

Document Links:[CGPI PI Module](#)[CGPI MH Module](#)**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

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
 5. Administrative exclusion from all measures

FEFLAG (rcvd on pull list)

FE case flagged for CGPI review / scoring?
 0. No
 1. Yes

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-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

DEMSEV (MH)

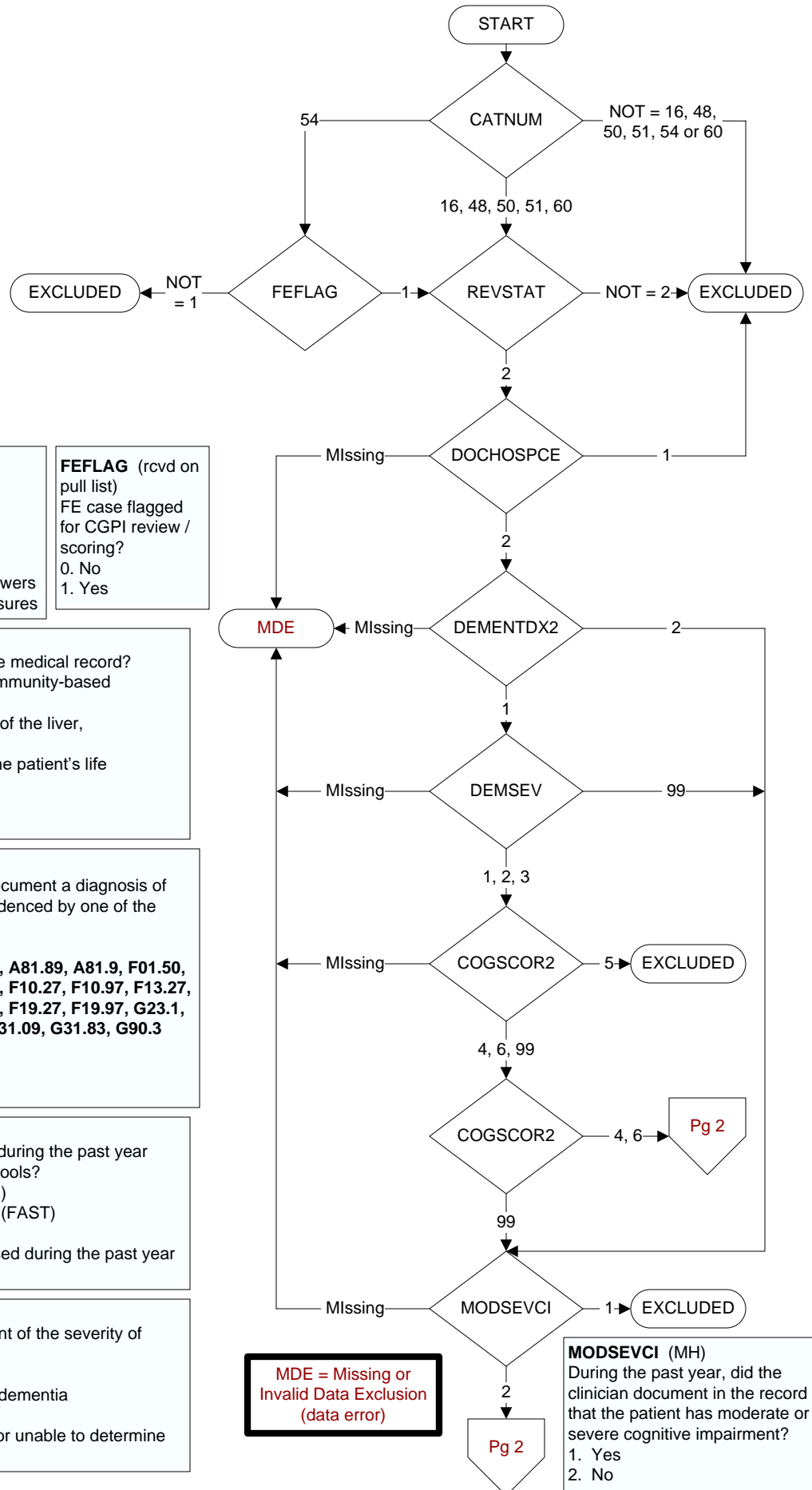
Was the severity of dementia assessed during the past year using one of the following standardized tools?

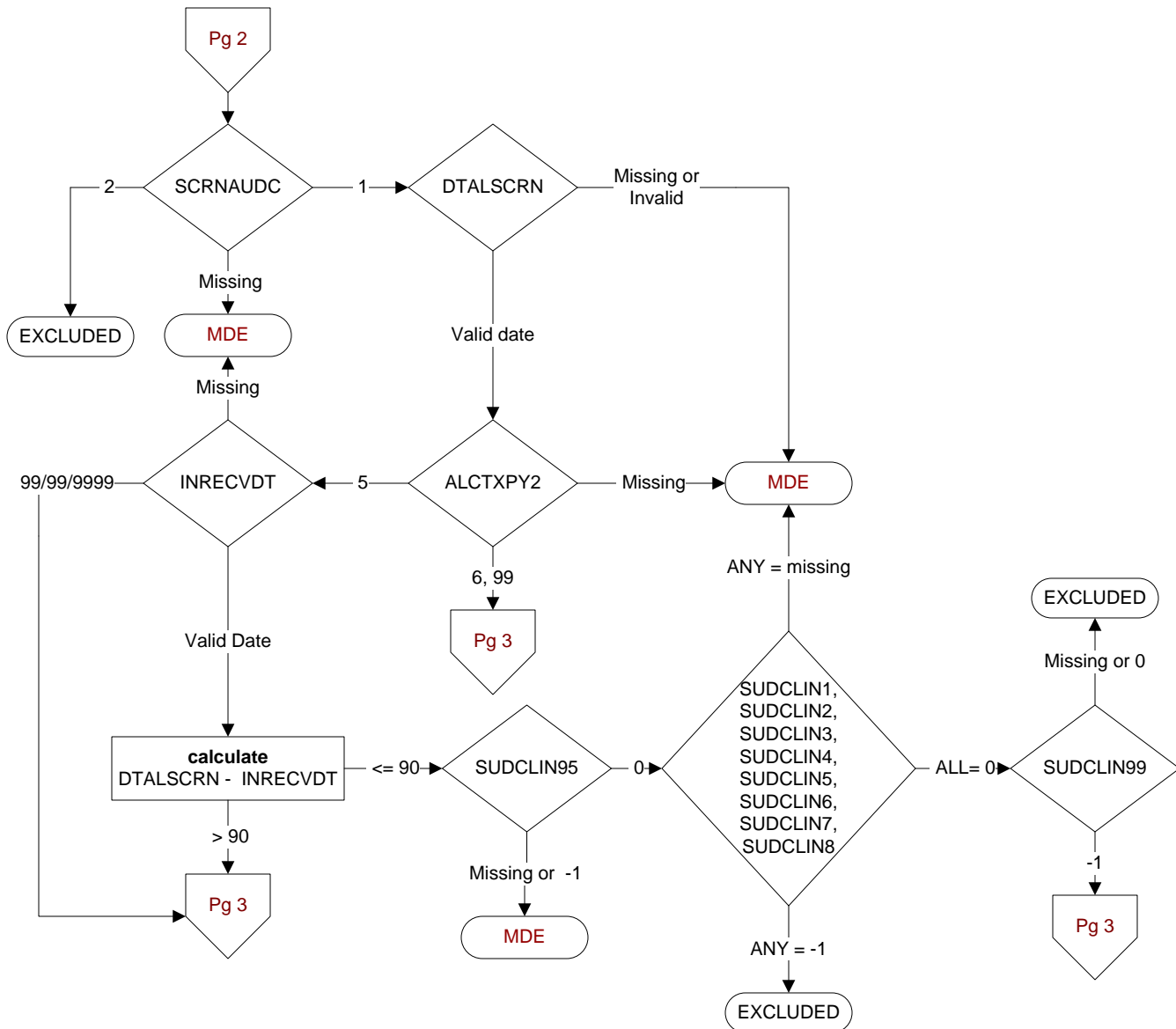
1. Clinical Dementia Rating Scale (CDR)
 2. Functional Assessment Staging Tool (FAST)
 3. Global Deterioration Scale (GDS)
 99. Severity of dementia was not assessed during the past year using one of the specified tools

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





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:
SUDCLIN1. 513 SUD-Individual
SUDCLIN2. 514 SUD-Home
SUDCLIN3. 519 SUD-PTSD
SUDCLIN4. 547 Intensive-SUD Treatment
SUDCLIN5. 523 Opioid Substitution
SUDCLIN6. 560 SUD-Group
SUDCLIN7. 545 SUD-Telephone
SUDCLIN8. 548 Intensive-SUD-Individual
SUDCLIN95. Not applicable
SUDCLIN99. None of the above

-1 = Yes
0 = No

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

-1 = Yes

0 = No

