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|  |  | **Organizational Identifiers** |  |  |
|  | VAMC  CONTROL  QIC  BEGDTE  REVDTE | Facility ID  Control Number  Abstractor ID  Abstraction Begin Date  Abstraction End Date | Auto-fill  Auto-fill  Auto-fill  Auto-fill  Auto-fill |  |
|  |  | **Patient Identifiers** |  |  |
|  | SSN  PTNAMEF  PTNAMEL  BIRTHDT  SEX  MARISTAT  RACE | Patient SSN  First Name  Last Name  Birth Date  Sex  Marital Status  Race | Auto-fill: no change  Auto-fill: no change  Auto-fill: no change  Auto-fill: no change  Auto-fill: can change  Auto-fill: no change  Auto-fill: no change |  |
| 1 | seenyr | Was the **Veteran** seen within the last twelve months by a physician, NP, PA, Psychologist, or Clinical Nurse Specialist in one of the “Nexus clinics”?  1. Yes  2. No | 1,2\*  If 1, go to nexusdt  **\*If 2 the record is excluded**   |  | | --- | | **Warning if 2** | | All the following must be true to answer “yes:”   * the patient was a Veteran * the clinic visit occurred within 12 months from the first day of the study interval to the end of the study interval; * the visit occurred at one of the Nexus clinics; * during the visit, the patient was seen face-to-face (includes clinical video telehealth (CVT) encounter) by a physician, NP, PA, Psychologist, or Clinical Nurse Specialist. The qualifying visit may NOT be a telephone call. Subsequent visits during the year may be phone calls. * Refer to list of Nexus Clinics   **If the Veteran is admitted to a VHA Residential Rehabilitation program or Domiciliary, consider applicable Nexus Clinic visits when answering this question.**  **Exclusion Statement:**  Although the stop code indicated a visit to a Nexus clinic, the Veteran was not seen by a physician, NP, PA, Psychologist, or Clinical Nurse Specialist in an applicable outpatient clinic within the study year. |
| 2 | nexusdt | Enter the date of the most recent visit to a Nexus clinic during which the patient was seen by a physician, NP, PA, Psychologist, or Clinical Nurse Specialist. | mm/dd/yyyy   |  | | --- | | < = 1 year prior or = stdybeg and < = stdyend | | Most recent visit = the visit in which the patient was seen most immediately prior to the end of the study interval  Enter the exact date of the visit to the Nexus clinic. The use of 01 to indicate missing day or month is not acceptable. |
| **If Mental Health flag = 1, go to othrcare; else go to hospice** | | | | |
| 3 | 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 non-VHA setting?  1. Yes  2. 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, go to end | 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.) |
| 4 | 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.  **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 |
| 5 | 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  If 1, go to end | 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 |
| 6 | termill | Is one of the following documented in the medical record?The patient has a diagnosis of cancer of the liver, pancreas, or esophagusOn the problem list it is documented the patient’s life expectancy is less than 6 months? 1. Yes  2. No | 1,2  If 1, go to end | Although all noted conditions may be applicable to the case, only one is necessary for exclusion from the Osteoporosis and Kidney Health Measures  The stage of cancer of the liver, esophagus, or pancreas is not applicable. Even if the patient is newly diagnosed, the case is excluded.  Patient’s life expectancy of less than six months must be documented on the problem list or in the computer field “health factors,” without exception.  **Suggested Data sources:** Consult notes, History and physical, Order summary, Clinic notes, Problem list |
| **Age > = 66 go to inltcset; if age < 66 auto-fill inltcset as 95 and go to osteotx as applicable** | | | | |
| 7 | inltcset | Is there documentation in the medical record the patient lived long-term (greater than 60 consecutive days) in a VHA or community-based institutional setting anytime during the past year? 1. Yes 2. No95. Not applicable | 1,2,95  If 1, go to end  Will be auto-filled as 95 if age < 66 | **The intent of this question is to determine if the patient lived long-term (greater than 60 days) in an institutional setting anytime during the past year.**  **Institutional settings may include, but are not limited to nursing homes, community living centers, long term care (LTC) facilities, assisted living facilities.**  **Exclude:** Residential Rehabilitation Treatment Programs (RRTP); Domiciliary facilities (DOM), group or personal care homes  **Suggested Data Sources:** Discharge summary, History and physical, other  admin/discharge reports |
| 8 | advillns | Is there documentation in the medical record the patient has an active condition/diagnosis considered an advanced illness? 1. Yes 2. No | 1,2 | ‘Active’ condition/diagnosis = the condition was ever diagnosed and there is no subsequent statement, prior to the most recent outpatient visit, indicating the condition was resolved or is inactive.  **Medical diagnoses must be recorded as the patient’s diagnosis by a physician, NP, PA, or CNS in clinic notes or discharge summary. Diagnoses documented on a problem list must be validated by a clinician diagnosis.**  Because a problem list may not be all-inclusive, it is expected that reviewer will read all progress notes for the Nexus clinics for a year to identify all diagnoses.  Advanced illness may include but is not limited to:   * Malignancies only on Table 5 * Parkinson’s * Alzheimer’s * CKD/ESRD diagnoses only on Table 5 * HF   Any provider (including nurses) can document advanced illness in any setting (including the home). A nurse may only document a medical diagnosis after a physician, NP, PA or CNS has documented the diagnosis.  Refer to Table 5: Advanced Illness for other specific disorders  **Suggested Data Sources:** H&P, nursing assessments, progress notes, problem list |
| 9 | demeds | Is there physician, NP, PA, CNS or pharmacist documentation in the medical record the patient has an active prescription for a dementia medication? 1. Yes  2. No | 1,2 | **An acceptable dementia medication must be documented as an active prescription.**  Acceptable dementia medications include:   * Donepezil * Galantamine * Rivastigmine * Memantine * Donepezil-memantine (combination)   **Suggested Data Sources: C**linical pharmacy notes, EMLR note, Medication reconciliation notes, Progress notes (clinic notes) |
| 10 | frailty | During the past year, is there documentation in the medical record the patient has any condition/diagnosis consistent with frailty? 1. Yes  2. No | 1,2   |  | | --- | | Warning if 2 and case is flagged for frailty | | Any provider (including nurses) can document frailty in any setting (including the home). A nurse may only document a medical diagnosis after a physician, NP, PA or CNS has documented the diagnosis.  Frailty may include but is not limited to:   * presence of pressure ulcers * abnormalities of gait and mobility * adult Failure To Thrive (FTT) * history of fall(s)   Refer to Table 6 for other specific disorders  **Suggested Data Sources**: H&P, nursing assessments, progress notes, problem list |
| **If (frailflag = 1 or frailty = 1) and (illflag = 1 or advillns = 1 or demeds = 1) go to end.** | | | | |
| **If female patient age is > 65 and <= 75 years, go to osteotx; else go to renaldis as applicable** | | | | |
| 11 | osteotx | At any time prior to (computer to display stdyend - 1 year) is there documentation in the medical record the patient received any of the following medications for treatment of osteoporosis?   * denosumab, 1mg injection * ivandronate sodium, 1 mg injection * teriparatide, 10 mcg injection * zoledronic acid, 1 mg   1. Yes  2. No | 1,2  If 2, autofill osteotxdt as 99/99/9999 and go to ostmed | Look back in the patient’s record to determine if the patient received any of the osteoporosis therapy medications at any time in her history.  **Suggested data sources:** BCMA, progress notes |
| 12 | osteotxdt | Enter the date of the most recent encounter for administration of the osteoporosis treatment medication. | mm/dd/yyyy  Will be auto-filled as 99/99/9999 if osteotx = 2   |  | | --- | | > patient’s DOB and <= 1 yearprior to stdyend |   If osteotx = 1 and osteotxdt = mm/dd/yyyy, go to renaldis as applicable | Look back in the patient’s record to determine the date of the most recent encounter in the specified time frame when the patient received any of the osteoporosis therapy medications at any time in her history. |
| 13 | ostmed | During the timeframe from (computer to display < = 3 years to stdybeg date and > 1 year prior to the stdyend) is there documentation in the medical record the patient had a dispensed prescription for any of the following medications for treatment of osteoporosis?   |  |  | | --- | --- | | **Description** | **Prescription** | | Bisphosphates | * Alendronate * Alendronate-cholecalciferol * Ibandronate * Risedronate * Zoledronic acid | | Other agents | * Abaloparatide * Denosumab * Raloxifene * Romosozumab * Teriparatide |   1, Yes  2. No | 1,2  If 2, auto-fill ostmedt as 99/99/9999 and go to ostscrn | Look back during the specified time frame to determine if there was a dispensed prescription for any of the specified medications used for the treatment of osteoporosis.  **Suggested data sources:** BCMA, Meds tab, Order Summary, Progress Notes |
| 14 | ostmedt | Enter the most recent date there was a dispensed prescription for any of the specified medications used for the treatment of osteoporosis. | mm/dd/yyyy  Will be auto-filled as 99/99/9999 if ostmed = 2   |  | | --- | | <=3 years prior to stdybeg and > 1 year prior to stdyend |   If ostmed = 1 and ostmedt = mm/dd/yyyy, go to renaldis as applicable | Look back during the specified time frame to determine the most recent there was a dispensed prescription for any of the specified medications used for the treatment of osteoporosis. |
| 15 | ostscrn | During the timeframe from (computer to display patient’s 65th birthday to stdyend), is there documentation in the medical record of any of the following screening tests for osteoporosis?   * Ultrasound bone density (radial, wrist and/or heel) * Computed Tomography (hips, pelvis, and/or spine) * DEXA scan (hips, pelvis, and/or spine) * DEXA scan (peripheral - radius, wrist and/or heel) * Dual energy X-ray absorptiometry (DXA), (hips, pelvis, and/or spine)   1. Yes  2. No  98. Patient refused osteoporosis screening | 1,2,98  If 2 or 98, autofill ostscrndt as 99/99/9999 and go to renaldis as applicable | Osteoporosis involves a gradual loss of calcium, causing bones to become thinner, more fragile, and more likely to break. Look back in the patient’s record to age 65 to determine whether a screening test for osteoporosis was done.  **Screening tests acceptable to answer “Yes” include:**   * Ultrasound bone density (peripheral sites i.e. radial, wrist and/or heel) * Computed Tomography (hips, pelvis, and/or spine) * DEXA scan (hips, pelvis, and/or spine) * DEXA scan (peripheral - radius, wrist and/or heel) * Dual energy X-ray absorptiometry (DXA), (hips, pelvis, and/or spine)   If there is no documentation of any of the osteoporosis screening tests during the specified timeframe, select value “2”.  **Suggested data source**: Imaging tab |
| 16 | ostscrndt | Enter the date of the patient’s most recent osteoporosis screening test. | mm/dd/yyyy   |  | | --- | | >= patient’s 65th birthday and < = study end |   Will be autofilled as 99/99/9999 if ostscrn = 2 or 98 | Look back in the patient’s record to age 65 to determine the date of the screening test  Enter the exact date if possible. If exact date cannot be determined, enter month and year at a minimum. If the day cannot be determined, enter 01 for day. |
| 17 | vaostscrn | Was the osteoporosis screening test performed by the VHA?  3. Screening performed at a VAMC  4. Screening performed outside VHA, fee basis  5. Screening performed private sector, not fee basis | 3,4,5 | * Value 3 = osteoporosis screening was performed at a VAMC. * Value 4 = osteoporosis screening performed outside VHA, **fee basis**, may be determined by checking to see if screening was ordered by and consult placed by VHA. If the screening was ordered by VHA and performed outside VHA, enter 4. * Value 5 = screening performed private sector, **not fee basis**, includes documentation the osteoporosis screening was performed outside VHA such as patient self-report documented by VHA PCP or outside screening report without evidence it was ordered by VHA. |
| **If case flagged for DM go to renaldis, else go to end.** | | | | |
| **Kidney Health Evaluation** | | | | |
| 18 | renaldis | At any time prior to or on (computer to display stdyend) is there documentation in the medical record of any one of the following:   * End stage renal disease (ESRD) * Dialysis   1. Yes  2. No | 1,2  If 1, go to end | **Review the medical record documentation during the specified timeframe to determine if there is documentation of any of the following renal/kidney disorders:**   * **End stage renal disease (ESRD)** may include but is not limited to: * Chronic kidney disease, stage 5 (stage V) * End stage renal failure * **Dialysis** may include but is not limited to: * Hemodialysis * Peritoneal dialysis   **Refer to Table 8 for other specific terminology for ESRD and dialysis.**  **Suggested Data Sources:** Progress notes, dialysis procedure notes |
| 19 | egfr | During the past year is there documentation in the medical record of an estimated glomerular filtration rate (eGFR)?  1. Yes  2. No | 1,2  If 2, autofill egfrdt as 99/99/9999 | The estimated glomerular filtration rate (eGFR) provides an assessment of the filtering capacity of the kidney.  **The eGFR may be taken from the laboratory report.**  **The eGFR may be reported as a numerical value or with cut points.**  Normal Reference Interval for informational purposes:  Male: 90.0 - 137.0 ml/min  Female: 90.0 – 128.0 ml/min |
| 20 | egfrdt | Enter the date of the most recent eGFR. | mm/dd/yyyy   |  | | --- | | <= 1 year prior to or = stdybeg and <= stdybeg | | Look for an eGFR test done in the past year.  Enter the exact date if possible. If exact date cannot be determined, enter month and year at a minimum. If the day cannot be determined, enter 01 for day. |
| 21 | ualb | During the past year is there documentation in the medical record of a quantitative urine albumin test?  1. Yes  2. No | 1,2  If 2, go to end | The quantitative urine albumin test detects and measures the amount of albumin in the urine to screen for kidney disease. |
| 22 | ualbdt | Enter the date of the most recent urine albumin test. | mm/dd/yyyy   |  | | --- | | <= 1 year prior to or = stdybeg and <= stdybeg | | Look for urine albumin test done in the past year.  Enter the exact date if possible. If exact date cannot be determined, enter month and year at a minimum. If the day cannot be determined, enter 01 for day. |
| 23 | ucreat | During the time frame from (computer display ualbdt – 4 days to ualbdt + 4 days) is there documentation in the medical record of a urine creatinine test.  1. Yes  2. No | 1,2  If 2, go to end | The urine creatinine test measures the amount of creatinine in the urine to evaluate kidney function. Look for a urine creatinine test done in the past year within 4 days prior to or after the urine albumin test. |
| 24 | ucreatdt | Enter the date of the most recent urine creatinine test. | mm/dd/yyyy   |  | | --- | | <= ualbdt - 4days and <= ualbdt + 4days | | Look for urine creatinine test done in the past year.  Enter the exact date if possible. If exact date cannot be determined, enter month and year at a minimum. If the day cannot be determined, enter 01 for day. |