## **Document Links:**

**HBPC Instrument** 

#### **CATNUM**

Sample cohort

HBPC - 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 required answers
- 5. Administrative Exclusion

#### **DOCHOSPCE** (HBPC)

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** (HBPC)

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:

A8100, A8101, A8109, A812, A8189, A819, Primary I60xx – I69xx + Secondary F0150 or F0151, F0390, F0391, any Primary xxx.xx + Secondary F0280 or F0281, F0390. F0391, F1027, F1997, G231, G300, G301, G308, G309, G3101, G3109, G3183, G903

- 1. Yes
- 2. No

#### **DEMSEV** (HBPC)

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 (HBPC)

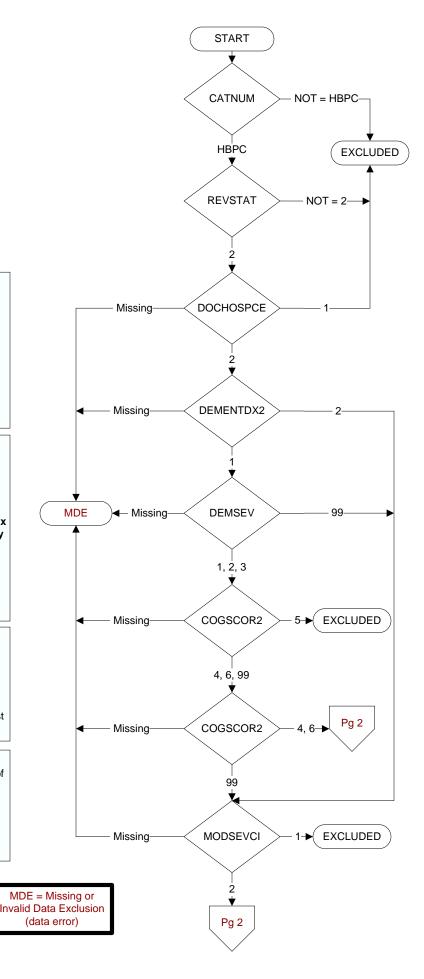
What was the outcome of the assessment of the severity of dementia assessment?

- 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 (HBPC)

During the past year, did the clinician document in the record that the patient has moderate or severe cognitive impairment?

- 1. Yes
- 2. No





Within the past year, did the patient have at least one clinical encounter where PTSD was identified as a reason for the clinical encounter as evidenced by one of the following ICD-10-CM diagnosis codes:

## F431, F4310 - F4312

- 1. Yes
- 2. No

#### PTSRNPC (HBPC)

Within the past five years, was the patient screened for PTSD using the Primary Care PTSD Screen (PC-PTSD)?

- 1. Yes
- 2. No

#### PCPTSDT (HBPC)

Enter the date of the <u>most recent</u> <u>screen</u> for PTSD using the PC-PTSD.

#### STDYBEG

(Rcvd on Pull List) Study Interval begin date

## PCPTSD (HBPC)

Enter the patient's answers to each of the Primary Care PTSD Screen questions:

Have you ever had any experience that was so frightening, horrible, or upsetting that, **IN THE PAST MONTH**, you:

- 1. Have had any nightmares about it or thought about it when you did not want to?
- 2. Tried hard not to think about it or went out of your way to avoid situations that remind you of it?
- 3. Were constantly on guard, watchful, or easily startled?
- 4. Felt numb or detached from others, activities, or your surroundings?
- 1. Yes
- 2 No
- 99. No answer documented

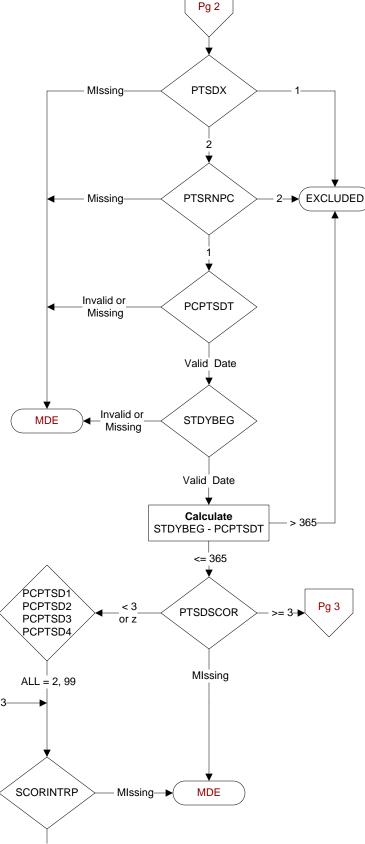
# PTSDSCOR (HBPC) Enter the total score for the

screen documented in the record. (Abstractor can enter default z if no total score is documented)

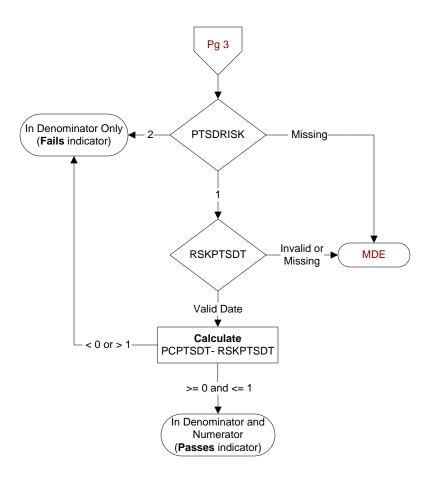
#### SCORINTRP (HBPC)

Enter the interpretation of the PC-PTSD score, <u>as documented in the medical record</u>.

1. Positive



**EXCLUDED** 



## **PTSDRISK**

On the day of or the day after the positive PC-PTSD screen, did the provider document a suicide ideation/behavior evaluation?

1. Yes

2. No

# **RSKPTSDT**

Enter the date the suicide ideation/behavior evaluation was completed.