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|  |  | **Organizational Identifiers** |  |  |
|  | VAMCCONTROLQICBEGDTEREVDTE | Facility IDControl NumberAbstractor IDAbstraction Begin DateAbstraction End Date | Auto-fillAuto-fillAuto-fillAuto-fillAuto-fill |  |
|  |  | **Patient Identifiers** |  |  |
|  | SSNFINPTNAMEFPTNAMELBIRTHDTSEXAGERACEETHNICITY | Patient SSNFINFirst NameLast NameBirth DateSexAge RaceEthnicity | Auto-fill: no changeAuto-fill: no changeAuto-fill: no changeAuto-fill: no changeAuto-fill: no changeAuto-fill: can changeCalculate age at STDYBEGAuto-fill: no changeAuto-fill: no change |  |

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| 1 | raceval | Is the prefilled race, (computer display race), the same race documented in demographics in the medical record?1. Yes
2. No
 | 1,2If 1, go to ethnicval; else go to racerec2 | Review the race information documented in demographics tab in the medical record. If the race is the same as the prefilled race, enter value “1”.If the race is not the same as the prefilled race, enter value “2”.**Only acceptable source**: demographics tab |
| 2 | racerec2 | What is the patient’s race documented in the medical record?1. White
2. Black or African American
3. American Indian or Alaska Native
4. Asian
5. Native Hawaiian or Pacific Islander
6. Multi-race (documentation of multiple race such as Black-White, Indian-White, etc.)
7. Not documented or unable to determine (UTD)
 | 1,2,3,4,5,6,7 | **Inclusion guidelines:*** **White:** A person having origins in any of the original peoples of Europe, the Middle East, or North Africa (e.g., German, Irish, English, Italian, Lebanese, Egyptian).
* **Black or African American:** A person having origins in any of the black racial groups of Africa (e.g., Jamaican, Haitian, Nigerian, Ethiopian, Somali, Negro).
* **American Indian or Alaska Native:** A person having origins in any of the original peoples of North America (including Central America) and who maintains tribal affiliation or community attachment (e.g., any recognized tribal entity in North and Central America, Native American).
* **Asian:** A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
* **Native Hawaiian or Pacific Islander:** A person having origins in any of the original peoples of the Hawaii, Guam, Samoa or other Pacific Islands.
* **Multi-race:** Specific documentation of multi (multiple) race or **documentation that indicates the patient is more than one race (e.g., Black-White, Indian-White), select value “6”.**
* Although the terms “Hispanic,” “Latino,” and “Spanish” are actually descriptions of the patient's ethnicity, it is not uncommon to find them referenced as race.
	+ If the patient's race is documented only as Hispanic, Latino, or Spanish, select “White.”
	+ If the race is documented as mixed Hispanic/Latino with another race, use whatever race is given (e.g., Black-Hispanic — select “Black”). Other terms for Hispanic, Latino, or Spanish include Chicano, Cuban, H (for Hispanic), Latin American, Latina, Mexican, Mexican-American, Puerto Rican, and South or Central American.

**Suggested data sources**: CPRS face sheet, demographics |
| 3 | ethnicval | Is the prefilled ethnicity, (computer display ethnicity), the same ethnicity documented in demographics in the medical record?1. Yes
2. No
 | 1,2 | Review the ethnicity information documented in demographics tab in the medical record to determine if it is the same as the prefilled ethnicity. For example, the prefilled ethnicity indicates patient is of Hispanic, Latino, or Spanish ethnicity and the same information is found in demographics; select value “1”.If the ethnicity in demographics is NOT the same as the prefilled ethnicity, enter value “2”. For example, the prefilled ethnicity indicates patient is of Hispanic, Latino, or Spanish ethnicity and the information found in demographics indicates the patient is NOT Hispanic, Latino, or Spanish; select value “2”.**Only acceptable source**: demographics tab |
| 4 | ethnicrec2 | Is there medical record documentation that the patient is of Hispanic, Latino, or Spanish ethnicity?1. Yes
2. No
 | 1,2 | **Hispanic, Latino, or Spanish ethnicity: A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race. The term “Spanish origin” can be used in addition to “Hispanic or Latino.”****Examples:**

|  |  |
| --- | --- |
| * Black-Hispanic
* Chicano
* Columbian
* Dominican
* Ecuadorian
* Guatemalan
* H
* Hispanic
 | * Latin American
* Latino/Latina
* Mexican-American
* Salvadoran
* Spaniard
* Spanish
* White-Hispanic
 |

Ethnicity may be documented as a field in administrative demographic information. Examples:* Ethnicity: Hispanic or Latino; select value “1”.
* Ethnicity: Not Hispanic or Latino; select value “2”.

**Suggested data sources**: CPRS face sheet, demographics, history and physical, progress notes |
| 5 | 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, the case is****excluded** | 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 Immunizations review.**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 **Exclusion statement:** The case is excluded from Immunization review due to hospice enrollment.  |
| **If Mental Health flag = 1, go to othrcare; else go to immcomp2** |
| 6 | othrcare | Is there evidence in the medical record that within the past two years, the patient refused VHA Primary Care and is receiving ONLY his/her primary care in a non­VHA setting?1. Yes2. No**To answer “1,” both evidence of refusal of VHA Primary Care and documentation of primary care received outside VHA must be present in the record.** | \*1,2**\*If 1, the case is excluded** | **There must be specific documentation of patient refusal of VHA Primary Care, and the refusal must have occurred within the past two years**. * **Examples:** record documents that patient does not wish to be seen in VHA Primary Care clinics, prefers to seek care elsewhere, or does not wish to receive care at all unless under emergency circumstances. Documentation of patient statements such as “I only signed up for VA for my MH service-connected condition.” or “My private physician does all my primary care” represent refusal of VHA Primary Care.

**Receiving primary care ONLY in a non-VHA setting**: The patient may be receiving mental health or other specialty care at the VAMC, but his/her primary care during the past two years was received outside VHA. * **Examples:** patient’s medical care is being provided by a primary care provider who does not practice in the VHA system; patient under care of non-VHA specialist who provides his/her primary care; patient receives care from other sources such as free clinics.

**Exclusion statement:** The case is excluded from Immunization review due to patient refusal of VHA Primary Care and documentation patient is receiving primary care in non­VHA setting.  |
| 7 | immcomp2 | During the past year is there documentation of any of the following in the medical record?* Active chemotherapy
* Bone marrow transplant
* Immunocompromising conditions
* Anatomic or functional asplenia
* Sickle cell disease and HB-S disease
* Cerebrospinal fluid leak(s)
* Cochlear implant(s)

1. Yes2. No | \*1,2**\*If 1, the case is excluded** | Select value “1” if there is documentation of any of the following in the medical record during the past year:* The patient is actively receiving chemotherapy. For example, a PCP note in the appropriate timeframe states “Patient is undergoing chemotherapy at XYZ Cancer Center.” or an Oncology note in the appropriate timeframe states: “Here today for IV chemo treatment.” Refer to Table 1 for Chemotherapy encounters or procedures that should be included if found documented in the medical record.
* History of bone marrow transplant
* Documentation of immunocompromising conditions that may include but are not limited to the following: immunoglobulin deficiencies, antibody deficiencies, other specified immune-deficiencies, graft-versus-host disease, end stage renal disease, organ transplants, and transplant rejection/failure. Refer to Table 2 for 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 and HB-S disease is a 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.
* Cerebrospinal fluid leak(s)
* Cochlear implant(s)

**Suggested data sources:** History and Physical, Progress notes, discharge summary, Problem list**Exclusion statement:** The case is excluded from Immunization review due to documentation the patient is immunocompromised. |
| 8 | tdapvac | During the timeframe from (computer to display 8/01/2009 to stdyend), what is the patient's Tdap (tetanus, diphtheria, andacellular pertussis) vaccination status?1. Tdap vaccine administered97. Documentation of: * History anaphylaxis due to Tdap vaccine or any component of the vaccine; OR
* History of encephalopathy due to Tdap vaccination (post tetanus vaccination encephalitis, post-diphtheria vaccination encephalitis, post-pertussis vaccination encephalitis)

98. Documentation of patient's or caregiver's refusal of Tdap vaccine99. None of the above/not documented/unable to determine from medical record documentation | 1,97,98,99If 97, go to zostervac as applicableIf 98 or 99 go totdttvac | **Include:** Tetanus, Diphtheria, and Acellular Pertussis (Tdap), Boostrix, AdacelLook for documentation during the specified timeframe that Tdap vaccine was administered to the patient.**Select value “1”**, if the patient received Tdap vaccine on or after August 1, 2009 to the study end date. Administration of Tdap vaccine must be documented in medical record including month, day, and year. Patient self-report is acceptable if the setting (e.g. the provider’s name) is recorded along with month and year of administration.**Select value “97”** if there is documentation in the patients history of any of the following: * History of anaphylaxis due to Tdap vaccine or any component of the vaccine; OR
* History of encephalopathy due to Tdap vaccination (post tetanus vaccination encephalitis, post-diphtheria vaccination encephalitis, post-pertussis vaccination encephalitis)

**To select value “98”** there must be documentation indicating the patient/caregiver refused the Tdap vaccine when it was offered.**Select value “99”** if there is no documentation of Tdap vaccine status or it is unable to be determined. * **If there is documentation that supports more than one allowable value (1, 97, 98), select the smallest number.**
	+ For example, a nursing note documents the patient refused Tdap vaccine and medication administration record documents Tdap vaccine was administered, select value "1".

**Suggested data sources:** History and Physical, Progress notes, Medication administration record (MAR) |
| 9 | tdapdt | Enter the date the most recent Tdap vaccine was administered. | mm/dd/yyyy

|  |
| --- |
| >= 08/01/2009 and <= stdyend |

If tdapvac = 1, goto zostervac, as applicable  | Enter the month, day, and year the most recent Tdap vaccine was administered.If specific day is unknown, the day may be entered as 01. |
| 10 | tdttvac | During the timeframe from (computer to display 8/01/2009 to stdyend), did the patient receive the Td (tetanus and diphtheria toxoids) or TT (tetanus toxoid) vaccine? 1.Td or TT vaccine administered97. Documentation of: * History of, anaphylaxis due to Td or TT vaccine or any component of the vaccine; OR
* History of encephalopathy due to TD or TT vaccination (post tetanus vaccination encephalitis, post-diphtheria vaccination encephalitis, post-pertussis encephalitis)

98. Documentation of patient's or caregiver's refusal of Td or TT vaccine99. None of the above/not documented/unable to determine from medical record documentation | 1,97,98,99If 97,98, or 99, go tozostervac as applicable | **Include**: Td (Tetanus and Diphtheria Toxoids), Tetanus Toxoid (TT) **Select value “1”**, if the patient received Td or TT vaccine during the specified timeframe and up to the study end date. Administration of Td or TT vaccine must be documented in medical record including month, day, and year. Patient self-report is acceptable if the setting (e.g., provider name) is recorded along with month and year of administration.**Select value “97”** if there is documentation in the patient’s history of any of the following: * History of anaphylaxis to the vaccine or any component of the vaccine; OR
* History of encephalopathy due to TD or TT vaccination (post tetanus vaccination encephalitis, post-diphtheria vaccination encephalitis, post-pertussis encephalitis)

**To select value “98”** there must be documentation that indicates the patient/caregiver refused the Td or TT vaccine when it was offered.**Select value “99”** if there is no documentation of Td or TT vaccine status or unable to be determined. * **If there is documentation that supports more than one allowable value (1, 97, 98), select the smallest number**.
	+ For example, a nursing note documents the patient refused Td vaccine and medication administration record documents Td vaccine was administered, select value "1".

**Suggested data sources:** History and Physical, Progress notes, Medication administration record (MAR) |
| 11 | tdttdt | Enter the date the most recent Td or TT vaccine was administered. | mm/dd/yyyy

|  |
| --- |
| >=08/01/2009   and <= stdyend |

 | Enter the month, day, and year the most recent Td or TT vaccine was administered. If more than one Td or TT vaccine was administered, enter the date of the most recent vaccination. If specific day is unknown, the day may be entered as 01. |
| **If age >= 50 years go to zostervac; else go to end** |
| 12 | zostervac | During the timeframe from (computer display date of patient’s 50th birthday to stdyend), did the patient receive one dose of the herpes zoster live vaccine (ZVL, Zostavax)? 1. One dose of Herpes Zoster live vaccine administered

97. Documentation of anaphylactic/ anaphylactoid reaction caused by ZVL or any other component of the vaccine 98. Documentation of patient's or caregiver's refusal of herpes zoster live vaccine99. None of the above/not documented/unable to determine from medical record documentation | 1,97,98,99If 97, go to endIf 98 or 99 go to hzrecvac | **Include**: Zostavax, zoster vaccine live (ZVL)**For the purpose of this study, vaccination data is being collected for adults age 50 and greater.****A single dose of live herpes zoster vaccine is recommended for adults age 50 years and older.** **Select value “1”** if the patient received live herpes zoster vaccine at any time during the specified timeframe. Administration of Zostavax, ZVL must be documented in medical record including month, day, and year. At a minimum the month and year are required are required to select value “1”Patient self-report is acceptable if the setting (e.g., provider name) is recorded along with month and year of administration.**Select value “97”** if there is documentation in the patients history of any of the following: * History of anaphylactic/anaphylactoid reaction to gelatin, neomycin, or any other component of the vaccine

**To select value “98”** there must be documentation that indicates the patient/caregiver refused the herpes zoster vaccine when it was offered.**Select value “99”** if there is no documentation of herpes zoster vaccine status or unable to be determined. * **If there is documentation that supports more than one allowable value (1, 97, 98), select the smallest number**.
	+ For example, a nursing note documents the patient refused herpes zoster vaccine and medication administration record documents herpes zoster vaccine was administered, select "1".

**Suggested data sources:** History and Physical, Progress notes, Medication administration record (MAR) |

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| --- | --- | --- | --- | --- | --- |
| 13 | zosterdt | Enter the date the most recent live herpes zoster vaccine was administered. | mm/dd/yyyyIf valid date, go to end

|  |
| --- |
| >= date of patient’s 50th birthdayand <=stdyend |

 | Enter the month, day, and year the live herpes zoster vaccine was administered. If specific day is unknown, the day may be entered as 01. |
| 14 | hzrecvac | During the timeframe from (computer display date of patient’s 50th birthday to stdyend), did the patient receive at least **one dose** of the herpes zoster recombinant vaccine (RZV, Shingrix)? 1. Yes

97. Documentation of history of anaphylactic or adverse reaction caused by the herpes zoster recombinant vaccine or component of the vaccine 98. Documentation of patient's or caregiver's refusal of herpes zoster recombinant vaccine99. None of the above/not documented/unable to determine from medical record documentation | 1,97,98,99If 97,98 or 99, go to end | **Include:** Shingrix, Herpes Zoster Recombinant Vaccine (RZV)For the purpose of this study, **one dose** **of recombinant herpes zoster vaccine with a second dose given at least 28 days after the first dose is recommended for patient’s aged 50 years and older.*** In order **to select value “1”**, administration of one dose of Shingrix, RZV must be documented in medical record including month, day, and year of administration of the first dose.
* Patient self-report is acceptable if the setting (e.g., provider name) is recorded along with month, day, and year of administration.
* **Select value “97”** if there is documentation in the patient’s history of any of the following:
* History of anaphylactic/anaphylactic reaction to gelatin, neomycin, or any other component of the vaccine
* **To select value “98”** there must be documentation that indicates the patient/caregiver refused the herpes zoster vaccine when it was offered.
* **Select value “99”** if there is no documentation of herpes zoster vaccine status or unable to be determined.
* **If there is documentation that supports more than one allowable value (1, 97, 98), select the smallest number.**

For example, a nursing note documents the patient refused herpes zoster vaccine and medication administration record documents Herpes Zoster Recombinant Vaccine (RZV) was administered and the date and time administered is documented, select "1". **Suggested data sources**: History and Physical, Progress notes, Medication administration record (MAR) |
| 15 | hzrecvac1dt | Enter the date the first dose of herpes zoster recombinant vaccine (RZV, Shingrix) was administered.  | mm/dd/yyyy

|  |
| --- |
| >= date of patient’s 50th birthdayand <=stdyend |
| If hzrecvac1dt <= 28 days prior to styend, go to end |

 | Enter the month, day, and year the first dose of herpes zoster recombinant vaccine was administered.  |
| 16 | hzrecvac2 | During the timeframe from (computer display hzrecvac1dt + 28 days to stdyend), did the patient receive a **second dose** of the herpes zoster recombinant vaccine (RZV, Shingrix)?1. Yes
2. No
 | 1,2If 2, go to end | **Include:** Shingrix, Herpes Zoster Recombinant Vaccine (RZV)For the purpose of this study, vaccination data is being collected for adults age 50 and greater.**Two (2) doses of recombinant herpes zoster vaccine is recommended for adults age 50 years and older.*** In order **to select value “1”**, administration of a second dose of Shingrix, RZV must be documented in medical record including month, day, and year of administration of both doses.
* Patient self-report is acceptable if the setting (e.g., provider name) is recorded along with month, day, and year of administration.
 |
| 17 | hzrecvac2dt | During the timeframe from (computer display hzrecvac1dt + 28 days to stdyend), enter the date the **second dose** of recombinant herpes zoster vaccine (RZV, Shingrix) was administered. | mm/dd/yyyy

|  |
| --- |
| >=hzrecvac1dt + 28 days and <=stdyend |

 | Enter the month, day, and year the second dose of herpes zoster recombinant vaccine was administered.  |