Document Links:

CGPI Validation Module

CGPI Core Module

CERNER (system flag)
Flag indicating facility has upgraded to the Cerner eHR

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 missing required answers
5. Administrative exclusion

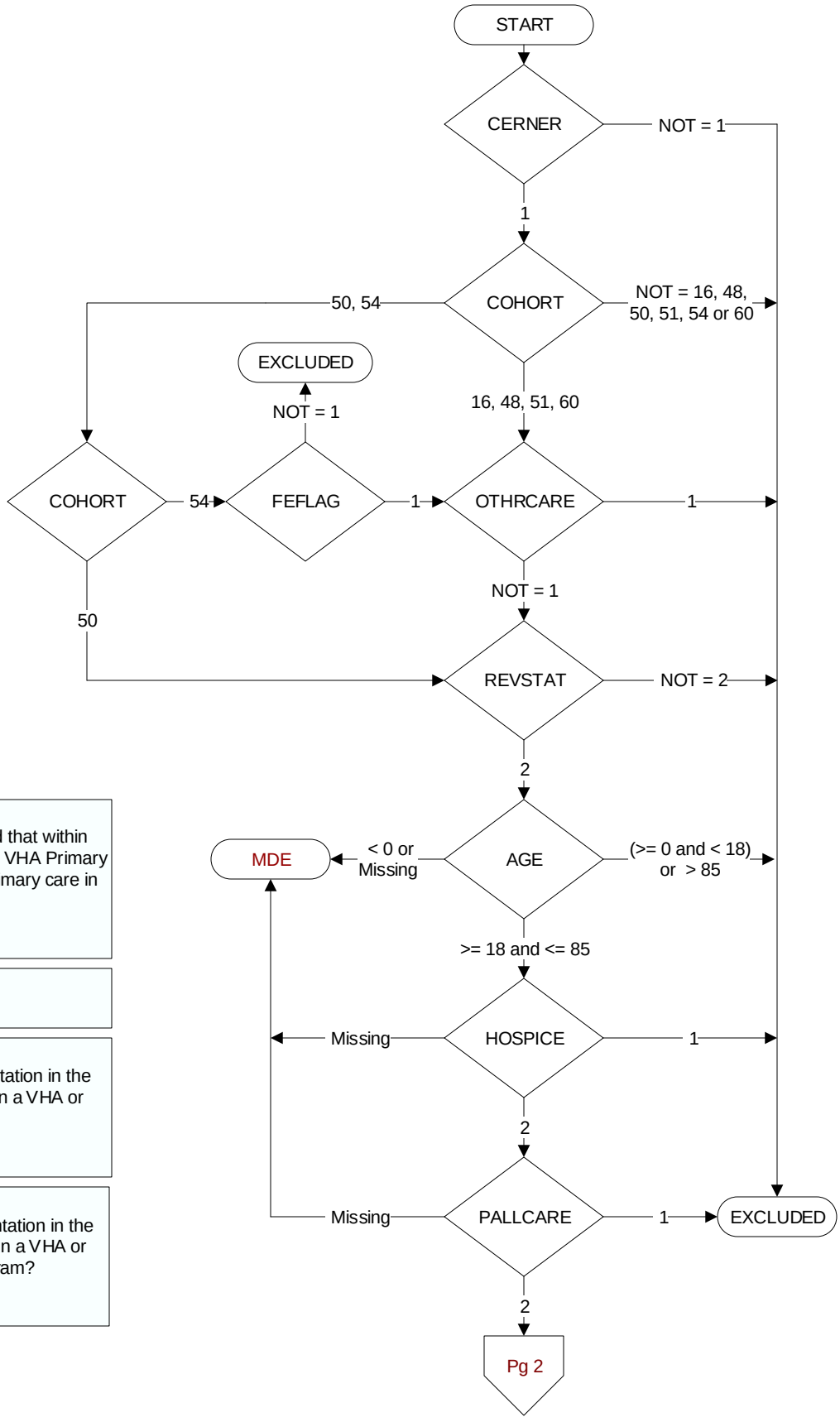
OTHRCARE (Validation)
Is there evidence in the medical record that within the past two years, the patient refused VHA Primary Care and is receiving ONLY his/her primary care in a non-VHA setting?
1. yes
2. no

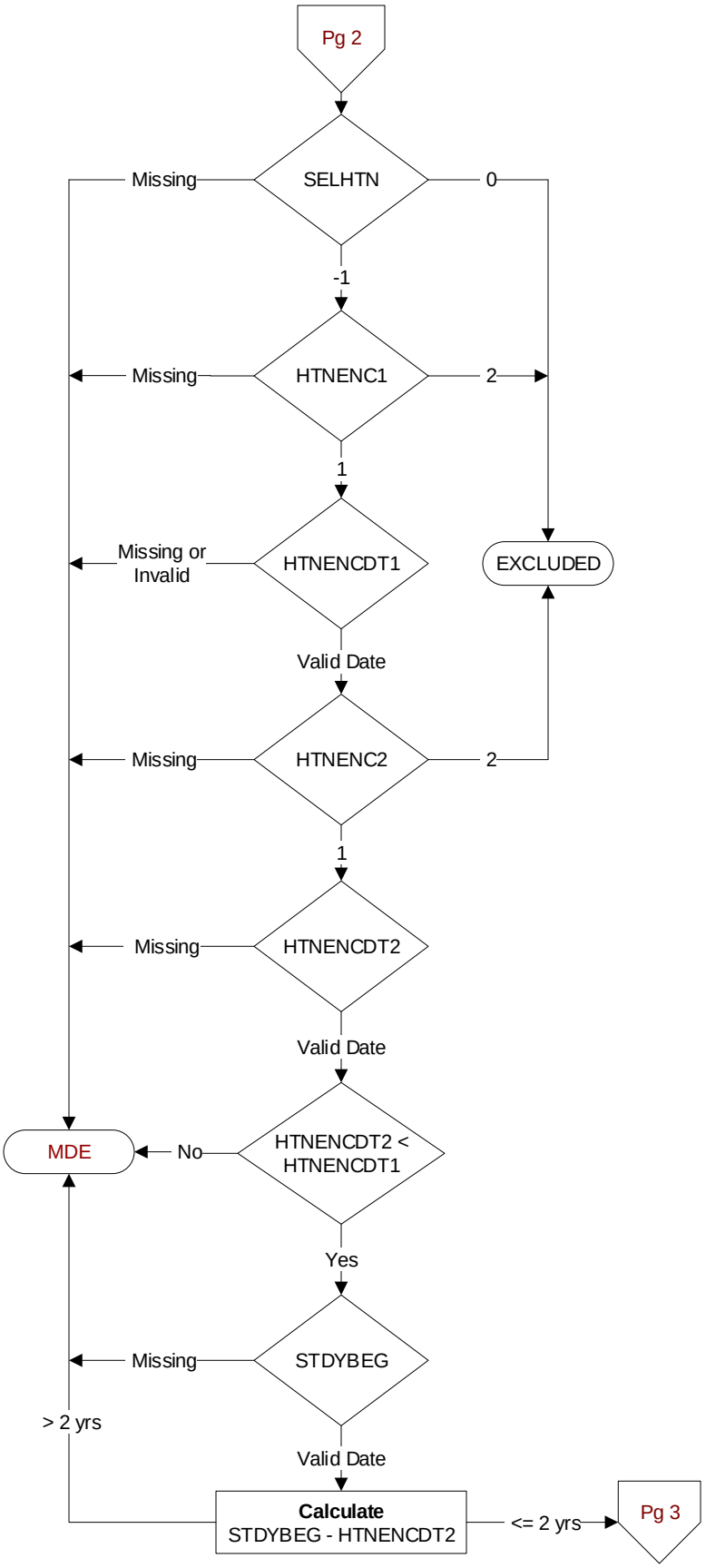
AGE (Calculated field)
NEXUS clinic visit date – BIRTHDT

HOSPICE (Validation)
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

PALLCARE (Validation)
During the past year is there documentation in the medical record the patient is enrolled in a VHA or community-based palliative care program?
1. Yes
2. No

MDE = Missing or Invalid Data Exclusion (data error)





Did the patient have one or more of the following active diagnoses? (Validation)

SELHTN = Hypertension

-1 = Yes
0 = No

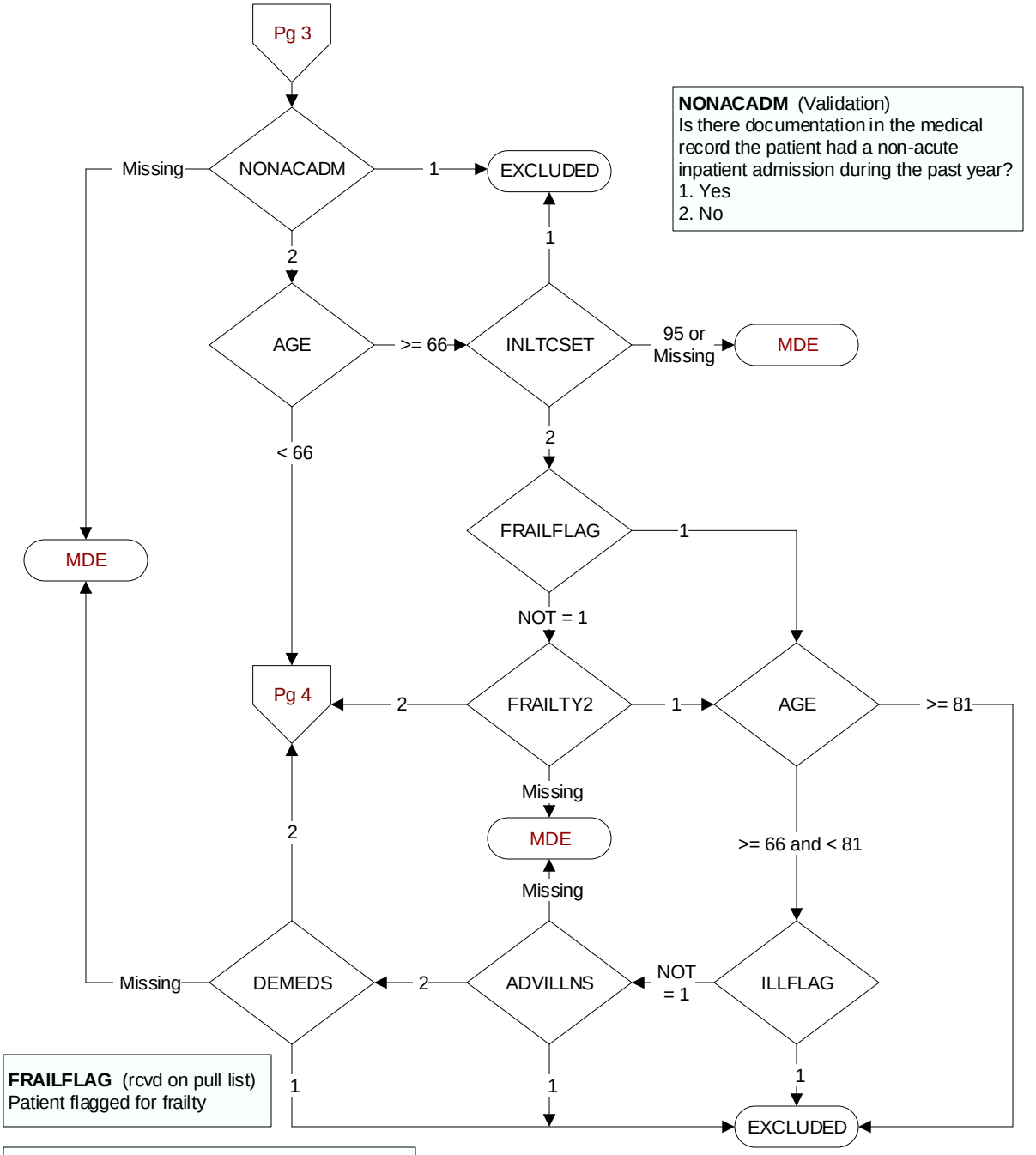
HTNENC1 (Validation)
During the timeframe (computer display stdybeg - 1 year to stdybeg - 6 months) is there documentation the patient had an outpatient encounter with a documented diagnosis of hypertension?
1. Yes
2. No

HTNENCDT1 (Validation)
Enter the date of the most recent outpatient encounter with documented diagnosis of hypertension during the timeframe from (computer display stdybeg - 1 year to stdybeg - 6 months).

HNTENC2 (Validation)
During the timeframe from (computer to display 2 years prior to stdybeg) to (computer to display htnencdt1-1 day) is there documentation the patient had an outpatient encounter with a documented diagnosis of hypertension?
1. Yes
2. No

HNTENCDT2 (Validation)
Enter the date of the most recent outpatient encounter with documented diagnosis of hypertension during the timeframe from (computer to display 2 years prior to stdybeg) to (computer to display htnencdt1- 1 day).

STDYBEG (rcvd on pull list)
Study Interval begin date



NONACADM (Validation)
Is there documentation in the medical record the patient had a non-acute inpatient admission during the past year?
1. Yes
2. No

FRAILFLAG (rcvd on pull list)
Patient flagged for frailty

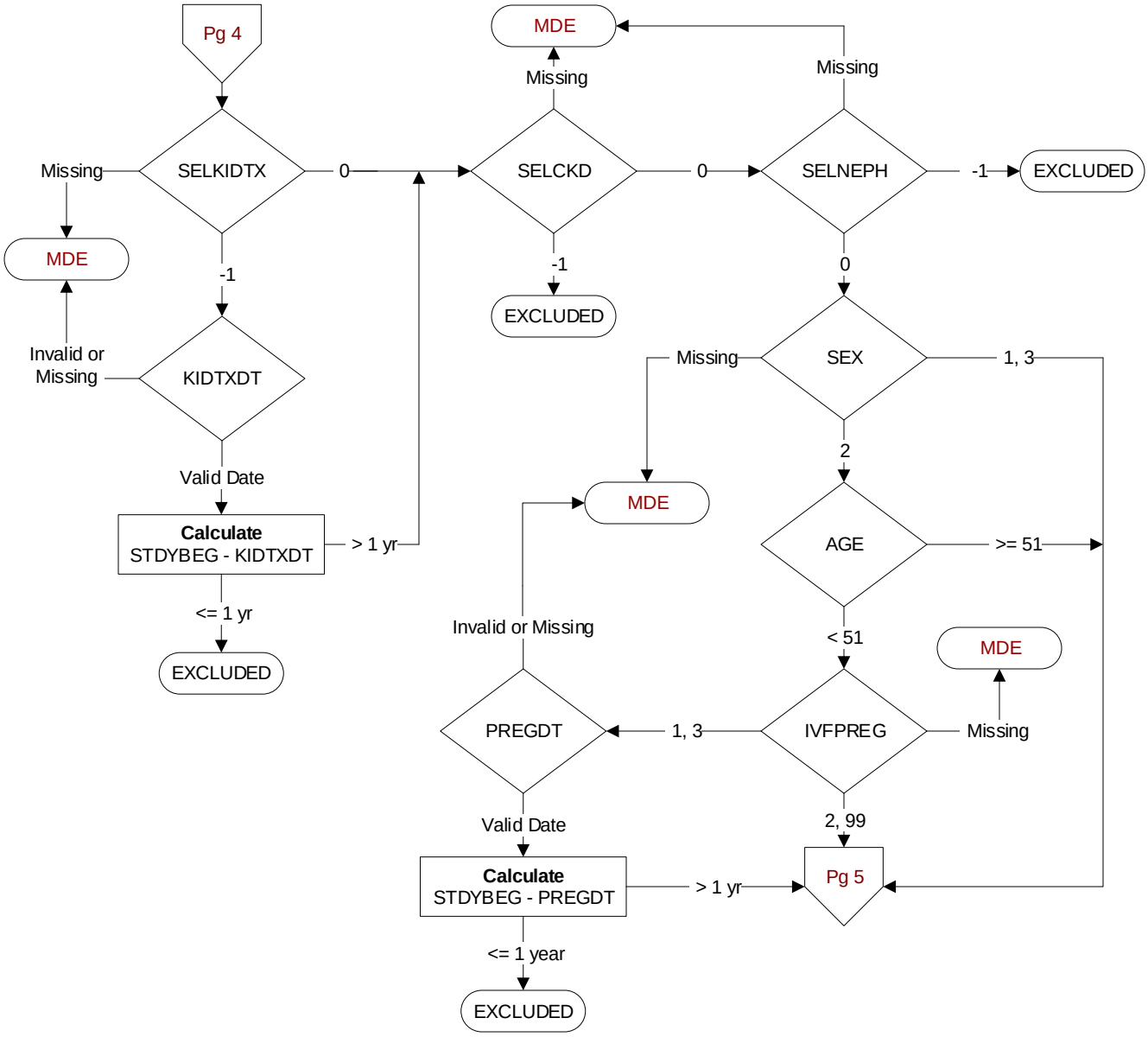
INLTCSET (Validation)
Is there documentation in the medical record the patient lived long-term (greater than 60 consecutive days) in a VHA or community-based institutional setting anytime during the past year?
1. Yes
2. No
95. Not applicable

FRAILTY2 (Validation)
During the past year, is there documentation in the medical record the patient has anycondition/diagnosis consistent with frailty documented on two different dates?
1. Yes
2. No

ADVILLNS (Validation)
During the past two years, is there documentation in the medical record the patient has an advanced illness diagnosis?
1. Yes
2. No

DEMEDS (Validation)
During the past two years, is there physician, NP, PA, CNS or pharmacist documentation in the medical record the patient has a prescription for a dementia medication?
1. Yes
2. No

ILLFLAG (rcvd on pull list)
Patient flagged for advanced illness



Did the patient have one or more of the following active diagnoses? (Validation)

SELCKD - Chronic Kidney (Renal) Disease, stage 5 or ESRD (end stage renal disease) or dialysis (hemodialysis or peritoneal dialysis) documented any time prior to the study end date
ICD-10 codes N185, N186, Z9115, Z992, 3E1M39Z, 5A1D00Z, 5A1D60Z, 5A1D70Z, 5A1D80Z, 5A1D90Z

SELKIDTX- Kidney Transplant
ICD-10 codes Z94.0, 0TY00Z0, 0TY00Z1, 0TY00Z2, 0TY10Z0, 0TY10Z1, 0TY10Z2,

KIDTXDT - Enter the date of the most recent kidney transplant done any time prior to the study end date.

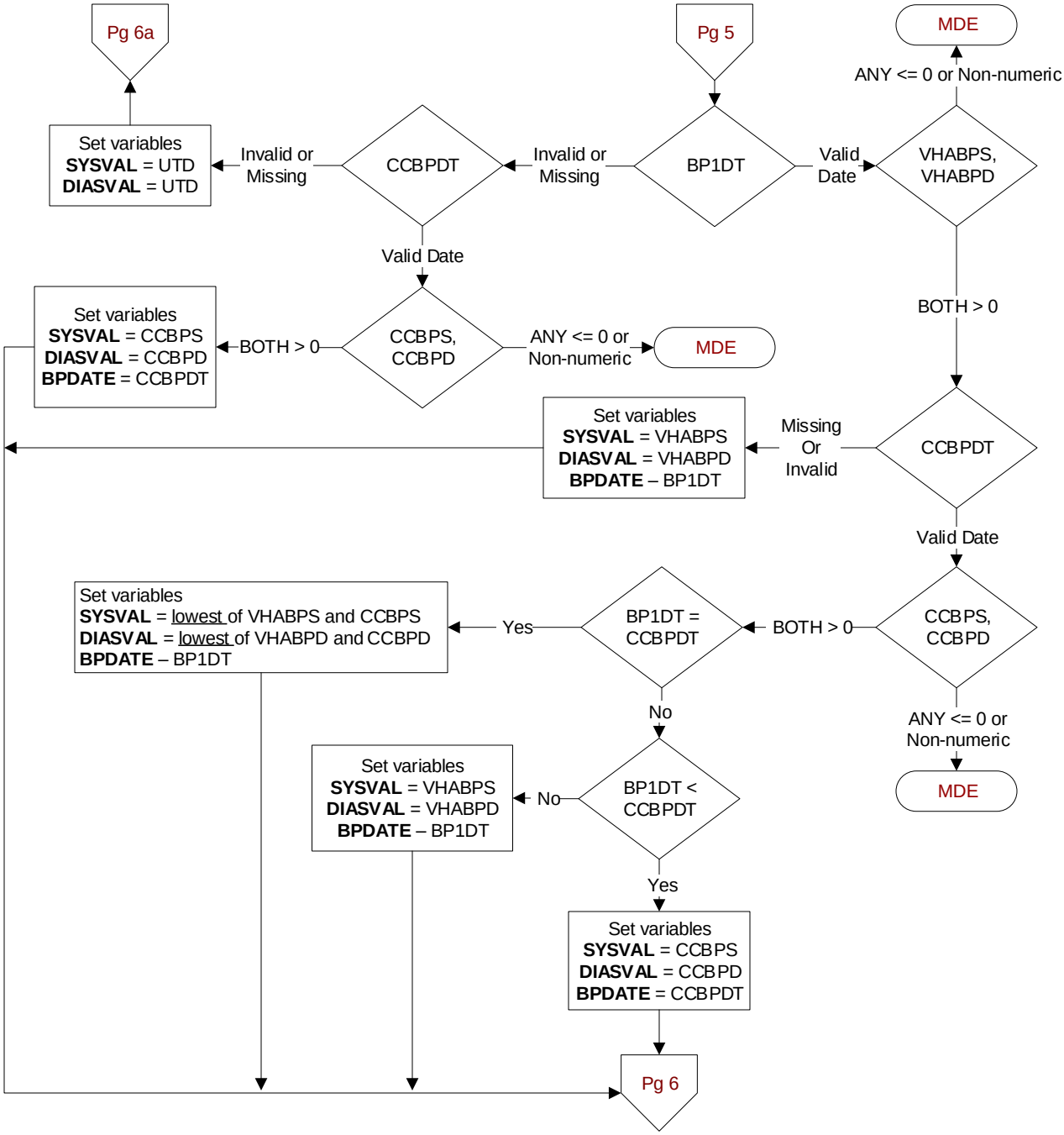
SELNEPH = Nephrectomy (kidney removal) documented any time prior to the study end date
ICD-10 PCS codes (0TB00ZZ, 0TB03ZZ, 0TB04ZZ, 0TB07ZZ, 0TB08ZZ, 0TB10ZZ, 0TB13ZZ, 0TB14ZZ, 0TB17ZZ, 0TB18ZZ, 0TT00ZZ, 0TT04ZZ, 0TT10ZZ, 0TT14ZZ, 0TT20ZZ, 0TT24ZZ

-1 = Yes
0 = No

SEX (rcvd on pull list)
Patient's gender
1. male
2. female
3. unknown

IVFPREG (Validation)
Does the record document any one of the following during the past two years:
1. Pregnancy
2. In vitro fertilization (IVF)
3. Both in vitro fertilization and pregnancy
99.None of the above

PREGDT (Validation)
Enter the most recent date evidence of pregnancy was documented in the medical record during the past two years.

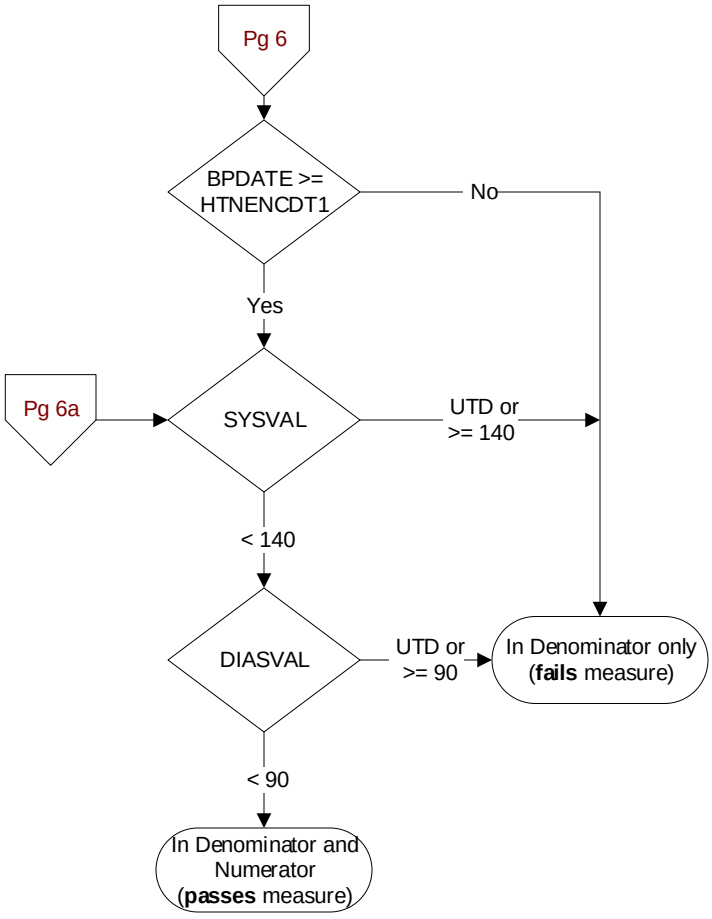


VHABPS (systolic value)
VHABPD (diastolic value)
(Core Module)
Enter the patient's blood pressure measured most recently at a VHA encounter within the past year.
(Exclude BP taken in ED, Ambulatory Surgery, Urgent Care visit, or during an inpatient admission)

CCBPS (systolic value)
CCBPD (diastolic value)
(Core Module)
Enter the most recent blood pressure documented in the record by Care Coordination (CC/H).

BP1DT (Core Module)
Enter the date this blood pressure was measured.

CCBPDT (Core Module)
Enter the date this blood pressure was measured.


Pg 6
BPDATE >= HTNENCDT1
No
Yes
Pg 6a
SYSVAL
UTD or >= 140
< 140
DIASVAL
UTD or >= 90
In Denominator only (**fails** measure)
< 90
In Denominator and Numerator (**passes** measure)