

**Document Links:**[CGPI Validation Module](#)[CGPI MH Module](#)**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 data
- 5. Administrative exclusion

**HOSPICE** (PI module)

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

**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, , F01.511, F01.518, F01.52 – F01.54, F01.A0, F01.A11, F01.A18, F01.A2 – F01.A4, F01.B0, F01.B11, F01.B18, F01.B2 – F01.B4, F01.C0, F01.C11, F01.C18, F01.C2 – F01.C4, F02.80, , F02.811, F02.818, F02.82 – F02.84, F02.A0, F02.A11, F02.A18, F02.A2 – F02.A4, F02.B0, F02.B11, F02.B18, F02.B2 – F02.B4, F02.C0, F02.C11, F02.C18, F02.C2 – F02.C4, F03.90, , F03.911, F03.918, F03.92 – F03.94, F03.A0, F03.A11, F03.A18, F03.A2 – F03.A4, F03.B0, F03.B11, F03.B18, F03.B2 – F03.B4, F03.C0, F03.C11, F03.C18, F03.C2 – F03.C4, 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?

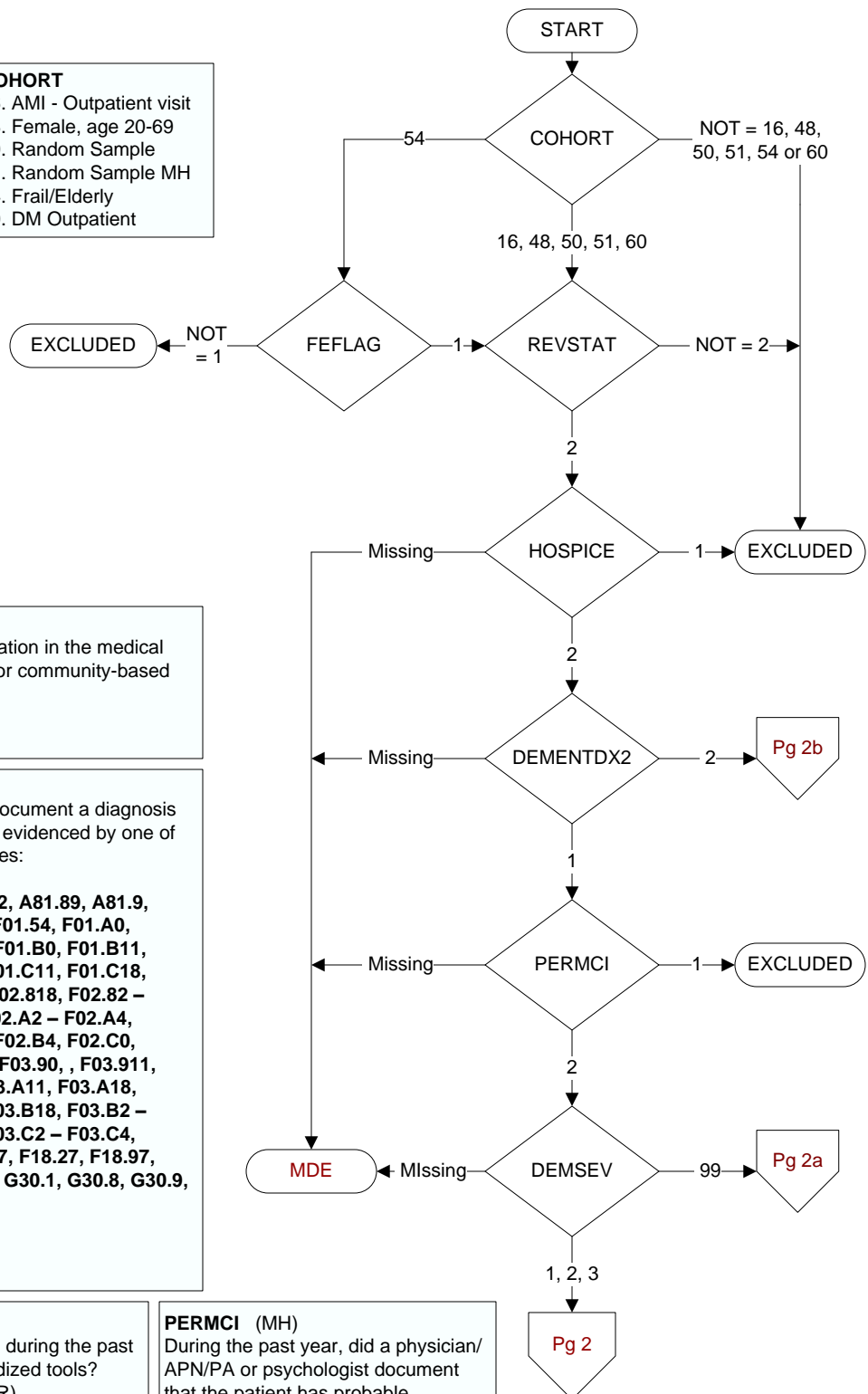
- 1. Clinical Dementia Rating Scale (CDR)
- 2. Functional Assessment Staging Tool (FAST)
- 3. Global Deterioration Scale (GDS)
- 99. Severity of dementia was not assessed during the past year using one of the specified tools

**PERMCI** (MH)

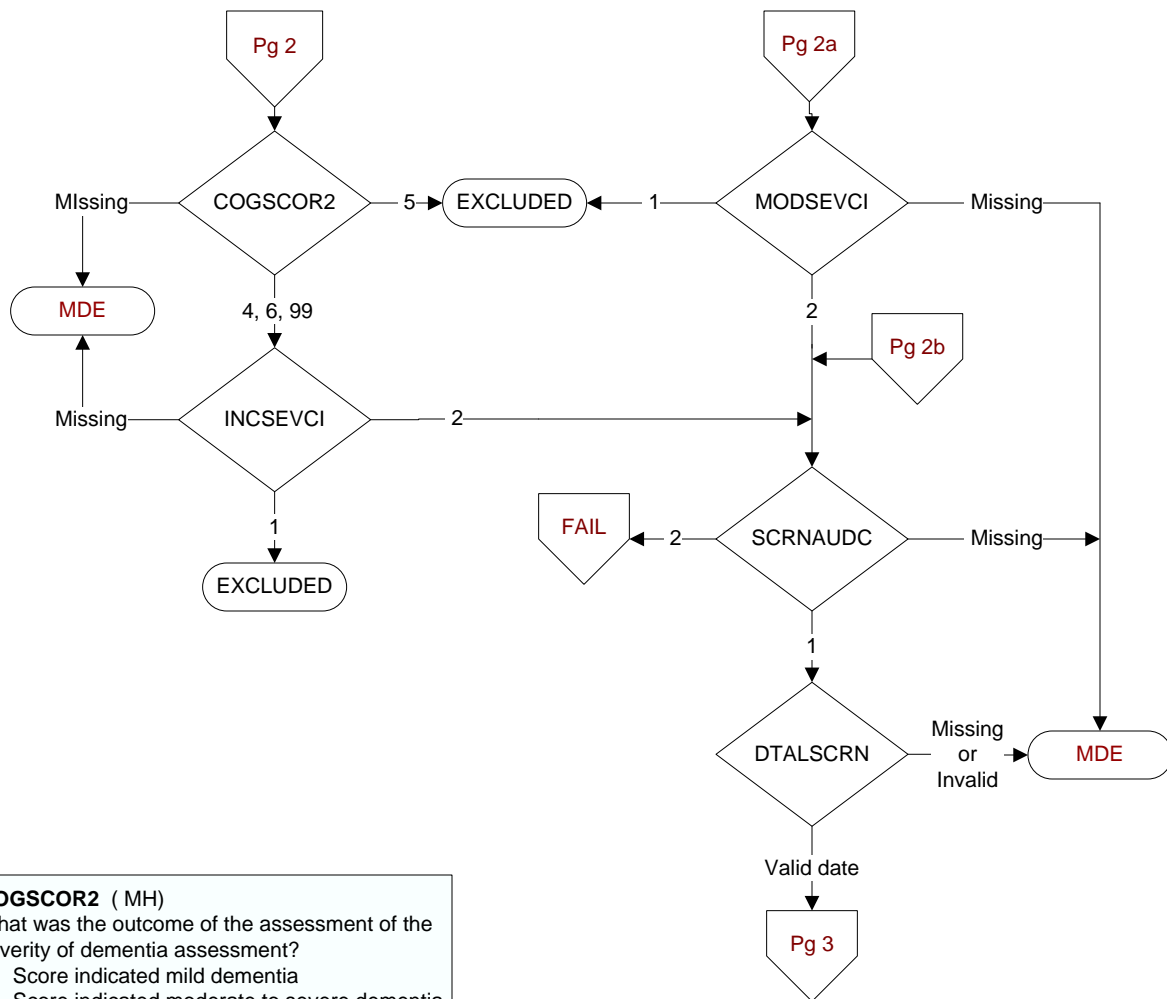
During the past year, did a physician/ APN/PA or psychologist document that the patient has probable permanent cognitive impairment using a Clinical Reminder?

- 1. Yes
- 2. No

**COHORT**  
 16. AMI - Outpatient visit  
 48. Female, age 20-69  
 50. Random Sample  
 51. Random Sample MH  
 54. Frail/Elderly  
 60. DM Outpatient



**MDE = Missing or Invalid Data Exclusion (data error)**



**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

**INCSEVCI (MH)**

During the timeframe from (computer display demsevd + 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

**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.

**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)

