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

DOCHOSPCE (PI module)
Is one of the following documented in the medical record:
- the patient is enrolled in a VHA or community-based Hospice program
- the patient has a diagnosis of cancer of the liver, pancreas, or esophagus
- on the problem list it is documented the patient's life expectancy is less than 6 months?

1. Yes
2. No

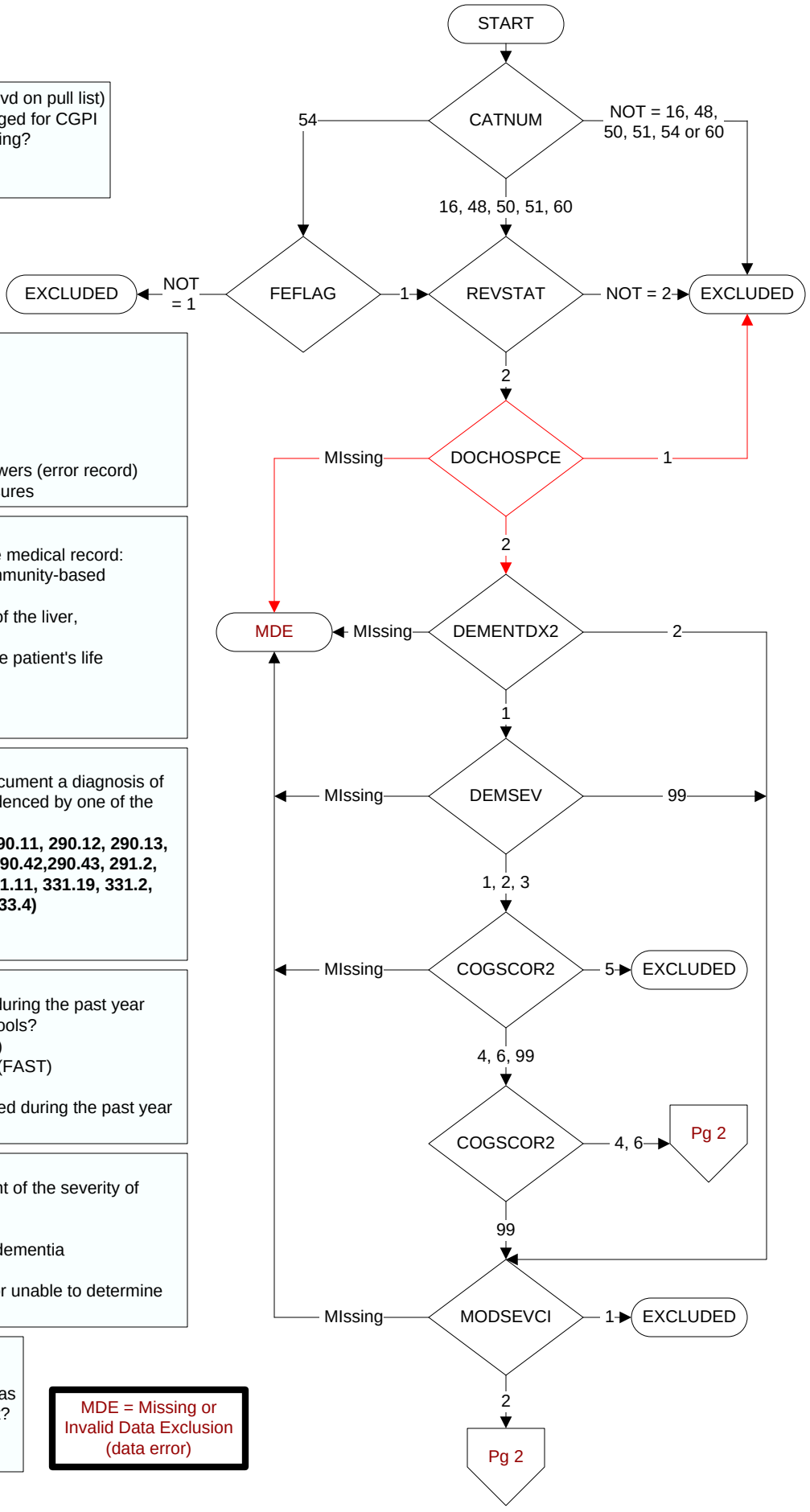
DEMENTDX2 (MH)
During the past year, does the record document a diagnosis of dementia/neurocognitive disorder as evidenced by one of the following ICD-9-CM codes?
(046.11, 046.19, 046.3, 290.0, 290.10, 290.11, 290.12, 290.13, 290.20, 290.21, 290.3, 290.40, 290.41, 290.42,290.43, 291.2, 292.82, 294.10, 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

MDE = Missing or Invalid Data Exclusion (data error)



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.

AUDC1 (MH)
Enter the score documented for AUDIT -C Question # 1 in the past year.
"How often did you have a drink containing alcohol in the past year?
0. Never
1. Monthly or less
2. Two to four times a month
3. Two to three times a week
4. Four or more times a week
99. Not documented

AUDC2 (MH)
Enter the score documented for AUDIT-C Question #2 in the past year.
"How many drinks containing alcohol did you have on a typical day when you were drinking in the past year?"
0. 1 or 2
1. 3 or 4
2. 5 or 6
3. 7 to 9
4. 10 or more
95. Not applicable
99. Not documented

AUDC3 (MH)
Enter the score documented for AUDIT-C Question #3 in the past year.
"How often did you have six or more drinks on one occasion in the past year?"
0. Never
1. Less than monthly
2. Monthly
3. Weekly
4. Daily or almost daily
95. Not applicable
99. Not documented

ALCSCOR (MH)
Enter the total AUDIT-C score documented within the past year in the medical record.
(If the total score is not documented in the record, enter default zz)

OUTDOC (MH)
Was the outcome of the alcohol screen documented in the medical record?
1. Outcome positive documented
2. Outcome negative documented
99. Outcome not documented