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|  |  | **Screening for Cognitive Impairment** |  |  |
| 1 | modsevci | During the past year, did the clinician document in the record that the patient has moderate or severe cognitive impairment? | \*1,2  If 2, auto-fill cogimpdt as 99/99/9999 and go to cogscrn | Clinician = physician, APN, PA  **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 Chronic, Severe Cognitive Impairment.” This is acceptable documentation of chronic, 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. |
| 2 | 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. |
| 3 | cogscrn | During the past year, was the patient screened for cognitive impairment, using a standardized instrument? | 1,2  **If 2, auto-fill cogtstdt as 99/99/9999, wichcog as 95, and cogscor as 95, and go to dementdx** | **The record must document that within the past year (from the first day of the study interval back to the first day of the study month one year previously) the patient was screened for cognitive impairment using a standardized tool. The standardized tool must be named.**  **Standardized tool:**  **Cognitive assessment tool that has been validated as identifying cognitive impairment and degree of impairment (i.e. mild, moderate, severe).**  Examples: Folstein Mini-Mental State Exam (MMSE), Blessed Orientation-Memory-Concentration test (BOMC), Functional Assessment Staging (FAST), Global Deterioration Scale (GDS), Clinical Dementia Rating (CDR) |
| 4 | cogtstdt | Enter the date of the most recent screen for cognitive impairment. | mm/dd/yyyy  Will be auto-filled as 99/99/9999 if  cogscrn = 2   |  | | --- | | < = 1 year prior to or = stdybeg and  < = stdyend | | Exact date must be entered. The use of 01 to indicate missing day or month is not acceptable. |
| 5 | wichcog | What instrument was used to screen the patient for cognitive impairment?  2. Mini-Mental State Examination (MMSE)  3. The Blessed Orientation-Memory-Concentration Test (BOMC)  8. other standardized instrument  95. not applicable | 2,3,8,95  Will be auto-filled as 95 if cogscrn = 2 | **Mini-Mental State Examination (MMSE)** = a series of questions to measure orientation to time and place, immediate recall, short-term verbal memory, calculation, language, and construct ability  **Blessed Orientation-Memory-Concentration Test (BOMC)** = six questions to assess orientation to time, recall of a short phrase, counting backward, and reciting the months in reverse order  **Clinical Dementia Rating Scale** = 5-point scale used to characterize six domains of cognitive and functional performance (memory, orientation, judgment & problem-solving, community affairs, home & hobbies, personal care)  **Global Deterioration Scale (GDS)** = provides an overview of the stages of cognitive function and is broken down into 7 stages.  **Functional Assessment Staging Tool (FAST)** = charts decline of patients with Alzheimer’s Disease and is broken down into 7 stages  If another standardized tool is used, the standardized instrument must be named, and the questions and scoring must be in accordance with the authentic screening tool. |
| 6 | cogscor | What was the outcome of the screen for cognitive impairment?  4. Score indicated mild cognitive impairment  5. Score indicated moderate to severe impairment  6. Score indicated no cognitive impairment  95. Not applicable  99. No score documented in the record or unable to determine outcome | 4,5,6,95,99  Will be auto-filled as 95 if cogscrn = 2  **\*If 5, go out of module**  **If <> 5, go to dementdx** | **Abstractor judgment may be used. The record must document the score of the screen and the abstractor must be able to determine whether the score indicates no cognitive impairment, mild cognitive impairment, or moderate to severe impairment.** The scoring of the cognitive screen and therefore the outcome will be determined based upon which standardized screen was utilized.  In order to answer “4” or “5,” the abstractor must be able to determine whether the score indicated mild cognitive impairment or moderate to severe cognitive impairment. For example, patient is screened with MMSE and documented score = 15, select “5.”  For the following tools, scores indicating a moderate degree of cognitive impairment are:   * **MMSE <=17** * **BOMC > 10** * **FAST >= 5** * **GDS >= 5** * **CDR >= 2**   **If documentation of the outcome of the screen or the score of the standardized tool does not indicate the degree of cognitive impairment, enter “99.”** |
| 7 | dementdx | During the past year, does the record document a diagnosis of dementia as evidenced by one of the following ICD-9-CM codes?   * Dementia (290.XX) * Alcohol-induced persisting amnesic disorder (291.1) * Alcohol-induced persisting dementia   ( 291.2)   * Dementia in conditions classified elsewhere (294.XX)   1. Yes  2. No | 1,2  **\*If 1, go out of module** | **The diagnosis of dementia or other condition associated with dementia may be found on a problem list or in health factors, but must be verified by physician/APN/PA documentation in the record.**  **Each health factor should have an associated date that represents the date the health factor was recorded.**  **Examples of dementia diagnoses below:**   * **Dementia (290.XX):** presenile dementia, senile dementia, vascular dementia, presbyophrenic psychosis * **Alcohol-induced persisting amnesic disorder (291.1):** Alcoholic polyneuritic psychosis, Wernicke-Korsakoff syndrome (alcoholic) * **Alcohol-induced persisting dementia (291.2):** alcoholic dementia NOS, alcoholism associated with dementia NOS, chronic alcoholic brain syndrome * **Dementia in conditions classified elsewhere (294.XX): organic psychotic brain syndromes (chronic),** Korsakoff’s psychosis, dementia with Parkinsonism, Lewy body dementia |

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|  |  | **Screening for Alcohol Misuse** |  |  |
| 8 | scrnaudc | Within the past year, was the patient screened for alcohol misuse with the AUDIT-C?  1. Yes  2. No | 1,2  If scrnaudc=2, auto-fill dtalscrn as 99/99/9999 and go alcdxaud1, else go to dtalscrn  If 2, auto-fill audc1 as 99, audc2 as 95, audc3 as 95, alcscor as zz, outdoc as 99, alscrall as 2, alcdr as 99, audcpos as 99, alcbac as 95, refr as 95, defdxsud as 95, and dxsudt as 99/99/9999, and go to alcdxaud1 | **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.** |
| 9 | dtalscrn | Enter the most recent date of screening for alcohol misuse with the AUDIT-C. | mm/dd/yyyy  If scrnaudc = 2, will be auto-filled as 99/99/9999   |  | | --- | | < = 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. |
| 10 | 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. |
| 11 | 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. |
| 12 | 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. |
| 13 | 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.  If scrnaudc = 2, auto-fill as zz | 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. |
| 14 | 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. |
| 15 | alscrall | Summary auto-fill measure:  Were all three required components of alcohol screening documented:  a) responses to questions (at least question #1 if nondrinker, where audc1=0), and  b) an AUDIT-C score, and  c) interpretation of AUDIT-C positive or negative  1. Yes  2. No | 1,2,  If audc1=1-4, audc2=0-4 and audc3=0-4, alcscor=0-12, and outdoc=1-2, auto-fill as 1  If audc1=0, alcscor=0, and outdoc= 1 or 2, auto-fill as 1  If audc1=99, audc2=99 and audc3=99 or alscor=zz or outdoc=99, auto-fill as 2 | The answer will be auto-filled based on audc1, audc2, audc3, alcscor, and outdoc. |
| 16 | alcdr | Summary Auto-Fill Measure:  Is the patient a past-year drinker?   1. Yes 2. No   99. Unable to determine | 1,2,99  If audc1 = 1-4, auto-fill as 1  If audc1 = 0, auto-fill as 2  If audc1 = 99 and audc3 = 1- 4, auto-fill as 1  If scrnaudc = 2 and audc1 = 99 and audc3 = 95, auto-fill as 99  If scrnaudc = 1 and audc1 = 99 and audc3 = 99, and alcscor > 0, auto-fill as 1  If scrnaudc = 1, and audc1 = 99 and audc3 = 99, and alcscor = 0, auto-fill as 2  If scrnaudc = 1 and audc1 = 99 and audc3 = 99 and alscor = zz, auto-fill as 99 | If the AUDIT-C Question #1 has a score of 1- 4, the patient has consumed alcohol within the past year.  If the AUDIT-C Question #1 has a score of 0, the patient has not consumed alcohol within the past year.  If the response to AUDIT-C Question #1 is not documented, but AUDIT-C Question #3 has a score of 1- 4, the patient consumed alcohol in the past year.  If the AUDIT-C score is not documented in the record or the response to the AUDIT-C Question #1 and AUDIT-C Question #3 are not documented, the patient’s use of alcohol within the past year cannot be determined. |
| 17 | audcpos | Summary Auto-Fill Measure:  Is the AUDIT-C screen positive?   1. Yes 2. No   99. Unable to determine | 1,2,99  If scrnaudc = 1 and alcscor = 4 -12, auto-fill as 1  If scrnaudc = 1 and sex = 2 and alcscor = 3, auto-fill as 1  If scrnaudc = 1 and and alcscor = 0-2, auto-fill as 2  If scrnaudc = 1 and sex = 1 and alcscor = 0-3, auto-fill as 2  If scrnaudc = 1 and and alcscor = zz, auto-fill as 99  If scrnaudc = 2,  auto-fill as 99  If audcpos = 2 AND outdoc = 2, auto-fill refr95 =-1, defdxsud as 95 and dxsudt as 99/99/9999 | Question will be auto-filled by the computer from previous answers. Abstractor is not responsible for data entry.  If the patient was screened by the AUDIT-C and the total score was 4 -12, the AUDIT-C was positive.  If the patient was female and screened by the AUDIT-C, and the score was 3-12, the AUDIT-C was positive.  If the patient was male and screened by the AUDIT-C and the score was 0-3, the AUDIT-C was negative.  If the patient was female and screened by the AUDIT-C, and the score was 0-2, the screen was negative. |
| 18 | alcdxaud1  audt1  alcdxaud2  audt2  alcdxaud3  audt3  alcdxaud4  audt4  alcdxaud99 | Within 12 months prior to the most recent screen date (if no screen, 12 months prior to the study begin date), were any of the following documented in the patient’s record? If box is checked, enter the first date within the time period the problem is noted in the record:  **Select all that apply:**  **Alcohol use disorders**:  □ Alcohol withdrawal (ICD 291)  □ Alcohol dependence (ICD 303.9)  □ Alcohol intoxication (ICD 303.0)  □ Alcohol abuse (ICD 305.0)  99. **None of the above documented** | |  | | --- | | < =12mos prior or = dtalscrn and < = stdyend or if dtalscrn 99/99/9999, < =12 mos prior to stdybeg and < = stdyend | | 99 cannot be entered if any box is checked |   alcdxaud1 -1 or <>  mm/dd/yyyy  alcdxaud2 -1 or <>  mm/dd/yyyy  alcdxaud3 -1 or <>  mm/dd/yyyy  alcdxaud4 -1 or <>  mm/dd/yyyy  99 | For each of the listed disorders/diagnoses, enter the first date that each was documented in the medical record, from 12 months prior to the screen date to the study end date, or in the 12 months prior to the study begin date if dtalcscrn=99/99/9999.  **The question seeks the patient’s history of alcohol misuse documented within the past 12 months, even if the alcohol problem occurred many years in the past. (Example: “patient has history of binge drinking in the past, but has not had a drink in 8 months.” Check Alcohol abuse.**  **Alcdxaud – Alcohol use disorders**. Diagnoses may be taken from the inpatient or outpatient setting. The abstractor is not limited to the codes provided and may take diagnoses from clinician documentation (progress notes, discharge summaries, or problem lists) even though an applicable code is not present.  Date of alcdxaud may be: the date of the progress note or encounter where the notation or diagnosis is found, or the date on the CPRS Problem List where the notation or diagnosis is found (“date of onset” column, or if no data in that column, then the date in the “last updated” column). |
| 19 | alcdxsud  sudt  alcdxsud99 | Within 12 months prior to the most recent screen date (if no screen, 12 months prior to the study begin date), were any of the following documented in the patient’s record? If box is checked, enter the first date within the time period the problem is noted in the record:  **Other substance use disorders**:  □ Cannabis, cocaine, amphetamine, inhalant, opioid, polysubstance, sedative, or prescription drug dependence (ICD 304.x) or abuse (ICD 305.2-305.9), excluding alcohol and tobacco  **99. None of the above documented** | |  | | --- | | < =12 mos prior or = dtalscrn and < = stdyend or if dtalscrn 99/99/9999, < =12 mos prior to stdybeg and < = stdyend | | 99 cannot be entered if any box is checked |   alcdxsud -1 or <>  mm/dd/yyyy  99 | For the listed disorders/diagnoses, enter the first date that a substance use disorder was documented in the medical record, from 12 months prior to the screen date to the study end date, or in the 12 months prior to the study begin date if dtalcscrn=99/99/9999.  **The question seeks the patient’s history of substance use documented within the past 12 months, even if the substance use problem occurred many years in the past.**  **Alcdxsud – Other substance use disorders.** Diagnoses may be taken from the inpatient or outpatient setting. The abstractor is not limited to the codes provided and may take diagnoses from clinician documentation (progress notes, discharge summaries, or problem lists) even though an applicable code is not present.  Date of alcdxsud may be: the date of the progress note or encounter where the notation or diagnosis is found, or the date on the CPRS Problem List where the notation or diagnosis is found (“date of onset” column, or if no data in that column, then the date in the “last updated” column). |
| 20 | alcdxotr1  otrdt1  alcdxotr2  otrdt2  alcdxotr3  otrdt3  alcdxotr4  otrdt4  alcdxotr5  otrdt5  alcdxotr99 | Within 12 months prior to the most recent screen date (if no screen, 12 months prior to the study begin date), were any of the following documented in the patient’s record? If box is checked, enter the first date within the time period the problem is noted in the record:  **Select all that apply:**  **Other alcohol related diagnoses:**  □ Alcohol liver disease (ICD 571 – 571.3)  □ Alcoholic cardiomyopathy (ICD 425.5)  □ Alcoholic polyneuropathy or alcoholic peripheral neuropathy (ICD 357.5)  □ Alcoholic gastritis (ICD 535.3)  □ Alcohol toxicity (ICD 980)  **99. None of the above documented** | |  | | --- | | < =12 mos prior to or= dtalscrn and < = stdyend or if dtalscrn 99/99/9999, < =12 mos prior to stdybeg and < = stdyend | | 99 cannot be entered if any box is checked |   alcdxotr1 -1 or <>  mm/dd/yyyy  alcdxotr2 -1 or <>  mm/dd/yyyy  alcdxotr3 -1 or <>  mm/dd/yyyy  alcdxotr4 -1 or <>  mm/dd/yyyy  alcdxotr5 -1 or <>  mm/dd/yyyy  99 | For each of the listed disorders/diagnoses, enter the first date that each was documented in the medical record, from 12 months prior to the screen date to the study end date, or in the 12 months prior to the study begin date if dtalcscrn=99/99/9999.  **The question seeks the patient’s history of alcohol related diagnoses documented within the past 12 months, even if the diagnoses occurred many years in the past.**  **Alcdxotr – Other alcohol-related diagnoses** – Diagnoses may be taken from the inpatient or outpatient setting. The abstractor is not limited to the codes provided and may take diagnoses from clinician documentation (progress notes, discharge summaries, or problem lists) even though an applicable code is not present**.**  Date of alcdxotr may be: the date of the progress note or encounter where the notation or diagnosis is found, or the date on the CPRS Problem List where the notation or diagnosis is found (“date of onset” column, or if no data in that column, then the date in the “last updated” column). |
| 21 | alcnote  notedt  noalcdoc | Within 12 months prior to the most recent screen date (if no screen, 12 months prior to the study begin date), was any other history of alcohol problems documented in the medical record? If box is checked, enter the first date within the time period the problem is noted in the record:  **□ Any other chart notation of alcohol problem**  **99. No other chart notation of alcohol problem documented** | |  | | --- | | < =12 mos prior or = dtalacrn and < = stdyend or if dtalscrn 99/99/9999, < =12 mos prior to stdybeg and < = stdyend | | 99 cannot be entered in any box is checked |   alcnote -1 or <>  mm/dd/yyyy  **If any alcdxaud -1, or alcdxotr -1, or alcnote -1, or alctxev -1,**  **auto-fill alcprob as 1.**  **If alcdxaud99 = -1, and alcdxotr99 = -1, and alcdxsud99 = -1, and noalcdoc = -1, OR only alcdxsud = -1, auto-fill alcprob as 2** | **The question seeks the patient’s history of alcohol misuse documented within the past 12 months, even if the alcohol problem occurred many years in the past. (Example: “patient reports DWI charge last year.” Check any other chart notation of alcohol problem, and enter the date of documentation.)**  **Alcnote - Any chart notation of an alcohol problem** without an alcohol-related ICD diagnoses**:** Any note in patient’s chart or problem list indicating the patient had an alcohol-related medical, legal, or psychosocial problem, such as (but not limited to) gastrointestinal bleeding, driving while intoxicated (DWI), injury, loss of job, etc. Documentation must note that the problem is explicitly related to alcohol use.  Date of alcnote may be: the date of the progress note or encounter where the notation or diagnosis is found, or the date on the CPRS Problem List where the notation or diagnosis is found (“date of onset” column, or if no data in that column, then the date in the “last updated” column). |
| 22 | alctxev  evdt  noalctx | Within 12 months prior to the most recent screen date (if no screen, 12 months prior to the study begin date), was any notation of alcohol treatment documented in the record?  If box is checked, enter the first date within the time period the problem is noted in the record:  **□ Any notation of alcohol treatment**  **99. None of the above documented** | |  | | --- | | < =12 mos prior or = dtalscrn and < = stdyend or if dtalscrn 99/99/9999, < =12 mos prior to stdybeg and < = stdyend | | 99 cannot be entered if any box is checked |   alctxev -1 or <>  mm/dd/yyyy  99 | **The question seeks the patient’s history of alcohol treatment EVER.**  **Alctxev - Alcohol (or addiction) treatment EVER:** Documentation in patient’s medical record that patient has ever received treatment or participated in a recovery program for an alcohol problem. A recovery program encompasses any VHA or community-based treatment for substance abuse, including support groups such as Alcoholics Anonymous (AA).  Date of alctxev may be: the date of the progress note or encounter where the notation or diagnosis is found, or the date on the CPRS Problem List where the notation or diagnosis is found (“date of onset” column, or if no data in that column, then the date in the “last updated” column).  Enter the date in the past 12 months when it was documented that patient had EVER been in alcohol treatment. Enter the date documented in the medical record, from 12 months prior to the screen date to the study end date, or in the 12 months prior to the study begin date if dtalcscrn=99/99/9999. |
| 23 | alcprob | **Summary Auto-Fill Measure**:  Was any history of problem drinking noted in the medical record in the 12 months prior to the dtalscrn, or if dtalscrn = 99/99/9999, in the 12 months prior to the study begin date? | 1,2  Will be auto-filled as 1 if alcdxaud -1, or alcdxotr -1 or alcnote -1, or alctxev -1  Will be auto-filled as 2 if only alcdxsud –1 or **alcdxaud99 = -1, and alcdxotr99 = -1, and alcdxsud99=-1, and noalcdoc = -1** | Question ALCPROB will be auto-filled by the computer from data entered in previous questions. Abstractor is not responsible for data entry.  If the date of alcdxaud, alcdxotr, alcnote, or alctxev is within the 12 months prior to the most recent screening (dtalcscrn) or if no screening was done (dtalcscrn=99/99/9999) within 12 months of study begin date 🡪 Alcprob = 1 (YES)  If no date of alcdxaud, alcdxotr, alcnote, or alctxev is entered within the specified period → Alcprob = 2 (NO)  **Does not include Alcdxsud.** |
| 24 | alctxpy | 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)  7. No  99. Unable to determine | 5,6,7,99  **If 5, enable Suicide Evaluation**  **If 7 or 99, auto-fill inrecvdt as 99/99/9999 and sudclin as 95, and go to alcbac** | 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  7 No = documentation that patient did NOT participate in a recovery program  99 Unable to determine = no documentation as to whether or not patient participated in a recovery program |
| 25 | 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 alctxpy = 7 or 99  **If alctxpy = 5, go to sudclin1, else go to alcbac**  **If alctxpy = 6, auto-fill sudclin as 95, and go to alcbac**  **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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| 26 | sudclin1  sudclin2  sudclin3  sudclin4  sudclin5  sudclin6  sudclin7  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  95. Not applicable  99. None of the above | 1,2,3,4,5,6,7,95,99  Will be auto-filled as 95 if alctxpy = 6, 7 or 99 | 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. | |
| 27 | alcbac  alcbac1  alba1dt  alcbac3  alba3dt  alcbac6  alba6dt  alcbac7  alba7dt  alcbac8  albc8dt  alcba95  alcba99 | At any time since the most recent alcohol screening, 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:**  1. Patient drinks within recommended limits (documented from patient self-report)  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 | alcbac1 -1 or <>  mm/dd/yyyy  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  < = stdyend |   95, 99  Will be auto-filled as 95 if scrnaudc  = 2  If 95 or 99, auto-fill alcwhobc as 95 and alcwhrbc as 95 | Assess the medical record for documentation of the following components of brief alcohol counseling. The counseling must have occurred since the alcohol screening referenced in question SCRNAUDC.  Alcbac1 – A clinician note indicates patient reports he/she drinks within recommended limits (< 14 drinks a week and < 4 drinks per occasion for men and < 7 drinks a week and < 3 drinks per occasion for women).  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, NP, CNS, RN, PA, MS Level counselor, or Addictions therapist. 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.  **Cont’d next page** | |
|  |  |  |  | **Brief alcohol counseling cont’d**  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. | |
| 28 | alcwhobc | Who offered the earliest alcohol counseling after alcohol screening:   1. RN 2. APN 3. MD/DO 4. PA 5. Social worker 6. Psychologist 7. MS level counselor 8. Addiction Therapist 9. Other allied healthcare professional 10. None of the above   95. Not applicable | 1,2,3,4,5,6,7,8,9,10,95  Will be auto-filled as 95 if alcbac = 95 or 99 | Identify the discipline of the individual who first offered alcohol counseling after the most recent screening for alcohol misuse, as identified in question SCRNAUDC.  Other allied healthcare professional = other allied healthcare professional who by virtue of educational background AND approved credentialing, privileging and/or scope of practice have been determined by the facility to be capable of diagnosing and treating mental illness. | |
| 29 | alcwhrbc | Where was the brief alcohol counseling offered?  1. Primary care clinic  2. Other medical or surgical clinics  3. Mental health or addictions clinics  4. Other clinics  5. Inpatient  6. Telephone   * 1. Not applicable   99. Unable to determine | 1,2,3,4,5,6,95,99  Will be auto-filled as 95 if alcbac = 95 or 99 | Indicate the clinical setting where brief alcohol counseling was documented or indicate telephone brief alcohol counseling when appropriate. | |
| 30 |  | Indicate whether **EACH** of the following referrals was made to address alcohol misuse and whether the patient had subsequent appointments for alcohol misuse in each of the following settings.  Enter the first date for each referral occurring AFTER the alcohol screening date.  Enter the earliest date the patient completed the appointment after the referral was made (or after the screening date if no referral was documented). If a referral was not documented, enter default 99/99/9999 for referral date.  **If the patient cancelled or failed to keep an appointment after referral, enter default 99/99/9999 for appointment date.**  **If an appointment is scheduled after the study end date, enter default 00/00/0000.**  For each referral documented, indicate the type of provider who referred patient to treatment for alcohol misuse or discussed referral only. | | | **Enter the earliest date after alcohol screening when the patient had a referral for alcohol misuse to each of the following settings**. In this regard “referral” is meant to indicate documentation in the medical record that a VA provider sent a consult or in some other way referred the patient to another provider to address alcohol misuse.  **In addition, the date of the first completed appointment after alcohol screening in each setting should be indicated. If no referral was documented, but a patient was seen in one of the following settings for alcohol misuse, the date of first completed appointment after alcohol screening is used.**  For patients who screen positive on the AUDIT-C, enter the earliest date after alcohol screening of referral for each of the following:  **Alcrefsp - VA Specialized addictions treatment** indicates referral to a specific VA clinic or inpatient unit for evaluation and/or addictions/alcohol treatment by addictions specialist  **Alcrefmh – VA Mental health** indicates referral to a VA inpatient unit or outpatient clinic that addresses general mental health issues (e.g. PTSD clinic, Mental Health clinic, Psychiatry or psychology clinic), where a purpose of the hospital stay or visit is explicitly noted to be to evaluate and address alcohol misuse  **Alcrefpc –** Referral to a VA health provider or VA behavior change counselor in the primary care setting for alcohol counseling and/or medications for alcohol dependence.  **Alcreftl –VA Telephone counseling** – indicates documented referral for counseling offered over the telephone by a VA clinician who is eligible to assess patients and document counseling in the medical record.  **Alcrfout** – **Outside VA for alcohol treatment** – indicates documentation of referral to non-VHA entity for alcohol treatment (AA, Vet Center, etc). |
|  | alcrefsp  alcrspdt  spaptdt  whorsp  alcrefmh  alcmhdt  mhaptdt  whormh  alcrefpc  alcrpcdt  pcaptdt  whorpc  alcreftl  alctldt  tlaptdt  whortl  alcrfout  alcoutdt  outaptdt  whorout  alcrefxx  alcxxdt  refr95  refr99 | |  |  |  |  | | --- | --- | --- | --- | | **Referral and/or Appointment**  **Indicate all that apply:** | **Referral Date**  > = dtalscrn and  < = stdyend    Will be auto-filled as 95 if  scrnaudc = 2  (referdt = alcrspdt, alcmhdt, alcrpcdt,alctldt, alcoutdt, alcrefxx) | **Appt. date:**  **1st Completed Appointment after referral or if no documentation of referral, first appointment after positive screen**  **Abstractor can enter 99/99/9999 or 00/00/0000**  (> = referdt and < = revdte, or if referdt = 99/99/9999, >= dtalscrn and <= revdte) | **Type of Health Care Provider who referred patient to treatment for alcohol misuse:**  1,2,3,4,5,6,  7,95  For each referdt = 99/99/9999, auto-fill as 95 | | □ Specialized addictions treatment |  |  |  | | □ Mental helthcliic |  |  |  | | □ Primary care clinic |  |  |  | | □ Referral for counseling offered by phone |  |  |  | | □ Referred outside VA for alcohol treatment |  |  |  | | □ Discussion of referral, no consult/referral |  |  |  | | 95 Not applicable |  |  |  | | 99 No referral or discussion of referral |  |  |  |   Type of Provider:  1. RN  2. Primary Care Provider (MD, DO, APN, PA)  3. Primary Care Mental Health Provider (PsyD, Psychologist PhD, Social Worker, MH case manager)  4. Other medical or surgical provider  5. Other Mental Health Provider  6. Other allied healthcare professional  7. None of the above  95.Not applicable | | | **Alcrefxx – Discussion of referral but no consult/ referral indicates documentation was found that one or more referral options was discussed with patient but no consult placed or referral documented (presumably patient declined)**  **Enter the date of the first completed appointment as a result of each type of referral. If the patient cancelled or failed to keep the appointment, enter default 99/99/9999. If an appointment is scheduled after the study end date, enter default 00/00/0000.**  **Other allied healthcare professional = other allied healthcare professional who by virtue of educational background AND approved credentialing, privileging and/or scope of practice have been determined by the facility to be capable of diagnosing and treating mental illness.** |
| 31 | defdxsud | Following the positive AUDIT-C, was a definitive diagnosis of substance use disorder made by a Primary Care or Mental Health clinician?  1. Yes 2. No 3. Patient had prior diagnosis of substance use disorder   95. Not applicable | 1,2,3,95  Will be auto-filled as 95 if **scrnaudc = 2 OR if audcpos = 2 AND outdoc = 2**  If 2 or 3, auto-fill dxsudt as 99/99/9999 | Primary Care clinician = MD, DO, APN, PA,  Mental Health clinician = MD, DO, APN, PA, Psychologist, or Mental Health Social Worker  Definitive diagnosis of substance abuse = alcohol abuse or alcohol dependence | |
| 32 | dxsudt | Enter the date the definitive diagnosis of substance use disorder was documented by the clinician. | mm/dd/yyyy  Will be auto-filled as 99/99/9999 if **scrnaudc = 2 OR if audcpos = 2 AND outdoc = 2 or if defdxsud = 2 or 3**   |  | | --- | | > = dtalscrn and < = stdyend | | Enter the exact date. The use of 01 to indicate missing month or day is not acceptable. | |
| **If alctxpy = 5, go to presudtx1, else go to deptxyr** | | | | | |
| 33 | presudtx1  presudtx2  presudtx3  presudtx4  presudtx5  presudtx6  presudtx7  presudtx99 | Within the year prior to the study year, 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  99. None of the above | 1,2,3,4,5,6,7,99  If <> 99, go to mor1audc | Review the documentation within the year prior to the study year 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. | |
| 34 | newaudx | Was alcohol use disorder newly diagnosed within the past year?  1. Yes  2. No | 1,2  If 2, auto-fill audxdt as 99/99/9999, whodxaud as 95, and go to mor1audc   |  | | --- | | Warning if 2 and defdxsud = 1 | | If there is documentation that the alcohol use disorder was newly diagnosed in the past year without evidence of a previous history of alcohol use disorder, enter “1.” | |
| 35 | audxdt | Enter the date of the new diagnosis of alcohol use disorder was documented in the record by the provider. | mm/dd/yyy  Will be auto-filled as 99/99/9999 if  newaudx = 2   |  | | --- | | < = 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. | |
| 36 | whodxaud | Within the past year, which provider documented the initial diagnosis of alcohol use disorder?  1. Primary Care Provider  2. Mental Health Provider  95. Not applicable  99. Unable to determine | 1,2,95,99  Will be auto-filled as 95 if newaudx = 2 | Initial diagnosis of alcohol use disorder = new diagnosis of the alcohol use disorder or new episode that occurs after at least 4 months without evidence of any treatment for alcohol use disorder  Primary Care provider = MD, DO, APN, PA  Mental Health provider = MD, DO, APN, PA, Psychologist, or Mental Health Social Worker | |
| 37 | refaudtx | Was the patient referred for treatment of alcohol use disorder in the past year?   1. Referred for treatment within VHA 2. Referred for treatment outside the VHA 3. Both 1 and 2 4. Documented patient already receiving care for mental health disorder   99. No documentation of referral for treatment of substance use disorder | 1,2,3,4,99  If 2, 4 or 99, go to mor1audc | Treatment of alcohol use disorder may include substance use case management appointment, psychotherapy (e.g., individual, group, couple, family), or prescription of medications used to treat alcohol use disorder such as naltrexone, acamprosate, disulfiram.  In order to answer “4”, there must be documentation by the primary care provider or mental health provider that the patient is already receiving care for a mental health disorder (e.g. depression, anxiety, substance abuse) and that provider will provide treatment for the alcohol use disorder.  Primary Care provider = MD, DO, APN, PA,  Mental Health provider = MD, DO, APN, PA, Psychologist, or Mental Health Social Worker | |
| 38 | wichref2 | Which provider made the initial referral for treatment of alcohol use disorder in the past year?  1. Primary Care Provider  2. Mental Health Provider  99. Unable to determine | 1,2,99 | Treatment of alcohol use disorder may include substance use case management appointment, psychotherapy (e.g., individual, group, couple, family), or prescription of medications used to treat alcohol use disorder such as naltrexone, acamprosate, disulfiram.  If an appointment for treatment of alcohol use disorder is scheduled after the study end date, enter “3.”  Primary Care provider = MD, DO, APN, PA,  Mental Health provider = MD, DO, APN, PA, Psychologist, or Mental Health Social Worker | |
| 39 | refaudt | Enter the date the referral for treatment of alcohol use disorder was placed. | mm/dd/yyyy   |  | | --- | | < = 1 year prior to or = stdybeg and  < = stdyend | | Enter the exact date. The use of 01 to indicate missing month and day is not acceptable. | |
| 40 | seenaud | After the initial referral was placed, is there documentation the patient was seen by a provider for treatment of alcohol use disorder?  1. Yes  2. No  3. Appointment is scheduled after study end date | 1,2,3  If 2 or 3, go to mor1audc, else go to seenaudt | Treatment of alcohol use disorder may include substance use case management appointment, psychotherapy (e.g., individual, group, couple, family), or prescription of medications used to treat alcohol use disorder such as naltrexone, acamprosate, disulfiram.  If an appointment for treatment of alcohol use disorder is scheduled after the study end date, enter “3.”  Primary Care provider = MD, DO, APN, PA,  Mental Health provider = MD, DO, APN, PA, Psychologist, or Mental Health Social Worker | |
| 41 | seenaudt | Enter the earliest date after initial referral when the patient was seen for treatment of alcohol use disorder. | mm/dd/yyyy  Abstractor can enter 99/99/9999   |  | | --- | | >= refaudt or  = stdybeg and  < = stdyend | | If there is no documentation the patient was seen for treatment of alcohol use disorder following the initial referral, enter 99/99/9999. | |
| 42 | audtxloc | Identify the setting where the patient received treatment for alcohol use disorder.  1. Outpatient treatment in VHA  2. Inpatient treatment in VHA  3. Both 1 and 2 | 1,2,3 | Treatment for alcohol use disorder may occur in an outpatient and/or inpatient setting. Treatment may include an appointment with a substance use case provider, psychotherapy, or prescription of medications used to treat alcohol use disorder. | |
| 43 | mor1audc | Within the past year, does the record document completion of more than one AUDIT-C? | 1,2  If 2, go to oplnaud | If there is only one AUDIT-C documented in the record within the past year, enter “2.”  **AUDIT-C completed during inpatient hospitalization is acceptable.** | |
| 44 | **txaudcdt1**  **txaudscr1**  **txaudout1** | Enter the date, total score and outcome for all AUDIT-C screens completed within the past year:   |  |  |  | | --- | --- | --- | | **Date** | **Total Score** | **Outcome** | |  |  |  | |  |  |  |   **Outcome:**  1. Outcome positive documented  2. Outcome negative documented  99. Outcome not documented | **Enter ALL AUDIT-C**  **mm/dd/yyyy**   |  | | --- | | < = 1 year prior to or = stdybeg and  < = stdyend |   **Total score**  **Abstractor can enter zz**   |  | | --- | | Whole numbers from 0-12  or zz if missing |   **Outcome**  **1,2,99** | The AUDIT-C consists of three questions. For each AUDIT-C completed in the past year enter:   * Date completed * Total score documented in the record * Outcome documented in the record   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.  The interpretation of the score (positive or negative) must be documented in the record. If the interpretation is not documented in the record, enter ‘”99.” | |
| 45 | oplnaud | Within the past year, did the clinician document a treatment plan for alcohol use disorder? | 1,2  If 1, go to oplnaudt  If 2 auto-fill oplnaudt as 99/99/9999, and go to audrx | A treatment plan for alcohol use disorder is the clinician’s plan for ongoing care of alcohol use disorder for the patient. The treatment plan may include:   * patient involvement * family involvement * individual therapy * group therapy * medications used to treat alcohol or substance use disorder such as buprenorphine (Suboxone), naltrexone, acamprosate, disulfiram | |
| 46 | oplnaudt | Enter the date the most recent treatment plan for alcohol use disorder was documented in the record. | mm/dd/yyyy  Will be auto-filled as 99/99/9999 if  oplnaud = 2   |  | | --- | | <= 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. | |
| 47 | audrx1  audrx2  audrx3  audrx4  audrx98  audrx99 | Within the past year, were any of the following medications for substance use disorder prescribed for the patient?  **Indicate all that apply:**  1. Buprenorphine (Suboxone)  2. Naltrexone  3. Acamprosate (Campral)  4. Disulfiram  98. Patient refused ALL above medications  99. None of the above | 1,2,3,4,98,99 |  | |
| 48 | sudbam | Within the past year, does the record document completion of the Brief Addiction Measure (BAM)? | 1,2  If 2, auto-fill sudbamdt as 99/99/9999 and if most recent txaudscr  >= 5, go to audnewtx, else if txaudscr < 5 or mor1audc = 2,  go to detsobr | The BAM (Brief Addiction Measure) is a 17 item symptom severity scale used for patients with substance use disorder. The BAM questions without response options are below:  1. In the past 30 days, would you say your physical health has been?  2. In the past 30 days, how many nights did you have trouble falling asleep or staying asleep?  3. In the past 30 days, how many days have you felt depressed, anxious, angry, or very upset throughout most of the day?  4. In the past 30 days, how many days did you drink any alcohol?  5. How many days did you have at least (5 – men, 4-women) drinks?  6. In the past 30 days, how many days did you use any illegal/street drugs or abuse any prescription medications?  7. What did you take?  8. In the past 30 days, how much were you bothered by cravings or urges to drink alcohol or use drugs?  9. How confident are you in your ability to be completely abstinent (clean) from alcohol and drugs in the next 30 days?  10. In the past 30 days, how many days did you attend self help meetings like AA or NA to support your recovery?  11. In the past 30 days, how many days were you in any situations or with any people that might put you at an increased risk for using alcohol or drugs (i.e., around risky “people, places, or things”)?  12. Does your religion or spirituality help support your recovery?  13. In the past 30 days, how many days did you spend much of the time at work, school, or doing volunteer work?  14. Do you have enough income (from legal sources) to pay for necessities such as housing, transportation, food and clothing for yourself and your dependents?  15. In the past 30 days, how much have you been bothered by arguments or problems getting along with any family members or friends?  16. In the past 30 days, how many days were you in contact or spend time with any family members or friends who are supportive of your recovery?  17. How satisfied are you with your progress toward achieving your recovery goals? | |
| 49 | sudbamdt | Enter the date the most recent BAM was completed. | mm/dd/yyyy  Will be auto-filled 99/99/9999 if  sudbam = 2  If most recent txaudscr >= 5, go to audnewtx, else if txaudscr < 5 or  mor1audc = 2,  go to detsobr   |  | | --- | | <= 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. | |
| 50 | audnewtx | Following the most recent positive AUDIT-C was there evidence in the record the clinician made a change to the treatment plan?  1. Yes  2. No | 1,2  If 2, auto-fill audplndt as 99/99/9999, and go to detsobr | Documentation by the clinician of a change in treatment may include interventions such as: changing medication, adjusting dose of medication, referral for counseling, or increase frequency of follow-up. | |
| 51 | audplndt | Enter the date the clinician documented a change in the treatment plan. | mm/dd/yyyy   |  | | --- | | > = most recent txaudcdt when txaudscr > = 5  and < = stdyend | | Enter the exact date. The use of 01 to indicate missing month or day is not acceptable. | |
| 52 | detsobr | At the most recent visit for alcohol use disorder treatment, did the clinician document a sobriety/abstinence determination?  1. Yes  2. No  99. Unable to determine | 1,2,99 | Sobriety/abstinence may be assessed by breathalyzer, urine alcohol test, or blood alcohol level. | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  | **Depression** |  |  |
| 53 | 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-9-CM codes:  **296.2x, 296.3x, 298.0, 300.4,** **301.12, 309.0, 309.1, 309.28, and 311** | 1,2  **If 1, enable Suicide Evaluation**  If 2, auto-fill recdepdt as 99/99/9999, newmddx as 95, newmddt as 99/99/9999, pretxmdd as 95, pretxmdt 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-9-CM codes: **296.2x, 296.3x, 298.0, 300.4,** **301.12, 309.0, 309.1, 309.28, and 311.**  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-9-CM codes, answer “1.”  Clinical encounter includes outpatient visits, ED visits, and inpatient admission. |
| 54 | 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   |  | | --- | | < = 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 any of the following ICD-9-CM codes: **296.2x, 296.3x, 298.0, 300.4,** **301.12, 309.0, 309.1, 309.28, and 311.**  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. |
| 55 | newmddx | Was depression newly diagnosed within the past year?  1. Yes  2. No  95. Not applicable | 1,2,95  If 2, auto-fill newmddt as 99/99/9999, and go to pretxmdd  Will be auto-filled  as 95 if  deptxyr = 2 | **New diagnosis of depression within the past year:**  **1) Depression is documented as a new diagnosis within the past year, OR**  2) A new episode of depression is documented in the past year  AFTER a period of at least 4 months **WITHOUT** evidence of any treatment for depression.  The period of at least 4 months without evidence of treatment for depression may start in the year prior to the study year.  For example, patient is seen on 9/08/08 for symptoms of depression and clinician documents a diagnosis of depression. Patient has history of depression, but documentation indicates that last treatment encounter for depression was on 8/18/07. At that time patient discontinued bupropion. Since at least 4 months had elapsed without evidence of on-going treatment for depression, select “1.” |
| 56 | newmddt | Enter the date the new diagnosis of depression was documented in the record by the provider. | mm/dd/yyyy  Will be auto-filled as 99/99/9999 if  deptxyr = 2 or newmddx = 2  If newmddx = 1, auto-fill pretxmdd as 95 and pretxmdt as 99/99/9999, and go to bpdxyr   |  | | --- | | < = 1 years prior to or = stdybeg and  < = stdyend | | Enter the exact date. The use of 01 to indicate missing month or day is not acceptable. |
| 57 | pretxmdd | Within the year prior to the study 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-9-CM codes:  **296.2x, 296.3x, 298.0, 300.4,** **301.12, 309.0, 309.1, 309.28, and 311**  1. Yes  2. No  95. Not applicable | 1,2,95  Will be auto-filled as 95 if newmddx = 1  If 2, auto-fill pretxmdt 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-9-CM codes: **296.2x, 296.3x, 298.0, 300.4,** **301.12, 309.0, 309.1, 309.28, and 311.**  If the patient had at least one clinical encounter within the year prior to the study year for depression as evidenced by documentation of one of the above ICD-9-CM codes, answer “1.”  Clinical encounter includes outpatient visits, ED visits, and inpatient admission. |
| 58 | pretxmdt | Within the year prior to the study year, enter the date 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 or pretxmedd = 2   |  | | --- | | > 1 year prior to stdybeg and < = 2 years prior to stdybeg | | 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 any of the following ICD-9-CM codes: **296.2x, 296.3x, 298.0, 300.4,** **301.12, 309.0, 309.1, 309.28, and 311.**  Enter the most recent date within the year prior to the study year documented in the record when the patient was seen for depression.  If the most recent clinical encounter for depression in the year prior to the study 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. |
| 59 | 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-9-CM codes:  **296.5x, 296.6x, 296.7, and 296.8x** | 1,2  If 1, go to recbpdt  \*If 2 and deptxyr = 2, go to phq2dt  If 2 and newmddx = 1, go to whodxdep; else if 2 and newmddx = 2, go to dephq9  **If 1 and deptxyr = 2, enable Suicide Evaluation** | 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-9-CM codes: **296.5x, 296.6x, 296.7, and 296.8x.**  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-9-CM codes, answer “1.”  Clinical encounter includes outpatient visits, ED visits, and inpatient admission. |
| 60 | 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   |  | | --- | | < = 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 any of the following ICD-9-CM codes: **296.5x, 296.6x, 296.7, and 296.8x.**  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. |
| 61 | newbpdx | Was bipolar disorder newly diagnosed within the past year? | 1,2  If 1, go to newbpdt  If 2, go to pretxbpd   |  | | --- | | Warning if 1 and newmddx = 1 | | **New diagnosis of bipolar disorder within the past year:**  1) An active diagnosis of bipolar disorder was not documented in the year prior to the past year, **OR**  2) A new episode of bipolar disorder is documented in the past year AFTER a period of at least 4 months **WITHOUT** evidence of any treatment for bipolar disorder. The period of at least 4 months without evidence of treatment for bipolar disorder may start in the year prior to the study year.  Example: Patient is seen on 9/08/08 for symptoms of agitation, irritability, and insomnia. After further assessment, clinician documents a diagnosis of bipolar disorder. Patient did not have history of BPD, but had history of depression. Last treatment encounter for depression was on 2/18/08. At that time patient discontinued sertraline and stopped going to individual therapy sessions. Select “1.” |
| 62 | newbpdt | Enter the date the new diagnosis of bipolar disorder was documented in the record by the provider. | mm/dd/yyyy  If newbpdx = 1, go to whodxdep   |  | | --- | | < = 1 years prior to or = stdybeg and  < = stdyend | | **Acceptable Provider**: MD, DO, PhD or PsyD Psychologist, LCSW, APN, PA, (or a MD, DO, PhD or PsyD Psychologist, LCSW, APN, PA trainee with appropriate co-signature).  Enter the exact date. The use of 01 to indicate missing month or day is not acceptable. |
| 63 | pretxbpd | Within the year prior to the study 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-9-CM codes:  **296.5x, 296.6x, 296.7, and 296.8x** | 1,2  If 2, auto-fill pretxbpdt as 99/99/9999, and go to dephq9 | 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-9-CM codes: **296.5x, 296.6x, 296.7, and 296.8x**  If the patient has at least one clinical encounter within year prior to the study year for bipolar disorder as evidenced by documentation of one of the above ICD-9-CM codes, answer “1.”  Clinical encounter includes outpatient visits, ED visits, and inpatient admission. |
| 64 | pretxbpdt | Within the year prior to the study year, enter the date of the most recent clinical encounter where bipolar disorder was identified as a reason for the clinical encounter. | mm/dd/yyyy  Will be auto-filled as 99/99/9999 if  bpdxyr = 2 or pretxbpd = 2  If 1 and newmddx = 2, go to dephq9   |  | | --- | | > 1 year prior to stdybeg and < = 2 years prior to stdybeg | | 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 documentation of any of the following ICD-9-CM codes: **296.5x, 296.6x, 296.7, and 296.8x**  Enter the most recent date within the year prior to the study year documented in the record when the patient was seen for bipolar disorder.  If the most recent clinical encounter for bipolar disorder within the year prior to the study 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. |
| 65 | whodxdep | Within the past year, which provider documented the initial diagnosis of depression (or initial diagnosis of bipolar disorder)?  1. Primary Care Provider  2. Mental Health Provider  99. Unable to determine | 1,2,99 | Initial diagnosis of depression (or bipolar disorder) = new diagnosis of depression (or bipolar disorder) or new episode of depression (bipolar disorder) that occurs after at least 4 months without evidence of any treatment of depression (or bipolar disorder)  Primary Care provider = MD, DO, APN, PA  Mental Health provider = MD, DO, APN, PA, Psychologist, or Mental Health Social Worker |
| 66 | refmddtx | Was the patient referred for treatment of depression (or bipolar disorder) in the past year?  1. Referred for treatment within VHA  2. Referred for treatment outside VHA  3. Both 1 and 2   1. Documented patient already receiving care for mental health disorder   99. No documentation of referral for treatment of depression | 1,2,3,4,99  \*If 2,4, or 99, go to dephq9 | Treatment of depression may include mental health case management appointment, appointment for psychotherapy (e.g., individual, group, couple, family), prescribing anti-depressant medications, or medications to treat bipolar disorder such as lithium.  Psychotherapy may include: Cognitive Behavioral Therapy (CBT), Interpersonal Therapy (IPT), Problem-solving Therapy (PST), Acceptance & Commitment Therapy  Do not include Assertive Community Therapy.  In order to answer “4”, there must be documentation by the primary care provider or mental health provider that the patient is already receiving care for a mental health disorder (e.g., anxiety, PTSD, substance abuse) and that provider will provide treatment for depression. |
| 67 | wicmdref | Which provider made the initial referral for treatment of depression (or bipolar disorder) in the past year?  1. Primary Care Provider  2. Mental Health Provider  99. Unable to determine | 1,2,99 | Primary Care provider = MD, DO, APN, PA,  Mental Health provider = MD, DO, APN, PA, Psychologist, or Mental Health Social Worker  **Examples:** Patient sees PCP with c/o fatigue, sadness, and difficulty concentrating. PHQ-2 screen obtained and outcome is positive. PCP refers the patient to mental health for further evaluation; select “1.”  Patient is seeing mental health social worker for SUD. PHQ-2 screen obtained and positive. PHQ-9 obtained and positive. Mental Health Social worker refers patient to psychiatrist; select “2.” |
| 68 | refmddt | Enter the date the referral for treatment of depression (or bipolar disorder) was placed. | mm/dd/yyyy   |  | | --- | | < = 1 year prior to or = stdybeg and  < = stdyend | | Enter the exact date. The use of 01 to indicate missing month and day is not acceptable. |
| 69 | seenmdd | After the initial referral was placed, is there documentation the patient was seen by a provider for treatment of depression (or bipolar disorder)?  1. Yes  2. No  3. Appointment is scheduled after study end date | 1,2,3  If 2 or 3, go to dephq9, else go to seenmddt | Treatment of depression (or bipolar disorder) may include mental health case management appointment, psychotherapy (e.g., individual, group, couple, family), prescription of anti-depressant medications, or medications used to treat bipolar disorder such as lithium.  If an appointment for treatment of depression (or bipolar disorder) is scheduled after the study end date, enter “3.”  Primary Care provider = MD, DO, APN, PA,  Mental Health provider = MD, DO, APN, PA, Psychologist, or Mental Health Social Worker |
| 70 | seenmddt | Enter the earliest date after initial referral when the patient was seen for treatment of depression (or bipolar disorder). | mm/dd/yyyy  Abstractor can enter 99/99/9999   |  | | --- | | >= refmddt or  = stdybeg and  < = stdyend | | If there is no documentation the patient was seen for treatment of depression (or bipolar disorder ) following the initial referral, enter 99/99/9999. |
| 71 | mddtxloc | Identify the setting where the patient received treatment for depression (or bipolar disorder).  1. Outpatient treatment in VHA  2. Inpatient treatment in VHA  3. Both 1 and 2 | 1,2,3 | Treatment for depression (or bipolar disorder) may occur in an outpatient and/or inpatient setting. Treatment may include an appointment with a mental health care provider, prescription of anti-depressant medication, medications used to treat bipolar disorder, or therapy. |
| 72 | mddtx1  mddtx2  mddtx3  mddtx4  mddtx5  mddtx6 | Is there documentation the treatment for depression (or bipolar disorder) included the following:   |  |  | | --- | --- | | 1. Prescription of anti-depressant medication | 1,2 | | 2. Cognitive Behavioral Therapy | 1,2 | | 3. Interpersonal Psychotherapy | 1,2 | | 4. Problem-solving Therapy | 1,2 | | 5. Acceptance and Commitment Therapy | 1,2 | | 6. Other type of therapy | 1,2 | | 1,2 | There are different anti-depressant drug classes and many different anti-depressant medications and medications used to treat bipolar disorder. Examples are listed below (Please refer to a drug handbook for a more complete listing).  **Tricyclic antidepressants**: amitriptyline,despipramine (Norpramin), doxepin (Sinequan), imipramine (Tofranil), aventyl.  **Other anti-depressants**: bupropion (Wellbutrin), citalopram (Celexa), fluoxetine (Prozac), mirtazapine (Remeron), paroxetine (Paxil), sertaline (Zoloft), desyrel, venlafaxine (Effexor)  **MAOI:**  phenelzine (Nardil), tranylcypromine (Parnate)  **For bipolar disorder:**  **Lithium:** lithium carbonate, Lithobid  **Anticonvulsants** such as carbemapazine (Tegretol), divalproex (Depakote), lamotrigine (Lamictal), topiramate (Topamax)  2 = Cognitive behavioral therapy is used to improve cognitive distortions, reduce distractibility, and correct errors in judgment.  3 = Interpersonal psychotherapy utilizes relaxation exercises, psychoeducation, self-reflection, and exploration of individual vulnerability to enhance personal and social adjustment.  4 =  Problem solving therapy is a brief psychological intervention that occurs in 4-8 sessions with the following steps addressed:  problem orientation, recognizing and identifying problems, selecting and defining a clear problems, generating solutions, decision making, creating and implementing a SMART action plan, and reviewing progress.  5 = The goal of Acceptance and Commitment therapy is to help clients consistently choose to act effectively (concrete behaviors as defined by their values) in the presence of difficult or disruptive “private” (cognitive or psychological) events. The acronym ACT has also been used to describe what takes place in therapy: accept the effects of life’s hardships, choose directional values, and take action. |
| 73 | dephq9 | Within the past year, did the record document completion of the PHQ-9? | 1,2  If 2, go to oplnmdd, else to dephq9dt | **The PHQ-9 completed by the patient or the practitioner, must appear in the record, or administration of the PHQ-9 with documentation of the patient’s responses to the individual questions must be documented in the record.**  **Exclude: PHQ-9 completed during inpatient hospitalization**  Patient Health Questionnaire (PHQ-9) asks:  Over the last 2 weeks, how often have you been bothered by any of the following problems?   1. Little interest or pleasure in doing things 2. Feeling down, depressed, or hopeless 3. Trouble falling asleep or staying asleep, or sleeping too much 4. Feeling tired or having little energy 5. Poor appetite or overeating 6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down 7. Trouble concentrating on things, such as reading the newspaper or watching television 8. Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual 9. Thought that you would be better off dead, or of hurting yourself in some way   10. If you checked off *any* problems, how *difficult* have these problems made it for you to do work, take care of things at home, or get along with other people? |
| 74 | dephq9dt1  depscor1  depout1  ans9scr1 | Starting with the most recent PHQ-9 completed in the outpatient setting within the past year: Enter the date, total score, outcome for each PHQ-9, and the score for PHQ-9 Question 9 for **ALL** PHQ-9 documented in the record.   |  |  |  |  | | --- | --- | --- | --- | | **Date** | **Total Score** | **Outcome** | **Score Question 9** | |  |  |  |  |   **Outcome:**   1. Outcome positive 2. Score suggestive of no depression 3. Score suggestive of mild depression 4. Score suggestive of moderate depression 5. Score suggestive of moderately severe depression 6. Score suggestive of severe depression   99. Outcome not documented  **Score PHQ-9 Question 9:**  **Over the last 2 weeks, how often have you been bothered by thoughts that you would be better off dead, or of hurting yourself in some way?**  0. Not at all → 0  1. Several days → 1  2. More than half the days → 2  3. Nearly every day → 3  95. Not applicable  99. No answer documented | **Enter ALL PHQ-9**  mm/dd/yyyy   |  | | --- | | <= 1 year prior to or = stdybeg and  <= stdyend |   Total score   |  | | --- | | Whole numbers from  0 – 27 or zz if missing |   **Abstractor can enter zz**  **Outcome**  1,3,4,5,6,7,99  **Score Question 9**  0,1,2,3,95,99 | For each PHQ-9 completed in the outpatient setting within the past year enter:   * Date of each PHQ-9 completed * Total score documented in the record * Outcome documented in the record * Score of PHQ-9 question 9 documented in the record   The total score must be documented in the record. The abstractor may NOT enter the total score if it is not documented in the record, even if all 9 questions have been answered and the total is evident. **For any score not documented in the record, enter zz.**  **If the Clinical Reminder for the PHQ-9 is in use, the outcome may be documented by notation of the score and the suggested severity of depression.**  **Documentation of PHQ-9 outcome by suggested severity of depression takes precedence over outcome documented as positive/negative. Select the applicable option for documentation of no depression, mild, moderate, moderately severe, or severe depression.**  If the outcome of the PHQ-9 is documented as “negative,” select “3.”  For any outcome not documented in the record, enter “99.”  **The answer key for PHQ-9 question 9 is as follows:**  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 #9 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.**  Enter the exact date. The use of 01 to indicate missing month or day is not acceptable. |
| 75 | oplnmdd | Within the past year, did the clinician document a treatment plan for depression (or bipolar disorder)? | 1,2  If 2, go leavduty | A treatment plan for depression (or bipolar disorder) is the clinician’s plan for ongoing care of depression (or bipolar disorder) for the patient. The treatment plan may include:   * patient involvement * family involvement * individual therapy * group therapy * anti-depressant medications (or medications for treatment of bipolar disorder) |
| 76 | oplnmddt | Enter the date the most recent treatment plan for depression (or bipolar disorder) was documented in the record. | mm/dd/yyyy  If most recent depscor > 9 OR depout = 1, 5, 6, OR 7, OR ans9scr = 1, 2, or 3, go to depnewtx, else go to leavduty   |  | | --- | | <= 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. |
| 77 | depnewtx | Following the most recent positive PHQ-9 was there evidence in the record the clinician made a change to the treatment plan?  1. Yes  2. No | 1,2  If 2, auto-fill deplandt as 99/99/9999, and go to leavduty | Documentation by the clinician of a change in treatment may include interventions such as: changing medication, adjusting dose of medication, referral for counseling, or increase frequency of follow-up. |
| 78 | deplandt | Enter the date the clinician documented a change in the treatment plan. | mm/dd/yyyy  **\*Go to leavduty**   |  | | --- | | > = most recent dephq9dt when depscor > 9 OR depout = 1, 5, 6, OR 7, OR ans9scr = 1, 2, or 3, and < = stdyend | | Enter the exact date. The use of 01 to indicate missing month or day is not acceptable. |

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|  |  | **Depression Screening** |  |  |
| 79 | phq2dt | Enter the date within the past year of the most recent screening for depression by the PHQ-2 or PHQ-9. | mm/dd/yyyy  Abstractor can enter 99/99/9999  **\*If 99/99/9999, go to leavduty**   |  | | --- | | < = 1 year prior to or = stdybeg and < = stdyend | | **Enter the most recent date within the past year of completion of the PHQ-2 or PHQ-9 depression screen documented in the record.**  **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  **If the patient was not screened for depression in the past year by the PHQ-2 or PHQ-9, enter 99/99/9999.**  Enter the exact date. The use of 01 to indicate missing month or day is not acceptable. |
| 80 | scrnphq | On the date of the most recent screening for depression, was the patient screened by the PHQ-2 or the PHQ-9?  2. Screened by PHQ-2  3. Screened by PHQ-9  4. Screened by PHQ-2 AND PHQ-9 on the same date | 2,3,4 | **If the patient was screened for depression by the PHQ-2 AND PHQ-9 on the same date (date of most recent screening for depression entered in PHQ2DT), select “4.”**  **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.”  **Patient Health Questionnaire (PHQ-9) asks:**  Over the last 2 weeks, how often have you been bothered by any of the following problems?   1. Little interest or pleasure in doing things 2. Feeling down, depressed, or hopeless 3. Trouble falling asleep or staying asleep, or sleeping too much 4. Feeling tired or having little energy 5. Poor appetite or overeating 6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down 7. Trouble concentrating on things, such as reading the newspaper or watching television 8. Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual 9. Thought that you would be better off dead, or of hurting yourself in some way   10. If you checked off *any* problems, how *difficult* have these problems made it for you to do work, take care of things at home, or get along with other people? |
| 81 | ph1scor | Enter the score for PHQ-2 Question 1 documented in the record:  **(**Question #1 of the PHQ-9 is PHQ-2 question #1 and should be used if available). 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 | **Use of the PHQ-2 Scaled Instrument is mandated for use after 12/01/06. If the “Yes or No” PHQ-2 is used to screen the patient, answer “99” to both questions since this instrument is not applicable.**  **If the PHQ-2 and the PHQ-9 were administered on the same date, enter the response or score documented for the PHQ-2 question 1.**  **The questions displayed are the “Scaled PHQ-2” in which the answer key for Question 1 is as follows:** 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.** |
| 82 | ph2scor | Enter the score for PHQ-2 Question 2 documented in the record:  **(**Question #2 of the PHQ-9 is PHQ-2 question #2 and should be used if available). 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  If scrnphq = 3, go to phq9ques, else go to phqtotal | **If the PHQ-2 and the PHQ-9 were administered on the same date, enter the response or score documented for the PHQ-2 question 2.**  **The questions displayed are the “Scaled PHQ-2” in which the answer key for Question 2 is as follows:** 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.** |
| 83 | 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.** |
| 84 | 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 scrnphq = 2 AND**  (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 if scrnphq = 2, 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.”** |
| 85 | phq9ques | Did the record document the patient’s responses to all 9 questions of the PHQ-9?  1. Yes  2. No | 1,2 | **Answer key to each of the nine questions on the PHQ-9 is as follows:**  Not at all → 0  Several days → 1  More than half the days → 2  Nearly every day → 3  **In order to answer “1,” the record must document the patient’s responses to all 9 questions on the PHQ-9.** |
| 86 | ph9total | Enter the total score of the PHQ-9 documented in the record. | \_\_\_ \_\_\_  Whole numbers only  0 to 27  Abstractor can enter zz   |  | | --- | | Warning if 0 AND ph1scor or ph2scor = 1, 2, or 3 OR if < sum of [ph1scor and ph2scor] | | The total score for PHQ-9 questions 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 all 9 questions have been answered and the total is evident.  The total score may range from 0 to 27.   |  |  | | --- | --- | | Total Score | Depression Severity | | 1-4 | Minimal depression | | 5-9 | Mild depression | | 10-14 | Moderate depression | | 15-19 | Moderately severe depression | | 20-27 | Severe depression |   **If no total score is documented in the record, enter default zz.** |
| 87 | ph9scor | Enter the score for PHQ-9 Question 9 documented in the record:  **Over the last 2 weeks, how often have you been bothered by thoughts that you would be better off dead, or of hurting yourself in some way?**  0. Not at all → 0  1. Several days → 1  2. More than half the days → 2  3. Nearly every day → 3  95. Not applicable  99. No answer documented | 0,1,2,3,95,99 | The answer key for PHQ-9 question 9 is as follows:  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 #9 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.** |
| 88 | phq10 | What was the result of question 10 on the PHQ9?  1. Not difficult at all  2. Somewhat difficult  3. Very difficult  4. Extremely difficult  95. Not applicable  99. No answer documented | 1,2,3,4,95,99 | Since the questionnaire relies on patient self-report, all responses should be verified by the clinician and a definitive diagnosis  made on clinical grounds, taking into account how well the patient understood the questionnaire, as well as other relevant  information from the patient. Diagnoses of Major Depressive Disorder or Other Depressive Disorder also require impairment of social, occupational, or other important areas of functioning (Question #10) and ruling out normal bereavement, a history of a Manic Episode (Bipolar Disorder), and a physical disorder, medication, or other drug as the biological cause of the depressive symptoms. |
| 89 | phq9out | Was the outcome of the PHQ-9 documented in the medical record?  1. Outcome positive  3. Score suggestive of no depression  4. Score suggestive of mild depression  5. Score suggestive of moderate depression  6. Score suggestive of moderately severe depression  7. Score suggestive of severe depression   1. Not applicable   99. No documentation of outcome | 1,3,4,5,6,7,95,99  If ph9total > 10, or (ph9scor = 1,2, or 3), or (phq9out = 1,5,6, or 7),**OR**  **If scrnphq = 4 AND**  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-9 score must be documented in the record. Documentation of “PHQ-9 negative” or “PHQ-9 positive” without patient response to the questions or total score is not acceptable, and “99” should be entered.**  **If the Clinical Reminder for the PHQ-9 is in use, the outcome may be documented by notation of the score and the suggested severity of depression.**  **Documentation of PHQ-9 outcome by suggested severity of depression takes precedence over outcome documented as positive/negative. Select the applicable option for documentation of no depression, mild, moderate, moderately severe, or severe depression.**  If the outcome of the PHQ-9 is documented as “negative,” select “3.” |

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| 90 | deprisk | On the day of or the day after the positive PHQ-2 or PHQ-9 depression screen or affirmative answer to PHQ-9 question 9, 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 depeval | If the patient has a positive PHQ-2, PHQ-9 or affirmative answer to PHQ-9 question 9 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, NP, CNS, or PA. Trainees 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 |
| 91 | 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. |
|  |  | Depression Triage |  |  |
| 92 | depeval | Following the positive PHQ-2 or PHQ-9 or affirmative answer to PHQ-9 question 9, did the provider document the patient needed further intervention?  1. Yes, documented further intervention needed  2. Documented no further intervention needed  99. No documentation regarding further intervention | 1,2,99  If 99, auto-fill depevldt as 99/99/9999, and go to nodepint | **Acceptable Provider**: MD, DO, PhD or PsyD Psychologist, LCSW, APN, PA (or a MD, DO, PhD or PsyD Psychologist, LCSW, APN, PA trainee with appropriate co-signature).  **Triage** = the process of classifying patients according to the urgency of their need for care. Triage includes identification of treatment setting, arrangement for treatment, and provision of provider and emergency contact information.  **Triage 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.**  If the provider documented that the patient needed further intervention for depression, select “1.”  For example, provider documents, “PHQ-2 positive. Patient reports having difficulty sleeping and getting up to go to work. Needs mental health evaluation.” Select “1.”  If the provider documented that no further intervention was needed for depression, select “2.” For example, clinician documents, “PHQ-2 pos, but no problems with day-to-day functioning reported by patient No further intervention necessary.” Select “2.”  If there is no documentation by the provider regarding whether the patient needed further intervention, select “99.” |
| 93 | depevldt | Enter the date of documentation by the provider indicating whether further intervention was needed. | mm/dd/yyyy  Will be auto-filled as 99/99/9999  if depeval = 99  If depeval = 2 and depevldt <> 99/99/9999, go to leavduty   |  | | --- | | >= phq2dt and  < = stdyend | | Enter the exact date. The use of 01 to indicate missing month and day is not acceptable. |
| 94 | nodepint | Following the positive PHQ-2 or PHQ-9 or affirmative answer to PHQ-9 question 9, did the provider document the patient refused further evaluation/treatment for depression?  1. Yes  2. No | 1,2  If 1, go to deptcont, else go to depcare | In order to answer “1,” the provider must document the patient’s refusal of further evaluation/treatment for depression in the medical record. |
| 95 | depcare | Following the positive PHQ-2 or PHQ-9 or affirmative answer to PHQ-9 question 9, did the provider document the patient was already receiving recommended care for depression?  1. Yes  2. No | 1,2  If 1, go to deptcont, else go to decarout | If the provider documents the patient is receiving treatment for depression, answer “1.” Any notation of current treatment by the provider is acceptable.  For example, “patient seeing counselor every 2 weeks for depression.” Select “1.” |
| 96 | decarout | Following the positive PHQ-2 or PHQ-9 or affirmative answer to PHQ-9 question 9, did the provider document the patient was to receive care for depression outside this VA?  1. Yes  2. No | 1,2  If 1, go to deptcont, else to to depmhevl | In order to answer “1,” the provider must document a plan for receiving care outside this VA. For example, physician noted, “Patient has been seeing counselor in his community and will continue this care.” Select “1.”  APN notes, “patient thinking about seeking counseling.” Select “2.” |

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| 97 | depmhevl | Following the positive PHQ-2 or PHQ-9 or affirmative answer to PHQ-9 question 9, did the provider document that the patient needed a mental health evaluation?  1. Yes, mental health evaluation needed  2. No mental health evaluation needed  99. No documentation regarding mental health evaluation | 1,2,99  If 1, auto-fill depcpfol as 95, and go to depurg, else go to depcpfol | **Acceptable Provider**: MD, DO, PhD or PsyD Psychologist, LCSW, APN, PA (or a MD, DO, PhD or PsyD Psychologist, LCSW, APN, PA trainee with appropriate co-signature).  If the provider documented the patient needed a mental health evaluation or the provider referred the patient to mental health, select “1.”  If the provider documented a mental health evaluation was not needed, select “2.” For example, MD notes, “Patient not suicidal. Will restart Zoloft and see in primary care clinic in 2 weeks.” |
| 98 | depcpfol | Following the positive PHQ-2 or PHQ-9 or affirmative answer to PHQ-9 question 9, did the provider document that the patient will follow-up with a primary care provider?  1. Yes  2. No  95. Not applicable | \*1,2,95  If 1, go to erlyeval  \*If 2, go to leavduty | If the provider is the primary care provider for the patient and documents the patient will return for an appointment, select “1.” If the provider is not the primary care provider, the primary care provider does not have to be named. Documentation of follow-up with primary care clinic is sufficient. |
| 99 | depurg | Following the positive PHQ-2 or PHQ-9 or affirmative answer to question 9, did the provider document the urgency of the mental health evaluation?  1. Immediate/emergent mental health evaluation needed  2. Urgent mental health evaluation needed  3. Non-urgent mental health evaluation needed  99. No documentation of urgency of care | 1,2,3,99  If 2, 3, or 99, auto-fill depmhdt as 99/99/9999, and go to depmhref, else go to depmhdt | **Determination of urgency** **= general statement or evidence of timeline for how soon the patient will need to be seen by mental health.**  **The following are examples (exact terms not required):**  **Immediate -** i.e. emergent, requires ER, immediate admission, etc. For example, physician notes, “Patient is agitated and poses a danger to self; transport to ER” or “patient needs to be seen emergently by mental health. Mental health notified and patient transported to psych unit.” Select “1.”  **Urgent -** i.e. requires further evaluation and or treatment within 24 hours. APN notes, “no imminent danger, will schedule to see mental health today.” Select “2.”  **Non-urgent -** i.e. not urgent, requires evaluation and treatment within 14 days. For example, “Patient oriented, cooperative, and would like to restart treatment. Follow-up with mental health appointment.” Select “3.”  If unable to determine from the documentation the provider’s determination of urgency of care for the patient, select “99.” |
| 100 | depmhdt | Enter the date the patient was emergently transferred to mental health care services. | mm/dd/yyyy   |  | | --- | | > = phq2dt and  < = stdyend |   If <> 99/99/9999, go to defdxdep  Will be auto-filled as 99/99/9999 if depurg = 2,3,99 | Emergently transferred to mental health care services = i.e. inpatient admission, 72 hour hold, transfer to ED, immediately see mental health provider.  If the emergent transfer/admission occurs within the same encounter, enter the date of the encounter.  Abstractor may enter 99/99/9999 if there was no documentation that the patient was transferred for emergent mental health care. |
| 101 | depmhref | Following the positive PHQ-2 or PHQ-9 or affirmative answer to PHQ-9 question 9, did the record document a consult was placed for a mental health evaluation?  1. Yes  2. No | 1,2  If 2, auto-fill deprefdt as 99/99/9999, depmhcom as 95, and dep24dt as 99/99/9999, and go to deptcont | Arrangement for treatment for the patient is a component of triage.  If there is documentation that a mental health consult was placed following the positive PHQ-2 or PHQ-9 or affirmative answer to PHQ-9 question 9, select “1.”  If there is no documentation that a mental health consult was placed following the positive PHQ-2 or PHQ-9 or affirmative answer to PHQ-9 question 9, select “2.” |
| 102 | deprefdt | Enter the date the mental health consult was placed. | mm/dd/yyyy   |  | | --- | | > = phq2dt and  < = stdyend | | Enter the exact date. The use of 01 to indicate missing month or day is not acceptable. |
| 103 | depmhcom | Following placement of a mental health consult request, did the record document the mental health evaluation was completed?  1. Yes  2. No  95. Not applicable | 1,2,95  Will be auto-filled as 95 if depmhref = 2  If 2, auto-fill dep24dt 99/99/9999 and go to deptcont | If there is documentation in the record by a mental health provider indicating the patient was evaluated, enter “1.”  If there is no documentation a mental health evaluation was completed, select “2.” |
| 104 | dep24dt | Enter the earliest date the mental health evaluation was completed. | mm/dd/yyyy  Will be auto-filled as 99/99/9999 if depmhref = 2 or depmhcom = 2   |  | | --- | | >= deprefdt and <= stdyend | | Enter the exact date. The use of 01 to indicate missing month or day is not acceptable. |
| 105 | deptcont | Following the positive PHQ-2 or PHQ-9 depression screen or affirmative answer to PHQ-9 question 9, did the provider document that contact information was provided to the patient?  1. Provider contact information provided  2. Emergency contact information provided  3. Both 1 and 2  99. None of the above documented | 1,2,3,99  If 99, auto-fill depcondt as 99/99/9999, erlyeval as 99/99/9999, and go to defdxdep | Depending on the provider’s triage of the patient, contact information may include:  **Provider contact** **= name and contact information for provider that will be caring for the patient or conducting the next interaction**  **Emergency contact = name and contact information for emergency services or emergency contact if the patient should require or want assistance**  Documentation that provider contact information or emergency contact information was provided to the patient is acceptable.  Contact information is a component of triage. Triage 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. |
| 106 | depcondt | Enter the date the provider documented contact information was provided to the patient. | mm/dd/yyyy  Will be auto-filled as 99/99/9999 if deptcont = 99   |  | | --- | | If depevldt <> 99/99/9999, >= depevldt and  <= stdyend  If depevldt = 99/99/9999, >= phq2dt and <= stdyend | | Enter the exact date the provider documented contact information was provided to the patient. The use of 01 to indicate missing month or day is not acceptable. |
| 107 | erlyeval | Enter the date of completion for the earliest follow-up evaluation for a positive depression screen by a primary care provider. | mm/dd/yyyy  Will be auto-filled as 99/99/9999 if  deptcont = 99  Abstractor can enter 99/99/9999   |  | | --- | | > = phq2dt and < = stdyend | | Earliest follow-up evaluation = the first comprehensive evaluation for depression completed most immediately following the positive depression screen by a primary care provider.  If there is no documentation that the primary care provider completed a follow-up evaluation for a positive depression screen, enter 99/99/9999. |
| 108 | defdxdep | Was a definitive diagnosis of depression made by a Primary Care or Mental Health provider as a result of the follow-up evaluation? 1. Yes  2. No  3. Patient had prior diagnosis of depression | 1,2,3  If 2 or 3, auto-fill dxdepdt as 99/99/9999, depmedrx as 95, and go to leavduty   |  | | --- | | **Warning if 3 and deptxyr = 2** | | **Acceptable Provider**: MD, DO, PhD or PsyD Psychologist, LCSW, APN, PA, (or a MD, DO, PhD or PsyD Psychologist, LCSW, APN, PA trainee with appropriate co-signature). |
| 109 | dxdepdt | Enter the date the definitive diagnosis of depression was documented by the clinician. | mm/dd/yyyy  Will be auto-filled as 99/99/9999 if  defdxdep = 2 or 3   |  | | --- | | >= phq2dt and < = stdyend | | Enter the exact date. The use of 01 to indicate missing month or day is not acceptable. |
| 110 | depmedrx | Within 4 weeks of the definitive diagnosis of depression, does the record document anti-depressants were prescribed for the patient? 1. Yes  2. No  3. Diagnosis of depression was made less than 4 weeks prior to study end date  95. Not applicable | 1,2,3,95  Will be auto-filled as 95 if defdxdep = 2 or 3   |  | | --- | | Cannot enter 3 if stdyend – dxdepdt > = 4 weeks | | There are different anti-depressant drug classes and many different anti-depressant medications. Examples are listed below (Please refer to a drug handbook for a more complete listing).  Tricyclic antidepressants: amitriptyline,despipramine (Norpramin), doxepin (Sinequan), imipramine (Tofranil), aventyl.  Other anti-depressants: bupropion (Wellbutrin), citalopram (Celexa), fluoxetine (Prozac), mirtazapine (Remeron), paroxetine (Paxil), sertaline (Zoloft), desyrel, venlafaxine (Effexor)  MAOI: phenelzine (Nardil), tranylcypromine (Parnate) |

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|  |  | **Screening for PTSD** |  |  |
| 111 | leavduty | Enter the patient’s most recent date of separation from active military duty.(Can be taken from other than Clinical Reminder) | mm/dd/yyyy  **Abstractor can enter 99/99/9999 if no date of separation can be found**  **If < = 09/11/2001, auto-fill vetserv4 = -1, and go to ptsdx**   |  | | --- | | > = 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 |
| 112 | vetserv  vetserv1  vetserv3  vetserv4  vetserv99 | Did the veteran serve in Operation Enduring Freedom (OEF) and/or Operation Iraqi Freedom (OIF) either on the ground, in nearby coastal waters, or in the air above, after September 11, 2001?Indicate all that apply:1. Service in Operation Enduring Freedom (OEF)Service in Operation Iraqi Freedom (OIF)No service in OEF or OIF99. Not documented/unable to determine | 1,3,4,99  Cannot enter 4 or 99 with any other number | If the patient’s most recent last service separation date was after 9/11/01, then a post deployment screening should have been done. If this screening was done after approximately April 2005, then the information on the patient’s participation in OEF vs. OIF will be available. If the OEF/OIF screening was done prior to this date (April 2005), only the fact that they served in either OEF or OIF will be listed – not which one of the 2 operations. This information, if available, can be found in the VA-Iraq/Afghanistan Post Deployment Reminder. If unable to find, ask the liaison for assistance.  OEF countries include Afghanistan, Georgia, Kyrgyzstan, Pakistan, Tajikistan, Uzbekistan, the Phillipines, and other.  OIF countries include Iraq, Kuwait, Saudi Arabia, Turkey, and other.  If the veteran did not serve in either of these Operations but the record documents where his/her service occurred, enter “4.”  **If unable to find documentation of where or when the veteran served, enter “99”.** |
| 113 | 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 ICD-9-CM code 309.81? | 1,2  **If 1, enable Suicide Evaluation**  **If 2, go to ptsrnpc**   |  | | --- | | **Warning if 2 and selptsd = -1** | | 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 the following ICD-9-CM code: **309.81**.  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 ICD-9-CM code 309.81, answer “1.”  Clinical encounter includes outpatient visits, ED visits, and inpatient admission. |
| 114 | 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   |  | | --- | | < = 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 ICD-9-CM code 309.81.  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. |
| 115 | newptsd | Was PTSD newly diagnosed within the past year?  1. Yes  2. No | 1,2  **\*If 2, auto-fill newptsdt as 99/99/9999, and go to preptsdx** | **New diagnosis of PTSD within the past year:**  **1) PTSD is documented as a new diagnosis within the past year, OR**  2) A new episode of PTSD is documented after at least 4 months **without** evidence of any treatment for PTSD.  The 4 month period may start in the year prior to the study year. For example, patient is seen on 9/08/08 for symptoms of PTSD and clinician diagnosed PTSD. Patient has history of PTSD, but documentation indicates that last treatment encounter for PTSD was on 3/18/08. At that time patient had completed group therapy and discontinued therapy. Since at least 4 months had elapsed without evidence of treatment for PTSD, select “1.” |
| 116 | newptsdt | Enter the date the new diagnosis of PTSD was made. | mm/dd/yyyy  Will be auto-filled as 99/99/9999 if  newptsd = 2  If newptsd = 1, go to whoptsd   |  | | --- | | < = 1 year prior to or = stdybeg and <= recptsdt | | Enter the exact date. The use of 01 to indicate missing month or day is not acceptable. |
| 117 | preptsdx | Within the year prior to the study year, did the patient have at least one clinical encounter where PTSD was identified as a reason for the clinical encounter as evidenced by ICD-9-CM code 309.81? | 1,2  If 2, auto-fill preptsdt as 99/99/9999, and go to pclc | 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 the following ICD-9-CM code: **309.81**.  If the patient has at least one clinical encounter within the year prior to the study year for PTSD as evidenced by documentation of ICD-9-CM code 309.81, answer “1.”  Clinical encounter includes outpatient visits, ED visits, and inpatient admission. |
| 118 | preptsdt | Within the year prior to the study year, enter the date of the most recent clinical encounter where PTSD was identified as a reason for the clinical encounter. | mm/dd/yyyy  Will be auto-filled as 99/99/9999  if preptsdx = 2  If preptsdx = 1, go to pclc   |  | | --- | | > 1 year prior to stdybeg and < = 2 years prior stdybeg | | Enter the date of the most recent clinical encounter within the year prior to the study year where PTSD was identified as a reason for the clinical encounter by evidence of ICD-9-CM code 309.81.  If the most recent clinical encounter for PTSD in the year prior to the study 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. |
| 119 | whoptsd | Which provider documented the initial diagnosis of PTSD?1. Primary Care Provider2. Mental Health Provider95. Not applicable99. Unable to determine | 1,2,95,99 | Initial diagnosis of PTSD = new diagnosis of PTSD or a new episode of PTSD that occurs after at least 4 months without evidence of any treatment for PTSD.  4 months without evidence of any treatment of PTSD  Primary Care provider = MD, DO, APN, PA  Mental Health provider = MD, DO, APN, PA, Psychologist, or Mental Health Social Worker |
| 120 | refptdtx | Was the patient referred for treatment of PTSD in the past year?  1. Referred for treatment within VHA  2. Referred for treatment outside VHA  3. Both 1 and 2  4. Documented patient already receiving care for mental health disorder  99.No documentation of referral for treatment of PTSD | 1,2,3,4,99  \*If 2, 4, or 99, go to pclc | Treatment of PTSD may include mental health case management appointment, appointment for psychotherapy (e.g., individual, group, couple, family), or prescribing anti-depressant medications.  Psychotherapy may include: Cognitive Behavioral Therapy (CBT), Interpersonal Therapy (IPT), Problem-solving Therapy (PST), Acceptance & Commitment Therapy  Do not include Assertive Community Therapy.  In order to answer “4”, there must be documentation by the primary care provider or mental health provider that the patient is already receiving care for a mental health disorder (e.g. depression, anxiety, substance abuse) and that provider will provide treatment for the PTSD. |

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| 121 | wichref1 | Which provider made the initial referral for treatment of PTSD in the past year?1. Primary Care Provider2. Mental Health Provider99. Unable to determine | 1,2,99 | Primary Care provider = MD, DO, APN, PA,  Mental Health provider = MD, DO, APN, PA, Psychologist, or Mental Health Social Worker  Examples: Patient sees PCP with c/o irritability, insomnia, and memory problems. PC-PTSD screen obtained and outcome is positive. PCP refers the patient to mental health for further evaluation; select “1.”  Patient is seeing mental health social worker for SUD. PC-PTSD screen obtained and positive. Mental Health Social worker refers patient to psychologist; select “2.” | | |
| 122 | refptxdt | Enter the date the referral for treatment of PTSD was placed. | mm/dd/yyyy   |  | | --- | | < = 1 year prior to or = stdybeg and  < = stdyend | | Enter the exact date. The use of 01 to indicate missing month and day is not acceptable. | | |
| 123 | seenptsd | After the initial referral was placed, is there documentation the patient was seen by a provider for PTSD?1. Yes2. No3. Appointment is scheduled after study end date | 1,2,3  If 2 or 3, go to pclc, else go to seenptdt | Treatment of PTSD may include mental health case management appointment, psychotherapy (e.g., individual, group, couple, family), or prescription of anti-depressant medications.  If an appointment for treatment of PTSD is scheduled, but is after the study end date, enter “3.”  Primary Care provider = MD, DO, APN, PA,  Mental Health provider = MD, DO, APN, PA, Psychologist, or Mental Health Social Worker | | |
| 124 | seenptdt | Enter the earliest date after initial referral when the patient was seen for treatment of PTSD. | mm/dd/yyyy  Abstractor can enter 99/99/9999   |  | | --- | | >= refptxdt or  = stdybeg and  < = stdyend | | Treatment for PTSD may occur in an outpatient and/or inpatient setting. Treatment may include an appointment with a mental health care provider, prescription of anti-depressant medication, or therapy. If there is no documentation the patient was seen for treatment of PTSD following the initial referral, enter 99/99/9999. | | |
| 125 | ptdtxloc | Identify the setting where the patient received treatment for PTSD.1. Outpatient treatment in VHA2. Inpatient treatment in VHA3. Both 1 and 295. Not applicable | 1,2,3,95 | Treatment for PTSD may occur in an outpatient and/or inpatient setting. Treatment may include an appointment with a mental health care provider, prescription of anti-depressant medication, or therapy. | | |
| 126 | ptsdtx1  ptsdtx2  ptsdtx3  ptsdtx4  ptsdtx5  ptsdtx6 | Is there documentation the treatment for  PTSD included the following:  |  |  | | --- | --- | | 1. Prescription of anti-depressant medication | 1,2 | | 2. Cognitive Behavioral Therapy | 1,2 | | 3. Interpersonal Psychotherapy | 1,2 | | 4. Problem-solving Therapy | 1,2 | | 5. Acceptance and Commitment Therapy | 1,2 | | 6. Other type of therapy | 1,2 | | 1,2 | There are different anti-depressant drug classes and many different anti-depressant medications. Examples are listed below (Please refer to a drug handbook for a more complete listing).  **Tricyclic antidepressants**: amitriptyline,despipramine (Norpramin), doxepin (Sinequan), imipramine (Tofranil), aventyl.  **Other anti-depressants**: bupropion (Wellbutrin), citalopram (Celexa), fluoxetine (Prozac), mirtazapine (Remeron), paroxetine (Paxil), sertaline (Zoloft), desyrel, venlafaxine (Effexor)  **MAOI:** phenelzine (Nardil), tranylcypromine (Parnate)  2 = Cognitive behavioral therapy is used to improve cognitive distortions, reduce distractibility, and correct errors in judgment.  3 = Interpersonal psychotherapy utilizes relaxation exercises, psychoeducation, self-reflection, and exploration of individual vulnerability to enhance personal and social adjustment.  4 =  Problem solving therapy is a brief psychological intervention that occurs in 4-8 sessions with the following steps addressed:  problem orientation, recognizing and identifying problems, selecting and defining a clear problems, generating solutions, decision making, creating and implementing a SMART action plan, and reviewing progress.  5 = The goal of Acceptance and Commitment therapy is to help clients consistently choose to act effectively (concrete behaviors as defined by their values) in the presence of difficult or disruptive “private” (cognitive or psychological) events. The acronym ACT has also been used to describe what takes place in therapy: accept the effects of life’s hardships, choose directional values, and take action. | | |
| 127 | pclc | Within the past year, did the record document completion of the PCL-C (PTSD checklist)?  1. Yes  2. No | 1,2  If 2, go to pclm, else go to pc1dt1 | **PCL-C:** 17 questions that ask about any problems and complaints that veterans have had in response to stressful life experiences within the last month.  **In order to answer “1,” all 17 questions with the patient’s answers must be documented in the record.**  1. Repeated, disturbing memories, thoughts, or images of a stressful experience from the past?  2. Repeated, disturbing dreams of a stressful experience from the past?  3. Suddenly acting or feeling as if a stressful experience were happening again (as if you were reliving it)?  4. Feeling very upset when something reminded you of a stressful experience from the past?  5. Having physical reactions (e.g., heart pounding, trouble breathing, or sweating) when something reminded you of a stressful experience from the past?  6. Avoid thinking about or talking about a stressful experience from the past or avoid having feelings related to it?  7. Avoid activities or situations because they remind you of a stressful experience from the past?  8. Trouble remembering important parts of a stressful experience from the past?  9. Loss of interest in things that you used to enjoy?  10. Feeling distant or cut off from other people?  11. Feeling emotionally numb or being unable to have loving feelings for those close to you?  12. Feeling as if your future will somehow be cut short?  13. Trouble falling or staying asleep?  14. Feeling irritable or having angry outbursts?  15. Having difficulty concentrating?  16. Being “super alert” or watchful on guard?  17. Feeling jumpy or easily startled?  **Responses to each of the 17 questions on the PCL-C are as follows:**   1. **Not at all** →1 2. **A little bit** →2 3. **Moderately**→ 3 4. **Quite a bit**→4 5. **Extremely**→5 | | |
| 128 | pcldt1  pclscor1  pclout1 | Starting with the most recent PCL-C completed in the outpatient setting within the past year: Enter the date, total score, and outcome for each PCL-C documented in the record.   |  |  |  | | --- | --- | --- | | **Date** | **Total Score** | **Outcome**  **1,2,99** | |  |  |  |   **Outcome**  1. Outcome positive  2. Outcome negative  99. Unable to determine outcome | **Enter ALL PCL-C** mm/dd/yyyy   |  | | --- | | <= 1 year prior to or = stdybeg and  <= stdyend |   \_\_ \_\_  Total score  **Abstractor can enter zz**   |  | | --- | | Whole numbers  17 - 85 |   Outcome  1,2, 99 | **For each PCL-C completed in the outpatient setting within the past year enter:**   * Date of each PCL-C completed * Total score documented in the record * Outcome documented in the record   **All 17 questions with the patient’s answers must be documented in the record AND the total score must be documented in the record.** The abstractor may NOT enter the total score if it is not documented in the record, even if all 17 questions have been answered and the total is evident. **A positive screen for the 17-question screen PCL-C is > = 50 points.**  **For any score not documented in the record, enter zz.**  For any outcome not documented in the record, enter “99.” PCL-C: 17 questions that ask about any problems and complaints that veterans have had in response to stressful life experiences within the last month. | | |
| 129 | pclm | Within the past year, did the record document completion of the PCL-M (PTSD checklist)?  1. Yes  2. No | 1,2  If 2, go to oplnptsd, else go to pc1mdt1 | **PCL-M:** 17 questions that ask about problems in response to stressful military experiences within the last month.  **In order to answer “1,” all 17 questions with the patient’s answers must be documented in the record.**  1. Repeated, disturbing memories, thoughts, or images of a stressful experience from the past?  2. Repeated, disturbing dreams of a stressful experience from the past?  3. Suddenly acting or feeling as if a stressful experience were happening again (as if you were reliving it)?  4. Feeling very upset when something reminded you of a stressful experience from the past?  5. Having physical reactions (e.g., heart pounding, trouble breathing, or sweating) when something reminded you of a stressful experience from the past?  6. Avoid thinking about or talking about a stressful experience from the past or avoid having feelings related to it?  7. Avoid activities or situations because they remind you of a stressful experience from the past?  8. Trouble remembering important parts of a stressful experience from the past?  9. Loss of interest in things that you used to enjoy?  10. Feeling distant or cut off from other people?  11. Feeling emotionally numb or being unable to have loving feelings for those close to you?  12. Feeling as if your future will somehow be cut short?  13. Trouble falling or staying asleep?  14. Feeling irritable or having angry outbursts?  15. Having difficulty concentrating?  16. Being “super alert” or watchful on guard?  17. Feeling jumpy or easily startled?  **Responses to each of the 17 questions on the PCL-M are as follows:**  **1. Not at all** →1  **2. A little bit** →2  **3. Moderately**→ 3  **4. Quite a bit**→4  **5. Extremely**→5 | | |
| 130 | pclmdt1  pclmscor1  pclmout1 | Starting with the most recent PCL-M completed in the outpatient setting within the past year: Enter the date, total score, and outcome for each PCL-M documented in the record.   |  |  |  | | --- | --- | --- | | **Date** | **Total Score** | **Outcome**  **1,2,99** | |  |  |  |   **Outcome**  1. Outcome positive  2. Outcome negative  99. Unable to determine outcome | **Enter ALL PCL-M** mm/dd/yyyy   |  | | --- | | <= 1 year prior to or = stdybeg and  <= stdyend |   \_\_ \_\_  Total score  **Abstractor can enter zz**   |  | | --- | | Whole numbers  17 - 85 |   Outcome  1,2, 99 | **For each PCL-M completed in the outpatient setting within the past year enter:**   * Date of each PCL-M completed * Total score documented in the record * Outcome documented in the record   **All 17 questions with the patient’s answers must be documented in the record AND the total score must be documented in the record.** The abstractor may NOT enter the total score if it is not documented in the record, even if all 17 questions have been answered and the total is evident. **A positive screen for the 17-question screen PCL-M is > = 50 points.**  **For any score not documented in the record, enter zz.**  For any outcome not documented in the record, enter “99.” | | |
| 131 | oplnptsd | Within the past year, did the clinician document a treatment plan for PTSD? | 1,2  If 2, go to mhtxrsk | A treatment plan for PTSD is the clinician’s plan for ongoing care of PTSD for the patient. The treatment plan may include:   * patient involvement * family involvement * individual therapy * group therapy * anti-depressant medications | | |
| 132 | oplnptdt | Enter the date the most recent treatment plan for PTSD was documented in the record. | mm/dd/yyyy  If pcldt1 <> 99/99/9999 AND most recent (pclscor > = 50 or pclout = 1) OR if pclmdt1 <> 99/99/9999 AND most recent (pclmscor > = 50 or pclmout = 1), go to chgptstx, else go to mhtxrsk   |  | | --- | | <= 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. | | |
| 133 | chgptstx | Following the most recent positive PCL-C was there evidence in the record the clinician made a change to the PTSD treatment plan?  1. Yes  2. No | 1,2  If 2, auto-fill chgptxdt as 99/99/9999, and go to mhtxrsk, else go to chgptxdt | Documentation by the clinician of a change in treatment may include interventions such as: changing medication, adjusting dose of medication, referral for counseling, or increase frequency of follow-up. | | |
| 134 | chgptxdt | Enter the date the clinician documented a change in the PTSD treatment plan. | mm/dd/yyyy  **\*If chgptstx = 1, go to mhtxrsk**   |  | | --- | | >= most recent pcldt when (pclscor > = 50 or pclout = 1) OR >= most recent plcmdt, when pclmscor > = 50 or pclmout = 1), and < = stdyend | | Enter the exact date. The use of 01 to indicate missing month or day is not acceptable. | | |
| 135 | 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, auto-fill pcptsdt as 99/99/9999, and go to ptsdscrn, else go to pcptsdt | 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 | | |
| 136 | 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. | | |
| 137 | ptsdscrn | Within five years prior to the first day of the study interval, but prior to 10/01/07, was the patient screened for PTSD using one of the following standardized instruments?  2. PTSD Checklist – Civilian Version (PCL-C)  3. PTSD Checklist – Military Version (PCL-M)  4. PTSD Checklist – Stressor Specific Version  (PCL-S)  99. Not screened by one of these instruments | 2,3,4,99  If 99, auto-fill ptsdate as 99/99/9999  \*If 99 AND ptsrnpc = 2, go to end, else go to ptsdate | PCL-C: 17 questions that ask about any problems and complaints that veterans have had in response to stressful life experiences within the last month.  PCL-M: 17 questions that ask about any problems and complaints that veterans have had in response to stressful military experiences within the last month.  PCL-S: 17 questions that ask about any problems and complaints that veterans have had in response to a specific stressful experience within the last month.  Screening for PTSD done by telephone is acceptable.  **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 | | |
| 138 | ptsdate | Enter the date of the most recent screen for PTSD using a PTSD checklist. | mm/dd/yyyy  If ptsdscrn = 99, will be auto-filled as 99/99/9999  **\*If ptsrnpc = 2, go to end**   |  | | --- | | < = 5 years prior or = stdybeg and  < 10/01/07 | | **Enter the date of the most recent screen for PTSD using a PTSD checklist (PCL).**  Initial screening may be done by a non-clinician, or a self-administered checklist may be used to ensure systematic, standardized, and efficient review of patient symptoms.  **Screening for PTSD done by telephone is acceptable.**  PCL-C: 17 questions more specific to PTSD symptoms in the last month  PCL-M: 17 questions more specific to PTSD symptoms in the last month as a result of military experience  PCL-S: 17 questions more specific to PTSD symptoms in the last month as a result of a specific stressful experience | | |
| 139 | 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.  **For screens completed prior to 10/01/08, abstractors may find the patient’s responses to the Primary Care PTSD Screen in a progress note or in the PTSD Screening Clinical Reminder in a detailed display of the Clinical Maintenance.**  **For screens completed on or after 10/01/08, 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.”** | | |
| 140 | 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.  **For screens completed prior to 10/01/08, the abstractor may find the total score for the PC-PTSD in the Clinical Reminder Summary. These reminders should be located in the health summary section under the reports tab of CPRS.**  **For screens completed on or after 10/01/08, 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.** | | |
| 141 | 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 > 10/01/07 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 mhtxrsk as applicable   |  | | --- | | 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.”** | | |
| 142 | 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, auto-fill rskptsdt as 99/99/9999, and go to ptsdeval | If the patient has a positive PC-PTSD screen or positive PHQ-2, PHQ-9 or affirmative answer to PHQ-9 question 9 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, NP, CNS, or PA. Trainees 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 | | |
| 143 | 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. | | |
| 144 | ptsdeval | Following the positive PC-PTSD screen, did the provider document the patient needed further intervention for PTSD?  1. Yes, documented further intervention needed  2. Documented no further intervention needed  99. No documentation regarding further intervention | 1,2,99  If 99, auto-fill evlptsdt as 99/99/9999 | **Acceptable Provider**: MD, DO, PhD or PsyD Psychologist, LCSW, APN, PA, (or a MD, DO, PhD or PsyD Psychologist, LCSW, APN, PA trainee with appropriate co-signature).  **Triage** = the process of classifying patients according to the urgency of their need for care. Triage includes identification of treatment setting, arrangement for treatment, and provision of provider and emergency contact information.  **Triage 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.**  If the provider documented that the patient needed further intervention for a positive PC-PTSD screen, select “1.”  For example, clinician documents, “PC-PTSD positive. Patient reports nightmares and anger outbursts. Needs mental health evaluation.” Select “1.”  If the provider documented that no further intervention was needed for PTSD, select “2.” For example, clinician documents, “PC-PTSD pos, but no problems with day-to-day functioning reported by patient No further intervention necessary.” Select “2.”  If there is no documentation by the provider regarding whether the patient needed further intervention, select “99.” | | |
| 145 | evlptsdt | Enter the date of documentation by the provider indicating whether further intervention for PTSD was needed. | mm/dd/yyyy  Will be auto-filled as 99/99/9999  if ptsdeval = 99  \*If ptsdeval = 2 and evlptsdt <> 99/99/9999, go to end   |  | | --- | | >= pcptsdt and < = stdyend | | Enter the exact date. The use of 01 to indicate missing month and day is not acceptable. | | |
| 146 | noptsint | Following the positive PC-PTSD screen, did the provider document the patient refused further evaluation/treatment for PTSD?  1. Yes  2. No | 1,2  If 1, go to ptsdcont, else go to ptsdcare | In order to answer “1,” the provider must document the patient’s refusal of further evaluation/treatment for PTSD in the medical record. | | |
| 147 | ptsdcare | Following the positive PC-PTSD screen, did the provider document the patient was already receiving recommended care for PTSD?  1. Yes  2. No | 1,2  If 1, go to ptsdcont, else go to outptsd | If the provider documents the patient is receiving treatment for PTSD, answer “1.” Any notation of current treatment by the provider is acceptable.  For example, “patient attends PTSD support group.” Select “1.” | | |
| 148 | outptsd | Following the positive PC-PTSD screen, did the provider document the patient was to receive care for PTSD outside this VA?  1. Yes  2. No | 1,2  If 1, go to ptsdcont, else to ptsdmhevl | In order to answer “1,” the provider must document a plan for receiving care outside this VA. For example, physician noted, “Patient has been seeing counselor in his community and will continue this care.” Select “1.”  APN notes, “patient thinking about seeking counseling.” Select “2.” | | |
| 149 | ptsdmhevl | Following the positive PC-PTSD screen, did the provider document that the patient needed a mental health evaluation?  1. Yes, mental health evaluation needed  2. No mental health evaluation needed  99. No documentation regarding mental health evaluation | 1,2,99  If 1, auto-fill pcptsdfo as 95, and go to ptsdurg, else go to pcptsdfo | **Acceptable Provider**: MD, DO, PhD or PsyD Psychologist, LCSW, APN, PA (or a MD, DO, PhD or PsyD Psychologist, LCSW, APN, PA trainee with appropriate co-signature).  If the provider documented the patient needed a mental health evaluation or the provider referred the patient to mental health, select “1.”  If the provider documented a mental health evaluation was not needed, select “2.” For example, MD notes, “Patient not agitated. No suicidal thoughts. Will see in primary care clinic in 2 weeks.” | | |
| 150 | pcptsdfo | Did the provider document that the patient will follow-up with a primary care provider for the positive PC-PTSD screen?  1. Yes  2. No  95. Not applicable | 1,2,95  \*If 1, go to erlyfolo  If 2,  go to end | If the provider is the primary care provider for the patient and documents the patient will return for an appointment, select “1.” The primary care provider does not have to be named. Documentation of follow-up with primary care clinic is sufficient. | | |
| 151 | ptsdurg | Following the positive PC-PTSD screen, did the provider document the urgency of the mental health evaluation?  1. Immediate/emergent mental health evaluation needed  2. Urgent mental health evaluation needed  3. Non-urgent mental health evaluation needed  99. No documentation of urgency of care | 1,2,3,99  If 2, 3, or 99, auto-fill ptsdmhdt as 99/99/9999, and go to ptsmhref, else go to ptsdmhdt | **Determination of urgency** **= general statement or evidence of timeline for how soon the patient will need to be seen by mental health.**  **The following are examples (exact terms not required):**  **Immediate -** i.e. emergent, requires ER, immediate admission, etc. For example, physician notes, “Patient is agitated and poses a danger to self; transport to ER” or “patient needs to be seen emergently by mental health. Mental health notified and patient transported to psych unit.” Select “1.”  **Urgent -** i.e. requires further evaluation and or treatment within 24 hours. APN notes, “no imminent danger, will schedule to see mental health today.” Select “2.”  **Non-urgent -** i.e. not urgent, requires evaluation and treatment within 14 days. For example, “Patient oriented, cooperative, and would like to restart treatment. Follow-up with mental health appointment.” Select “3.”  If unable to determine from the documentation the provider’s determination of urgency of care for the patient, select “99.” | | |
| 152 | ptsdmhdt | Enter the date the patient was emergently transferred to mental health care services. | mm/dd/yyyy   |  | | --- | | > = pcptsdt and  < = stdyend |   If <> 99/99/9999, go to defptsdx  Will be auto-filled as 99/99/9999 if ptsdurg = 2,3,99 | Emergently transferred to mental health care services = i.e. inpatient admission, 72 hour hold, transfer to ED, immediately see mental health provider.  If the emergent transfer/admission occurs within the same encounter, enter the date of the encounter.  Abstractor may enter 99/99/9999 if there was no documentation that the patient was transferred for emergent mental health care. | | |
| 153 | ptsmhref | Following the positive PC-PTSD screen, did the record document a consult was placed for a mental health evaluation?  1. Yes  2. No | 1,2  If 2, auto-fill refptsdt as 99/99/9999, ptsmhcom as 95, and ptscomdt as 99/99/9999, and go to ptsdcont | Arrangement for treatment for the patient is a component of triage.  If there is documentation that a mental health consult was placed following the positive PC-PTSD screen, select “1.”  If there is no documentation that a mental health consult was placed following the positive PC-PTSD screen, select “2.” | | |
| 154 | refptsdt | Enter the date the mental health consult was placed. | mm/dd/yyyy   |  | | --- | | > = pcptsdt and  < = stdyend | | Enter the exact date. The use of 01 to indicate missing month or day is not acceptable. | | |
| 155 | ptsmhcom | Following placement of a mental health consult request, did the record document the mental health evaluation was completed?  1. Yes  2. No  95. Not applicable | 1,2,95  Will be auto-filled as 95 if ptsmhref = 2  If 2, auto-fill ptscomdt 99/99/9999 and go to ptsdcont | If there is documentation in the record by a mental health provider indicating the patient was evaluated, enter “1.”  If there is no documentation indicating a mental health evaluation was completed, select “2.” | | |
| 156 | ptscomdt | Enter the earliest date the mental health evaluation was completed. | mm/dd/yyyy  Will be auto-filled as 99/99/9999 if ptsmhref = 2 or ptsmhcom = 2   |  | | --- | | >= refptsdt and  <= stdyend | | Enter the exact date. The use of 01 to indicate missing month or day is not acceptable. | | |
| 157 | ptsdtcont | Following the positive PC-PTSD screen, did the provider document that contact information was provided to the patient?  1. Provider contact information provided  2. Emergency contact information provided  3. Both 1 and 2  99. None of the above documented | 1,2,3,99  If 99, auto-fill ptscondt as 99/99/9999 | Depending on the provider’s triage of the patient, contact information may include:  **Provider contact** **= name and contact information for provider that will be caring for the patient or conducting the next interaction**  **Emergency contact = name and contact information for emergency services or emergency contact if the patient should require or want assistance**  Documentation that provider contact information or emergency contact information was provided to the patient is acceptable.  Contact information is a component of triage. Triage 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. | | |
| 158 | ptscondt | Enter the date the provider documented that contact information was provided to the patient. | mm/dd/yyyy   |  | | --- | | If evlptsdt <> 99/99/9999, >= evlptsdt and <= stdyend  If evlptsdt = 99/99/9999, >= pcptsdt and <= stdyend | | Enter the exact date the provider documented contact information was provided to the patient. The use of 01 to indicate missing month or day is not acceptable. | | |
| 159 | erlyfolo | Enter the date of completion for the earliest follow-up evaluation for a positive PC-PTSD screen by a primary care provider. | mm/dd/yyyy  **Abstractor can enter 99/99/9999**   |  | | --- | | > = pcptsdt and < = stdyend | | Earliest follow-up evaluation = the first comprehensive evaluation for PTSD completed most immediately following the initial positive screen by a primary care provider.  If there is no documentation the primary care provider completed the follow-up evaluation for a positive PC-PTSD screen, enter 99/99/9999.  Enter the exact date. The use of 01 to indicate missing day or month is not acceptable. | | |
| 160 | defptsdx | Was a definitive diagnosis of PTSD made by a Primary Care or Mental Health provider as a result of the follow-up evaluation? 1. Yes  2. No  3. Patient had prior diagnosis of PTSD   1. Not applicable | 1,2,3,95  If 2 or 3, auto-fill dxptsdt as 99/99/9999   |  | | --- | | **Warning if 3 and ptsdx = 2** | | **Acceptable Provider**: MD, DO, PhD or PsyD Psychologist, LCSW, APN, PA (or a MD, DO, PhD or PsyD Psychologist, LCSW, APN, PA trainee with appropriate co-signature). | | |
| 161 | dxptsdt | Enter the date the definitive diagnosis of PTSD was documented by the provider. | mm/dd/yyyy  Will be auto-filled as 99/99/9999 or defptsdx = 2 or 3   |  | | --- | | >= pcptsdt and < = stdyend | | Enter the exact date. The use of 01 to indicate missing month or day is not acceptable. | | |
| **If ALCTXPY = 5 or DEPTXYR = 1 or BPDXYR = 1 or PTSDX =1, go to MHTXRSK, else go to end.** | | | | | | |
|  |  | MH Treatment: Suicide Evaluation |  | |  | |
| 162 | mhtxrsk | Did the provider document a suicide ideation/behavior evaluation within the past year?  1. Yes  2. No | 1,\*2  **\*If 2, go to desmhpro, else go to mhsuidt** | | 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 Documentation of Suicide Risk Evaluation:**  The provider must document one of the following:   * A clinical reminder is available from 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. * 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, NP, CNS, or PA. Trainees in ANY of these categories may complete a suicide risk evaluation with appropriate co-signature.   **Suggested sources**: clinic notes, ED notes, consultation, Clinical Reminder | |
| 163 | mhsuidt  mhrsksu  mhposutx  mhsuref  mhsuidt2  mhrsksu2  mhposutx2  mhsuref2 | Enter the date and outcome of the **two most recent outpatient** suicide ideation/behavior evaluations documented by the provider within the past year.  For each suicide ideation/behavior evaluation date when the provider documented risk for suicide, indicate whether the provider documented a treatment plan and a referral for the patient.   |  |  |  |  |  | | --- | --- | --- | --- | --- | | **Date of Suicide Evaluation**  **Abstractor may enter 99/99/9999 for mhsuidt2**  **If mhsuidt2 = 99/99/9999, auto-fill mhrsksu2, mhposutx2, and mhsuref2 as 95**  mm/dd/yyyy   |  | | --- | | <= 1 year prior to or = stdybeg and < = stdyend | | **Outcome**  **1,2,95**  **If 1, go to Treatment Plan**  **If mhrsksu AND mhrsksu2 = 2 or 95, go to desmhpro, else if 1, go to Treatment Plan** | **Treatment plan**  1. Yes  2. No  95. Not applicable | **Referral**  1. Yes  2. No  95. Not applicable | |  |  |  |  | |  |  |  |  |   **Outcome**  1. Documented patient is at risk for suicide  2. Documented patient is NOT at risk for suicide | | | | * Enter the date and the outcome for the two most recent outpatient suicide evaluations documented by the provider within the past year. If there is only one suicide evaluation documented within the past year, enter 99/99/9999 for the second date. * If the provider documents the patient is demonstrating suicidal ideation/behavior or is at risk for suicide, enter “1” for outcome. If the provider documents the patient is not demonstrating suicidal ideation/behavior or is not at risk for suicide, enter “2” for outcome. The term ‘risk’ does not need to be present to answer the outcome question. * For each suicide ideation/behavior evaluation when the provider documented the patient was at risk for suicide, enter “1” or “2” to indicate whether the provider documented a treatment plan for the patient. The treatment plan should address the interventions the provider plans to take as a result of the suicide/behavior evaluation. * For each suicide ideation/behavior evaluation when the provider documented the patient was at risk for suicide, enter “1” or “2” to indicate whether the provider documented a referral for the patient. Referral for further evaluation of the patient may include referral to another mental health care provider, to an emergency department, or admission to inpatient facility. Based on the provider’s evaluation of suicide risk and judgment, referral may not be necessary. If referral is not documented, enter “2.”   Enter the exact date. The use of 01 to indicate missing month or day is not acceptable. |
| 164 | mhsupln | Following the most recent suicide ideation/behavior evaluation when the provider identified suicide risk, does the treatment plan include documentation of the following:  1. Patient Involvement  2. Family Involvement  3. Both 1 and 2  99. None of the above | 1,2,3,99 | | | A treatment plan is the provider’s plan for ongoing care of the patient. The treatment plan should include involvement of the patient and family. |
| 165 | desmhpro | Does the record identify the principal mental health provider for this patient? | 1,2 | | | The identity of the principal mental health provider must be documented in the record.  During ongoing care, the principal mental health provider should ensure that regular contact is maintained with the patient.  The principal mental health provider is responsible for coordinating development of the treatment plan, monitoring the veteran’s progress, and coordinating revisions in the treatment plan when necessary.  Suggested data source: Mental Health Treatment Plan |