**Document Links:**

CGPI Validation Module

CGPI MH Module

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

**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

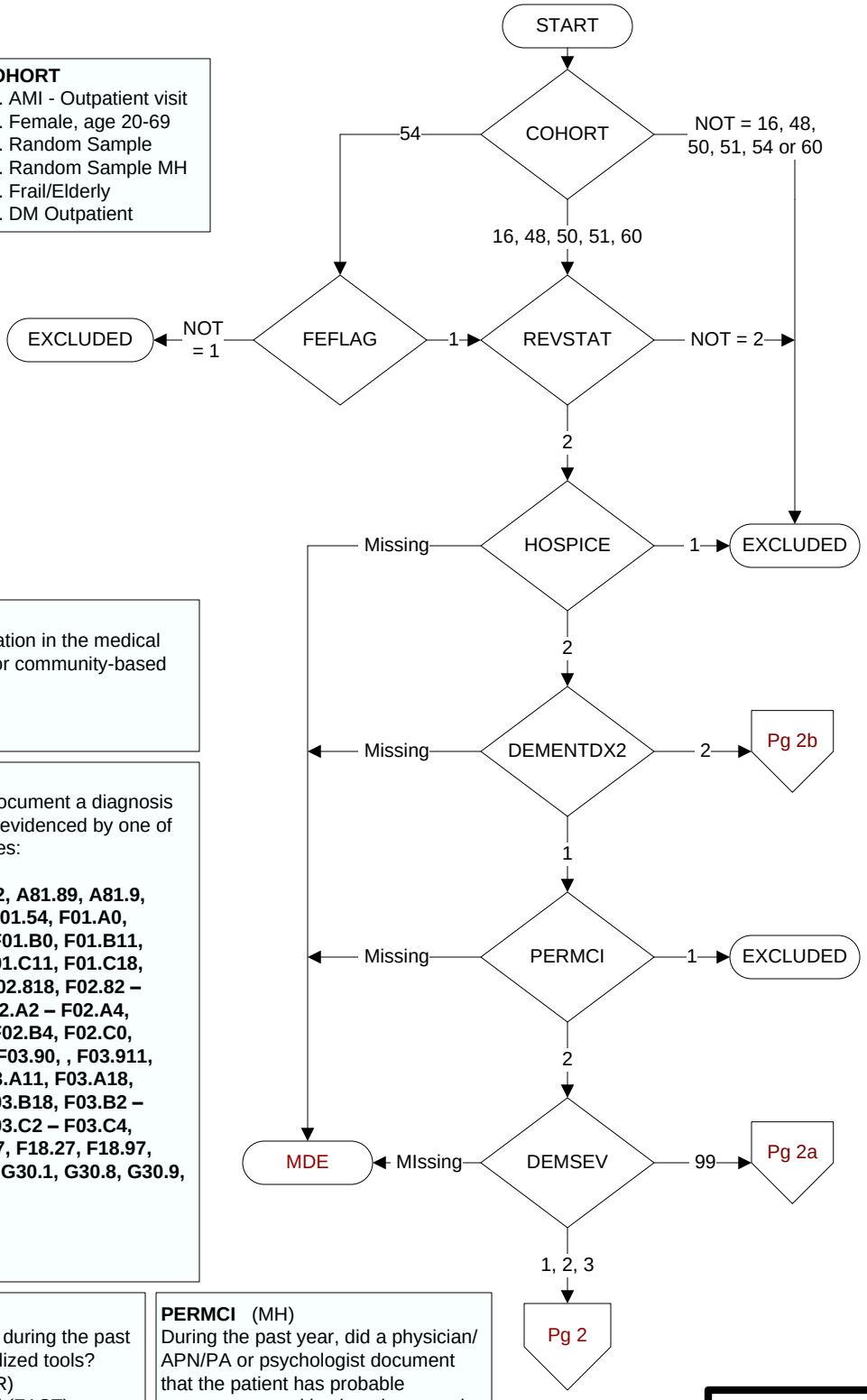
**DEMENTDX2** (MH)
During the past year, does the record document a diagnosis of dementia/neurocognitive disorder as evidenced by one of the following ICD-10-CM diagnosis codes:

**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**

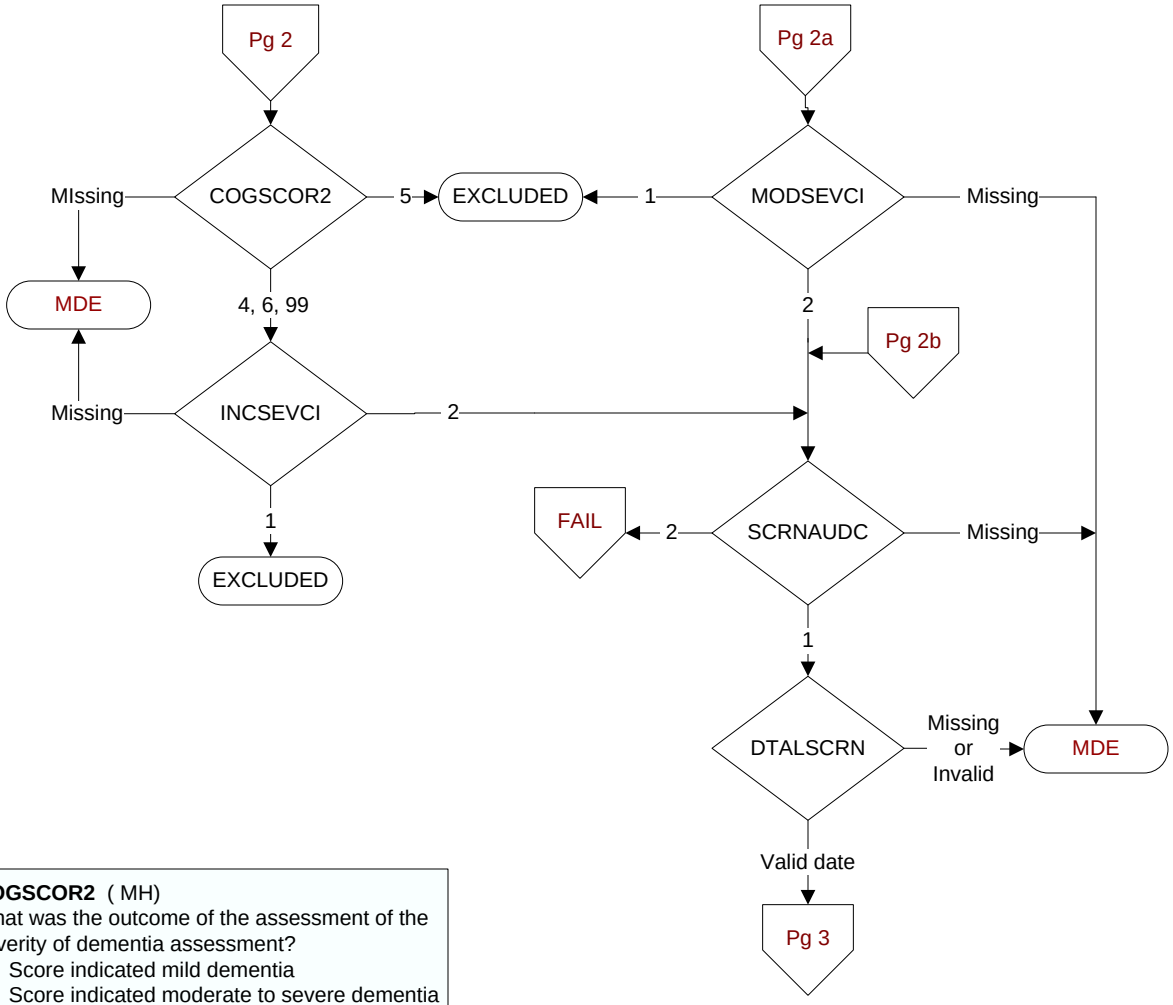
1. Yes
2. No

**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




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 demsevdt + 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 <u>total</u> 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)