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| **If dochospce = 1, go out of module; else go to dementdx2** | | | | |
|  |  | **Assessment of Cognitive Function** |  |  |
| 1 | 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:  **A8100, A8101, A8109, A812, A8189, A819, F0150, F0151, F0280, F0281, F0390, F0391, F1027, F1997, G231, G300, G301, G308, G309, G3101, G3109, G3183, G903**  1. Yes  2. No | 1,2  If 2, go to modsevci | **The problem list or health factors may be used to perform an initial search for the diagnosis of dementia or other condition associated with dementia; however, the documentation of the applicable ICD-10-CM code must be found in association with an inpatient or outpatient encounter during the past year.**  **Each health factor should have an associated date that represents the date the health factor was recorded.**  **For the purposes of this question, acceptable dementia diagnosis codes are included in the table on the next page.**  Suggested data sources: Clinic/progress notes (e.g. primary care, neurology, geriatrics, psychiatry), history and physical, discharge summary, outpatient encounter diagnosis codes, admission/discharge codes |
| **ICD-10-CM Code Dementia/neurocognitive Disorder Code Table**   |  |  |  |  | | --- | --- | --- | --- | | **ICD-10-CM Code** | **ICD-10-CM Description** | **ICD-10-CM Code** | **ICD-10-CM Description** | | A81.00 | Creutzfeldt-Jakob disease, unspecified | F19.97 | Other psychoactive substance use, unspecified with psychoactive substance-induced persisting dementia | | A81.01 | Variant Creutzfeldt-Jakob disease | G23.1 | Progressive supranuclear palsy | | A81.09 | Creutzfeldt-Jakob disease, other | G30.0 | Alzheimer's disease with early onset | | A81.2 | Progressive multifocal leukoencephalopathy | G30.1 | Alzheimer's disease with late onset | | A81.89 | Other atypical virus infections of central nervous system [included for Prion disease of the CNS NEC] | G30.8 | Other Alzheimer's disease | | A81.9 | Atypical virus infection of central nervous system, unspecified [Prion diseases of the central nervous system NOS] | G30.9 | Alzheimer's Disease, Unspecified | | F02.80 | Dementia in other diseases classified elsewhere without behavioral disturbance | G31.01 | Pick's Disease | | F02.81 | Dementia in other diseases classified elsewhere with behavioral disturbance | G31.09 | Other Frontotemporal Dementia | | F03.90 | Unspecified dementia without behavioral disturbance | G31.83 | Dementia with Lewy Bodies | | F03.91 | Unspecified dementia with behavioral disturbance | G90.3 | Multi-system atrophy | | F10.27 | Alcohol dependence with alcohol-induced persisting dementia |  |  | | | | | |

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| 2 | 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 | 1,2,3,99  If 99, go to modsevci | **Clinical Dementia Rating Scale** (CDR) = 5-point scale used to characterize six domains of cognitive and functional performance (memory, orientation, judgment & problem-solving, community affairs, home & hobbies, personal care)  **Functional Assessment Staging Tool (FAST)** = charts decline of patients with Alzheimer’s Disease and is broken down into 7 stages.  **Global Deterioration Scale (GDS)** = provides an overview of the stages of cognitive function and is broken down into 7 stages. |
| 3 | 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 | 4,\*5,6,99  If 4 or 6, go to scrnaudc  **\*If 5, go out of module**  **If 99, go to modsevci** | **Abstractor judgment may be used. The record must document the score of the assessment and the abstractor must be able to determine whether the score indicates no dementia, mild dementia, or moderate to severe dementia.** The scoring of the dementia assessment and therefore the outcome will be determined based upon which standardized tool was utilized.  In order to answer “4” or “5,” the abstractor must be able to determine whether the score indicated mild dementia or moderate to severe dementia. For example, patient is assessed with CDR and documented score = 2, select “5.”  **Clinical Dementia Rating Scale:** Score may range from 0 (normal) to 3 (severe dementia)  **Functional Assessment Staging Tool (FAST):** Score may range from 1 (normal) to 7 (severe dementia)  **Global Deterioration Scale (GDS)** : Score (stage) may range from 1 (no cognitive impairment) to 7 (very severe cognitive decline)  For the above tools, scores indicating at least moderate degree of dementia are:   * **FAST >= 5** * **GDS >= 5** * **CDR >= 2**   **If documentation of the outcome of the assessment or the score of the standardized tool does not indicate the severity of dementia, enter “99.”** |
| 4 | 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 | 1,2  If 2, auto-fill cogimpdt as 99/99/9999 and go to scrnaudc | Clinician = physician, APN, PA, or psychologist  **In order to answer “1,” there must be clinician documentation in the record that the patient has moderate, moderate to severe, or severe cognitive impairment OR a clinician notation that the patient is too cognitively impaired to be screened.**  In addition, the Clinical Reminder for mental health screening allows providers to establish this exclusion by checking the box to indicate **“Unable to screen due to Moderate or Severe Cognitive Impairment.” This is acceptable documentation of moderate or severe cognitive impairment.**  If the clinician documentation notes “mild cognitive impairment” or “cognitive impairment” without specifying severity, answer “2.”  Sources: Clinical Reminder for mental health screening, clinician notes. |
| 5 | cogimpdt | Enter the date of the most recent clinician documentation of moderate or severe cognitive impairment. | mm/dd/yyyy  \*If modsevci = 1, go out of module   |  | | --- | | < = 1 year prior to or = stdybeg and  < = stdyend | | Enter the exact date. The use of 01 to indicate missing month or day is not acceptable. |
|  |  | **Screening for Alcohol Misuse** |  |  |
| 6 | scrnaudc | Within the past year, was the patient screened for alcohol misuse with the AUDIT-C?  1. Yes  2. No | 1,\*2  \*If 2, go to deptxyr | **Screening for alcohol misuse = the patient was screened within the past year using AUDIT-C questions OR AUDIT-C question # 1 alone if answer was “never” (audc1=0).**  **Screening for alcohol use by telephone is acceptable.**  **AUDIT-C completed during inpatient hospitalization is acceptable.**  AUDIT-C:  Question #1 = “How often did you have a drink containing alcohol in the past year?”  Question #2 = “How many drinks containing alcohol did you have on a typical day when you were drinking in the past year?”  Question #3 = “How often did you have six or more drinks on one occasion in the past year?” |
| 7 | dtalscrn | Enter the most recent date of screening for alcohol misuse with the AUDIT-C. | mm/dd/yyyy   |  | | --- | | < = 1 year prior to or = stdybeg and < = stdyend | | Most recent date patient was screened for alcohol misuse = the most recent date the AUDIT-C was documented in the record.  Enter the exact date. The use of 01 to indicate missing month or day is not acceptable. |
| 8 | 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?   1. Never 2. Monthly or less 3. Two to four times a month 4. Two to three times a week 5. Four or more times a week   99. Not documented | 0,1,2,3,4,99  If 0, auto-fill audc2 and audc3 as 95 | AUDIT-C Question #1 = “How often did you have a drink containing alcohol in the past year?” Each answer is associated with the following scores:  Never 🡪 0  Monthly or less🡪 1  Two to four times a month 🡪 2  Two to three times a week 🡪 3  Four or more times a week 🡪 4  Not documented 🡪 99  Answers to Question #1 of the AUDIT-C are scored as indicated. If the patient’s answers are documented in the record, the abstractor may assign the score in accordance with the patient’s response. If the score of Question #1 is documented without the question, the abstractor may enter that score. If neither the question response nor the score of the individual question is documented, enter 99. |
| 9 | 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?”   1. 0, 1 or 2 drinks 2. 3 or 4 3. 5 or 6 4. 7 to 9 5. 10 or more   95. Not applicable  99. Not documented | 0,1,2,3,4,95,99  Will be auto-filled as 95 if audc1 = 0 | AUDIT-C Question #2 = “How many drinks containing alcohol did you have on a typical day when you were drinking in the past year?” Each answer is associated with the following scores:  0 drinks 🡪 0  1 or 2 drinks 🡪 0  3 or 4 drinks 🡪 1  5 or 6 drinks 🡪 2  7 to 9 drinks 🡪 3  10 or more drinks 🡪 4  Not documented 🡪 99  Answers to Question #2 of the AUDIT-C are scored as indicated. If the patient’s answers are documented in the record, the abstractor may assign the score in accordance with the patient’s response. If the score of Question #2 is documented without the question, the abstractor may enter that score. If neither the question response nor the score of the individual question is documented, enter 99. |
| 10 | 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?”   1. Never 2. Less than monthly 3. Monthly 4. Weekly 5. Daily or almost daily   95. Not applicable  99. Not documented | 0,1,2,3,4,95,99  Will be auto-filled as 95 if audc1 = 0 | AUDIT-C Question #3 = “How often did you have six or more drinks on one occasion in the past year?” Each answer is associated with the following scores:  Never 🡪 0  Less than monthly 🡪 1  Monthly 🡪 2  Weekly 🡪 3  Daily or almost daily 🡪 4  Not documented 🡪 99  Answers to Question #3 of the AUDIT-C are scored as indicated. If the patient’s answers are documented in the record, the abstractor may assign the score in accordance with the patient’s response. If the score of Question #3 is documented without the question, the abstractor may enter that score. If neither the question response nor the score of the individual question is documented, enter 99. |
| 11 | alcscor | Enter the total AUDIT-C score documented within the past year in the medical record. | \_\_ \_\_  Abstractor may enter default zz if the total score of the AUDIT-C is not documented in the record.  If scrnaudc = 1 valid values = 0-12. | The abstractor may not enter the total AUDIT-C score calculated from the questions if it is NOT documented in the record. If the total score is not documented in the record, enter default zz.  If scrnaudc =2, the computer will auto-fill alcscor as zz. |
| 12 | outdoc | Was the outcome of the alcohol screen documented in the medical record?  1. Outcome positive documented  2. Outcome negative documented  99. Outcome not documented | 1,2,99 | The interpretation of the score (positive or negative) must be documented in the record. |
| 13 | alctxpy2 | Within the year prior to the most recent alcohol screening with AUDIT-C, did the patient participate in a recovery program for alcohol abuse or dependence?  5. Yes, in VHA  6. Yes, but not in VHA (includes AA)  99. No or unable to determine | 5,6, 99  **If 99, auto-fill inrecvdt as 99/99/9999 and sudclin as 95, and go to alcbac as applicable** | Recovery program for alcohol abuse or dependence = VHA alcohol or addictions treatment programs (specified stop codes) or community-based treatment programs, including support groups such as Alcoholics Anonymous (AA). **The patient must have attended the program in the year prior to the most recent alcohol screening. Enrollment alone is not sufficient.**  5 Yes, specialty addictions or alcohol recovery program in VHA  6 Yes, but not in VHA, and can include support groups, e.g. AA  99 No documentation that the patient participated in a recovery program or unable to determine |
| 14 | inrecvdt | Enter the date of the patient’s most recent participation in a recovery program for alcohol abuse or dependence in the year prior to alcohol screening. | mm/dd/yyyy  Will be auto-filled as 99/99/9999 if alctxpy2 = 99  **If alctxpy2 = 5, and dtalscrn - inrecvdt <= 90 days, go to sudclin1, else go to alcbac as applicable**  **If unable to find month and year at a minimum, the abstractor may enter default 99/99/9999**   |  | | --- | | If scrnaudc = 1, < = 1 year prior to or = dtalscrn and < = dtalscrn  If scrnaudc = 2, < = 1 year prior to or = stdybeg and < = stdyend | | Question is limited only to those patients participating in an alcohol recovery program in the year prior to alcohol screening. If the patient participated in a series of group therapy meetings or a series of meetings with a counselor, use the date of the most recent encounter.  If the patient is receiving SUD treatment outside the VHA, enter the date the provider notes that the SUD treatment was given. If the provider does not note the date the treatment was received, enter the date of the note where the provider documented the patient was receiving non-VHA SUD treatment.  **If the exact date cannot be found, month and year must be entered at a minimum.**  **If participation occurred at another VAMC and even month and year cannot be found, the abstractor may enter default 99/99/9999. The default should be entered only after requesting help from the Liaison in locating the information from the VAMC where participation in an alcohol recovery program took place.** |

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| 15 | sudclin1  sudclin2  sudclin3  sudclin4  sudclin5  sudclin6  sudclin7  sudclin8  sudclin95  sudclin99 | Within 90 days prior to the most recent alcohol screening with AUDIT-C, was the patient seen in any of the following VHA substance use disorders (SUD) clinics?  **Indicate all that apply:**  1. 513 SUD-Individual  2. 514 SUD-Home  3. 519 SUD-PTSD  4. 547 Intensive-SUD Treatment  5. 523 Opioid Substitution  6. 560 SUD-Group  7. 545 SUD-Telephone  8. 548 Intensive-SUD-Individual  95. Not applicable  99. None of the above | 1,2,3,4,5,6,7,8,95,99  Will be auto-filled as 95 if alctxpy2 = 99  If sudclin99 = -1, go to alcbac as applicable; else go to deptxyr | Review the documentation within 90 days prior to the most recent alcohol screening with the AUDIT-C to determine if the patient was seen in any of the specified SUD clinics. Designation of the clinic by the title of the note is acceptable. Stop codes are included for reference, but may not be found in the record. |
| **If alcscor or [sum of values in AUDC1 + AUDC2 + AUDC3 (excluding values of 95 and 99)] is >= 5, go to alcbac; else go to deptxyr** | | | | |
| 16 | alcbac  alcbac3  alba3dt  alcbac6  alba6dt  alcbac7  alba7dt  alcbac8  albc8dt  alcba95  alcba99 | During the timeframe from (Computer to enter DTALSCRN to DTALSCRN +14 days), does the record document any of the following components of brief alcohol counseling for past-year drinkers?  **Indicate all that apply and the date counseling was noted in the record:**  3. Advice to abstain  6. Personalized counseling regarding relationship of alcohol to the patient’s specific health issues  7. General alcohol-related counseling (not linked to patient’s issues)  8. Explicitly advised patient to drink within recommended limits  95. Not applicable  99.No alcohol counseling documented | 3,6,7,8,95,99  alcbac3 -1 or <>  mm/dd/yyyy    alcbac6 -1 or <>  mm/dd/yyyy  alcbac7 -1 or <>  mm/dd/yyyy  alcbac8 -1 or <> mm/dd/yyyy   |  | | --- | | >= dtalscrn and  < = dtalscrn + 14 days |   95, 99 | Assess the medical record for documentation of the following components of brief alcohol counseling. The counseling must have occurred within 14 days since the alcohol screening referenced in question SCRNAUDC.  Alcbac3 - Advice to abstain from alcohol  Alcbac6 - Personalized alcohol feedback: Patient counseled on relationship of alcohol use to his/her health. This can include the relation or interaction of alcohol use with any of the patient’s: (1) medical problems (hypertension, CHF, cirrhosis, hepatitis, etc.); (2) medications; (3) mental health diagnoses or concerns (for example depression or PTSD), (4) current life problems explicitly linked to alcohol use (e.g. a note that patient was counseled that alcohol use was impacting his relationship or legal problems), and/or (5) patient’s health worries/concerns: breast cancer, dementia, falls.  Alcbac7- General counseling on the relationship of alcohol to health is documented without clear documentation that the counseling relates alcohol use to a specific problem that the patient has or is concerned about. This would be appropriate if CPRS notes indicated that a general handout was given or a nurse gave general information to a patient about alcohol and health that was given to all patients irrespective of the patient’s health problems.  Alcbac8 - Patient must be explicitly advised to drink within specified recommended limits. Recommended limits are: < 14 drinks a week and < 4 drinks per occasion for men, and < 7 drinks a week and < 3 drinks per occasion for women.  **Acceptable provider:** For a “provider” to be deemed acceptable to perform brief alcohol counseling, he/she must be a MD/DO, Psychologist, LCSW, LCSW-C, LMSW, LISW, APN, RN, PA, MS Level counselor, Addictions therapist, or clinical pharmacist (RPH/PharmD). A trainee with appropriate co-signature, or other allied health professional who by virtue of educational background AND approved credentialing, privileging, and/or scope of practice, has been determined by the facility to be capable of brief alcohol counseling, may perform the counseling.  Telephone counseling is permitted if documented by a health care provider as defined immediately above. Enter the date of the progress note or encounter date. |

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|  |  | **Depression** |  |  |
| 17 | deptxyr | Within the past year, did the patient have at least one clinical encounter where depression was identified as a reason for the clinical encounter as evidenced by one of the following ICD-10-CM diagnosis codes:  **F32, F320 - F325, F328, F329, F33, F330, F331, F332, F333, F334, F3340, F3341, F3342, F339, F341, F338, F0631, F0632**  1. Yes  2. No | 1,2  If 2, auto-fill recdepdt as 99/99/9999, and go to bpdxyr | Depression does not have to be listed as the only reason for the clinical encounter, but identified as one of the reasons for the clinical encounter as evidenced by any of the following ICD-10-CM diagnosis codes:   * **F32, F320 - F325, F328, F329, F33, F330, F331, F332, F333, F334, F3340, F3341, F3342, F339, F341, F338, F0631, F0632**   The diagnosis of depression may have been made prior to the past year, but if the patient has at least one clinical encounter within the past year for depression as evidenced by documentation of one of the above ICD-10 diagnosis codes, answer “1.”  Clinical encounter includes outpatient visits, ED visits, and inpatient admission. |
| 18 | recdepdt | Enter the date within the past year of the most recent clinical encounter where depression was identified as a reason for the clinical encounter. | mm/dd/yyyy  Will be auto-filled as 99/99/9999 if  deptxyr = 2  \*If deptxyr = 1, go to leavduty   |  | | --- | | < = 1 year prior to or = stdybeg and  < = stdyend | | Depression does not have to be listed as the only reason for the clinical encounter, but identified as one of the reasons for the clinical encounter as evidenced by documentation of the specified ICD-10 diagnosis code.  Enter the most recent date within the past year documented in the record when the patient was seen for depression.  If the most recent clinical encounter for depression within the past year was an inpatient admission, enter the date of discharge.  Enter the exact date. The use of 01 to indicate missing month or day is not acceptable. |
| 19 | bpdxyr | Within the past year, did the patient have at least one clinical encounter where bipolar disorder was identified as a reason for the clinical encounter as evidenced by one of the following ICD-10-CM diagnosis codes:  **F30, F301, F3010 – F3013, F302 – F304, F308, F309, F31, F310, F311, F3110 – F3113, F312, F313, F3130 – F3132, F314 – F316, F3160 – F3164, F317, F3170 – F3178, F318, F3181, F3189, F319**  1. Yes  2. No | 1,2  \*If 2 and deptxyr = 2, go to phq2dt; else if 2, go to leavduty | Bipolar disorder does not have to be listed as the only reason for the clinical encounter, but identified as one of the reasons for the clinical encounter as evidenced by any of the following ICD-10-CM diagnosis codes:   * **F30, F301, F3010 – F3013, F302 – F304, F308, F309, F31, F310, F311, F3110 – F3113, F312, F313, F3130 – F3132, F314 – F316, F3160 – F3164, F317, F3170 – F3178, F318, F3181, F3189, F319**   The diagnosis of bipolar disorder may have been made prior to the past year, but if the patient has at least one clinical encounter within the past year for bipolar disorder as evidenced by documentation of one of the above ICD-10 diagnosis codes, answer “1.”  Clinical encounter includes outpatient visits, ED visits, and inpatient admission. |
| 20 | recbpdt | Enter the date within the past year of the most recent clinical encounter where bipolar disorder was identified as a reason for the clinical encounter. | mm/dd/yyyy  If bpdxyr = 1, go to leavduty   |  | | --- | | < = 1 year prior to or = stdybeg and  < = stdyend | | Bipolar disorder does not have to be listed as the only reason for the clinical encounter, but identified as one of the reasons for the clinical encounter as evidenced by one of the specified ICD-10 diagnosis codes.  Enter the date within the past year of the most recent clinical encounter when the patient was seen for bipolar disorder.  If the most recent clinical encounter for bipolar disorder within the past year was an inpatient admission, enter the date of discharge.  Enter the exact date. The use of 01 to indicate missing month or day is not acceptable. |

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|  |  | **Depression Screening** |  |  |
| 21 | phq2dt | Enter the date within the past year of the most recent screening for depression by the PHQ-2. | mm/dd/yyyy  Abstractor can enter 99/99/9999  **\*If 99/99/9999, go to leavduty**   |  | | --- | | < = 1 year prior to or = stdybeg and < = stdyend | | **NOTE: For depression screening completed on or after 10/01/2016, the VHA will only accept screening completed with the PHQ-2.**  **If the patient was not screened for depression in the past year by the PHQ-2, enter 99/99/9999.**  **Acceptable setting for depression screening:** outpatient encounter, inpatient hospitalization, screening by telephone, and televideo (real time) with face-to-face encounter between the provider and patient  **PHQ-2 = Patient Health Questionnaire (2 questions - scaled)**  Question 1: “Over the past two weeks, have you often been bothered by little interest or pleasure in doing things?”  Question 2: “Over the past two weeks, have you often been bothered by feeling down, depressed, or hopeless?”  Answers to PHQ-2 are scaled, ranging from “not at all” to “nearly every day.”  Documentation of the stem time frame (i.e., over the past 2 weeks) in the questions is not required at this time.  Enter the exact date. The use of 01 to indicate missing month or day is not acceptable. |
| 22 | ph1scor | Enter the score for PHQ-2 Question 1 documented in the record: Over the past 2 weeks, have you been bothered by little interest or pleasure in doing things? 0. Not at all → 0  1. Several days → 1  2. More than half the days → 2  3. Nearly every day → 3  99. No answer documented | 0,1,2,3,99 | **Enter the response or score documented for the PHQ-2 question 1:** Over the past 2 weeks, have you been bothered by little interest or pleasure in doing things?Not at all → 0 Several days → 1  More than half the days → 2  Nearly every day → 3  **If the patient’s answers are documented in the record, the abstractor may assign the score in accordance with the patient’s response. If the score of Question #1 is documented without the question, the abstractor may enter that score. If neither the question response nor the score of the individual question is documented, enter 99.** |
| 23 | ph2scor | Enter the score for PHQ-2 Question 2 documented in the record: Over the past 2 weeks, have you been bothered by feeling down, depressed, or hopeless? 0. Not at all → 0  1. Several days → 1  2. More than half the days → 2  3. Nearly every day → 3  99. No answer documented | 0,1,2,3,99 | **Enter the response or score documented for the PHQ-2 question 2:** Over the past 2 weeks, have you been bothered by feeling down, depressed, or hopeless?Not at all → 0 Several days → 1  More than half the days → 2  Nearly every day → 3  **If the patient’s answers are documented in the record, the abstractor may assign the score in accordance with the patient’s response. If the score of Question #2 is documented without the question, the abstractor may enter that score. If neither the question response nor the score of the individual question is documented, enter 99.** |
| 24 | phqtotal | Enter the total score for the **PHQ-2** documented in the medical record. | \_\_\_\_\_  **Abstractor may enter default z if no PHQ-2 total score for either question is documented in the record**  **Valid values = 0-6, z** | **The total score for PHQ-2 questions 1 and 2 must be documented in the medical record. The abstractor may NOT enter the total score if it is not documented in the record, even if both questions have been answered and the total is evident. If there is a score for only one question, and it is called the “total,” enter that score.**  **If no total score is documented in the record, enter default z.** |
| 25 | outcome3 | What was the outcome of the PHQ-2 documented in the record?  1. Outcome positive (suggestive of depression)  2. Outcome negative (no indication of depression)  99. Outcome not documented | 1,2,99  **\*If**  (phqtotal = > 3 OR ph1scor = 3 OR ph2scor = 3), OR[sum (exclude values >3) of ph1scor and ph2scor] = > 3, OR outcome3 = 1, go to deprisk, else, go to leavduty | **The interpretation of the PHQ-2 score (positive or negative) must be documented in the record. If the outcome of the PHQ-2 is not documented in the record, enter “99.”** |

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| 26 | deprisk | On the day of or the day after the positive PHQ-2, did the provider document a suicide ideation/behavior evaluation? 1. Yes  2. No | 1,2  If 2, auto-fill deprskdt as 99/99/9999, and go to leavduty | If the patient has a positive PHQ-2 and a positive PC-PTSD screen on the same date, only one suicide ideation/behavior evaluation is required on that date. In this situation, the suicide ideation/behavior evaluation may precede either the depression screen or PTSD screen.  A standardized instrument is NOT required for suicide risk evaluation.  Suicide evaluation includes an appraisal of the patient’s subjective experience (suicide ideation, wish, plan, and intent) and behaviors (warning signs).  **Acceptable Provider Documentation of Suicide Risk Evaluation:**   * A clinical reminder is available from Patient Care Services (PCS) and is acceptable if all required elements (feelings of hopelessness, suicidal thoughts, suicide plans if having suicidal thoughts, and history of suicide attempts) of the reminder are completed by the provider and contained in the medical record; **OR** * If the PCS Clinical Reminder is **NOT** used, there must be at a minimum, a notation by the provider that the suicide risk evaluation was completed.  The provider notation is an attestation that hopelessness, suicidal thoughts, suicide plan if having suicidal thoughts, and history of suicide attempts were addressed with the patient.   Suicide ideation/behavior evaluation can be performed face-to-face, by telemedicine, or by telephone as long as the provider – patient exchange is documented in the medical record and accurately reflects the encounter.   * **Acceptable Provider**: For a “provider” to be deemed acceptable for suicide risk evaluation he/she must be an MD, DO, PhD or PsyD Psychologist, LCSW, LCSW-C, LMSW, LISW, MFT, LPMHC, APN, PA, RN, or clinical pharmacist (RPH/PharmD). Trainee in ANY of these categories may complete a suicide risk evaluation with appropriate co-signature.   **Suggested sources**: progress notes, ED notes, H&P, consultation, Clinical Reminder |
| 27 | deprskdt | Enter the date the suicide ideation/behavior evaluation was completed. | mm/dd/yyyy   |  | | --- | | < = 1 day after or = phq2dt and < = 1 day after stdyend | | Enter the exact date. The use of 01 to indicate missing month or day is not acceptable. |
|  |  | Screening for PTSD |  |  |
| 28 | leavduty | Enter the patient’s most recent date of separation from active military duty. | mm/dd/yyyy  **Abstractor can enter 99/99/9999 if no date of separation can be found**   |  | | --- | | > = 01/01/1930 and < = stdyend | | If the facility has installed the latest clinical reminder, the date should come forward from the administration files.  If you click on the reminder from the cover sheet or on the clinical maintenance button, it will show the most recent last service separation date. This date is critical in determining the frequency of PTSD screening. **If the veteran has more than one tour of duty, enter the most recent date of separation (only the most recently entered last service separation date shows).**  **Annual screening is required if no separation date is found; therefore, it is critical that the date of separation be located. Ask the Liaison to retrieve the date from the administrative file if it is not present in the Clinical Reminder.** As a last resort, if no date can be found, the abstractor can enter default 99/99/9999 |
| 29 | ptsdx | 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 | 1,2  **If 2, go to ptsrnpc** | PTSD does not have to be listed as the only reason for the clinical encounter, but identified as one of the reasons for the clinical encounter as evidenced by one of the following ICD-10-CM diagnosis codes:   * + **F431, F4310 - F4312**   The diagnosis of PTSD may have been made prior to the past year, but if the patient has at least one clinical encounter within the past year for PTSD as evidenced by documentation of the specified ICD-10 diagnosis code, answer “1.”  Clinical encounter includes outpatient visits, ED visits, and inpatient admission. |
| 30 | recptsdt | Enter the date within the past year of the most recent clinical encounter where PTSD was identified as a reason for the clinical encounter. | mm/dd/yyyy  **\*If ptsdx = 1, go to end**   |  | | --- | | < = 1 year prior to or = stdybeg and  < = stdyend | | Enter the date of the most recent clinical encounter within the past year where PTSD was identified as a reason for the clinical encounter by evidence of the specified ICD-10 diagnosis code.  If the most recent clinical encounter for PTSD within the past year was an inpatient admission, enter the date of discharge.  Enter the exact date. The use of 01 to indicate missing month or day is not acceptable. |
| 31 | ptsrnpc | Within the past five years, was the patient screened for PTSD using the Primary Care PTSD Screen (PC-PTSD)?  1. Yes  2. No | 1,\*2  **\*If 2, go to end** | The **Primary Care PTSD Screen** is a standardized tool consisting of four questions. **In order to answer “1”, the abstractor must see the exact wording of questions 1 through 4 below.** Documentation of the stem question (text prior to question #1) is not required.  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?   **Acceptable setting for PTSD screening:** outpatient encounter, inpatient hospitalization, screening by telephone, and televideo (real time) with face-to-face encounter between the provider and patient |
| 32 | pcptsdt | Enter the date of the most recent screen for PTSD using the PC-PTSD. | mm/dd/yyyy   |  | | --- | | < = 5 years prior or = stdybeg and  < = stdyend | | Enter the exact date. The use of 01 to indicate missing month or day is not acceptable. |
| 33 | pcptsd  pcptsd1  pcptsd2  pcptsd3  pcptsd4 | 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 | 1,2,99 | **If more than one PC-PTSD screen was performed on the date of the most recent screening AND any PC-PTSD screen was positive, enter the responses for the positive PC-PTSD screen.**  A positive Primary Care PTSD screen is a score of 3 or greater.  **The PC-PTSD screen must be documented in a clinic note.**  **For each question, enter the veteran’s “yes” or “no” answer to the question. If the question was not asked or the answer not recorded, enter “99.”** |
| 34 | ptsdscor | Enter the total score for the PC-PTSD screen documented in the record. | \_\_\_  **Abstractor can enter default z if no total score is documented**   |  | | --- | | Whole numbers  0 – 4 | | **If more than one PC-PTSD screen was performed on the date of the most recent screening AND any PC-PTSD screen was positive, enter the total score for the positive PC-PTSD screen.**  A positive Primary Care PTSD screen is a score of 3 or greater.  **The total score must be documented in a clinic note. The abstractor may NOT enter total score if it is not documented in the record, even if all the questions have been answered and the total is evident.**  **If the total score is NOT documented in the record, enter default z.** |
| 35 | scorintrp | Enter the interpretation of the PC-PTSD score, as documented in the medical record.   1. Positive 2. Negative   99. No interpretation documented | 1,2, 99  \*If (pcptsdt <= 1 year prior to stdybeg and <= stdyend) AND (ptsdscor > 3) or  [sum (exclude values > 1) of pcptsd1 and  pcptsd2 and pcptsd3 and pcptsd4 > 3] or (scorintrp = 1), go to ptsdrisk; else  go to end   |  | | --- | | Warning window if ptsrnpc = 1, ptsdscor 3 or > and scorintrp = 2; or if ptsrnpc = 1, ptsdscor < 3 and scorintrp = 1 | | **If more than one PC-PTSD screen was performed on the date of the most recent screening AND any PC-PTSD screen was positive, enter the outcome for the positive PC-PTSD screen.**  **If the record contains both a total score and an interpretation of positive or negative, enter “positive” or “negative” as documented in the record, even if the interpretation conflicts with the score.**  **If there was no interpretation of the screening outcome, enter “99.”** |
| 36 | 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 | 1,2  If 2, go to end | If the patient has a positive PC-PTSD screen or positive PHQ-2 completed on the same date, only one suicide ideation/behavior evaluation is required on that date. In this situation, the suicide ideation/behavior evaluation may precede either the PTSD screen or the depression screen.  A standardized instrument is NOT required for suicide risk evaluation.  Suicide evaluation includes an appraisal of the patient’s subjective experience (suicide ideation, wish, plan, and intent) and behaviors (warning signs).  **Acceptable Provider Documentation of Suicide Risk Evaluation:**   * A clinical reminder is available from Patient Care Services (PCS) and is acceptable if all required elements (feelings of hopelessness, suicidal thoughts, suicide plans if having suicidal thoughts, and history of suicide attempts) of the reminder are completed by the provider and contained in the medical record; **OR** * If the PCS Clinical Reminder is **NOT** used, there must be at a minimum, a notation by the provider that the suicide risk evaluation was completed.  The provider notation is an attestation that hopelessness, suicidal thoughts, suicide plan if having suicidal thoughts, and history of suicide attempts were addressed with the patient.   Suicide ideation/behavior evaluation can be performed face-to-face, by telemedicine, or by telephone as long as the provider – patient exchange is documented in the medical record and accurately reflects the encounter.   * **Acceptable Provider**: For a “provider” to be deemed acceptable for suicide risk evaluation he/she must be an MD, DO, PhD or PsyD Psychologist, LCSW, LCSW-C, LMSW, LISW, MFT, LPMHC, APN, PA, RN, or clinical pharmacist (RPH/PharmD) . Trainee in ANY of these categories may complete a suicide risk evaluation with appropriate co-signature.   **Suggested sources**: progress notes, ED notes, H&P, consultation, Clinical Reminder |

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| 37 | rskptsdt | Enter the date the suicide ideation/behavior evaluation was completed. | mm/dd/yyyy   |  | | --- | | < = 1 day after or = pcptsdt and < = 1 day after stdyend | | Enter the exact date. The use of 01 to indicate missing month or day is not acceptable. |