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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  If VALNEXUS = 1, calculate age at PNEXUSDT; else if SEENYR2 = 1, calculate age at NEXUSDT2; else if Cohort 61 and IPADM =1, calculate age at ADMDT |  |
| 1 | nonvet | Did the record document the patient was a non-Veteran?   1. Yes 2. No | 1\*,2  **\*If 1, the record is excluded** | In order to answer “1,” there must be documentation that the patient is not a Veteran.  Examples: non-Veteran female patient who is married to a Veteran, active duty military personnel receiving care at this VA  **Exclusion Statement:**  Non-Veteran cases are excluded from outpatient review. |
| 2 | dxexcld | Does the patient have one of the following diagnoses?   1. Multiple Sclerosis (MS), without primary problem of paraplegia 2. Amyotrophic Lateral Sclerosis (ALS) 3. Guillain-Barre Syndrome 4. Malignant tumor of the spinal cord   99. None of the above | 1,2,3,4,99  **If 1, 2, 3, or 4, the record is excluded**  **If 99 and cohort = 61, go to ipadm, else go to pnexusdt** | **Excluded:** MS in which patient does not have primary problem of paraplegia, ALS (commonly known as Lou Gehrig’s disease), Guillain-Barre Syndrome, and malignant tumor of the spinal cord  **Included:** Benign tumors of the spinal cord**,** MS in which patient does have primary problem of paraplegia (paralysis of the legs and lower part of the body) associated with the disease process.  **Exclusion Statement**:  The patient’s diagnosis does not meet inclusion criteria for the spinal cord injury and disorders cohort. |
| 3 | ipadm | Did the patient with a diagnosis of spinal cord injury have an inpatient admission at this VA within the past year?  1. Yes  2. No | 1,\*2  \*If 2, go to pnexusdt, if applicable | The inpatient admission does not have to be related to the spinal cord injury. If the only admission at this VA in the past year is for the patient’s annual SCI evaluation, answer “1.” |
| 4 | admdt | Enter the date of admission to inpatient care. | mm/dd/yyyy  **Can be modified**   |  | | --- | | < = 1 year prior or = stdybeg and < = stdyend | | **May be auto-filled from the pull list; can be modified.**  A patient of a hospital is considered an inpatient upon issuance of written doctor’s orders to that effect. |
| 5 | dcdate | Enter the date of discharge. | mm/dd/yyyy   |  | | --- | | >=admdt and warning if > 6 months after admdt | | May be auto-filled from the pull list. If the discharge date is not auto-filled, enter the exact date. |
| **If PNEXUSDT = blank; go to SEENYR2** | | | |  |
| 6 | pnexusdt | **Computer will prefill** 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  **Pre-fill from pull list**   |  | | --- | | < = 1 year prior or = stdybeg and < = stdyend |   **Cannot modify** | **Computer will pre-fill the most recent Nexus clinic visit date during the past year during which the patient was seen by a physician/NP/PA, psychologist or Clinical Nurse Specialist.** |
| 7 | valnexus | On (computer to display pnexusdt), is there documentation the patient was seen by a physician, NP, PA, Psychologist, or Clinical Nurse Specialist in one of the “Nexus clinics”?  1. Yes  2. No | 1,2  **If 2, go to seenyr2** | **To answer “yes” all of the following are required:**   * the visit must have occurred on the date displayed in the question; **and** * the patient must be seen by a physician/NP/PA, psychologist or Clinical Nurse Specialist; **and** * the visit must be a face to face OR clinical video telehealth (CVT), VA Video Connect (VVC), OR telephone encounter; **and** * the visit must be in one of the Nexus clinics   **Note:** “Nexus clinics” include primary care, specialty clinics and mental health clinics. Refer to Table 8 to view the Nexus clinics list to determine the patient was seen in a Nexus clinic.  If the Veteran is admitted to a VHA Residential Rehabilitation program or Domiciliary, consider applicable Nexus Clinic visits when answering this question.   * Telephone encounter: Please note that the VHA sampling criteria for telephone encounters requires documentation of a qualifying primary telephone stop code, secondary NEXUS stop code AND CPT code. The stop codes differ by clinic type and the CPT codes differ by provider type, purpose of encounter and length of encounter. The only acceptable CPT codes are: 90833, 90836, 90838, 98968 and 99443. The telephone encounter duration must be a minimum of 21 minutes. Although a more recent telephone encounter is sometimes found in the record, the encounter did not meet the criteria for VHA telephone encounter.   **If any above requirement is NOT met, enter “2”.** |
| 8 | pcvt | **Computer prefill**: Was the Nexus clinic visit on (computer display pnexusdt) a clinical video telehealth (CVT) encounter?  1. Yes  2. No | 1,2  **Pre-fill from pull list**  **Cannot modify**  If 1, go to valcvt; else if ptele = 1, go to valtele; else go to pnxusloc | **Computer will pre-fill response value to indicate if the most recent Nexus clinic visit was/was not a Clinical video telehealth (CVT) encounter.**  CVT is a real-time interactive video encounter between the physician, NP, PA, Psychologist, or Clinical Nurse Specialist (CNS) and the patient. |
| 9 | valcvt | On (computer to display pnexusdt), is there documentation the visit with a physician, NP, PA, Psychologist, or Clinical Nurse Specialist was a clinical video telehealth (CVT) encounter?   1. Yes 2. No | 1,2  If 1 or 2, go to pnxusloc | **CVT is a real-time interactive video encounter between the physician, NP, PA, Psychologist, or Clinical Nurse Specialist (CNS) and the patient.**  **Note:** The clinic note title/description may not reflect CVT. Please read note to determine if visit was conducted via CVT.  CVT visit documentation may also describe method used such as VA Video Connect (VVC).   * If the visit with a physician, NP, PA, Psychologist, or Clinical Nurse Specialist on the date displayed was a clinical video telehealth (CVT) encounter, enter “1”. * If the visit was not a CVT encounter, enter “2”.   **Exclude**: telephone encounter |
| 10 | ptele | **Computer prefill**: Was the Nexus clinic visit on (computer display pnexusdt) a telephone encounter?  1. Yes  2. No | 1,2  **Pre-fill from pull list**  **Cannot modify**  If 1, go to valtele; else go to pnxusloc | **Computer will pre-fill response value to indicate if the most recent Nexus clinic visit was/was not a telephone encounter.**  **Exclude**: Clinical video telehealth (CVT) or VA Video Connect (VVC). |
| 11 | valtele | On (computer to display pnexusdt), is there documentation the visit with a physician, NP, PA, Psychologist, or Clinical Nurse Specialist was a telephone encounter?   1. Yes 2. No | 1,2 | If the visit with a physician, NP, PA, Psychologist, or Clinical Nurse Specialist on the date displayed was a telephone encounter, enter “1”.  If the visit was not a telephone encounter, enter “2”.  **Exclude**: Clinical video telehealth (CVT) or VA Video Connect (VVC). |
| 12 | pnxusloc | **Computer will prefill** the name of the Nexus clinic location for the visit on (computer display pnexusdt) when the patient was seen by a physician, NP, PA, psychologist, or Clinical Nurse Specialist (CNS). | \_\_\_\_\_\_\_\_\_\_  pnxusloc  **Pre-fill from pull list**  **Cannot modify** | **Computer will prefill the name of the Nexus clinic location for the visit that occurred on PNEXUSDT when the patient was seen by a physician, NP, PA, psychologist, or Clinical Nurse Specialist (CNS).** |
| 13 | valnexloc | Does (computer to display pnxusloc), the Nexus clinic location name where the patient was seen by a physician, NP, PA, psychologist, or Clinical Nurse Specialist (CNS) on (computer to display pnexusdt), match the clinic location name documented in the record.  1. Yes  2. No | 1,2  **If 1 or 2, go to othrcare as applicable** | * **Look for documentation that the Nexus clinic location name displayed is the same Nexus clinic location name documented in the record for the visit on PNEXUSDT.** * The clinic location name displayed may include the clinic stop code (e.g., 323 ABC PACT TEAM 1); however, if the clinic location name displayed matches the documentation in the medical record select “1”. The stop code does not need to be present in the medical record documentation to select value”1”.   + For example, clinic location name displayed is “502 MH OP1 PSY1” and the clinic location name in outpatient encounter information is “MH OP1 PSY1”; select value “1”.   **Suggested data sources**: outpatient encounter, patient care encounter (PCE), past clinic visits (CVP) |
| 14 | seenyr2 | During the timeframe from (computer display stdybeg – 1 year to stdyend),was the Veteran seen by a physician, NP, PA, Psychologist, or Clinical Nurse Specialist in one of the “Nexus clinics”?  1. Yes  2. No | 1,\*2  **\*If 2, the record is excluded**   |  | | --- | | **Warning if 2** |   **\*If 2 and cohort <> 61, the record is excluded**  **If 2 and ipadm = 2, the record is excluded,**  **else if ipadm = 1, go to hospice** | For purposes of EPRP, Nexus refers to a designated group of clinics having a specific stop code (primary or secondary) as shown in Table 8.  **To answer “yes” all of the following are required:**   * the visit must have occurred during the timeframe displayed in the question; **and** * the patient must be seen by a physician/NP/PA, psychologist or Clinical Nurse Specialist; **and** * the visit must be a face to face OR clinical video telehealth (CVT), OR VA Video Connect (VVC), OR telephone encounter; **and** * the visit must be in one of the Nexus clinics   **Note:** “Nexus clinics” include primary care, specialty clinics and mental health clinics. Refer to Table 8 to view the Nexus clinics list to determine the patient was seen in a Nexus clinic.  If the Veteran is admitted to a VHA Residential Rehabilitation program or Domiciliary, consider applicable Nexus Clinic visits when answering this question.   * Telephone encounters: Please note that the VHA sampling criteria for telephone encounters requires documentation of a qualifying primary telephone stop code, secondary NEXUS stop code AND CPT code. The stop codes differ by clinic type and the CPT codes differ by provider type, purpose of encounter and length of encounter. The only acceptable CPT codes are: 90833, 90836, 90838, 98968 and 99443. The telephone encounter duration must be a minimum of 21 minutes.   **If any above requirement is NOT met, enter “2”.**  **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. |
| 15 | nexusdt2 | 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 | | **Enter the exact 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.** |
| 16 | nexuscvt2 | Was the Nexus clinic visit on (computer display nexusdt2) a clinical video telehealth (CVT) encounter?   1. Yes 2. No | 1,2  If 1, go to nxusloc2 | **CVT is a real-time interactive video encounter between the physician, NP, PA, Psychologist, or Clinical Nurse Specialist (CNS) and the patient.**  **Note:** The clinic note title/description may not reflect CVT. Please read note to determine if visit was conducted via CVT.  CVT visit documentation may also describe method used such as VA Video Connect (VVC).   * If the visit with a physician, NP, PA, Psychologist, or Clinical Nurse Specialist on the date displayed was a clinical video telehealth (CVT) encounter, enter “1”. * If the visit was not a CVT encounter, enter “2”.   **Exclude**: telephone encounter |
| 17 | nexustele2 | Was the Nexus clinic visit on (computer display nexusdt2) a telephone encounter?   1. Yes 2. No | 1,2 | If the visit with a physician, NP, PA, Psychologist, or Clinical Nurse Specialist on the date displayed was a telephone encounter, enter “1”.  If the visit was not a telephone encounter, enter “2”.  **Exclude**: Clinical video telehealth (CVT) or VA Video Connect (VVC) |
| 18 | nxusloc2 | For the NEXUS clinic visit with a physician, NP, PA, psychologist or Clinical Nurse Specialist (CNS) on (computer display NEXUSDT2), enter the NEXUS clinic location name.   |  | | --- | |  | | \_\_\_\_\_\_\_\_\_\_\_  Text field | **This question asks for entry of the name of the Nexus clinic location for the visit that occurred on the date entered in NEXUSDT2. Nexus clinic location names vary by facility.**  Some examples of clinic location names:   * PRO-VVC-OPS-M-GENPSYCH4 PRO * DEE VOD PACT PROV 2 * CO-PACT SILVER 3   Suggested data sources: outpatient encounter, patient care encounter (PCE), past clinic visits (CVP) |
| 19 | wichnxus2 | Computer will auto-fill the Nexus clinic location name.   |  | | --- | |  | | Computer auto-fill  If VALNEXUS = 1, auto-fill PNXUSLOC; if SEENYR2 = 1, auto-fill NXUSLOC2  **Cannot modify** | **Computer will auto-fill based on VALNEXUS response value.**  If VALNEXUS = 1, auto-fill PNXUSLOC; if VALNEXUS = 2 and SEENYR2 = 1, auto-fill NXUSLOC2. |
| **If Mental Health flag = 1, go to othrcare; otherwise, go to hospice** | | | | |
| 20 | 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**  **Warning if 1** | **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. |
| 21 | 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  **Warning if 1** | **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:** Problems List,Consult notes, History and physical, Order summary, Clinic notes |
| 22 | 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 |
| **Age > = 66 go to inltcset; if age < 66, auto-fill inltcset as 95 and go to dementdx2** | | | | |
| 23 | 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. No 95. Not applicable | 1,2,95  If 1, go to dementdx2  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 |
| 24 | 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, |
| 25 | 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) |
| 26 | 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 |
| **Nexus Clinics ONLY applicable to SCI patients**   |  |  | | --- | --- | | **201** | Physical Medicine & Rehabilitation Service (PM&RS) **Physician** | | **210** | Spinal Cord Injury (SCI) | | **215** | SCI Home Care Program | | **315** | Neurology | | **414** | Urology Clinic | | | | | |

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| --- | --- | --- | --- | --- |
|  |  | **Assessment of Cognitive Function** |  |  |
| 27 | 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, F01.51, F02.80, F02.81, F03.90, F03.91, 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 fluvac21** | **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-CM 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 table on the next page.**  Suggested data sources: Clinic/progress notes (e.g. primary care, neurology, geriatrics, psychiatry), history and physical, discharge summary, outpatient encounter diagnosis codes, admission/discharge codes |
| **ICD-10-CM Code Dementia/neurocognitive Disorder Code Table**   |  |  |  |  | | --- | --- | --- | --- | | **ICD-10-CM Code** | **ICD-10-CM Description** | **ICD-10-CM Code** | **ICD-10-CM Description** | | A81.00 | Creutzfeldt-Jakob disease, unspecified | F13.97 | Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced persisting dementia | | A81.01 | Variant Creutzfeldt-Jakob disease | F18.17 | Inhalant abuse with inhalant-induced dementia | | A81.09 | Creutzfeldt-Jakob disease, other | F18.27 | Inhalant dependence with inhalant-induced dementia | | A81.2 | Progressive multifocal leukoencephalopathy | F18.97 | Inhalant use, unspecified with inhalant-induced persisting dementia | | A81.82 | Gerstmann-Straussler-Scheinker Syndrome | F19.17 | Other psychoactive substance use with psychoactive substance-induced persisting dementia | | A81.89 | Other atypical virus infections of central nervous system [included for Prion disease of the CNS NEC] | F19.27 | Other psychoactive substance dependence with psychoactive substance-induced persisting dementia | | A81.9 | Atypical virus infection of central nervous system, unspecified [Prion diseases of the central nervous system NOS] | F19.97 | Other psychoactive substance use, unspecified with psychoactive substance-induced persisting dementia | | F01.50 | Vascular Dementia without Behavioral Disturbance | G23.1 | Progressive supranuclear palsy | | F01.51 | Vascular Dementia with Behavioral Disturbance | G30.0 | Alzheimer's disease with early onset | | F02.80 | Dementia in other diseases classified elsewhere without behavioral disturbance | G30.1 | Alzheimer's disease with late onset | | F02.81 | Dementia in other diseases classified elsewhere with behavioral disturbance | G30.8 | Other Alzheimer's disease | | F03.90 | Unspecified dementia without behavioral disturbance | G30.9 | Alzheimer's Disease, Unspecified | | F03.91 | Unspecified dementia with behavioral disturbance | G31.01 | Pick's Disease | | F10.27 | Alcohol dependence with alcohol-induced persisting dementia | G31.09 | Other Frontotemporal Dementia | | F10.97 | Alcohol use, unspecified with alcohol-induced persisting dementia | G31.83 | Dementia with Lewy Bodies | | F13.27 | Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced persisting dementia | G90.3 | Multi-system atrophy | | | | | |
| 28 | 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 |
| 29 | 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 fluvac21**   |  | | --- | | < = 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. |
| 30 | 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.  **If the severity of dementia was not assessed during the past year using one of the specified tools, enter 99.** |
| 31 | 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) |
| 32 | 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 fluvac21** | **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.”** |
| 33 | incsevci | During the timeframe 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 fluvac21** | * **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.** * In addition, the Clinical Reminder for mental health screening allows providers to establish this exclusion by checking the box to indicate **“Unable to screen due to Moderate or Severe Cognitive Impairment.” This is acceptable documentation of moderate or severe cognitive impairment.** * 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. |
| 34 | 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 fluvac21**   |  | | --- | | > demsevdt and  < = stdyend | | Enter the exact date. The use of 01 to indicate missing month or day is not acceptable. |
| 35 | 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 fluvac21 | * **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.** * In addition, the Clinical Reminder for mental health screening allows providers to establish this exclusion by checking the box to indicate **“Unable to screen due to Moderate or Severe Cognitive Impairment.” This is acceptable documentation of moderate or severe cognitive impairment.** * 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. |
| 36 | cogimpdt | Enter the date of the most recent physician/APN/PA or psychologist documentation of moderate or severe cognitive impairment. | mm/dd/yyyy  Will be auto-filled as 99/99/9999 if  modsevci = 2   |  | | --- | | < = 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. |
|  |  | **Immunizations** |  |  |
| 37 | fluvac21 | During the period from (computer display 7/01/2021 to (pulldt or <= stdyend if stdyend > pulldt)), did the patient receive influenza vaccination?  1. received vaccination from VHA   1. received vaccination from private sector provider   98. patient refused vaccination  99. no documentation patient received  vaccination | 1,3,98,99  **If 98 or 99, go to allerflu** | **Note: The intent is to look for influenza immunization administered during the current influenza immunization period (i.e. 7/01/2021 through 6/30/2022).** For the purposes of review, influenza immunization given up to the pull list date (unless the study end date is after the pull list date) is acceptable. For example, the pull list date is 11/02/2021 and medical record contains documentation the influenza immunization was administered on 11/01/2021, enter value “1”.  **Acceptable documentation of influenza immunization:**   1. Notation of “flu shot given” with month and year 2. Influenza vaccine given in another setting, i.e., acute care, NHCU, etc., with month and year documented 3. Patient self-report of flu shot at community facility with month and year documented. 4. Checkmark on a checklist, with month and year, clinician’s signature or initials and documentation of a clinic visit or vaccination clinic.   **Unacceptable documentation :**   1. Any documentation that does not indicate the vaccine was actually given and there is no month or year documented. 2. Documentation of the vaccine in the Immunization Health Summary, **WITHOUT** verification in a progress note that the vaccine was actually given.   **Additional guidelines:**  **To select value “98”, the documentation must indicate that the patient refused the flu vaccine during the vaccination season (7/01/2021 – 6/30/2022). For example, documentation from 8/23/2021 states “patient stated he did not wish to receive flu vaccination,” select value “98”.**  **Select value “99”for patients who had no visits at all during immunization season (7/01/2021 – 6/30/2022) and did not receive the influenza immunization at this VAMC or anywhere else during immunization season.** |
| 38 | fluvacdt | Enter the date influenza vaccination was given. | mm/dd/yyyy  If fluvac21 = 1 or 3, go to bnmrtrns   |  | | --- | | > = 7/01/2021 and  < = 6/30/2022 and  (< = pulldt or < = stdyend if > pulldt) | | Although the day may be entered as day = 01, if the specific date is unknown, the exact month and year must be entered accurately.  **If the exact month is unknown, but there is documentation the patient received the flu vaccine in fall or winter, enter “10” as the default month.** |
| 39 | allerflu | Is one of the following documented in the medical record? Previous severe allergic reaction to any component of the influenza vaccine, or after a previous dose of any influenza vaccineHistory of Guillain-Barre Syndrome 1. Yes  2. No | 1,2 | **Severe allergic reaction to any influenza vaccine component must be documented in the medical record. Notation does not have to state “anaphylactic.”**   * A previous severe allergic reaction to influenza vaccine, regardless of the component suspected of being responsible for the reaction, is a contraindication to future receipt of the vaccine. * Signs of a severe allergic reaction can include: difficulty breathing, hoarseness or wheezing, swelling around the eyes or lips, hives, paleness, weakness, fast heart beat or dizziness * History of an allergy to eggs is no longer a contraindication to receiving the vaccine.   **History of Guillain-Barre Syndrome** - may be anytime in the patient’s history and must be documented in the medical record. |
| 40 | 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 tobscrn18 as applicable | **Bone marrow transplant - must be documented the procedure occurred during the past year.** |
| 41 | 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 tobscrn18 as applicable | **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 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.” |
| 42 | 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 tobscrn18 as applicable | **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, organ transplants, transplant rejection/failure. (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 |
| **If age >=60 go to** **ppsvac23, else go to** **tobscrn18 as applicable** | | | | |
| 43 | ppsvac23 | At any time, not later than the study end date, did the veteran receive the **PPSV23** (**Pneumovax 23®, Pnu-Imune 23®)** or pneumococcal (Pneumovax) vaccination, either as an inpatient or outpatient?   1. received **PPSV23** (Pneumovax 23®, Pnu-Imune 23®) or pneumococcal (Pneumovax) vaccination from VHA 2. received **PPSV23** (Pneumovax 23®, Pnu-Imune 23®) or pneumococcal (Pneumovax) vaccination from private sector provider   98. patient refused **PPSV23** (Pneumovax 23®, Pnu-Imune 23®) or pneumococcal (Pneumovax) vaccination  99. no documentation patient received **PPSV23** (Pneumovax 23®, Pnu-Imune 23®) or pneumococcal (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 pneumococcal (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 pneumococcal (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.   Unacceptable:   * Notation in the record that patient has had a PPSV23 (Pneumovax 23®, Pnu-Imune 23®) or pneumococcal (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 pneumococcal (Pneumovax) vaccination. |
| 44 | ppsv23dt | Enter the date of the **PPSV23** (Pneumovax 23®, Pnu-Imune 23®) or pneumococcal (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 pneumococcal (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. |
| 45 | 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, 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.   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. |
| 46 | pcvdt20 | Enter the date of the PCV20 or PREVNAR 20™ vaccination. | mm/dd/yyyy  **If pcvdt20 – birthdt >= 60 yrs, go to tobscrn18 as applicable**   |  | | --- | | >= 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.** |
| 47 | 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) |
| 48 | 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 tobscrn18 as applicable**   |  | | --- | | > 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. |
| 49 | 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. |
| **If [(dementdx2 = 1) AND (permci = 1)] OR [(demsev = 1, 2 or 3) AND (cogscor2=5)] OR (incsevci = 1) OR (modsevci=1)], go to renaldis as applicable; else if Cerner flag <> 1, go to tobscrn18; else if Cerner flag = 1, go to tobscrn18c** | | | | |
|  |  | **Screening for Tobacco Use** |  |  |
| 50 | tobscrn18 | During the past year, was the patient screened for tobacco use by an acceptable provider using the **National Clinical Reminder for Tobacco Use**?  1. Yes  2. No  98. Patient declined to answer National Clinical Reminder for Tobacco Use screening questions | 1,2,98  If 2 or 98, go to renaldis as applicable | **On or after 10/01/2018, tobacco screening must be completed by an acceptable provider using the National Clinical Reminder for Tobacco Use.**  Acceptable providers include: physicians, APN, PA, RN, LPN, pharmacists, social workers, psychologists, dentists, Addictions Therapists/substance abuse counselors, Licensed Professional Mental Health Counselors (LPMHC), and Marriage and Family Therapists.  Health/medical technicians or clerical staff are not acceptable providers to complete tobacco use screening or follow-up.  The first question of the National Clinical Reminder for Tobacco Use is:  Do you smoke cigarettes, or use tobacco every day, some days, or not at all?  🞎 Every Day  🞎 Some Days  🞎 Not at all  🞎 Declined to Answer  In order to answer “yes” to this question, the tobacco screening must be completed by an acceptable provider using the National Clinical Reminder for Tobacco Use with documentation of one of the responses as noted above such as “The patient uses tobacco every day”.  The questions will not appear in the documentation.  The lead in is Tobacco Use Screening, not the question.  Examples of documentation that may be seen in the medical record include:  **Tobacco Use Screening:**  **The patient uses tobacco every day.**  **OR**  **Tobacco Use Screening:**  **The patient uses tobacco some days.**  **OR**  **Tobacco Use Screening:**  **The patient is a former tobacco user.**  **The patient quit less than one year ago.**  Cont’d next page  Tobacco Screening cont’d.  **OR**  **Tobacco Use Screening:**      The patient has never used tobacco.  In order to answer “98”, the documentation of refusal must be associated with the National Clinical Reminder for Tobacco Use. Refusal to answer other questions (e.g., Have you used tobacco in the past year; have you ever used tobacco?) is not acceptable.  An example of documentation that may be seen in the medical record includes:  **Tobacco Use Screening:**  **The patient declines to say if they use tobacco.**  **(FAILS – reminder reset)**  Tobacco use includes: cigarettes, cigars, pipe smoking, snuff, dip, or chewing tobacco (smokeless tobacco categories). Tobacco products do NOT include electronic cigarettes, vaping devices, or any electronic nicotine delivery system  Depending on the patient’s response, additional questions may be asked. |
| 51 | tobscrndt | Enter the date of the most recent tobacco use screening by an acceptable provider using the National Clinical Reminder for Tobacco Use. | mm/dd/yyyy   |  | | --- | | <= 1 yr prior to stdybeg and <= stdyend | | Enter the exact date of the most recent tobacco use screening by an acceptable provider using the National Clinical Reminder for Tobacco Use. |
| 52 | tobscrn1 | Enter the response to Tobacco Use Screening question #1 “Do you smoke cigarettes, or use tobacco every day, some days, or not at all?”  1. Every Day  2. Some Days  3. Not at all | 1,2,3  If 1 or 2, go to tobscrn2; else go to renaldis as applicable | Enter the patient’s response to Tobacco Use Screening question #1 “Do you smoke cigarettes, or use tobacco every day, some days, or not at all?” documented in the medical record. |
| 53 | tobscrn2 | Enter the response to the Tobacco Use Screening question “Do you smoke or use tobacco within 30 minutes of waking up?”  1. Yes  2. No  99. Not documented | 1,2,99 | Enter the patient’s response to the Tobacco Use Screening question “Do you smoke or use tobacco within 30 minutes of waking up?” documented in the medical record. |
| 54 | tobscrn3 | Enter the response to the Tobacco Use Screening question “How long have you smoked or used tobacco?”  1. Less than 1 year  2. 1 year to less than 5 years  3. 5 years to 15 years  4. More than 15 years and less than 30 years  5. 30 years or more  99. Not documented | 1,2,3,4,5,99  If 1,2,3,4,5, or 99, go tuconsel2 | Enter the patient’s response to the Tobacco Use Screening question “How long have you smoked or used tobacco?” documented in the medical record.  This question is for informational purposes and is not used in scoring. |
| 55 | tuconsel2 | During the past year was the patient advised to quit smoking or stop using tobacco using the National Clinical Reminder for Tobacco Use?  1. Yes  2. No | 1, 2  If 2, auto-fill tucnsldt2 as 99/99/9999 and go to tucrefer2 | For all patients screened for tobacco use on or after 10/01/2018, Advised to Quit must be documented using the National Clinical Reminder for Tobacco use which includes general guidance on elements such as:   * Quitting smoking or tobacco use is one of the most important things you can do to protect and improve your health and VA has the resources to support you. * Set a quit date when you are ready to quit. * Get support from your family and friends. * Review any past quit attempts- What helped? What didn't? * On the day you plan to quit, get rid of all cigarettes and tobacco products from your home, car or work. * Using a combination of behavioral counseling or other support strategies and FDA-approved cessation medications is the most effective way to ensure success in quitting. * Any provider who is able to screen for tobacco use is able to advise patient to quit and offer individual intervention or specialty smoking cessation clinic, including physicians, APN, PA, RN, LPN, pharmacists, social workers, psychologists, dentists, and substance abuse counselors. * Provider documentation of advice to quit using tobacco via telephone is acceptable. * Provision of a brochure or pamphlet to the patient without documented direct discussion of how to quit is NOT acceptable. |
| 56 | tucnsldt2 | Enter the date the patient was advised to quit smoking or stop using tobacco using the National Clinical Reminder for Tobacco Use. | mm/dd/yyyy  Will be auto-filled as 99/99/9999 if  tuconsel2 = 2   |  | | --- | | <= 1 year prior to stdybeg and <= stdyend | | Exact date must be entered. The use of 01 to indicate missing day or month is not acceptable.  All “Advice to Quit” guidance provided on or after 10/01/2018 must be documented using the National Clinical Reminder for Tobacco. |
| 57 | tucrefer2 | During the past year, did the provider provide information about behavioral counseling or treatment options other than medication to assist patient with quitting smoking or using tobacco using the National Clinical Reminder for Tobacco Use?   1. Yes 2. No | 1,2  If 2, auto-fill tucrefdt2 as 99/99/9999, and go to offtucrx2 | Any provider who is able to screen or advise to quit is able to provide information about behavioral counseling or treatment options other than medication to assist patient with quitting smoking or using tobacco including physicians, APN, PA, RN, LPN, pharmacists, social workers, psychologists, dentists, and addictions therapists/substance abuse counselors, Licensed Professional Mental Health Counselors (LPMHC), and Marriage and Family Therapists.  Information about behavioral counseling/other options must be documented using the National Clinical Reminder for Tobacco Use, which includes:   * Behavioral counseling or other support strategies greatly increases your chances of successfully quitting smoking or tobacco use by helping you develop a quit plan and providing support and other strategies to make behavioral changes to help you quit. * VA has a number of behavioral counseling options to help you with quitting, including:   + Provide information about the facility smoking or tobacco use treatment options or clinics   + VA's national quitline, 1-855-QUIT-VET, with counseling available Monday-Friday   If documentation indicates the program was offered, answer “1” even if the patient refused to enroll or participate. |
| 58 | tucrefdt2 | Enter the date the patient was offered information about behavioral counseling or treatment options other than medication for individual intervention or to a tobacco use cessation program using the National Clinical Reminder for Tobacco Use. | mm/dd/yyyy  Will be auto-filled as 99/99/9999 if  tucrefer2 = 2   |  | | --- | | <= 1 year prior to stdybeg and <= stdyend | | Exact date must be entered. The use of 01 to indicate missing day or month is not acceptable.  All “Information about Behavioral Counseling/Other Options” provided on or after 10/01/2018, must be documented using the National Clinical Reminder for Tobacco Use. |
| 59 | offtucrx2 | During the past year, was the patient offered FDA approved medications by a provider to assist in tobacco use cessation using the National Clinical Reminder for Tobacco Use?  1. Yes  2. No | 1,2  If 2, go to renaldis as applicable | **All “Offering of Medications” provided on or after 10/01/2018, must be documented using the National Clinical Reminder for Tobacco Use.**  Any provider who is able to screen or advise to quit is able to provide information about FDA approved medications to assist patient with quitting smoking or using tobacco including physicians, APN, PA, RN, LPN, pharmacists, social workers, psychologists, dentists, addictions therapists/substance abuse counselors, Licensed Professional Mental Health Counselors (LPMHC), and Marriage and Family Therapists.  Documentation of offer of FDA approved tobacco cessation medications using the National Clinical Reminder for Tobacco Use includes:  Medications for Nicotine replacement therapy such as the patch, gum or lozenge, and other medications such as varenicline or bupropion, can play an important role in the initial weeks and months after you quit smoking or tobacco use.  Medications help with cravings and withdrawal symptoms and they greatly increase your chances of successfully quitting.  If the provider offered tobacco cessation medication to the patient and the patient accepted or declined, enter “1”.  If there is no documentation the provider offered tobacco use cessation medication to the patient, enter “2”.  Examples of tobacco cessation products and medications such as:  **Nicotine replacement products (OTC):**   * Nicotine patch (Nicoderm CQ, Habitrol) * Nicotine gum (Nicorette) * Nicotine lozenges (Commit)   **Nicotine replacement products prescription:**   * Nicotine inhaler (Nicotrol inhaler) - prescription only * Nicotine nasal spray (Nicotrol) - prescription only   Oral medications: Bupropion (Zyban, Wellbutrin), varenicline (Chantix) – prescription only |
| 60 | tucmedt2 | Enter the date the patient was offered medication to assist with quitting smoking or to stop using tobacco using the National Clinical Reminder for Tobacco Use. | mm/dd/yyyy  Go to renaldis as applicable   |  | | --- | | <= 1 year prior to stdybeg and <= stdyend | | Exact date must be entered. The use of 01 to indicate missing day or month is not acceptable.  All “Information about Offering FDA Approved Medications” provided on or after 10/01/2018, must be documented using the National Clinical Reminder for Tobacco Use. |
| **Tobacco Use Screening (Cerner Facilities)** | | | | |
| 61 | tobscrn18c | During the past year, was the patient screened for tobacco use by an acceptable provider?  1. Yes  2. No  98. Patient declined to answer screening questions | 1,2,98  If 2 or 98, go to renaldis as applicable | **Tobacco screening must be completed by an acceptable provider**.  Acceptable providers include: physicians, APN, PA, RN, LPN, pharmacists, social workers, psychologists, dentists, Addictions Therapists/substance abuse counselors, Licensed Professional Mental Health Counselors (LPMHC), and Marriage and Family Therapists.  Health/medical technicians or clerical staff are not acceptable providers to complete tobacco use screening or follow-up.  The screening question is:  Do you smoke cigarettes, or use tobacco every day, some days, or not at all?  🞎 Every Day  🞎 Some Days  🞎 Not at all  🞎 Declined to Answer  In order to answer “yes” to this question, the tobacco screening must be completed by an acceptable provider with documentation of one of the responses as noted above such as “The patient uses tobacco every day”.  The questions will not appear in the documentation.  Examples of documentation that may be seen in the medical record include:  **Tobacco Use Screening:**  **The patient uses tobacco every day.**  **OR**  **Tobacco Use Screening:**  **The patient uses tobacco some days.**  **OR**  **Tobacco Use Screening:**  **The patient is a former tobacco user.**  **The patient quit less than one year ago.**  **OR**  **Tobacco Use Screening:**      The patient has never used tobacco. In order to answer “98”, the documentation of refusal must be clearly related to the screening question (i.e., Have you used tobacco in the past year; have you ever used tobacco?) is not acceptable.  An example of documentation that may be seen in the medical record includes:  **Tobacco Use Screening:**  **The patient declines to say if they use tobacco.**  **Tobacco use includes** cigarettes, cigars, pipe smoking, snuff, dip, or chewing tobacco (smokeless tobacco categories). Tobacco products do NOT include electronic cigarettes, vaping devices, or any electronic nicotine delivery system  Depending on the patient’s response, additional questions may be asked. |
| 62 | tobscrndtc | Enter the date of the most recent tobacco use screening by an acceptable provider. | mm/dd/yyyy   |  | | --- | | <= 1 year prior to stdybeg and <= stdyend | | Enter the exact date of the most recent tobacco use screening by an acceptable provider. |
| 63 | postobscrnc | Was the tobacco screening done on (computer to display tobscrndtc) positive for tobacco use?   1. Yes 2. No | 1,2  If 2, go to renaldis as applicable | Positive tobacco use includes documentation of any use of the following: cigarettes, cigars, pipe smoking, snuff, dip, or chewing tobacco (smokeless tobacco categories).  Tobacco products do NOT include electronic cigarettes, vaping devices, or any electronic nicotine delivery system.  For documented tobacco use screen, select value “1” for documentation that indicates the patient uses tobacco some days or every day in the past year. |
| 64 | tuconsel2c | During the past year was the patient advised to quit smoking or stop using tobacco?  1. Yes  2. No | 1, 2  If 2, auto-fill tucnsldt2c as 99/99/9999 and go to tucrefer2c | Advised to Quit documentation must include general guidance on elements such as:   * Quitting smoking or tobacco use is one of the most important things you can do to protect and improve your health and VA has the resources to support you. * Set a quit date when you are ready to quit. * Get support from your family and friends. * Review any past quit attempts- What helped? What didn't? * On the day you plan to quit, get rid of all cigarettes and tobacco products from your home, car or work. * Using a combination of behavioral counseling or other support strategies and FDA-approved cessation medications is the most effective way to ensure success in quitting. * **Any provider who is able to screen for tobacco use is able to advise patient to quit and offer individual intervention or specialty smoking cessation clinic**, including physicians, APN, PA, RN, LPN, pharmacists, social workers, psychologists, dentists, Addictions Therapists/substance abuse counselors, Licensed Professional Mental Health Counselors (LPMHC), and Marriage and Family Therapists. * Provider documentation of advice to quit using tobacco via telephone is acceptable.   Provision of a brochure or pamphlet to the patient without documented direct discussion of how to quit is NOT acceptable. |
| 65 | tucnsldt2c | Enter the date the patient was advised to quit smoking or stop using tobacco. | mm/dd/yyyy  Will be auto-filled as 99/99/9999 if  tuconsel2c = 2   |  | | --- | | <= 1 year prior to stdybeg and <= stdyend | | Exact date must be entered. The use of 01 to indicate missing day or month is not acceptable. |
| 66 | tucrefer2c | During the past year, did the provider provide information about behavioral counseling or treatment options other than medication to assist patient with quitting smoking or using tobacco?   1. Yes 2. No | 1,2  If 2, auto-fill tucrefdt2c as 99/99/9999, and go to offtucrx2c | Any provider who is able to screen or advise to quit is able to provide information about behavioral counseling or other treatment options other than medication to assist patient with quitting smoking or using tobacco, including physicians, APN, PA, RN, LPN, pharmacists, social workers, psychologists, dentists, Addictions Therapists/substance abuse counselors, Licensed Professional Mental Health Counselors (LPMHC), and Marriage and Family Therapists.  Documentation of information about behavioral counseling/other treatment options must include:   * Behavioral counseling or other support strategies greatly increases your chances of successfully quitting smoking or tobacco use by helping you develop a quit plan and providing support and other strategies to make behavioral changes to help you quit. * VA has a number of behavioral counseling options to help you with quitting, including:   + Provide information about the facility smoking or tobacco use treatment options or clinics   + VA's national quitline, 1-855-QUIT-VET, with counseling available Monday-Friday   If documentation indicates the program was offered, answer “1” even if the patient refused to enroll or participate. |
| 67 | tucrefdt2c | Enter the date the patient was offered information about behavioral counseling or treatment options other than medication for individual intervention or to a tobacco use cessation program. | mm/dd/yyyy  Will be auto-filled as 99/99/9999 if  tucrefer2c = 2   |  | | --- | | <= 1 year prior to stdybeg and <= stdyend | | Exact date must be entered. The use of 01 to indicate missing day or month is not acceptable. |
| 68 | offtucrx2c | During the past year, was the patient offered FDA approved medications by a provider to assist in tobacco use cessation?  1. Yes  2. No | 1,2  If 2, go to renaldis as applicable | **“Offering of Medications” must be documented. Any provider who is able to screen or advise to quit is able to provide information about FDA approved medications to assist patient with quitting smoking or using tobacco** including physicians, APN, PA, RN, LPN, pharmacists, social workers, psychologists, dentists, Addictions Therapists/substance abuse counselors, Licensed Professional Mental Health Counselors (LPMHC), and Marriage and Family Therapists.  Documentation of offer of FDA approved tobacco cessation medications includes:  Medications for Nicotine replacement therapy such as the patch, gum or lozenge, and other medications such as varenicline or bupropion, can play an important role in the initial weeks and months after you quit smoking or tobacco use.  Medications help with cravings and withdrawal symptoms and they greatly increase your chances of successfully quitting.  If the provider offered tobacco cessation medication to the patient and the patient accepted or declined, enter “1”.  If there is no documentation the provider offered tobacco use cessation medication to the patient, enter “2”.  Examples of tobacco cessation products and medications such as:  **Nicotine replacement products (OTC):**   * Nicotine patch (Nicoderm CQ, Habitrol) * Nicotine gum (Nicorette) * Nicotine lozenges (Commit)   **Nicotine replacement products prescription:**   * Nicotine inhaler (Nicotrol inhaler) - prescription only * Nicotine nasal spray (Nicotrol) - prescription only   Oral medications: Bupropion (Zyban, Wellbutrin), varenicline (Chantix) – prescription only |
| 69 | tucmedt2c | Enter the date the patient was offered medication to assist with quitting smoking or to stop using tobacco. | mm/dd/yyyy   |  | | --- | | <= 1 year prior to stdybeg and <= stdyend | | Exact date must be entered. The use of 01 to indicate missing day or month is not acceptable. |
| **If DM flag = 1, go to renaldis; else go to end** | | | | |
|  |  | **Diabetes Care** |  |  |
| 70 | 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 | **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 9 for other specific terminology for ESRD and dialysis.**  Suggested Data Sources: Progress notes, dialysis procedure notes |
| 71 | fundexam | Within the past year, does the record document a funduscopic examination of the retina?   1. exam performed by VHA 2. exam performed by a private sector provider 3. explicit statement by ophthalmologist or optometrist that retinal imaging no longer necessary for this blind patient 4. Patient refused funduscopic examination of retina   99. no documentation funduscopic exam was  performed | 1,3,97,98,99  **If 97, 98, or 99, auto-fill fundt as 99/99/9999, eyespec as 95, and go to prevscop** | Blind patients are not excluded from this question unless option #97 is applicable.  Documentation that indicates funduscopic exam of the retina was performed: reference to optic disc, arterioles, no hemorrhage or exudates, microaneuryms, no papilledema, any reference to terms indicating retinopathy. Documentation of a dilated eye exam may include abbreviations such as Dil, DL, DI, or DFE. The term “non-mydriatic” means non-dilated.  **Documentation Acceptable to Select Value “1” or “3”:**   * Presence of a note, report, or letter summarizing results of a retinal or dilated eye exam completed by an eye care specialist (ophthalmologist or optometrist), or a photograph or chart of retinal abnormalities * Note by the PCP/staff that the funduscopic or retinal examwas completed by a private eye care specialist (ophthalmologist or optometrist), date of exam, and result of exam. The month and year should be known. * Retinal photo taken in the ambulatory care setting and sent to an eye care specialist for review, **if the results are in the record.** * Screening for retinopathy by digital imaging (dilated or non-dilated), read by an ophthalmologist or optometrist * Eye exam results read by a system that provides an artificial intelligence (AI) interpretation * If there is documentation of bilateral eye enucleation (removal of both eyes) anytime during the Veteran’s history, select “1”.   **Unacceptable:**  Pt referred to ophthalmology/optometry but no exam results available.  In order to answer “98,” there must be documentation in the record by the provider that the patient refused to have a funduscopic exam of the retina performed. |
| 72 | fundt | Enter the date the funduscopic exam of the retina was performed. | mm/dd/yyyy  If fundexam = 97, 98 or 99, will be auto-filled as 99/99/9999   |  | | --- | | < = 1 year prior or = stdybeg and < = stdyend | | Day may be entered as 01, if exact date is unknown. At a minimum, the month and year must be entered accurately.  If FUNDEXAM = 97 or 99, FUNDT will auto-fill as 99/99/9999. Abstractor cannot enter the default date of 99/99/9999 if FUNDEXAM = 1 or 3.  If bilateral eye enucleation (removal of both eyes) is documented and the exact date is not found, enter 01 for missing day and/or month. |
| 73 | eyespec | How was the funduscopic/retinal exam performed?   1. by an ophthalmologist 2. by an optometrist 3. by a primary care practitioner   6. a digital image/retinal photo (dilated or non-dilated)was sent to be read by an ophthalmologist or optometrist   1. not applicable   99. unable to determine from documentation in the medical record | 1 2,3,6,95,99  If fundexam = 97, 98, or 99, will be auto-filled as 95  **If 3 or 99, go to prevscop; else go to end** | **Eye care specialist=ophthalmologist or optometrist**  **Scoring for the retinal or dilated retinal exam of diabetic patients will be based on whether the exam was performed by an ophthalmologist or optometrist, by retinal photo sent to an eye care specialist or by funduscopic digital imaging (dilated or non-dilated) sent to an ophthalmologist or optometrist for reading.**  If uncertain regarding the specialty of the clinicians who perform funduscopic exams at the VAMC, request assistance from the Liaison.  **If the patient was seen by an eye care specialist outside VHA and it is known the eye exam was accomplished (i.e. documentation the funduscopic or retinal exam was done by eye care specialist, date of exam, and result of exam), but the specialty is unknown, use response “1” as default.**  Answer ‘6’ as applicable to use of retinal digital imaging/retinal photo, either dilated or non-dilated, taken in Primary Care or other ambulatory clinic, and sent to an ophthalmologist or optometrist for reading.  **If use of the Inoveon, Joslin, or Vanderbilt system is documented in the record, this is acceptable.** |
| 74 | prevscop | Within the year previous to the past year, did the patient have a funduscopic exam of the retina performed by an ophthalmologist, an optometrist, or by retinal digital imaging sent to an ophthalmologist or optometrist for reading   1. Yes 2. No 3. Explicit statement by ophthalmologist or optometrist that retinal imaging no longer necessary for this blind patient | 1,2,97  **If 2 or 97, go to end** | **Year previous to the past year** = Determine “the past year” by counting back one year to the first day of the month of the first date of the study interval (as is calculated for “within the past year.”). The year’s period prior to this date is within the year previous to the past year.  Blind patients are not excluded from this question unless option #97 is applicable.  Documentation that indicates funduscopic exam of the retina was performed: reference to optic disc, arterioles, no hemorrhage or exudates, microaneurysms, no papilledema, any reference to terms indicating retinopathy. Documentation of a dilated eye exam may include abbreviations such as Dil, DL, DI, or DFE. The term “non-mydriatic” means non-dilated.  **Acceptable:**   * Presence of a note, report, or letter summarizing results of a retinal or dilated eye exam completed by an eye care specialist (ophthalmologist or optometrist), or a photograph or chart of retinal abnormalities * Note by the PCP/staff that the funduscopic or retinal examwas completed by a private eye care specialist (ophthalmologist or optometrist), date of exam, and result of exam. The month and year should be known. * Retinal photo taken in the ambulatory care setting and sent to an eye care specialist (ophthalmologist or optometrist) for review, **if the results are in the record.** * **Screening for retinopathy by digital imaging (dilated or non-dilated), read by an ophthalmologist or optometrist**   **Unacceptable:**  Pt referred to ophthalmology/optometry but no exam results available. |
| 75 | prevdt | Enter the date of the retinal exam performed within the year previous to the past year. | mm/dd/yyyy   |  | | --- | | < = 2 yrs prior to stdybeg and > 1 yr prior to stdybeg | | Day may be entered as 01, if exact date is unknown. At a minimum, the month and year must be entered accurately.  Will auto-fill as 99/99/9999 if PREVSCOP = 2 or 97. Abstractor cannot enter the default date of 99/99/9999 if PREVSCOP = 1. |
| 76 | retinpath2 | Did the report from the retinal eye exam within the year previous to the past year indicate a finding of retinopathy?  1. Yes  2. No  99. No report available | 1,2,99 | **The intent of the eye exam indicator is to ensure that patients with evidence of any type of retinopathy have an eye exam annually, while members who remain free of retinopathy (i.e., the retinal exam was negative for retinopathy) are screened every other year.**   * + - * **If there is documentation of a negative retinal or dilated eye exam by an eye care professional (optometrist, ophthalmologist), select “2”.** * **Documentation does not have to state specifically “no diabetic retinopathy” to be considered negative for retinopathy; however, it must be clear that the patient had a dilated or retinal eye exam and retinopathy was not present.**   + - * **If there is any documentation of retinopathy (including hypertensive) or retinopathy synonym, select “1.”**   **Proliferative Diabetic Retinopathy Synonyms:**  Any hemorrhage Photocoagulation  Preretinal or vitreous hemorrhage Rubeosis  Background retinopathy Iritis  Diabetic retinal or eye changes Fibrosis  Laser treatment of the eyes Diabetic iritis  Macular lesion  New vessels on the disc, (NVD) iris, or retina  Macular changes with retinopathy Preproliferative Retinopathy Synonyms: Diabetic macular edema Multiple cotton wool spots  Retinal blot hemorrhages Venous beading/looping  Intraretinal microvascular abnormalities (IRMA) Nonproliferative Diabetic Retinopathy Synonyms: Blot hemorrhage Microaneuryms  Hard exudates Soft exudates  **Exclude:** macular degeneration w/o mention of retinopathy  R/O retinopathy; rule out retinopathy |