

**CATNUM**

Sample category  
 16. AMI - Outpatient visit  
 36. SCI Dx  
 48. Female, age 20-69  
 50. Random Sample  
 51. Random Sample MH  
 54. Frail/Elderly  
 60. DM Outpatient  
 61. Inpatient SC  
 68. Contract CBOC

**FEFLAG** (rcvd on pull list)  
FE case flagged for CGPI review / scoring?

0. No  
 1. Yes

**REVSTAT**

REVIEW STATUS (not abstracted)

0. Abstraction has not begun  
 1. Abstraction in progress  
 2. Abstraction completed w/o errors  
 3. TVG failure (exclusion)  
 4. Record contains missing required answers (error record)  
 5. Administrative exclusion from all measures

**DEMENTDX2** (MH)

During the past year, does the record document a diagnosis of dementia/neurocognitive disorder as evidenced by one of the following ICD-9-CM codes?

(046.11, 046.19, 046.3, 290.0, 290.10, 290.11, 290.12, 290.13, 290.20, 290.21, 290.3, 290.40, 290.41, 290.42, 290.43, 291.2, 292.82, 294.10, 294.11, 294.8, 331.0, 331.11, 331.19, 331.2, 331.7, 331.82, 331.89, 331.9, 333.0 or 333.4)

1. Yes  
 2. No

**DEMSEV** (MH)

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

**COGSCOR2** (MH)

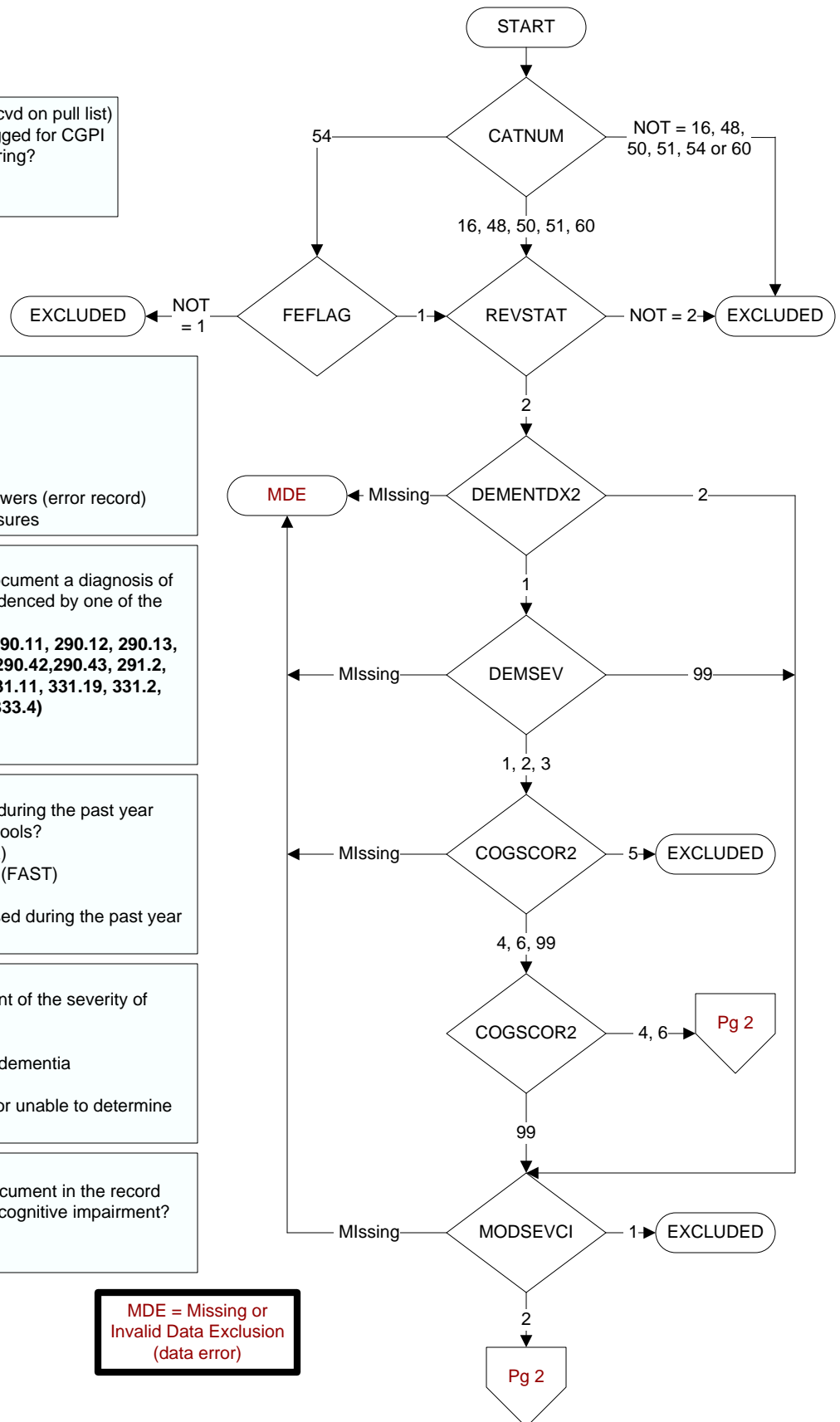
What was the outcome of the assessment of the severity of dementia assessment?

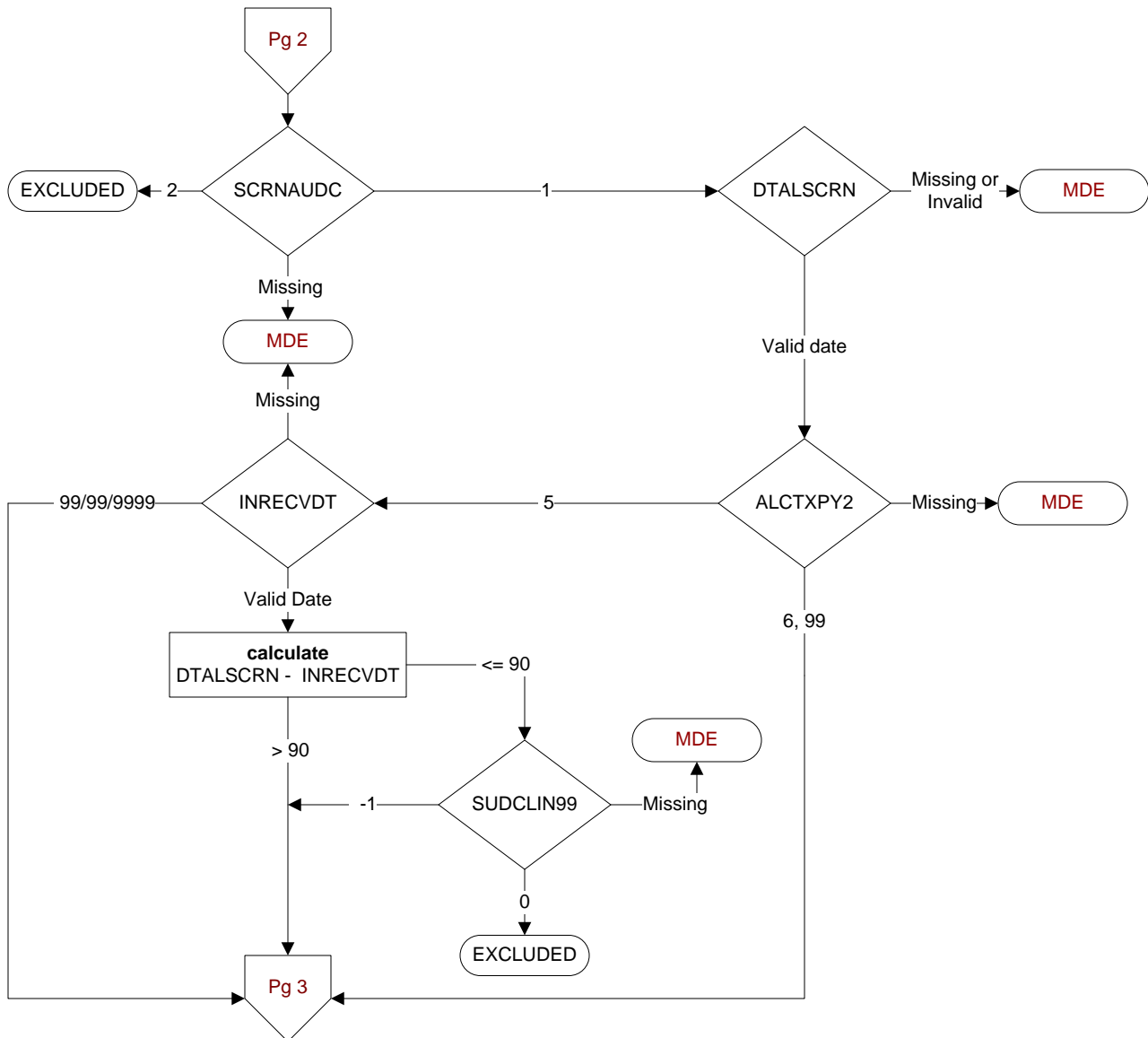
4. Score indicated mild dementia  
 5. Score indicated moderate to severe dementia  
 6. Score indicated no dementia  
 99. No score documented in the record or unable to determine outcome

**MODSEVCI** (MH)

During the past year, did the clinician document in the record that the patient has moderate or severe cognitive impairment?

1. Yes  
 2. No





**SCRNAUDC (MH)**  
Within the past year, was the patient screened for alcohol misuse with the AUDIT-C?  
1. Yes  
2. No

**DTALSCRN (MH)**  
Enter the most recent date of screening for alcohol misuse with the AUDIT-C.

**ALCTXPY2 (MH)**  
Within the year prior to the most recent alcohol screening with AUDIT-C, did the patient participate in a recovery program for alcohol abuse or dependence?  
5. Yes, in VHA  
6. Yes, but not in VHA (includes AA)  
99. No or unable to determine

**INRECVDT(MH)**  
Enter the date of the patient's most recent participation in a recovery program for alcohol abuse or dependence in the year prior to alcohol screening.

**SUDCLIN (MH)**  
Within 90 days prior to the most recent alcohol screening with AUDIT-C, was the patient seen in any of the following VHA substance use disorders (SUD) clinics?  
**Indicate all that apply:**  
1. 513 SUD-Individual  
2. 514 SUD-Home  
3. 519 SUD-PTSD  
4. 547 Intensive-SUD Treatment  
5. 523 Opioid Substitution  
6. 560 SUD-Group  
7. 545 SUD-Telephone  
8. 548 Intensive-SUD-Individual  
95. Not applicable  
99. None of the above

**ALCSCOR (MH)**

Enter the total AUDIT-C score documented within the past year in the medical record.

At any time since the most recent alcohol screening, does the record document any of the following components of brief alcohol counseling for past-year drinkers? (MH)

Indicate **all that apply** and the **date** counseling was noted in the record:

**ALCBAC3.** Advice to abstain

**ALBA3DT** = Date of ALCBAC3

**ALCBAC6.** Personalized counseling regarding relationship of alcohol to the patient's specific health issues

**ALBA6DT** = Date of ALCBAC6

**ALCBAC7.** General alcohol-related counseling (not linked to patient's issues)

**ALBA7DT** = Date of ALCBAC7

**ALCBAC8.** Patient advised to drink within recommended limits

**ALBA8DT** = Date of ALCBAC8

**ALCBA95.** Not applicable

**ALCBA99.** No alcohol counseling documented

