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

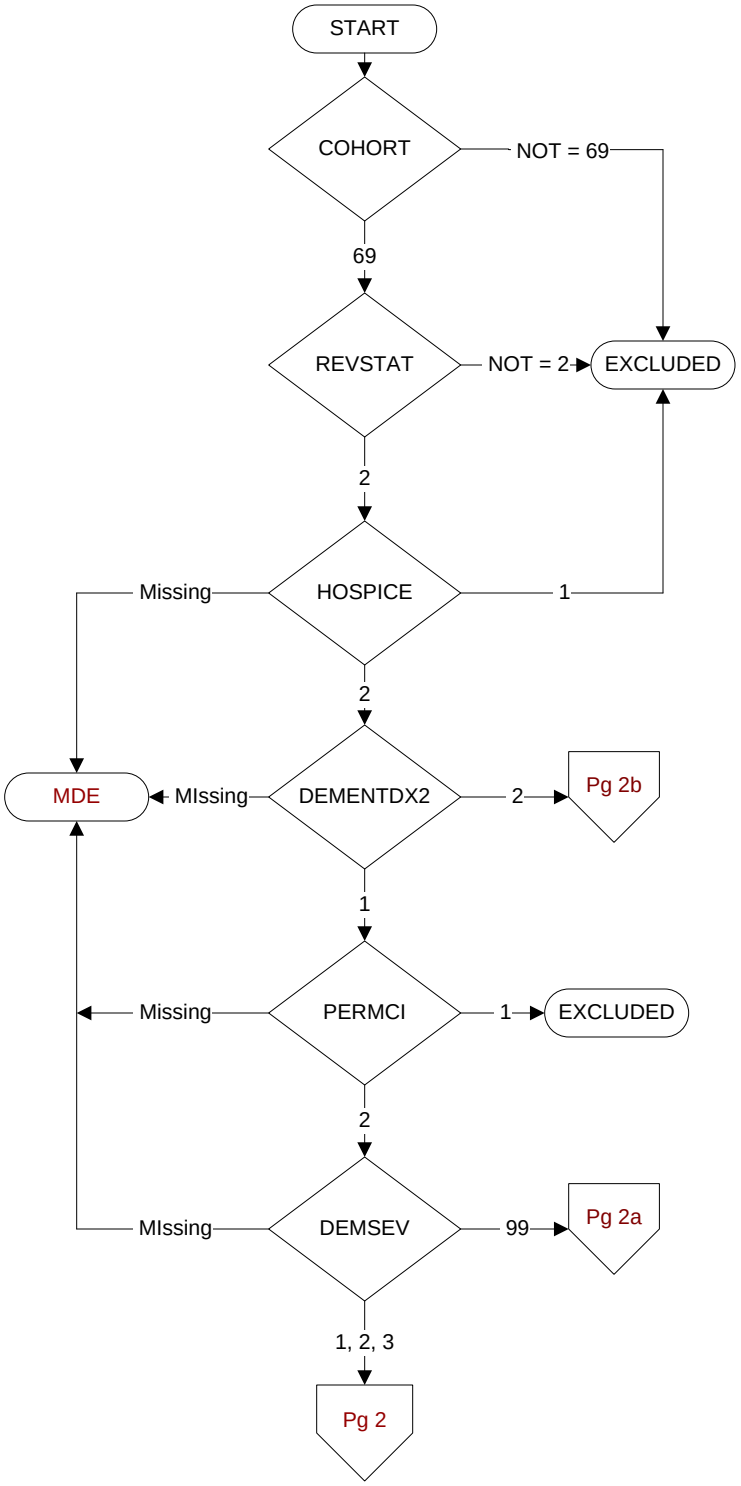
DEMENTDX2 (MH)
During the past year, does the record document a diagnosis of dementia/neurocognitive disorder as evidenced by one of the following ICD-10-CM diagnosis codes:

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

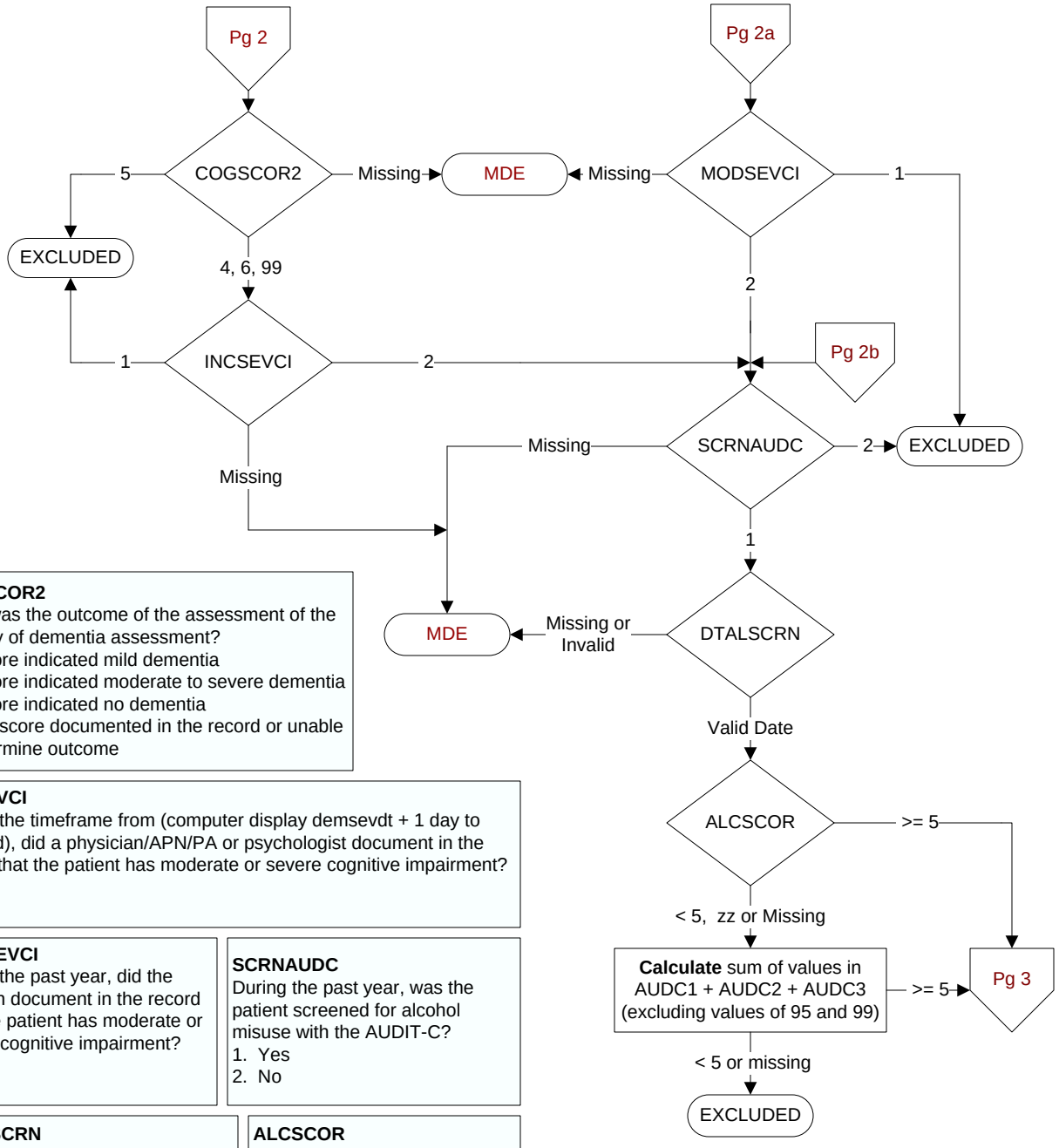
1. Yes
2. No

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 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
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.

ALCSCOR
Enter the total AUDIT-C score documented within the past year in the medical record.

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

During the timeframe from (Computer to enter DTALSCRN to DTALSCRN +14 days), does the record document any of the following components of brief alcohol intervention/counseling for past-year drinkers?

Indicate all that apply and the date brief alcohol intervention/counseling was noted in the record:

ALCBAI3. Advised/informed patient to abstain OR explicitly advised/informed patient to drink within recommended limits
ALBAI3DT: Date of ALCBAI3
ALCBAI4. Provided personalized feedback regarding relationship of alcohol to the patient's specific health issues OR general alcohol-related intervention/ counseling (not linked to patient's issues)
ALBAI4DT: Date of ALCBAI4
ALCBAI99.No alcohol intervention/counseling documented

-1 = Yes
0 = No