addictions therapist, clinical pharmacist (RPH/PharmD), clinical pharmacy specialist, mental health pharmacist, or rehabilitation counselor.  A trainee with appropriate co-signature, or other allied health professional who by virtue of educational background AND approved credentialing, privileging, and/or scope of practice, has been determined by the facility to be capable of brief alcohol intervention/counseling, may perform the intervention/counseling.  **Cont’d next page**  **Brief alcohol intervention/counseling cont’d**  LPNs are *not* an acceptable provider.   * **Brief alcohol intervention/counseling by telephone or clinical video telehealth (CVT) is permitted if documented by a health care provider as defined immediately above.** * Enter the date of the progress note or encounter date.   **Cerner suggested data sources:** Form browser and select AUDIT-C follow up form |
|  |  | **Depression** |  |  |
| 52 | deptxyr | 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:  **F01.51, F32.0 - F32.5, F32.81, F32.89,**  **F32.9, F32.A, F33.0 - F33.3, F33.40 - F33.42, F33.8, F33.9, F34.1, F34.81, F34.89, F43.21, F43.23, F53.0, F53.1, O90.6, O99.340 – O99.345**  1. Yes  2. No | 1,2  If 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:**   * **F01.51, F32.0 - F32.5, F32.81, F32.89, F32.9, F32.A,**   **F33.0 - F33.3, F33.40 - F33.42, F33.8, F33.9, F34.1, F34.81, F34.89, F43.21, F43.23, F53.0, F53.1, O90.6, O99.340 – O99.345**   * 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 encounters (face to face, clinical video telehealth, telephone), outpatient encounters (face to face, clinical video telehealth, telephone), ED encounters, and inpatient admission.   **Cerner suggested data sources:** Diagnoses and problems/documentation – search diagnoses and problems for applicable code and verify use during the past year in Coding Summary found in Documentation |
| 53 | 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/yyyy  Will be auto-filled as 99/99/9999 if  deptxyr = 2  If deptxyr = 1, go to ptsdx   |  | | --- | | < = 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. |

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| 54 | bpdxyr | 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:  **F30.10 – F30.13, F30.2 – F30.4, F30.8, F30.9, F31.0, F31.10 – F31.13, F31.2, F31.30 – F31.32, F31.4, F31.5, F31.60 – F31.64, F31.70 – F31.78, F31.81, F31.89, F31.9**  1. Yes  2. No | 1,2  **If 2, go to scrnphq2** | **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:**   * **F30.10 – F30.13, F30.2 – F30.4, F30.8, F30.9, F31.0, F31.10 – F31.13, F31.2, F31.30 – F31.32,**   **F31.4, F31.5, F31.60 – F31.64, F31.70 – F31.78,**  **F31.81, F31.89, F31.9**   * 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 encounters (face to face, clinical video telehealth, telephone), outpatient encounters (face to face clinical video telehealth, telephone), ED encounters, and inpatient admission.   **Cerner suggested data sources:** Diagnoses and problems/documentation – search diagnoses and problems for applicable code and verify use during the past year in Coding Summary found in Documentation |
| 55 | 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/yyyy  **If bpdxyr = 1, go to ptsdx**   |  | | --- | | < = 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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|  |  | **Depression Screening** |  |  |
| 56 | scrnphq2 | During the past year was the patient screened for depression by the **PHQ-2**?  1. Yes  2. No  98. Patient refused depression screening by the PHQ-2 | 1,2,98  **If 2 or 98, go to**  **scrnphq9** | **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.”  Documentation of the stem time frame (i.e., over the past 2 weeks) in the questions is not required at this time.  **Acceptable setting for depression screening**: HBPC encounter, outpatient encounter, screening by telephone, and clinical video telehealth (CVT), inpatient hospitalization |
| 57 | phq2dt | Enter the date of the most recent screening for depression by the **PHQ-2**. | mm/dd/yyyy   |  | | --- | | < = 1 year prior to or = stdybeg and  < = stdyend | | **The date refers to the date of the signature on the encounter note.**  Enter the exact date. The use of 01 to indicate missing month or day is not acceptable. |
| 58 | ph1scor | Enter the score for PHQ-2 Question 1 documented in the record:  **Over the past 2 weeks, have you been bothered by little interest or pleasure in doing things?**  0. Not at all → 0  1. Several days → 1  2. More than half the days → 2  3. Nearly every day → 3  99. No answer documented | 0,1,2,3,99 | **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 → 0  Several days → 1  More than half the days → 2  Nearly 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.** |
| 59 | ph2scor | Enter the score for PHQ-2 Question 2 documented in the record:  **Over the past 2 weeks, have you been bothered by feeling down, depressed, or hopeless?**  0. Not at all → 0  1. Several days → 1  2. More than half the days → 2  3. Nearly every day → 3  99. No answer documented | 0,1,2,3,99 | **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 → 0  Several days → 1  More than half the days → 2  Nearly 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.** |
| 60 | phqtotal | 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**  If (ph1scor = 3 OR ph2scor = 3) OR [sum (exclude values >3) of ph1scor and ph2scor] = >=3, go to deplan; else go to ptsdx | * **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.** * **A positive score for the PHQ-2 is 3 or greater.** * If no total score is documented in the record, enter default z. |
| 61 | scrnphq9 | During the past year was the patient screened for depression by the **PHQ-9**?  1. Yes  2. No  98. Patient refused depression screening by the PHQ-9 | 1,2,98  If 2 or 98, go to ptsdx | **PHQ-9 = Patient Health Questionnaire (9 questions - scaled)** “Over the past two weeks, have you often 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 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. Thoughts that you would be better off dead, or of hurting yourself 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?   **Acceptable setting for depression screening:** outpatient encounter, screening by telephone, and clinical video telehealth (CVT) , inpatient hospitalization  **Cerner suggested data sources**: Form browser and select depression screening |
| 62 | phq9ques | Did the record document the patient’s responses to all 9 questions of the PHQ-9?  1. Yes  2. No | 1,2 | **Answer key to each of the nine questions on the PHQ-9 is as follows:**  Not at all → 0  Several days → 1  More than half the days → 2  Nearly every day → 3  **In order to answer “1,” the record must document the patient’s responses to all 9 questions on the PHQ-9.** |
| 63 | phq9dt | Enter the date of the most recent screening for depression by the PHQ-9. | mm/dd/yyyy   |  | | --- | | < = 1 year prior to or = stdybeg and  <=stdyend | | **The date refers to the date of the signature on the encounter note. Enter the exact date. The use of 01 to indicate missing month or day is not acceptable** |
| 64 | ph9total | Enter the total score of the PHQ-9 documented in the record. | \_\_\_  Whole numbers only  0 to 27  Abstractor can enter zz  If >=3, go to deplan; else go to ptsdx | 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.   |  |  | | --- | --- | | 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 total score is not documented in the record, enter default zz.** |

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|  |  | **Depression Disposition** |  |  |
| 65 | deplan | During the time frame from (if scrnph2=1, computer to display phq2dt + 14 days; else computer to display phq9dt + 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. Yes  2. No  98. 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 should indicate follow-up related to the positive PHQ-2 and 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 (e.g., completion of a full PHQ-9 is acceptable) * 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   **Suggested data sources:** HBPC progress note including the note in which positive PHQ-2 was documented or subsequent notes by PCP, RN, psychologist, psychiatrist, or social worker within 14 days after the positive PHQ-2 screen, mental health consultation |
|  |  | **Screening for PTSD** |  |  |
| 66 | ptsdx | 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:  **F43.1, F43.10 - F43.12**  1. Yes  2. No | 1,2  **If 2, go to pmilsepdt** | **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:**   * + **F43.1, F43.10 - F43.12** * 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 HBPC encounters (face to face, clinical video telehealth, telephone) outpatient encounters (face to face, clinical video telehealth, telephone), ED encounters, and inpatient admission.   **Cerner suggested data sources:** Diagnoses and problems/documentation – search diagnoses and problems for applicable code and verify use during the past year in Coding Summary found in Documentation |
| 67 | recptsdt | 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 vacssrs**   |  | | --- | | < = 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. |
| 68 | pmilsepdt | **Computer will pre-fill** the date of military service separation from the pull list. | mm/dd/yyyy  **Computer pre-fill**  **Cannot modify**  **If blank, go to milsepdt**   |  | | --- | | > = 01/01/1930 and < = stdyend | | Computer will pre-fill the date of military service separation from the pull list. |
| 69 | valsepdt | Is (computer to display pmilsepdt) the most recent service separation date documented in the record?  1. Yes 2. No | 1,2  If 1, go to pcptsd5 | * **If the facility has installed the latest clinical reminder, the service separation 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.** * If the service separation date in the medical record is the same as the prefilled date, select value 1. * If the service separation date in the medical record does not match the prefilled date, enter value 2. |
| 70 | milsepdt | Enter the veteran’s most recent date of separation from active military duty. | mm/dd/yyyy   |  | | --- | | > = 01/01/1930 and < = stdyend |   **Abstractor can enter 99/99/9999 if date of separation cannot be found** | * **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 date of military separation cannot be found, the abstractor can enter default 99/99/9999   **Cerner suggested data sources**: Joint Longitudinal Viewer (JLV) then demographics widget and select Military Service link for date of separation (DOS) |
| 71 | pcptsd5 | During the time frame from (computer to display stdybeg – 5 years to stdyend), was the patient screened for PTSD using the Primary Care PTSD5 (PC-PTSD5)?  1. Yes  2. No  98. Patient refused screening by the PC-PTSD5 | 1,2, 98  If 2 or 98, go to scrptsd5i9 | **NOTE: For PTSD screening completed on or after 1/01/2021, the VHA will only accept screening completed with the PC-PTSD5.**  **The PC-PTSD5 screen begins with an item to assess whether the veteran has had any exposure to traumatic events:**  Sometimes things happen to people that are unusually or especially frightening, horrible, or traumatic. For example:   * + a serious accident or fire   + a physical or sexual assault or abuse   + an earthquake or flood   + a war   + seeing someone be killed or seriously injured   + having a loved one die through homicide or suicide. * **Have you ever experienced this kind of event? Yes/No**   **Note: Due to an issue with the PC-PTSD5 screen clinical reminder, the lead in traumatic event question may include “IN THE PAST MONTH” at the beginning or end of the question AND/OR a different term to describe the event.**For example, documentation of either of the following is acceptable:  “IN THE PAST MONTH, have you ever had any experience that was so frightening, horrible or traumatic” OR “Have you ever had any experience that was so frightening, horrible or upsetting that, IN THE PAST MONTH, you”.  **If the veteran denies exposure, the PC-PTSD5 is complete with a score of 0.**  **If the veteran indicates he/she has experienced a traumatic event in the past, five additional yes/no questions will be asked.**  **In the past month, have you:**  1. Had nightmares about the event(s) or thought about the event(s) when you did not want to?  2. Tried hard not to think about the event(s) or went out of your way to avoid situations that remind you of the event(s)?  3. Been constantly on guard, watchful, or easily startled?  4. Felt numb or detached from people, activities, or your surroundings?  5. Felt guilty or unable to stop blaming yourself or others for the event(s) or any problems the event(s) may have caused?  **Cont’d next page**  **NOTE:** “In the past month” may precede each question.  **The PC-PTSD5 screen must be documented in a clinic/progress note.**  **Acceptable setting for PTSD screening: HBPC encounter,** outpatient encounter, screening by telephone, and clinical video telehealth (CVT), inpatient hospitalization |
| 72 | pcptsd5dt2 | Enter the date of the most recent screen for PTSD using the PC-PTSD5. | mm/dd/yyyy  If pcptsd5dt2 >12/31/2020, go to traumevt   |  | | --- | | <= 5 years prior to or = stdybeg and  < = stdyend | | Enter the date of the most recent screen for PTSD using the PC-PTSD5.  The date refers to the date of the signature on the encounter note. The use of 01 to indicate missing month or day is not acceptable. |
| 73 | scrptsd5i9 | During the time frame from (computer to display stdybeg – 5 years to 12/31/2020), was the patient screened for PTSD using the Primary Care PTSD5 +I9?  1. Yes  2. No  98. Patient refused screening by the PC-PTSD5 +I9 | 1,2,98  If 2 or 98 and pcptsd5 = 2 or 98, go to vacssrs; else if 2 or 98, go to traumevt | **NOTE:** For PTSD screening completed on or after 01/01/2021, the VHA will only accept screening completed with the PC-PTSD5.  **The PC-PTSD5 +I9 is a five item screen plus item 9 of the**  **PHQ-9. The PC-PTSD5 + I9 screen must be documented in a clinic/progress note.**  **The PC-PTSD5 +I9 screen begins with an item to assess whether the veteran has had any exposure to traumatic events:**  Sometimes things happen to people that are unusually or especially frightening, horrible, or traumatic. For example:   * + a serious accident or fire   + a physical or sexual assault or abuse   + an earthquake or flood   + a war   + seeing someone be killed or seriously injured   + having a loved one die through homicide or suicide. * **Have you ever experienced this kind of event? Yes/No**   **If the veteran denies exposure, the PC-PTSD5 is complete with a score of 0.**  **If the veteran indicates he/she has experienced a traumatic event in the past, five additional yes/no questions will be asked.**  **In the past month, have you:**  1. Had nightmares about the event(s) or thought about the event(s) when you did not want to?  2. Tried hard not to think about the event(s) or went out of your way to avoid situations that remind you of the event(s)?  3. Been constantly on guard, watchful, or easily startled?  4. Felt numb or detached from people, activities, or your surroundings?  5. Felt guilty or unable to stop blaming yourself or others for the event(s) or any problems the event(s) may have caused?  **“Item 9” or question #6 of this instrument:** 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?  Answers to Item 9 (or question 6) are scaled, ranging from “not at all” to “nearly every day.”  **Item 9 (or question 6) must be included as part of the PC-PTSD5 + I9 tool.**  **Cont’d next page**  **PC-PTSD5 +I9 cont’d**  **Acceptable setting for PTSD screening:** HBPC encounter,outpatient encounter, screening by telephone, and clinical video telehealth (CVT), inpatient hospitalization |
| 74 | pcptsd5dt | Enter the date of the most recent screen for PTSD using the PC-PTSD5+ I9. | mm/dd/yyyy   |  | | --- | | <= 5 years prior to stdybeg and < = 12/31/2020 | | Enter the date of the most recent screen for PTSD using the PC-PTSD5 +I9.  The date refers to the date of the signature on the encounter note.  The use of 01 to indicate missing month or day is not acceptable. |
| 75 | traumevt | Enter the response documented in the record for PC-PTSD5 exposure to traumatic event(s).  **Sometimes things happen to people that are unusually or especially frightening, horrible, or traumatic. For example:**   * a serious accident or fire * a physical or sexual assault or abuse * an earthquake or flood * a war * seeing someone be killed or seriously injured * having a loved one die through homicide or suicide.   **Have you ever experienced this kind of event?**  1. Yes  2. No  99. Response not documented | 1,2,99  **If 2** or  **99, go to vacssrs** | **The PC-PTSD5 screen must be documented in a clinic/progress note.**  **The PC-PTSD5 is a five item screen. The screen begins with an item to assess whether the veteran has had any exposure to traumatic events:**  Sometimes things happen to people that are unusually or especially frightening, horrible, or traumatic. For example:   * a serious accident or fire * a physical or sexual assault or abuse * an earthquake or flood * a war * seeing someone be killed or seriously injured * having a loved one die through homicide or suicide.   **Have you ever experienced this kind of event? Yes/No**  **If the veteran denies exposure, the PC-PTSD5 is complete with a score of 0.**  **Documentation of examples of traumatic events is not required.**  **If no response is documented, enter “99”.** |
| 76 | scrptsd1  scrptsd2  scrptsd3  scrptsd4  scrptsd5 | Enter the patient’s answers to each of the PC-PTSD5 Screen questions: **In the past month, have you:**  1. Had nightmares about the event(s) or thought about the event(s) when you did not want to?  2. Tried hard not to think about the event(s) or went out of your way to avoid situations that remind you of the event(s)?  3. Been constantly on guard, watchful, or easily startled?  4. Felt numb or detached from people, activities, or your surroundings?  5. Felt guilty or unable to stop blaming yourself or others for the event(s) or any problems the event(s) may have caused?  1. Yes  2. No  99. Response not documented | 1,2,99 | **The PC-PTSD5 screen must be documented in a clinic/progress note.**  **NOTE: “In the past month” may precede each question.**  **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.”** |
| 77 | scorptsd5 | Enter the total score for the PC-PTSD5 screen documented in the record. | \_\_\_  **Abstractor can enter default z if no total score is documented**   |  | | --- | | Whole numbers  0 – 5 |   If (scorptsd5 >= 4) or  [sum (exclude values > 1) of scrptsd1,  scrptsd2, scrptsd3, scrptsd4, and scrptsd5 >=4, go to ptsdeval; else  go to vacssrs | * **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 more than one PTSD screen was performed on the date of the most recent screening AND any PTSD screen was positive, enter the total score for the positive PTSD screen.** * **A positive PTSD screening is a score of 4 or greater.** * If the total score is NOT documented in the record, enter default z. |
| 78 | ptsdeval | On (if pcptsd5dt and pcptsd5dt2 are valid, computer to display most recent date; else display valid pcptsd5dt or pcptsd5dt2), did the provider document the patient needed further intervention for the positive PTSD screen?1. Yes, documented further intervention needed2. Documented no further intervention needed98. Documented patient refused further intervention for positive PTSD screen99. No documentation regarding further intervention | 1,2,98,99  If 2, 98 or 99, go  to vacssrs | **Acceptable Provider:** MD, DO, Licensed Psychologist (PhD/PsyD), LCSW, LCSW-C, LMSW, LISW, LMFT, LPMHC, APRN (NP/CNS), PA, Clinical Pharmacist (RPH/PharmD), clinical pharmacy specialist, mental health pharmacist, or rehabilitation counselor. Trainee in any of these categories with appropriate co-signature is acceptable.  If the provider documented that the patient needed further intervention for PTSD, select “1.”  For example, provider documents, “PC-PTSD screen positive. Patient reports having difficulty sleeping and is very anxious. Needs mental health evaluation.” Select “1.”  If the provider documented that no further intervention was needed for PTSD, select “2.” For example, clinician documents, “PC-PTSD positive, but no problems with day-to-day functioning reported by patient No further intervention necessary.” Select “2.”  If there is no documentation by the provider regarding whether the patient needed further intervention, select “99.” |
| 79 | ptsfolint1 ptsfolint2  ptsfolint3  ptsfolint4 ptsfolint5 ptsfolint7 ptsfolint99 | On (if pcptsd5dt and pcptsd5dt2 are valid, computer to display most recent date; else display valid pcptsd5dt or pcptsd5dt2), select the further intervention(s) documented by the provider as follow-up to the positive PTSD screen:**Indicate all that apply:**1. Documented the patient is already receiving treatment for PTSD2. Documented the patient is receiving care for PTSD outside VHA3. Documented referral/consult for stat/emergent mental evaluation was placed4. Documented referral/consult for routine/non-emergent mental health evaluation was placed/will be placed5. Documented the patient’s PTSD will be managed in Primary Care7. Documented emergency contact information was provided to the patient99. None of the above documented | 1,2,3,4,5,7,99  Cannot enter 99 with any other number   |  | | --- | | Warning if 99 | | On the same date as the positive PTSD screen, please indicate all further interventions documented by the provider.  Acceptable Provider: MD, DO, Licensed Psychologist (PhD/PsyD) , LCSW, LCSW-C, LMSW, LISW, LMFT, LPMHC, APRN (NP/CNS), PA, Clinical Pharmacist (RPH/PharmD), clinical pharmacy specialist, mental health pharmacist, or rehabilitation counselor. Trainee in any of these categories with appropriate co-signature is acceptable.  If none of the interventions are documented, enter 99. |
| 80 | vacssrs | During the past year, did an acceptable provider complete the Columbia-Suicide Severity Rating Scale (C-SSRS) Screener?1. Yes2. No98. Patient refused to complete the C-SSRS Screener | 1,2,98  If 2 or 98, go to vacsre | **Note: On or after 1/01/2021, the C-SSRS Screener must be completed annually for all veterans.**  **The acceptable provider asks the patient questions 1 and 2 of the C-SSRS Screener:**  1) Have you wished you were dead or wished you could go to sleep and not wake up?  2) Have you had any actual thoughts of killing yourself?  If YES to 2, provider asks questions 3, 4, 5, and 7. If NO to 2, go directly to question 7.  3) Have you been thinking about how you might do this? e.g. “I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it….and I would never go through with it.”  4) Have you had these thoughts and had some intention of acting on them? as opposed to “I have the thoughts but I definitely will not do anything about them.”  5) Have you started to work out or worked out the details of how to kill yourself? **If YES, ask:**  6) Do you intend to carry out this plan?  7) Have you ever done anything, started to do anything, or prepared to do anything to end your life?   * Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn’t swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn’t jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc. * If YES, ask:   8) Was this within the past 3 months?   * The C-SSRS Screener can be performed face-to-face, by CVT, or by telephone as long as the provider – patient exchange is documented in the medical record and accurately reflects the encounter.   **Cont’d next page** |
|  |  |  |  | **CSSR-S cont’d**   * **Acceptable Provider**:  |  |  | | --- | --- | | Addiction Therapist | Occupational Therapist (OT) | | Advanced Practice Registered Nurse (APRN): NP/CNS | Peer Support Specialist | | \*Clinical Pharmacy Specialist | Physical Therapist (PT) | | Kinesiotherapist (KT) | Physician (MD/DO), Medical Residents | | Licensed Clinical Social Worker (LCSW) | Physician Assistant (PA) | | Licensed Independent Social Worker (LISW) | Psych Tech (psychometrician) | | Licensed Marriage and Family Therapist (LMFT) | Registered Nurse (RN) | | Licensed Master of Social Work (LMSW) | Rehabilitation Counselor | | Licensed Practical Nurse (LPN) | Respiratory Therapist (RT) | | Licensed Professional Mental Health Counselor (LPMHC) | Unlicensed Assistive Personnel Health Tech, Medical Assistant, Nursing Assistant) | | Licensed Psychologist (PhD/PsyD) | Vocational Rehabilitation Specialist | | Medical Instrument Technologist (MIT) |  |   Trainee in ANY of these categories may complete a C-SSRS Screener with appropriate co-signature.  **\*Exclude clinical pharmacy specialist performing anticoagulation only.**  Suggested sources: progress notes, ED notes, H&P, consultation, Clinical Reminder |
| 81 | vacssrsdt | Enter the most recent date the C-SSRS Screener was completed. | mm/dd/yyyy   |  | | --- | | <= 1year prior to or = stdybeg and <= stdyend | | Enter the most recent date the C-SSRS Screener was completed. |
| 82 | vacssrs1 | Enter the score for C-SSRS Screener Question 1 documented in the record: (Time period designated, e.g. Over the past month) Have you wished you were dead or wished you could go to sleep and not wake up?1. Yes2. No99. Score not documented | 1,2,99 | The score for the C-SSRS Screener question 1 is “yes” or “no”. Enter the score as documented in the medical record. This item must be completed and cannot be left blank.  If the C-SSRS Screener score for question 1 is not documented in the record, enter “99”. |
| 83 | vacssrs2 | Enter the score for C-SSRS Screener Question 2 documented in the record: (Time period designated, e.g. Over the past month) Have you had any actual thoughts of killing yourself?1. Yes2. No 99. Score not documented | 1,2,99  If 2, auto-fill vacssrs3 as 95 and go to vacssrs7 | The score for the C-SSRS Screener question 2 is “yes” or “no”. Enter the score as documented in the medical record. This item must be completed and cannot be left blank  If the C-SSRS Screener score for question 2 is not documented in the record, enter “99”. |
| 84 | vacssrs3 | Enter the score for C-SSRS Screener Question 3 documented in the record: (Time period designated, e.g. Over the past month) Have you been thinking about how you might do this?1. Yes2. No95. Not applicable99. Score not documented | 1,2,95,99  Will be auto-filled as 95 if vacssrs2 = 2 | The score for the C-SSRS Screener question 3 is “yes” or “no”. Enter the score as documented in the medical record. If “yes” to question 2, this item must be completed.  If “no” to question 2, this item DOES NOT have to be completed.  If the C-SSRS Screener score for question 3 is not documented in the record, enter “99”. |
| 85 | vacssrs4 | Enter the score for C-SSRS Screener Question 4 documented in the record: (Time period designated e.g., Over the past month) Have you had these thoughts and had some intention of acting on them?1. Yes2. No99. Score not documented | 1,2,99 | The score for the C-SSRS Screener question 4 is “yes” or “no”. Enter the score as documented in the medical record. If “yes” to question 2, this item must be completed.  If “no” to question 2, this item DOES NOT have to be completed.  If the C-SSRS Screener score for question 4 is not documented in the record, enter “99”. |
| 86 | vacssrs5 | Enter the score for C-SSRS Screener Question 5 documented in the record: (Time period designated e.g., Over the past month) Have you started to work out or worked out the details of how to kill yourself?1. Yes2. No99. Score not documented | 1,2,99  If 2, auto-fill vacssrs6 as 95 and go to vacssrs7 | The score for the C-SSRS Screener question 5 is “yes” or “no”. Enter the score as documented in the medical record. If “yes” to question 2, this item must be completed.  If “no” to question 2, this item DOES NOT have to be completed.  If the C-SSRS Screener score for question 5 is not documented in the record, enter “99”. |
| 87 | vacssrs6 | Enter the score for C-SSRS Screener Question 6 documented in the record: Do you intend to carry out this plan?1. Yes2. No95. Not applicable 99. Score not documented | 1,2,95,99  Will be auto-filled as 95 if vacssrs5 = 2 | The score for the C-SSRS Screener question 6 is “yes” or “no”. Enter the score as documented in the medical record. If “yes” to question 5, this item must be completed.  If “no” to question 2 or 5, this item does not have to be completed.  If the C-SSRS Screener score for question 6 is not documented in the record, enter “99”. |
| 88 | vacssrs7 | Enter the score for C-SSRS Screener Question 7 documented in the record: In your lifetime, have you ever done anything, started to do anything, or prepared to do anything to end your life?1. Yes2. No 99. Score not documented | 1,2,99  If 2 or 99, auto-fill vacssrs8 as 95 and go to cssrsout as applicable | The score for the C-SSRS Screener question 7 is “yes” or “no”. Enter the score as documented in the medical record. This item must be completed and cannot be left blank.  If the C-SSRS Screener score for question 7 is not documented in the record, enter “99”. |
| 89 | vacssrs8 | Enter the score for C-SSRS Screener Question 8 documented in the medical record: Was this within the past 3 months?1. Yes2. No95. Not applicable 99. Score not documented | 1,2,95,99  Will be auto-filled as 95 if vacssrs7 = 2 or 99 | The score for the C-SSRS Screener question 8 is “yes” or “no”. Enter the score as documented in the medical record.  If “yes” to question 7, this item must be completed.  If “no” to question 7, this item does not have to be completed.  If the C-SSRS Screener score for question 8 is not documented in the record, enter “99”. |
| **If (vacssrs3, vacssrs4, vacssrs5, or vacssrs8 = 1, auto-fill cssrsout=1 AND go to adminpt) OR if ((vacssrs2 = 2 or (vacssrs3 = 2 and vacssrs4 = 2 and vacssrs5 = 2)) and (vacssrs7 = 2 or vacssrs8 = 2)), auto-fill cssrsout = 2 and go to bnmrtrns; else go to cssrsout** | | | | |
| 90 | cssrsout | Enter the interpretation of the C-SSRS Screener as documented in the medical record.1. Positive2. Negative 99. No interpretation documented | 1,2,99  If 1, go to adminpt, else go to **bnmrtrns**  Will be auto-filled as 1 if vacssrs3, vacssrs4, vacssrs5 or vacssrs8 = 1  Will be auto-filled as 2 if ((vacssrs2 = 2) or (vacssrs3, vacssrs4, and  vacssrs5 = 2) and  ((vacssrs7 = 2 or vacssrs8 = 2)) | **NOTE**: Due to an issue with the outcome being passed from the Clinical Reminder to the note, a positive or negative outcome will be auto-filled based on the answers to any of the questions above.  If there was no interpretation of the screening outcome of the C-SSRS Screener, enter “99.”  Any of the following would result in a positive Columbia Screen:   * YES to Question 3: Have you been thinking about how you might do this? (Time period over the past month) OR * YES to Question 4: Have you had these thoughts and had some intention of acting on them? (Time period over the past month) OR * YES to Question 5: Have you started to work out or worked out the details of how to kill yourself? (Time period over the past month) OR * YES to Question 8: Was this within the past 3 months? |
| 91 | adminpt | On (computer to display vacssrsdt), the same calendar day as the positive C-SSRS, is there evidence the patient was admitted to inpatient or residential treatment for mental health care?  1. Yes 2. No | 1,2  **If 1, go to bnmrtrns** | **If the provider that completed the C-SSRS admits the patient to inpatient or residential treatment for mental health OR sends the patient to the Emergency Department for inpatient admission, select value 1.** |
| 92 | vacsre | On (if vacssrs = 1, computer to display vacssrsdt; else display, During the past year), is there evidence of a signed Comprehensive Suicide Risk Evaluation (CSRE) in the record?1. Yes2. No98. Patient refused to complete CSRE | 1,2,98  If 1 and vacssrs = 1,  auto-fill vacsredt = vacssrsdt and go to csreacu; else if 1, go to vacsredt  If 2 or 98, go to bnmrtrns | **Note: The CSRE must be completed by an acceptable provider and signed on the same calendar date as the positive Columbia-Suicide Severity Rating Scale (C-SSRS) screener. If a C-SSRS was not performed, look for evidence of a signed CSRE during the past year.**  The note title for the CSRE may be labeled Suicide Risk Evaluation-Comprehensive.   * CSRE can be performed face-to-face, by clinical video telehealth (CVT), or by telephone as long as the acceptable provider – patient exchange is documented in the medical record and accurately reflects the encounter.   **Acceptable Provider:**   |  |  | | --- | --- | | Advanced Practice Registered Nurse (APRN): NP/CNS | Licensed Professional Mental Health Counselor (LPMHC) | | Clinical Pharmacy Specialist (mental health) | Licensed Psychologist (PhD/PsyD) | | Licensed Clinical Social Worker (LCSW) | Physician (MD/DO) | | Licensed Independent Social Worker (LISW) | Physician Assistant (PA) | | Licensed Marriage and Family Therapist (LMFT) | Rehabilitation Counselor holding state licensure and included in local bylaws as independent practitioner | | Licensed Master of Social Work (LMSW) |  |   Trainee in ANY of these categories may complete a CSRE with appropriate co-signature.  **Note:** RNs are not an acceptable provider. Nor is LPN, Addiction Therapist, Clinical Pharmacy Specialist (Other), Kinesiotherapist, Medical Instrument Technologist, Occupational Therapist, Peer Support Specialist, Physical Therapist, Psych Tech, Rehabilitation Counselor without state licensure and not included in bylaws as independent practitioner, Respiratory Therapist, Vocational Rehabilitation Specialist, or Unlicensed Assistive Personnel, including Health Tech, Medical Assistant and Nursing Assistant. |
| 93 | vacsredt | Enter the most recent date the CSRE was completed during the past year. | mm/dd/yyyy  If vacsre and vacssrs = 1, will be auto-filled = vacssrsdt   |  | | --- | | <= 1year prior to or = stdybeg and <= stdyend | | Enter the most recent date the CSRE was completed. |
| 94 | csreacu | Enter the Clinical Impression of Acute Risk as documented in the medical record:1. High Risk - (as evidenced by):2. Intermediate Risk – (as evidenced by):3. Low Risk – (as evidenced by):99. Acute risk not documented | 1,2,3,99  If 99, go to csrechr | Only one risk level is selected by the acceptable provider and an explanation is provided in the “as evidenced by section” for that risk level.  Note: This item must be completed and cannot be left blank. |
| 95 | csreatex | Enter the evidence of Acute Risk documented by the acceptable provider.  |  | | --- | |  | | Free text entry | Enter the explanation of Acute Risk as documented in the record by the acceptable provider. |
| 96 | csrechr | Enter the Clinical Impression of Chronic Risk as documented in the medical record:1. High Risk - (as evidenced by):2. Intermediate Risk – (as evidenced by):3. Low Risk – (as evidenced by):99. Chronic risk not documented | 1,2,3,99  If 99, go to csreint1 | Only one risk level is selected by the acceptable provider and an explanation is provided in the as evidenced by section for that risk level.  Note: This item must be completed and cannot be left blank. |
| 97 | csrechrtex | Enter the evidence of Chronic Risk documented by the acceptable provider.  |  | | --- | |  | | Free text entry | Enter the explanation of Chronic Risk as documented in the record by the acceptable provider. |
| 98 | csreint1  csreint2  csreint3  csreint4  csreint5  csreint6  csreint7  csreint8  csreint9  csreint10  csreint11  csreint12  csreint13  csreint14  csreint15  csreint16  csreint17  csreint18  csreint19  csreint20  csreint21  csreint22  csreint23  csreint24  csreint25  csreint26  csreint27  csreint99 | **Please enter the course of action documented in the record from the following list of interventions****General Strategies for Managing Risk in any setting (The provider may add additional comment/interventions as needed.)**  **Select all that apply:**   1. Alert Suicide Prevention Coordinator for consideration of a Patient Record Flag Category I High Risk for Suicide 2. Complete or Update Veteran’s Safety Plan 3. Increased frequency of Suicide Risk Screening [text box] 4. Provide Lethal Means Safety Counseling (e.g., provision of gun locks) 5. Obtain additional information from collateral sources [Optional: comment] 6. For prescribers only: Review of prescribed medications for risk for self-harm and/or new pharmacotherapy intervention to reduce suicide risk (Optional: comment) 7. Address barriers to treatment engagement by: [text box] 8. Address psychosocial needs by: [text box] 9. Address medical conditions by: [text box] 10. Consult/Referral to additional services and support: [text box for options] 11. Referral to evidence based psychotherapy 12. Referral to psychiatry/medication assessment or management 13. Referral to Chaplaincy/pastoral care 14. Referral to vocational rehabilitation/occupational rehabilitation services 15. Referral for PRRC and/or ICMHR services   **Cont’d next page** | 1,2,3,4,5,6,7,8,9,10,11,12,13,14,15,16,17,18,  19,20,21,22,23,24,25,  26,27, 99   |  | | --- | | Hard Edit: If csreint11,12,13,  14,15, or 16 = -1, csreint10  must = -1 | | **Please select all interventions documented by the acceptable provider in the CSRE template.**  The wording in the option does not have to exactly match the intervention in the record; however, the intent must be the same. For example, option 8, provider may document “Updated Veteran’s safety plan.”  The provider may add additional comment/interventions as needed as indicated by [text box].  If the provider does not have any documentation in the text box for the applicable options, do not select that option as an intervention.   * **Acceptable Provider**: For a “provider” to be deemed acceptable to complete the CSRE, he/she must be an MD, DO, Licensed Psychologist (PhD/PsyD), LCSW, LCSW-C, LMSW, LISW, LMFT, LPMHC, APRN (NP/CNS), PA, clinical pharmacist (RPH/PharmD), clinical pharmacy specialist (mental health). Trainee in ANY of these categories may complete a CSRE with appropriate co-signature.   **Note:** RNs are *not* an acceptable provider. Nor is LPN, Addiction Therapist, Peer Support Specialist, or Unlicensed Assistive Personnel, including Health Tech, Medical Assistant and Nursing Assistant. |
|  |  | **Interventions cont’d**  1. Referral for residential mental health services 2. Other Consult submitted to: [text box for user to enter a name] 3. Discussion with Veteran to continue to see assigned Primary Care Provider for medical care 4. Discussion with Veteran regarding enhancement of a sense of purpose and meaning 5. Educate Veteran on smartphone VA applications (e.g. Virtual Hope Box, PTSD Coach) 6. Conduct medication reconciliation 7. Involve family/support system in Veteran’s care 8. Provide Opioid Overdose Education and Naloxone Distribution (OEND) 9. Provide resources/contacts for benefits information 10. Provide Veteran with phone number for Veteran's Crisis Line: 1-800-273-8255 (press 1) 11. Other/Comments: [text box] 12. Obtain consultation from Suicide Risk Management Consultation Program on ways to address Veteran’s risk by sending a request for consultation by email to: Email (Left Click and Allow)   99. No interventions documented by the provider |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  | **Immunizations** |  |  |
| 99 | bnmrtrns | Is there documentation in the medical record the patient had a bone marrow transplant during the past year?  1. Yes  2. No | 1,2  If 1, go to end | **Bone marrow transplant - must be documented the procedure occurred during the past year.** |
| 100 | chemoexc | Is there documentation in the medical record the patient received chemotherapy during the past year?  1. Yes  2. No | 1, 2  If 1, go to end | **Documentation the patient received chemotherapy during the past year excludes the case from the pneumococcal measures.**  **Received chemotherapy:** the abstractor should look for evidence of a diagnosis of cancer and documentation that the patient received some type of chemotherapy for the cancer during the past year.  For example, a PCP note in the appropriate time frame states “Patient is undergoing chemotherapy at XYZ Cancer Center.” or an Oncology note in the appropriate time frame states: “Here today for IV chemo treatment.” |
| 101 | immcomp | At any time in the patient’s history through (computer to display stdyend), is there documentation of any of the following in the medical record?   * Immunocompromising conditions * Anatomic or functional asplenia * Sickle cell disease and HB-S disease * Cerebrospinal fluid leak(s) * Cochlear implant(s)   1. Yes  2. No | 1,2  If 1, go to end | **Individuals with immunocompromising conditions, anatomic or functional asplenia, cerebrospinal fluid leaks, or cochlear implants are excluded from the pneumococcal measures.**   * **Immunocompromising conditions may include but are not limited to:** immunoglobulin deficiencies, antibody deficiencies, other specified immune-deficiencies, graft-versus-host disease, end stage renal disease. (Refer to Table 1-Immunocompromising Conditions.) * **Anatomic or functional asplenia includes** congenital absence of the spleen, surgical removal of the spleen or diseases of the spleen. * **Sickle cell disease** isa group of disorders that affects hemoglobin. Individuals with this disorder have atypical hemoglobin molecules called hemoglobin S (or HB-S) which can distort red blood cells into a sickle shape.   **Suggested Data Sources:** History and Physical, Problem List |
| 102 | ppsvac23 | At any time, not later than the study end date, did the veteran receive the **PPSV23** (**Pneumovax 23®, Pnu-Imune 23®)** or Pneumovax vaccination, either as an inpatient or outpatient?   1. received **PPSV23 (**Pneumovax 23®, Pnu-Imune 23®) or Pneumovax vaccination from VHA 2. received **PPSV23** (Pneumovax 23®, Pnu-Imune 23®) or Pneumovax vaccination from private sector provider   98. patient refused **PPSV23** (Pneumovax 23®, Pnu-Imune 23®) or Pneumovax vaccination 99. no documentation patient received **PPSV23** (Pneumovax 23®, Pnu-Imune 23®) or Pneumovax vaccination | 1,3,98,99  If 98 or 99, go to pcvvac20 | **The intent of this question is to determine if the patient received the pneumococcal polysaccharide vaccine (PPSV23) or Pneumovax vaccination. PPSV23 includes Pneumovax 23® and Pnu-Imune 23®, vaccination.**   * **At a minimum the year of the PPSV23 (Pneumovax 23®, Pnu-Imune 23®) or Pneumovax 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. * If a vaccine administration note during the period from 10/01/2012 to 12/31/2015 states “pneumococcal” vaccine was given with documentation of the manufacturer and lot number and the immunization summary indicates pneumococcal polysaccharide vaccine (PPV23 or PPSV23), select value 1.   Note: Unspecified pneumococcal vaccination documented prior to 10/01/2012 will be captured in a subsequent question.   * Documentation in the Immunization Health Summary (under the reports tab in CPRS) or Joint Longitudinal Viewer (JLV) that the vaccine information was provided by the IZ Gateway IIS. IZ Gateway immunization information must include: * Name of vaccine (e.g., PPSV23) * Date administered: MM/DD/YYYY (e.g., 01/31/2023) * Location will include IZG, state abbreviation (e.g., FL), and IIS. For example, Location: IZG: AZ IIS   Unacceptable:   * Notation in the record that patient has had a PPSV23 (Pneumovax 23®, Pnu-Imune 23®) or Pneumovax vaccination if year of administration is not documented. * Documentation the patient received any other pneumococcal vaccination   **Select value “98” for Patient refusal** where each time it was offered, patient stated he/she does not want the **PPSV23** (Pneumovax 23®, Pnu-Imune 23®) or Pneumovax vaccination. |
| 103 | ppsv23dt | Enter the date of the **PPSV23** (Pneumovax 23®, Pnu-Imune 23®) or Pneumovax vaccination. | mm/dd/yyyy   |  | | --- | | Warning if >15 years prior to stdybeg and <= stdyend | | **At a minimum the year of the PPSV23 (Pneumovax 23®, Pnu-Imune 23®) or Pneumovax vaccination must be documented.**  Enter the exact date of vaccination. If only the year is documented, enter the year with 01 for month and day. |
| 104 | pcvvac20 | On or after 6/08/2021 and not later than the study end date, did the veteran receive the **pneumococcal conjugate 20 (PCV20 or PREVNAR 20™)** vaccination, either as an inpatient or outpatient?  1. received **PCV20** or PREVNAR 20™ vaccination from VHA  3. received PCV20 or PREVNAR 20™ vaccination from private sector provider  98. patient refused PCV20 or PREVNAR 20™ vaccination 99. no documentation patient received PCV20 or PREVNAR 20™ vaccination | 1,3,98,99  If 98 or 99 go to pneunsp | **The intent of this question is to determine if the patient received the PCV20 orPREVNAR 20™ pneumococcal vaccination. Only documentation of the PCV20 or PREVNAR 20™ vaccine is acceptable for this question.**   * At a minimum the year of the PCV20 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. * Documentation in the Immunization Health Summary (under the reports tab in CPRS) or Joint Longitudinal Viewer (JLV) that the vaccine information was provided by the IZ Gateway IIS. IZ Gateway immunization information must include: * Name of vaccine (e.g., PREVNAR 20) * Date administered: MM/DD/YYYY (e.g., 01/31/2023) * Location will include IZG, state abbreviation (e.g., FL), and IIS. For example, Location: IZG: AZ IIS   Unacceptable:   * Notation in the record that patient has had a PCV20 vaccination if year of administration is not documented. * Documentation the patient received any other pneumococcal vaccination * Documentation the patient received a pneumococcal vaccination, but type is unable to be determined   **Select value “98” for Patient refusal** where each time it was offered, patient stated he/she does not want the **PCV20** vaccination. |
| 105 | pcvdt20 | Enter the date of the PCV20 or PREVNAR 20™ vaccination. | mm/dd/yyyy  **If pcvdt20 – birthdt >= 60 yrs, go to end**   |  | | --- | | >= 06/08/2021 and <= stdyend | | Notation in the record that patient has had the PCV20 or PREVNAR 20™ vaccination is not acceptable unless, at a minimum, the year is documented.  **Enter the year if that is the only information known, with 01 for month and day.** |
| 106 | pneunsp | Prior to 10/01/2012, is there documentation in the medical record of an unspecified pneumococcal vaccination?  1. Yes 2. No | 1,2  If 2, go to pneurxn | Select value “1” ***only*** if an unspecified pneumococcal vaccination is documented in the medical record any time before October 1, 2012.  Unspecified pneumococcal vaccination may be represented by the following documentation:   * Pneumococcal vaccine, unspecified formulation (CVX code 109) * The CVX code may be seen in the Joint Longitudinal Viewer (JLV) immunization summary by hovering over the pneumococcal, unspecified formulation hyperlink. |
| 107 | pneunspdt | Enter the date that the unspecified pneumococcal vaccination was given. | mm/dd/yyyy  **If pneunspdt  - birthdt >= 60 yrs) or (valid ppsv23dt – birthdt >= 60 yrs), go to end**   |  | | --- | | > Patient’s DOB and <= 9/30/2012 | | **Hard Edit:** Cannot = valid ppsv23dt  or pcvdt20 | | Enter the exact date that the unspecified pneumococcal vaccination was given.  At a minimum the month and year must be documented.  If the day is unknown enter 01 for the day. |
| 108 | pneurxn | Is there documentation in the medical record of a prior anaphylactic reaction to a pneumococcal vaccine?  1. Yes  2. No | 1,2 | **Prior anaphylactic reaction to a pneumococcal vaccine must be documented in the medical record.**  **Anaphylactic reaction -** Sudden, potentially severe and life-threatening allergic reaction. Symptoms may start with a feeling of uneasiness, tingling sensations and dizziness and rapidly progress to generalized itching and hives, swelling, wheezing and difficulty breathing, and fainting. |