

**Document Links:**[HBPC Instrument](#)**COHORT**

69 – Home Based Primary Care

**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 from all measures

**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

**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, F01.511, 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

**PERMCI**

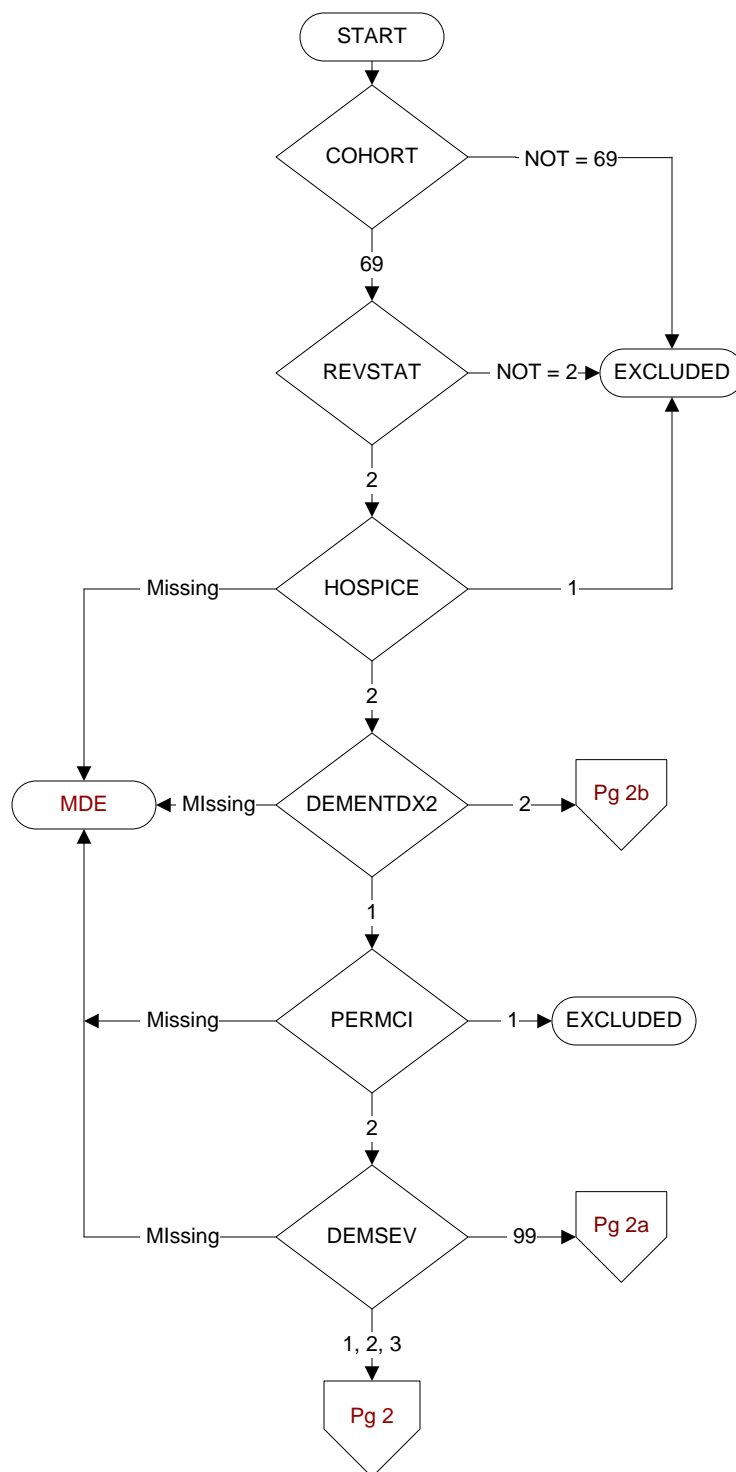
During the past year, did a physician/APN/PA or psychologist document that the patient has probable permanent cognitive impairment using a Clinical Reminder?

- 1. Yes
- 2. No

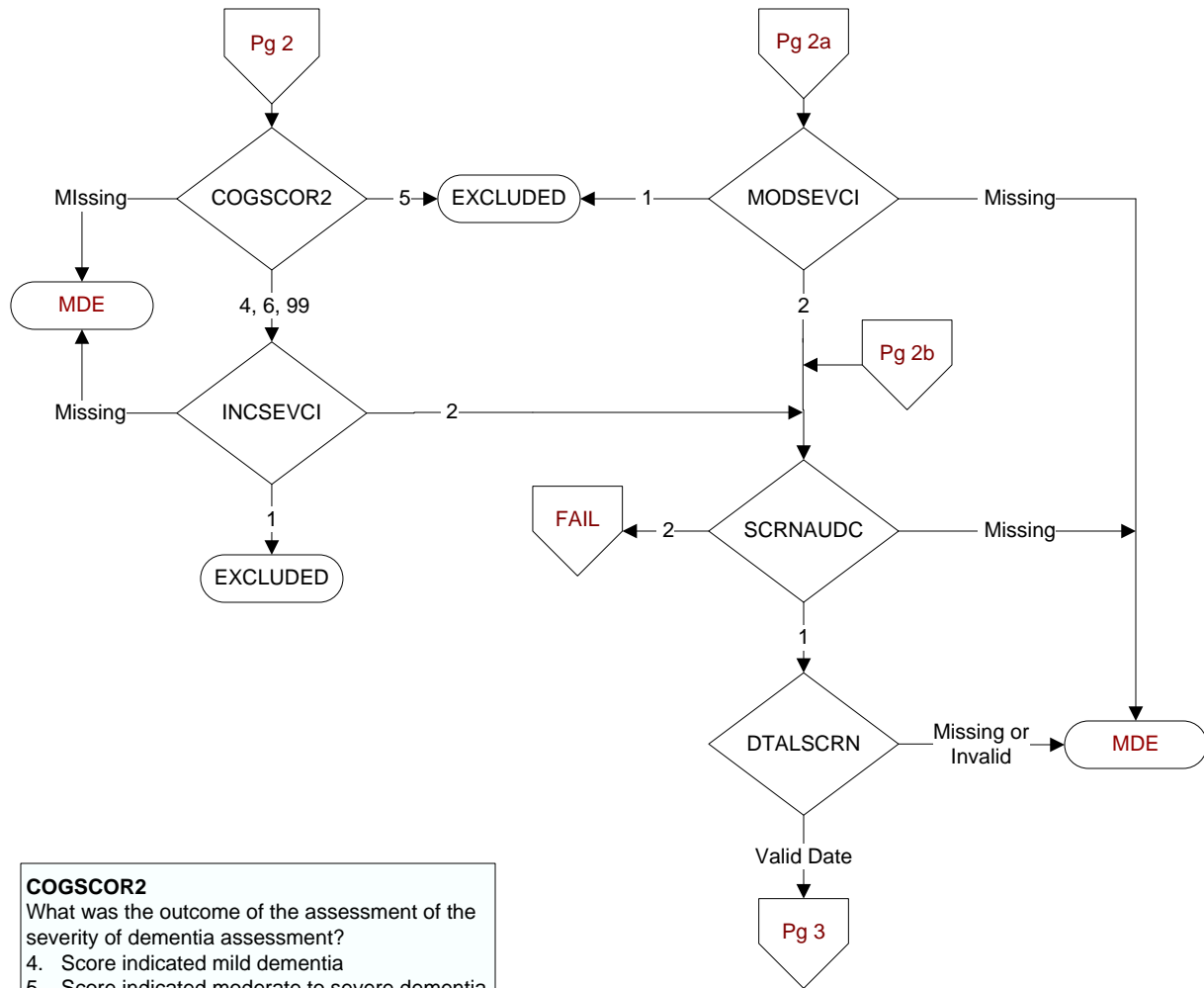
**DEMSEV**

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



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

**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

**INCSEVCI**

During the time frame 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**

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**

During the past year, was the patient screened for alcohol misuse with the AUDIT-C?

- 1. Yes
- 2. No

**DTALSCRN**

Enter the most recent date of screening for alcohol misuse with the AUDIT-C.

**AUDC1**

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**

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**

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**

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)

