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| **[Link to Mnemonics and Questions](https://secure.wvmi.org/QUESTIONS/Specifications/Mnemonics%20and%20Questions/fy2023q1/MnemonicQuestions1q23.xlsx)** | | | | |
|  |  | **Assessment of Cognitive Function** |  |  |
| 1 | dementdx2 | During the past year, does the record document a diagnosis of dementia/neurocognitive disorder as evidenced by one of the following ICD-10-CM diagnosis codes:  **A81.00, A81.01, A81.09, A81.2, A81.82, A81.89, A81.9, F01.50, , F01.511, F01.518, F01.52 – F01.54, F01.A0, F01.A11, F01.A18, F01.A2 – F01.A4, F01.B0, F01.B11, F01.B18, F01.B2 – F01.B4, F01.C0, F01.C11, F01.C18, F01.C2 – F01.C4, F02.80, F02.811, F02.818, F02.82 – F02.84, F02.A0, F02.A11, F02.A18, F02.A2 – F02.A4, F02.B0, F02.B11, F02.B18, F02.B2 – F02.B4, F02.C0, F02.C11, F02.C18, F02.C2 – F02.C4, F03.90, F03.911, F03.918, F03.92 – F03.94, F03.A0, F03.A11, F03.A18, F03.A2 – F03.A4, F03.B0, F03.B11, F03.B18, F03.B2 – F03.B4, F03.C0, F03.C11, F03.C18, F03.C2 – F03.C4, F10.27, F10.97, F13.27, F13.97, F18.17, F18.27, F18.97, F19.17, F19.27, F19.97, G23.1, G30.0, G30.1, G30.8, G30.9, G31.01, G31.09, G31.83, G90.3**  1. Yes  2. No | 1,2  **If 2, go to scrnaudc** | **The problem list or health factors may be used to perform an initial search for the diagnosis of dementia or other condition associated with dementia; however, the documentation of the applicable ICD-10-CM code must be found in association with an inpatient or outpatient encounter during the past year.**  **Each health factor should have an associated date that represents the date the health factor was recorded.**  **For the purposes of this question, acceptable dementia diagnosis codes are included in the VHA ICD-10-CM Dementia Codes Table 10.**  Suggested data sources: Clinic/progress notes (e.g. primary care, neurology, geriatrics, psychiatry), history and physical, discharge summary, outpatient encounter diagnosis codes, admission/discharge codes  **Cerner suggested data sources:** Diagnoses and problems/documentation – search diagnoses and problems for applicable code and verify use during the past year in Coding Summary found in Documentation |

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| 2 | permci | During the past year, did a physician/APN/PA or psychologist document that the patient has probable permanent cognitive impairment using a Clinical Reminder?   1. Yes 2. No | 1,2  If 2, auto-fill permcidt as 99/99/9999 and go to demsev | **Note:** A VHA Clinical Reminder for capture of probable permanent cognitive impairment is scheduled for release in June 2021.  **In order to answer “1,” there must be physician/APN/PA or psychologist documentation of the Clinical Reminder in the progress note that the veteran has probable permanent cognitive impairment and should be excluded from future mental health screening or other applicable clinical reminders.**  **Acceptable Source**: Clinical Reminder taxonomy which may be present in a Mental Health Screening note or other applicable templates or Clinical Reminders |
| 3 | permcidt | Enter the date of the most recent physician/APN/PA or psychologist documentation that the patient has probable permanent cognitive impairment. | mm/dd/yyyy  Will be auto-filled as 99/99/9999 if  permci = 2  **\*If permci = 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. |
| 4 | demsev | Was the severity of dementia assessed during the past year using one of the following standardized tools?   1. Clinical Dementia Rating Scale (CDR) 2. Functional Assessment Staging Tool (FAST) 3. Global Deterioration Scale (GDS)   99. Severity of dementia was not assessed during the past year using one of the specified tools | 1,2,3,99  **If 99, go to modsevci** | **Clinical Dementia Rating Scale** (CDR) = 5-point scale used to characterize six domains of cognitive and functional performance (memory, orientation, judgment & problem-solving, community affairs, home & hobbies, personal care)  **Functional Assessment Staging Tool (FAST)** = charts decline of patients with Alzheimer’s Disease and is broken down into 7 stages.  **Global Deterioration Scale (GDS)** = provides an overview of the stages of cognitive function and is broken down into 7 stages.  **If the severity of dementia was not assessed during the past year using one of the specified tools, enter 99.** |
| 5 | demsevdt | Enter the most recent date the assessment of severity of dementia using a specified tool was completed. | mm/dd/yyyy   |  | | --- | | < = 1 year prior to or = stdybeg and  < = stdyend | | Enter the most recent date the assessment of the severity of dementia using a specified tool was completed.  **Acceptable tools:** Clinical Dementia Rating Scale (CDR), Functional Assessment Staging Tool (FAST), Global Deterioration Scale (GDS) |
| 6 | cogscor2 | What was the outcome of the assessment of the severity of dementia assessment?  4. Score indicated mild dementia  5. Score indicated moderate to severe dementia  6. Score indicated no dementia  99. No score documented in the record or unable to determine outcome | 4,\*5,6,99  **\*If 5, go out of module** | **Abstractor judgment may be used. The record must document the score of the assessment and the abstractor must be able to determine whether the score indicates no dementia, mild dementia, or moderate to severe dementia.** The scoring of the dementia assessment and therefore the outcome will be determined based upon which standardized tool was utilized.  In order to answer “4” or “5,” the abstractor must be able to determine whether the score indicated mild dementia or moderate to severe dementia. For example, patient is assessed with CDR and documented score = 2, select “5.”  **Clinical Dementia Rating Scale:** Score may range from 0 (normal) to 3 (severe dementia)  **Functional Assessment Staging Tool (FAST):** Score may range from 1 (normal) to 7 (severe dementia)  **Global Deterioration Scale (GDS)** : Score (stage) may range from 1 (no cognitive impairment) to 7 (very severe cognitive decline)  For the above tools, scores indicating at least moderate degree of dementia are:   * **FAST >= 5** * **GDS >= 5** * **CDR >= 2**   **If documentation of the outcome of the assessment or the score of the standardized tool does not indicate the severity of dementia, enter “99.”** |
| 7 | incsevci | During the timeframe from (computer display demsevdt + 1 day to stdyend), did a physician/APN/PA or psychologist document in the record that the patient has moderate or severe cognitive impairment?   1. Yes 2. No | 1,2  If 2, go to scrnaudc | * **In order to answer “1,” there must be physician/APN/PA or psychologist documentation in the record that the patient has moderate, moderate to severe, or severe cognitive impairment OR physician/APN/PA or psychologist notation that the patient is too cognitively impaired for mental health screening.** * In addition, the Clinical Reminder for mental health screening allows providers to establish this exclusion by checking the box to indicate **“Unable to screen due to Moderate or Severe Cognitive Impairment.” This is acceptable documentation of moderate or severe cognitive impairment.** * If the physician/APN/PA or psychologist documentation notes “mild cognitive impairment” or “cognitive impairment” without specifying severity, answer “2.” * Although a diagnosis of major neurocognitive disorder may indicate dementia, it does not specify the severity of the dementia. If this is the only documentation related to cognitive impairment, answer “2”.   **Sources**: Clinical Reminder for mental health screening, clinician notes. |
| 8 | incsevcidt | Enter the date of the most recent physician/APN/PA or psychologist documentation of moderate or severe cognitive impairment. | mm/dd/yyyy  **If incsevci = 1, go out of module**   |  | | --- | | > demsevdt and  < = stdyend | | Enter the exact date. The use of 01 to indicate missing month or day is not acceptable. |
| 9 | modsevci | During the past year, did a physician/APN/PA or psychologist document in the record that the patient has moderate or severe cognitive impairment?   1. Yes 2. No | 1,2  If 2, auto-fill cogimpdt as 99/99/9999 and go to scrnaudc | * **In order to answer “1,” there must be physician/APN/PA or psychologist documentation in the record that the patient has moderate, moderate to severe, or severe cognitive impairment OR physician/APN/PA or psychologist notation that the patient is too cognitively impaired for mental health screening.** * In addition, the Clinical Reminder for mental health screening allows providers to establish this exclusion by checking the box to indicate **“Unable to screen due to Moderate or Severe Cognitive Impairment.” This is acceptable documentation of moderate or severe cognitive impairment.** * If the physician/APN/PA or psychologist documentation notes “mild cognitive impairment” or “cognitive impairment” without specifying severity, answer “2.” * Although a diagnosis of major neurocognitive disorder may indicate dementia, it does not specify the severity of the dementia. If this is the only documentation related to cognitive impairment, answer “2”.   **Sources**: Clinical Reminder for mental health screening, clinician notes. |
| 10 | cogimpdt | Enter the date of the most recent physician/APN/PA or psychologist documentation of moderate or severe cognitive impairment. | mm/dd/yyyy  Will be auto-filled as 99/99/9999 if modsevci = 2  **\*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. |

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|  | |  | | **Screening for Alcohol Misuse** | |  |  |
| 11 | | scrnaudc | | Within the past year, was the patient screened for alcohol misuse with the AUDIT-C?  1. Yes  2. No | | 1,\*2  \*If 2, go to deptxyr | **Screening for alcohol misuse = the patient was screened within the past year using AUDIT-C questions OR AUDIT-C question # 1 alone if answer was “never” (audc1=0).**  **AUDIT-C:**  **Question #1** = “How often did you have a drink containing alcohol in the past year?”  **Question #2** = “How many drinks containing alcohol did you have on a typical day when you were drinking in the past year?”  **Question #3** = “How often did you have six or more drinks on one occasion in the past year?”  **Acceptable setting for alcohol screening:** outpatient encounter, screening by telephone, and clinical video telehealth (CVT), inpatient hospitalization  **Cerner suggested data sources**: Form browser and select social history |
| 12 | | dtalscrn | | Enter the most recent date of screening for alcohol misuse with the AUDIT-C. | | mm/dd/yyyy   |  | | --- | | < = 1 year prior to or = stdybeg and  < = stdyend | | Most recent date patient was screened for alcohol misuse = the most recent date the AUDIT-C was documented in the record.  Enter the exact date. The use of 01 to indicate missing month or day is not acceptable.  **Cerner suggested data sources:** Form browser and select social history |
| 13 | | 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. |
| 14 | | 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. |
| 15 | | 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. |
| 16 | | alcscor | | Enter the total AUDIT-C score documented within the past year in the medical record. | | \_\_ \_\_  Abstractor may enter default zz if the total score of the AUDIT-C is not documented in the record.  If scrnaudc = 1 valid values = 0-12. | **The abstractor may not enter the total AUDIT-C score calculated from the questions if it is NOT documented in the record.**  If the total score is not documented in the record, enter default zz.  If scrnaudc =2, the computer will auto-fill alcscor as zz. |
| **If alcscor or [sum of values in AUDC1 + AUDC2 + AUDC3 (excluding values of 95 and 99)] is >= 5, go to alcbai; else go to deptxyr** | | | | | | | |
| 17 | alcbai  alcbai3  albai3dt  alcbai4  albai4dt  alcbai99 | | During the timeframe from (Computer to display DTALSCRN to DTALSCRN +14 days), does the record document any of the following components of brief alcohol intervention/counseling for past-year drinkers?  **Indicate all that apply and the date brief alcohol intervention/counseling was noted in the record:**  3. Advised/informed patient to abstain **OR** explicitly advised/informed patient to drink within recommended limits  4. Provided personalized feedback regarding relationship of alcohol to the patient’s specific health issues **OR**  general alcohol-related intervention/counseling (not linked to patient’s issues)  99. No alcohol intervention/counseling documented | | 3,4,99  alcbai3 -1 or <>  mm/dd/yyyy    alcbai4 -1 or <>  mm/dd/yyyy   |  | | --- | | >= dtalscrn and  < = dtalscrn + 14 days | | | **Assess the medical record for documentation of the following components of brief alcohol intervention/counseling. The intervention/counseling must have occurred within 14 days since the alcohol screening referenced in question SCRNAUDC.**   * **Alcbai3** – **Advised/informed patient to abstain from alcohol OR explicitly advised patient 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. * **Alcbai4** – **Provided personalized alcohol feedback to patient on relationship of alcohol use to his/her health OR provided general intervention/counseling on alcohol use and health risks.**    + Personalized feedback: 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; **OR**   + General intervention/counseling: Documentation indicates a general handout or information about alcohol use and health risks was given to the patient.   **Acceptable provider:** For a “provider” to be deemed acceptable to perform brief alcohol intervention/counseling, he/she must be a MD/DO, Licensed Psychologist (PhD/PsyD), LCSW, LCSW-C, LMSW, LISW, LMFT, LPC, LPMHC, APRN (NP/CNS), RN, PA, MS Level counselor, addictions therapist, clinical pharmacist (RPH/PharmD), clinical pharmacy specialist, mental health pharmacist, or rehabilitation counselor. 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 intervention/counseling, may perform the intervention/counseling.  LPNs are *not* an acceptable provider.  **Cont’d next page**  **Brief alcohol intervention/counseling cont’d**   * **Brief alcohol intervention/counseling by telephone or clinical video telehealth (CVT) is permitted if documented by a health care provider as defined immediately above.** * Enter the date of the progress note or encounter date.   **Cerner suggested data sources:** Form browser and select AUDIT-C follow up form |
|  |  | | **Depression** | |  | |  |
| 18 | deptxyr | | Within the past year, did the patient have at least one clinical encounter where depression was identified as a reason for the clinical encounter as evidenced by one of the following ICD-10-CM diagnosis codes:  **F01.51, F32.0 - F32.5, F32.81, F32.89,**  **F32.9, F32.A, F33.0 - F33.3, F33.40 - F33.42, F33.8, F33.9, F34.1, F34.81, F34.89, F43.21, F43.23, F53.0, F53.1, O90.6, O99.340 – O99.345**  1. Yes  2. No | | 1,2  If 2, auto-fill recdepdt as 99/99/9999, and go to bpdxyr | | **Depression does not have to be listed as the only reason for the clinical encounter, but identified as one of the reasons for the clinical encounter as evidenced by any of the following ICD-10-CM diagnosis codes:**   * **F01.51, F32.0 - F32.5, F32.81, F32.89, F32.9, F32.A,**   **F33.0 - F33.3, F33.40 - F33.42, F33.8, F33.9, F34.1, F34.81, F34.89, F43.21, F43.23, F53.0, F53.1, O90.6,**  **O99.340 – O99.345**     * The diagnosis of depression may have been made prior to the past year, but if the patient has at least one clinical encounter within the past year for depression as evidenced by documentation of one of the above ICD-10 diagnosis codes, answer “1.” * Clinical encounter includes outpatient encounters (face to face, clinical video telehealth, telephone), ED encounters, and inpatient admission.   **Cerner suggested data sources:** Search Diagnoses & Problems for applicable diagnosis code, verify use within appropriate timeframe in Coding Summary found in Documentation |
| 19 | recdepdt | | Enter the date within the past year of the most recent clinical encounter where depression was identified as a reason for the clinical encounter. | | mm/dd/yyyy  Will be auto-filled as 99/99/9999 if  deptxyr = 2  \*If deptxyr = 1, go to ptsdx   |  | | --- | | < = 1 year prior to or = stdybeg and  < = stdyend | | | Depression does not have to be listed as the only reason for the clinical encounter, but identified as one of the reasons for the clinical encounter as evidenced by documentation of the specified ICD-10 diagnosis code.  Enter the most recent date within the past year documented in the record when the patient was seen for depression.  If the most recent clinical encounter for depression within the past year was an inpatient admission, enter the date of discharge.  Enter the exact date. The use of 01 to indicate missing month or day is not acceptable. |
| 20 | bpdxyr | | Within the past year, did the patient have at least one clinical encounter where bipolar disorder was identified as a reason for the clinical encounter as evidenced by one of the following ICD-10-CM diagnosis codes:  **F30.10 – F30.13, F30.2 – F30.4, F30.8, F30.9, F31.0, F31.10 – F31.13, F31.2, F31.30 – F31.32, F31.4, F31.5, F31.60 – F31.64, F31.70 – F31.78, F31.81, F31.89, F31.9**  1. Yes  2. No | | 1,2  If 2, go to scrnphq2 | | **Bipolar disorder does not have to be listed as the only reason for the clinical encounter, but identified as one of the reasons for the clinical encounter as evidenced by any of the following ICD-10-CM diagnosis codes:**   * **F30.10 – F30.13, F30.2 – F30.4, F30.8, F30.9, F31.0,**   **F31.10 – F31.13, F31.2, F31.30 – F31.32, F31.4,**  **F31.5, F31.60 – F31.64, F31.70 – F31.78,**  **F31.81, F31.89, F31.9**   * The diagnosis of bipolar disorder may have been made prior to the past year, but if the patient has at least one clinical encounter within the past year for bipolar disorder as evidenced by documentation of one of the above ICD-10 diagnosis codes, answer “1.” * Clinical encounter includes outpatient encounters (face to face, clinical video telehealth, telephone), ED encounters, and inpatient admission.   **Cerner suggested data sources:** Diagnoses and problems/documentation – search diagnoses and problems for applicable code and verify use during the past year in Coding Summary found in Documentation |
| 21 | recbpdt | | Enter the date within the past year of the most recent clinical encounter where bipolar disorder was identified as a reason for the clinical encounter. | | mm/dd/yyyy  **If bpdxyr = 1, go to ptsdx**   |  | | --- | | < = 1 year prior to or = stdybeg and  < = stdyend | | | Bipolar disorder does not have to be listed as the only reason for the clinical encounter, but identified as one of the reasons for the clinical encounter as evidenced by one of the specified ICD-10 diagnosis codes.  Enter the date within the past year of the most recent clinical encounter when the patient was seen for bipolar disorder.  If the most recent clinical encounter for bipolar disorder within the past year was an inpatient admission, enter the date of discharge.  Enter the exact date. The use of 01 to indicate missing month or day is not acceptable. |

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|  |  | **Depression Screening** |  |  |
| 22 | scrnphq2 | During the past year was the patient screened for depression by the **PHQ-2**?  1. Yes  2. No  98. Patient refused depression screening by the PHQ-2 | 1,2, 98  If 2 or 98, go to ptsdx | **NOTE: For depression screening completed on or after 1/01/2021, the VHA will only accept screening completed with the PHQ-2.**  **PHQ-2 = Patient Health Questionnaire (2 questions - scaled)**  **Question 1**: “Over the past two weeks, have you often been bothered by little interest or pleasure in doing things?”  **Question 2**: “Over the past two weeks, have you often been bothered by feeling down, depressed, or hopeless?”   * Answers to PHQ-2 are scaled, ranging from “not at all” to “nearly every day.” * Documentation of the stem time frame (i.e., over the past 2 weeks) in the questions is not required at this time.   **Acceptable setting for depression screening:** outpatient encounter, screening by telephone, and clinical video telehealth (CVT) , inpatient hospitalization  **Cerner suggested data sources**: Form browser and select depression screening |
| 23 | phq2dt | Enter the date of the most recent screening for depression by the **PHQ-2**. | mm/dd/yyyy   |  | | --- | | < = 1 year prior to or = stdybeg and  < = stdyend | | **The date refers to the date of the signature on the encounter note.**  Enter the exact date. The use of 01 to indicate missing month or day is not acceptable. |
| 24 | ph1scor | Enter the score for PHQ-2 Question 1 documented in the record: Over the past 2 weeks, have you been bothered by little interest or pleasure in doing things? 0. Not at all → 0  1. Several days → 1  2. More than half the days → 2  3. Nearly every day → 3  99. No answer documented | 0,1,2,3,99 | **Enter the response or score documented for the PHQ-2 question 1:** Over the past 2 weeks, have you been bothered by little interest or pleasure in doing things?Not at all → 0 Several days → 1  More than half the days → 2  Nearly every day → 3   * **If the patient’s answers are documented in the record, the abstractor may assign the score in accordance with the patient’s response.** * **If the score of Question #1 is documented without the question, the abstractor may enter that score.** * **If neither the question response nor the score of the individual question is documented, enter 99.** |
| 25 | ph2scor | Enter the score for PHQ-2 Question 2 documented in the record: Over the past 2 weeks, have you been bothered by feeling down, depressed, or hopeless? 0. Not at all → 0  1. Several days → 1  2. More than half the days → 2  3. Nearly every day → 3  99. No answer documented | 0,1,2,3,99 | **Enter the response or score documented for the PHQ-2 question 2:** Over the past 2 weeks, have you been bothered by feeling down, depressed, or hopeless?Not at all → 0 Several days → 1  More than half the days → 2  Nearly every day → 3   * **If the patient’s answers are documented in the record, the abstractor may assign the score in accordance with the patient’s response.** * **If the score of Question #2 is documented without the question, the abstractor may enter that score.** * **If neither the question response nor the score of the individual question is documented, enter 99.** |
| 26 | 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  **If (ph1scor = 3 OR ph2scor = 3) OR [sum (exclude values >3) of ph1scor and ph2scor] >= 3, go to depeval; else go to ptsdx** | * **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.** * **A positive score for the PHQ-2 is 3 or greater.** * If no total score is documented in the record, enter default z. |

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|  |  | Depression Disposition |  |  |
| 27 | depeval | On (computer to display phq2dt), did the provider document the patient needed further intervention for the positive depression screen?1. Yes, documented further intervention needed2. Documented no further intervention needed 98. Documented patient refused further intervention for positive depression screen 99. No documentation regarding further intervention | 1,2,98,99  If 2, 98 or 99, go to ptsdx | **Acceptable Provider:** MD, DO, Licensed Psychologist (PhD/PsyD), LCSW, LCSW-C, LMSW, LISW, LMFT, LPMHC, APRN (NP/CNS), PA, or Clinical Pharmacist (RPH/PharmD), clinical pharmacy specialist, mental health pharmacist, or rehabilitation counselor. Trainee in any of these categories with appropriate co-signature is acceptable.  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 positive, 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.” |
| 28 | depfolint1  depfolint2  depfolint3  depfolint4  depfolint5  depfolint7  depfolint99 | On (computer to display phq2dt), select the further intervention(s) documented by the provider as follow-up to the positive depression screen: **Indicate all that apply:**  1. Documented the patient is already receiving treatment for depression  2. Documented the patient is receiving care for depression outside VHA  3. Documented referral/consult for stat/emergent mental evaluation was placed  4. Documented referral/consult for routine/non-emergent mental health evaluation was placed/will be placed  5. Documented the patient’s depression will be managed in Primary Care  7. Documented emergency contact information was provided to the patient  99. None of the above documented | 1,2,3,4,5,7,99  Cannot enter 99 with any other number   |  | | --- | | Warning if 99 | | On the same date as the positive depression screen, please indicate all further interventions documented by the provider.  **Acceptable Provider:** MD, DO, Licensed Psychologist (PhD/PsyD), LCSW, LCSW-C, LMSW, LISW, LMFT, LPMHC, APRN (NP/CNS), PA, Clinical Pharmacist (RPH/PharmD), clinical pharmacy specialist, mental health pharmacist or rehabilitation counselor. Trainee in any of these categories with appropriate co-signature is acceptable.  If none of the interventions are documented, enter 99. |
|  |  | Screening for PTSD |  |  |
| 29 | ptsdx | Within the past year, did the patient have at least one clinical encounter where PTSD was identified as a reason for the clinical encounter as evidenced by one of the following ICD-10-CM diagnosis codes:F43.1, F43.10 - F43.12 1. Yes  2. No | 1,2  **If 2, go to pmilsepdt** | **PTSD does not have to be listed as the only reason for the clinical encounter, but identified as one of the reasons for the clinical encounter as evidenced by one of the following ICD-10-CM diagnosis codes:**   * + **F43.1, F43.10 - F43.12** * The diagnosis of PTSD may have been made prior to the past year, but if the patient has at least one clinical encounter within the past year for PTSD as evidenced by documentation of the specified ICD-10 diagnosis code, answer “1.” * Clinical encounter includes outpatient encounters (face to face, clinical video telehealth, telephone), ED encounters, and inpatient admission.   **Cerner suggested data sources**: Diagnoses and problems/documentation – search diagnoses and problems for applicable code and verify use during the past year in Coding Summary found in Documentation |
| 30 | recptsdt | Enter the date within the past year of the most recent clinical encounter where PTSD was identified as a reason for the clinical encounter. | mm/dd/yyyy  **\*If ptsdx = 1, go to vacssrs**   |  | | --- | | < = 1 year prior to or = stdybeg and  < = stdyend | | Enter the date of the most recent clinical encounter within the past year where PTSD was identified as a reason for the clinical encounter by evidence of the specified ICD-10 diagnosis code.  If the most recent clinical encounter for PTSD within the past year was an inpatient admission, enter the date of discharge.  Enter the exact date. The use of 01 to indicate missing month or day is not acceptable. |
| 31 | pmilsepdt | Computer will pre-fill the date of military service separation from the pull list. | mm/dd/yyyy  **Computer pre-fill**  **Cannot modify**  **If blank, go to milsepdt**   |  | | --- | | > = 01/01/1930 and < = stdyend | | Computer will pre-fill the date of military service separation from the pull list. |
| 32 | valsepdt | Is (computer to display pmilsepdt) the most recent service separation date documented in the record.  1. Yes 2. No | 1,2  If 1, go to pcptsd5 | * **If the facility has installed the latest clinical reminder, the service separation 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.** * If the service separation date in the medical record is the same as the prefilled date, select value 1. * If the service separation date in the medical record does not match the prefilled date, enter value 2. |
| 33 | milsepdt | Enter the veteran’s most recent date of separation from active military duty. | mm/dd/yyyy   |  | | --- | | > = 01/01/1930 and < = stdyend |   **Abstractor can enter 99/99/9999 if date of separation cannot be found** | * **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 date of military separation cannot be found, the abstractor can enter default 99/99/9999   **Cerner suggested data sources**: Joint Longitudinal Viewer (JLV) then demographics widget and select Military Service link for date of separation (DOS) |
| 34 | pcptsd5 | On or after 9/01/2018, was the patient screened for PTSD using the Primary Care PTSD5 (PC-PTSD5)?  1. Yes  2. No  98. Patient refused screening by the PC-PTSD5 | 1,2, 98  If 2 or 98, go to scrptsd5i9 | **NOTE: For PTSD screening completed on or after 1/01/2021, the VHA will only accept screening completed with the PC-PTSD5.**  **The PC-PTSD5 screen begins with an item to assess whether the veteran has had any exposure to traumatic events:**  Sometimes things happen to people that are unusually or especially frightening, horrible, or traumatic. For example:   * + a serious accident or fire   + a physical or sexual assault or abuse   + an earthquake or flood   + a war   + seeing someone be killed or seriously injured   + having a loved one die through homicide or suicide. * **Have you ever experienced this kind of event? Yes/No**   **If the veteran denies exposure, the PC-PTSD5 is complete with a score of 0.**  **If the veteran indicates he/she has experienced a traumatic event in the past, five additional yes/no questions will be asked.**  **In the past month, have you:**  1. Had nightmares about the event(s) or thought about the event(s) when you did not want to?  2. Tried hard not to think about the event(s) or went out of your way to avoid situations that remind you of the event(s)?  3. Been constantly on guard, watchful, or easily startled?  4. Felt numb or detached from people, activities, or your surroundings?  5. Felt guilty or unable to stop blaming yourself or others for the event(s) or any problems the event(s) may have caused?  **The PC-PTSD5 screen must be documented in a clinic/progress note.**  **Acceptable setting for PTSD screening:** outpatient encounter, screening by telephone, and clinical video telehealth (CVT), inpatient hospitalization  **Cerner suggested data sources**: Form browser and select VA PC-PTSD-5 |
| 35 | pcptsd5dt2 | Enter the date of the most recent screen for PTSD using the PC-PTSD5. | mm/dd/yyyy  If pcptsd5dt2 >12/31/2020, go to traumevt   |  | | --- | | >= 9/01/2018 and  < = stdyend | | Enter the date of the most recent screen for PTSD using the PC-PTSD5.  The date refers to the date of the signature on the encounter note. The use of 01 to indicate missing month or day is not acceptable. |
| 36 | scrptsd5i9 | During the timeframe from 9/01/2018 to 12/31/2020, was the patient screened for PTSD using the Primary Care PTSD5 +I9?  1. Yes  2. No  98. Patient refused screening by the PC-PTSD5 +I9 | 1,2,98  If 2 or 98 and pcptsd5 = 2 or 98, go to ptsrnpc; else if 2 or 98, go to traumevt | **NOTE:** For PTSD screening completed on or after 1/01/2021, the VHA will only accept screening completed with the PC-PTSD5.  **The PC-PTSD5 +I9 is a five item screen plus item 9 of the PHQ-9. The PC-PTSD5 + I9 screen must be documented in a clinic/progress note.**  **The PC-PTSD5 +I9 screen begins with an item to assess whether the veteran has had any exposure to traumatic events:**  Sometimes things happen to people that are unusually or especially frightening, horrible, or traumatic. For example:   * + a serious accident or fire   + a physical or sexual assault or abuse   + an earthquake or flood   + a war   + seeing someone be killed or seriously injured   + having a loved one die through homicide or suicide. * **Have you ever experienced this kind of event? Yes/No**   **If the veteran denies exposure, the PC-PTSD5 is complete with a score of 0.**  **If the veteran indicates he/she has experienced a traumatic event in the past, five additional yes/no questions will be asked.**  **In the past month, have you:**  1. Had nightmares about the event(s) or thought about the event(s) when you did not want to?  2. Tried hard not to think about the event(s) or went out of your way to avoid situations that remind you of the event(s)?  3. Been constantly on guard, watchful, or easily startled?  4. Felt numb or detached from people, activities, or your surroundings?  5. Felt guilty or unable to stop blaming yourself or others for the event(s) or any problems the event(s) may have caused?  **“Item 9” or question #6 of this instrument:** 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?  Answers to Item 9 (or question 6) are scaled, ranging from “not at all” to “nearly every day.”  **Item 9 (or question 6) must be included as part of the PC-PTSD5 + I9 tool.**  **Cont’d next page**  **PC-PTSD5 +I9 screen cont’d**  **Acceptable setting for PTSD screening:** outpatient encounter, screening by telephone, and clinical video telehealth (CVT), inpatient hospitalization |
| 37 | pcptsd5dt | Enter the date of the most recent screen for PTSD using the PC-PTSD5+ I9. | mm/dd/yyyy   |  | | --- | | >= 9/01/2018 and  < = 12/31/2020 | | Enter the date of the most recent screen for PTSD using the PC-PTSD5 +I9.  The date refers to the date of the signature on the encounter note. The use of 01 to indicate missing month or day is not acceptable. |
| 38 | traumevt | Enter the response documented in the record for PC-PTSD5 exposure to traumatic event(s).  **Sometimes things happen to people that are unusually or especially frightening, horrible, or traumatic. For example:**   * a serious accident or fire * a physical or sexual assault or abuse * an earthquake or flood * a war * seeing someone be killed or seriously injured * having a loved one die through homicide or suicide.   **Have you ever experienced this kind of event?**  1. Yes  2. No  99. Response not documented | 1,2,99  If 2 or 99, go to vacssrs | **The PC-PTSD5 screen must be documented in a clinic/progress note.**  **The PC-PTSD5 is a five item screen. The screen begins with an item to assess whether the veteran has had any exposure to traumatic events:**  Sometimes things happen to people that are unusually or especially frightening, horrible, or traumatic. For example:   * a serious accident or fire * a physical or sexual assault or abuse * an earthquake or flood * a war * seeing someone be killed or seriously injured * having a loved one die through homicide or suicide.   **Have you ever experienced this kind of event? Yes/No**  **If the veteran denies exposure, the PC-PTSD5 is complete with a score of 0.**  **Documentation of examples of traumatic events is not required.**  **If no response is documented, enter “99”.** |
| 39 | scrptsd1  scrptsd2  scrptsd3  scrptsd4  scrptsd5 | Enter the patient’s answers to each of the PC-PTSD5 Screen questions: **In the past month, have you:**  1. Had nightmares about the event(s) or thought about the event(s) when you did not want to?  2. Tried hard not to think about the event(s) or went out of your way to avoid situations that remind you of the event(s)?  3. Been constantly on guard, watchful, or easily startled?  4. Felt numb or detached from people, activities, or your surroundings?  5. Felt guilty or unable to stop blaming yourself or others for the event(s) or any problems the event(s) may have caused?  1. Yes  2. No  99. Response not documented | 1,2,99 | **The PC-PTSD5 screen must be documented in a clinic/progress 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.”** |
| 40 | scorptsd5 | Enter the total score for the PC-PTSD5 screen documented in the record. | \_\_\_  **Abstractor can enter default z if no total score is documented**   |  | | --- | | Whole numbers  0 – 5 |   **If (scorptsd5 >= 4) or**  **[sum (exclude values > 1) of scrptsd1,**  **scrptsd2, scrptsd3,  scrptsd4 and scrptsd5  >= 4, go to ptsdeval; else**  **go to vacssrs** | * **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 more than one PTSD screen was performed on the date of the most recent screening AND any PTSD screen was positive, enter the total score for the positive PTSD screen.** * **A positive PTSD screen is a score of 4 or greater.** * If the total score is NOT documented in the record, enter default z. |

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| 41 | ptsrnpc | Within the past five years and prior to 10/01/2018, was the patient screened for PTSD using the Primary Care PTSD Screen  (PC-PTSD)?  1. Yes  2. No | 1,2  **If 2, go to ptsdsips** | 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 clinical video telehealth (CVT) |
| 42 | pcptsdt | Enter the date of the most recent screen for PTSD using the PC-PTSD. | mm/dd/yyyy   |  | | --- | | < = 5 years prior or = stdybeg and  < = 9/30/2018 | | Enter the exact date. The date refers to the date of the signature on the encounter note. The use of 01 to indicate missing month or day is not acceptable. |
| 43 | pcptsd  pcptsd1  pcptsd2  pcptsd3  pcptsd4 | Enter the patient’s answers to each of the Primary Care PTSD Screen questions: Have you ever had any experience that was so frightening, horrible, or upsetting that, **IN THE PAST MONTH**, you:  1. Have had any nightmares about it or thought about it when you did not want to?  2. Tried hard not to think about it or went out of your way to avoid situations that remind you of it?  3. Were constantly on guard, watchful, or easily startled?  4. Felt numb or detached from others, activities, or your surroundings?  1. Yes  2. No  99. No answer documented | 1,2,99 | **If more than one PC-PTSD screen was performed on the date of the most recent screening AND any PC-PTSD screen was positive, enter the responses for the positive PC-PTSD screen.**  A positive Primary Care PTSD screen is a score of 3 or greater.  **The PC-PTSD screen must be documented in a clinic note.**  **For each question, enter the veteran’s “yes” or “no” answer to the question. If the question was not asked or the answer not recorded, enter “99.”** |
| 44 | 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 (pcptsdt <= 1 year prior to stdybeg and <= stdyend) AND (ptsdscor >= 3) or**  **[sum (exclude values > 1) of pcptsd1 and**  **pcptsd2 and pcptsd3 and pcptsd4 >= 3, go to ptsdeval; else**  **go to vacssrs** | * **If more than one PC-PTSD screen was performed on the date of the most recent screening AND any PC-PTSD screen was positive, enter the total score for the positive PC-PTSD screen. A positive Primary Care PTSD screen is a score of 3 or greater.** * **The total score must be documented in a clinic note. The abstractor may NOT enter total score if it is not documented in the record, even if all the questions have been answered and the total is evident.** * If the total score is NOT documented in the record, enter default z. |
| 45 | ptsdeval | On (if valid, computer to display pcptsdt; else if pcptsd5dt and pcptsd5dt2 are valid, display most recent date; else display valid pcptsd5dt or pcptsd5dt2**)** did the provider document the patient needed further intervention for the positive PTSD screen? 1. Yes, documented further intervention needed2. Documented no further intervention needed98. Documented patient refused further intervention for positive PTSD screen99. No documentation regarding further intervention | 1,2,98,99  If 2, 98 or 99, go  to vacssrs | **Acceptable Provider:** MD, DO, Licensed Psychologist (PhD/PsyD), LCSW, LCSW-C, LMSW, LISW, LMFT, LPMHC, APRN (NP/CNS), PA, Clinical Pharmacist (RPH/PharmD), clinical pharmacy specialist, mental health pharmacist, or rehabilitation counselor. Trainee in any of these categories with appropriate co-signature is acceptable.  If the provider documented that the patient needed further intervention for PTSD, select “1.”  For example, provider documents, “PC-PTSD screen positive. Patient reports having difficulty sleeping and is very anxious. 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 positive, 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.” |
| 46 | ptsfolint1 ptsfolint2  ptsfolint3  ptsfolint4 ptsfolint5 ptsfolint7 ptsfolint99 | On (if valid, computer to display pcptsdt; else if pcptsd5dt and pcptsd5dt2 are valid, display most recent date; else display valid pcptsd5dt or pcptsd5dt2), select the further intervention(s) documented by the provider as follow-up to the positive PTSD screen:Indicate all that apply:1. Documented the patient is already receiving treatment for PTSD2. Documented the patient is receiving care for PTSD outside VHA3. Documented referral/consult for stat/emergent mental evaluation was placed4. Documented referral/consult for routine/non-emergent mental health evaluation was placed/will be placed5. Documented the patient’s PTSD will be managed in Primary Care7. Documented emergency contact information was provided to the patient 99.None of the above documented | 1,2,3,4,5,7,99  Cannot enter 99 with any other number  **If any = -1, go to vacssrs**   |  | | --- | | Warning if 99 | | On the same date as the positive PTSD screen, please indicate all further interventions documented by the provider.  Acceptable Provider: MD, DO, Licensed Psychologist (PhD/PsyD) , LCSW, LCSW-C, LMSW, LISW, LMFT, LPMHC, APRN (NP/CNS), PA, Clinical Pharmacist (RPH/PharmD), clinical pharmacy specialist, mental health pharmacist, or rehabilitation counselor. Trainee in any of these categories with appropriate co-signature is acceptable.  If none of the interventions are documented, enter 99. |
| 47 | ptsdsips | During the past year, was the patient screened for PTSD using the Single Item PTSD Screener-B (SIPS-B) at a VHA facility that uses the Cerner electronic health record?  1. Yes 2. No | 1,2  If 2, go to vacssrs | The SIPS-B is used to screen adults for PTSD in the Department of Defense Military Health System facilities.  **At this time, the SIPS-B may be documented at VHA facilities that use the Cerner electronic health record. The VHA only accepts screening completed with the PC-PTSD5.**  **SIPS-B Question:** Think about the biggest threat to life you’ve EVER witnessed or experienced first-hand. In the PAST MONTH, how much have you been bothered by disturbing memories, feeling distant from others, or avoiding certain activities as a result of this experience?  The response scale is 0 (not bothered at all) to 10 (extremely bothered). A rating of 3 or greater is considered positive and should prompt completion of the PTSD Checklist (PCL-5) or referral to behavioral health for PCL-5 completion and further evaluation. |
| 48 | sipsbdt | Enter the most recent date the SIPS-B was completed. | mm/dd/yyyy  If valid date, go to vacssrs   |  | | --- | | < = 1 year prior or = stdybeg and  < = stdyend | | Enter the most recent date the SIPS-B was completed. |

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| 49 | vacssrs | During the past year, did an acceptable provider complete the Columbia-Suicide Severity Rating Scale (C-SSRS) Screener?1. Yes2. No98. Patient refused to complete the C-SSRS Screener | 1,2,98  **If 2 or 98, go to vacsre** | **Note: On or after 1/01/2021, the C-SSRS Screener must be completed annually for all veterans.**  **The acceptable provider asks the patient questions 1 and 2 of the C-SSRS Screener:**  1) Have you wished you were dead or wished you could go to sleep and not wake up?  2) Have you had any actual thoughts of killing yourself?  If YES to 2, provider asks questions 3, 4, 5, and 7. If NO to 2, go directly to question 7.  3) Have you been thinking about how you might do this? e.g. “I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it….and I would never go through with it.”  4) Have you had these thoughts and had some intention of acting on them? as opposed to “I have the thoughts but I definitely will not do anything about them.”  5) Have you started to work out or worked out the details of how to kill yourself? **If YES, ask:**  6) Do you intend to carry out this plan?  7) Have you ever done anything, started to do anything, or prepared to do anything to end your life?   * Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn’t swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn’t jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc. * If YES, ask:   8) Was this within the past 3 months?   * The C-SSRS Screener can be performed face-to-face, by clinical video telehealth (CVT), or by telephone as long as the provider – patient exchange is documented in the medical record and accurately reflects the encounter.   **Cont’d next page** |
|  |  |  |  | **CSSR-S cont’d**   * **Acceptable Provider**:  |  |  | | --- | --- | | Addiction Therapist | Occupational Therapist (OT) | | Advanced Practice Registered Nurse (APRN): NP/CNS | Peer Support Specialist | | \*Clinical Pharmacy Specialist | Physical Therapist (PT) | | Kinesiotherapist (KT) | Physician (MD/DO) | | Licensed Clinical Social Worker (LCSW) | Physician Assistant (PA) | | Licensed Independent Social Worker (LISW) | Psych Tech (psychometrician) | | Licensed Marriage and Family Therapist (LMFT) | Registered Nurse (RN) | | Licensed Master of Social Work (LMSW) | Rehabilitation Counselor | | Licensed Practical Nurse (LPN) | Respiratory Therapist (RT) | | Licensed Professional Mental Health Counselor (LPMHC) | Unlicensed Assistive Personnel (Health Tech, Medical Assistant, Nursing Assistant) | | Licensed Psychologist (PhD/PsyD) | Vocational Rehabilitation Specialist | | Medical Instrument Technologist (MIT) |  |   Trainee in ANY of the above categories may complete a C-SSRS Screener with appropriate co-signature.  **\*Exclude clinical pharmacy specialist performing anticoagulation only.**  Suggested sources: progress notes, ED notes, H&P, consultation, Clinical Reminder  **Cerner suggested data source**: Form browser and select ambulatory comprehensive intake, CSSRS form |
| 50 | vacssrsdt | Enter the most recent date the C-SSRS Screener was completed. | mm/dd/yyyy   |  | | --- | | <= 1year prior to or = stdybeg and <= stdyend | | Enter the most recent date the C-SSRS Screener was completed. |
| 51 | vacssrs1 | Enter the score for C-SSRS Screener Question 1 documented in the record: (Time period designated, e.g. Over the past month) Have you wished you were dead or wished you could go to sleep and not wake up?1. Yes2. No99. Score not documented | 1,2,99 | The score for the C-SSRS Screener question 1 is “yes” or “no”. Enter the score as documented in the medical record. This item must be completed and cannot be left blank.  If the C-SSRS Screener score for question 1 is not documented in the record, enter “99”. |
| 52 | vacssrs2 | Enter the score for C-SSRS Screener Question 2 documented in the record: (Time period designated, e.g. Over the past month) Have you had any actual thoughts of killing yourself?1. Yes2. No99. Score not documented | 1,2,99  If 2, auto-fill vacssrs3 as 95 and go to vacssrs7 | The score for the C-SSRS Screener question 2 is “yes” or “no”. Enter the score as documented in the medical record. This item must be completed and cannot be left blank.  If the C-SSRS Screener score for question 2 is not documented in the record, enter “99”. |
| 53 | vacssrs3 | Enter the score for C-SSRS Screener Question 3 documented in the record: (Time period designated, e.g. Over the past month) Have you been thinking about how you might do this?1. Yes2. No95. Not applicable99. Score not documented | 1,2,95,99  Will be auto-filled as 95 if vacssrs2 = 2 | The score for the C-SSRS Screener question 3 is “yes” or “no”. Enter the score as documented in the medical record. If “yes” to question 2, this item must be completed.  If “no” to question 2, this item DOES NOT have to be completed.  If the C-SSRS Screener score for question 3 is not documented in the record, enter “99”. |
| 54 | vacssrs4 | Enter the score for C-SSRS Screener Question 4 documented in the record: (Time period designated e.g., Over the past month) Have you had these thoughts and had some intention of acting on them?1. Yes2. No99. Score not documented | 1,2,99 | The score for the C-SSRS Screener question 4 is “yes” or “no”. Enter the score as documented in the medical record. If “yes” to question 2, this item must be completed.  If “no” to question 2, this item DOES NOT have to be completed.  If the C-SSRS Screener score for question 4 is not documented in the record, enter “99”. |
| 55 | vacssrs5 | Enter the score for C-SSRS Screener Question 5 documented in the record: (Time period designated e.g., Over the past month) Have you started to work out or worked out the details of how to kill yourself?1. Yes2. No99. Score not documented | 1,2,99  If 2, auto-fill vacssrs6 as 95 and go to vacssrs7 | The score for the C-SSRS Screener question 5 is “yes” or “no”. Enter the score as documented in the medical record. If “yes” to question 2, this item must be completed.  If “no” to question 2, this item DOES NOT have to be completed.  If the C-SSRS Screener score for question 5 is not documented in the record, enter “99”. |
| 56 | vacssrs6 | Enter the score for C-SSRS Screener Question 6 documented in the record: Do you intend to carry out this plan?1. Yes2. No95. Not applicable99. Score not documented | 1,2,95,99  Will be auto-filled as 95 if vacssrs5 = 2 | The score for the C-SSRS Screener question 6 is “yes” or “no”. Enter the score as documented in the medical record. If “yes” to question 5, this item must be completed.  If “no” to question 2 or 5, this item does not have to be completed.  If the C-SSRS Screener score for question 6 is not documented in the record, enter “99”. |
| 57 | vacssrs7 | Enter the score for C-SSRS Screener Question 7 documented in the record: In your lifetime, have you ever done anything, started to do anything, or prepared to do anything to end your life?1. Yes2. No99. Score not documented | 1,2,99  If 2 or 99, auto-fill vacssrs8 as 95 and go to cssrsout as applicable | The score for the C-SSRS Screener question 7 is “yes” or “no”. Enter the score as documented in the medical record. This item must be completed and cannot be left blank.  If the C-SSRS Screener score for question 7 is not documented in the record, enter “99”. |
| 58 | vacssrs8 | Enter the score for C-SSRS Screener Question 8 documented in the medical record: Was this within the past 3 months?1. Yes2. No95. Not applicable99. Score not documented | 1,2,95,99  Will be auto-filled as 95 if vacssrs7 = 2 or 99 | The score for the C-SSRS Screener question 8 is “yes” or “no”. Enter the score as documented in the medical record.  If “yes” to question 7, this item must be completed.  If “no” to question 7, this item does not have to be completed.  If the C-SSRS Screener score for question 8 is not documented in the record, enter “99”. |
| **If (vacssrs3, vacssrs4, vacssrs5, or vacssrs8 = 1), auto-fill cssrsout=1 AND go to adminpt) OR if ((vacssrs2 = 2 or (vacssrs3 = 2 and vacssrs4 = 2 and vacssrs5 = 2)) and (vacssrs7 = 2 or vacssrs8 = 2)), auto-fill cssrsout = 2 and go to end; else go to cssrsout** | | | | |
| 59 | cssrsout | Enter the interpretation of the C-SSRS Screener as documented in the medical record.1. Positive2. Negative99. No interpretation documented | 1,2,99  If 1, go to adminpt, else go to end  Will be auto-filled as 1 if vacssrs3, vacssrs4, vacssrs5, or vacssrs8 = 1  Will be auto-filled as 2 if ((vacssrs2 = 2) or (vacssrs3, vacssrs4, and  vacssrs5 = 2) and  ((vacssrs7 = 2 or vacssrs8 = 2)) | **NOTE**: Due to an issue with the outcome being passed from the Clinical Reminder to the note, a positive or negative outcome will be auto-filled based on the answers to any of the questions above.  If there was no interpretation of the screening outcome of the C-SSRS Screener, enter “99.”  Any of the following would result in a positive Columbia Screen:   * YES to Question 3: Have you been thinking about how you might do this? (Time period over the past month) OR * YES to Question 4: Have you had these thoughts and had some intention of acting on them? (Time period over the past month) OR * YES to Question 5: Have you started to work out or worked out the details of how to kill yourself? (Time period over the past month) OR * YES to Question 8: Was this within the past 3 months? |
| 60 | adminpt | On (computer to display vacssrsdt), the same calendar day as the positive C-SSRS, is there evidence the patient was admitted to inpatient or residential treatment for mental health care?  1. Yes 2. No | 1,2  **If 1, go to end** | **If the provider that completed the C-SSRS admits the patient to inpatient or residential treatment for mental health OR sends the patient to the Emergency Department for inpatient admission, select value 1.** |
| 61 | vacsre | On (if vacssrs = 1, computer to display vacssrsdt; else display, During the past year), is there evidence of a signed Comprehensive Suicide Risk Evaluation (CSRE) in the record?1. Yes2. No98. Patient refused to complete CSRE | 1,2,98  If 1 and vacssrs = 1, auto-fill vacsredt = vacssrsdt and go to csreacu; else if 1, go to vacsredt  If 2 or 98, go to end | **Note: The CSRE must be completed by an acceptable provider and signed on the same calendar date as the positive Columbia-Suicide Severity Rating Scale (C-SSRS) screener. If a C-SSRS was not performed, look for evidence of a signed CSRE during the past year.**  The note title for the CSRE may be labeled Suicide Risk Evaluation-Comprehensive.   * CSRE can be performed face-to-face, by clinical video telehealth (CVT), or by telephone as long as the acceptable provider – patient exchange is documented in the medical record and accurately reflects the encounter. * **Acceptable Provider:**  |  |  | | --- | --- | | Advanced Practice Registered Nurse (APRN): NP/CNS | Licensed Professional Mental Health Counselor (LPMHC) | | Clinical Pharmacy Specialist | Licensed Psychologist (PhD/PsyD) | | Licensed Clinical Social Worker (LCSW) | Physician (MD/DO) | | Licensed Independent Social Worker (LISW) | Physician Assistant (PA) | | Licensed Marriage and Family Therapist (LMFT) | Rehabilitation Counselor holding state licensure and included in local bylaws as independent practitioner | | Licensed Master of Social Work (LMSW) |  |   Trainee in ANY of these categories may complete a CSRE with appropriate co-signature.  **Note:** RNs are not an acceptable provider. Nor is LPN, Addiction Therapist, Kinesiotherapist, Medical Instrument Technologist, Occupational Therapist, Peer Support Specialist, Physical Therapist, Psych Tech, Rehabilitation Counselor without state licensure and not included in bylaws as independent practitioner, Respiratory Therapist, Vocational Rehabilitation Specialist or Unlicensed Assistive Personnel, including Health Tech, Medical Assistant and Nursing Assistant. |
| 62 | vacsredt | Enter the most recent date the CSRE was completed during the past year. | mm/dd/yyyy  If vacsre and vacssrs = 1 will be auto-filled = vacssrsdt   |  | | --- | | <= 1year prior to or = stdybeg and <= stdyend | | Enter the most recent date the CSRE was completed during the past year. |
| 63 | csreacu | Enter the Clinical Impression of Acute Risk as documented in the medical record:1. High Risk - (as evidenced by):2. Intermediate Risk – (as evidenced by):3. Low Risk – (as evidenced by):99. Acute risk not documented | 1,2,3,99  If 99, go to csrechr | Only one risk level is selected by the acceptable provider and an explanation is provided in the “as evidenced by section” for that risk level.  Note: This item must be completed and cannot be left blank. |
| 64 | csreatex | Enter the evidence of Acute Risk documented by the acceptable provider.  |  | | --- | |  | | Free text entry | Enter the explanation of Acute Risk as documented in the record by the acceptable provider. |
| 65 | csrechr | Enter the Clinical Impression of Chronic Risk as documented in the medical record:1. High Risk - (as evidenced by):2. Intermediate Risk – (as evidenced by):3. Low Risk – (as evidenced by):99. Chronic risk not documented | 1,2,3,99  If 99, go to csreint1 | Only one risk level is selected by the acceptable provider and an explanation is provided in the as evidenced by section for that risk level.  Note: This item must be completed and cannot be left blank. |
| 66 | csrechrtex | Enter the evidence of Chronic Risk documented by the acceptable provider.  |  | | --- | |  | | Free text entry | Enter the explanation of Chronic Risk as documented in the record by the acceptable provider. |
| 67 | csreint1  csreint2  csreint3  csreint4  csreint5  csreint6  csreint7  csreint8  csreint9  csreint10  csreint11  csreint12  csreint13  csreint14  csreint15  csreint16  csreint17  csreint18  csreint19  csreint20  csreint21  csreint22  csreint23  csreint24  csreint25  csreint26  csreint27  csreint99 | Please enter the course of action documented in the record from the following list of interventions.General Strategies for Managing Risk in any setting (The provider may add additional comment/interventions as needed).Select all that apply:  1. Alert Suicide Prevention Coordinator for consideration of a Patient Record Flag Category I High Risk for Suicide 2. Complete or Update Veteran’s Safety Plan 3. Increased frequency of Suicide Risk Screening [text box] 4. Provide Lethal Means Safety Counseling (e.g., provision of gun locks) 5. Obtain additional information from collateral sources [Optional: comment] 6. For prescribers only: Review of prescribed medications for risk for self-harm and/or new pharmacotherapy intervention to reduce suicide risk (Optional: comment) 7. Address barriers to treatment engagement by: [text box] 8. Address psychosocial needs by: [text box] 9. Address medical conditions by: [text box] 10. Consult/Referral to additional services and support: [text box for options] 11. Referral to evidence based psychotherapy 12. Referral to psychiatry/medication assessment or management 13. Referral to Chaplaincy/pastoral care 14. Referral to vocational rehabilitation/occupational rehabilitation services 15. Referral for PRRC and/or ICMHR services 16. Referral for residential mental health services 17. Other Consult submitted to: [text box for user to enter a name]   **Cont’d next page** | 1,2,3,4,5,6,7,8,9,10,  11,12,13,14,15,16,  17,18,19,20,21,22,  23,24,25,26,27, 99   |  | | --- | | Hard Edit: If csreint11,12,13,  14,15, or 16 = -1, csreint10  must = -1 | | **Please select all interventions documented by the acceptable provider in the CSRE template.**  The wording in the option does not have to exactly match the intervention in the record; however, the intent must be the same. For example, option 8, provider may document “Updated Veteran’s safety plan.”  The provider may add additional comment/interventions as needed as indicated by [text box].  If the provider does not have any documentation in the text box for the applicable options, do not select that option as an intervention.   * **Acceptable Provider**: For a “provider” to be deemed acceptable to complete the CSRE, he/she must be an MD, DO, Licensed Psychologist (PhD/PsyD), LCSW, LCSW-C, LMSW, LISW, LMFT, LPMHC, APRN (NP/CNS), PA, clinical pharmacist (RPH/PharmD), clinical pharmacy specialist (mental health). Trainee in ANY of these categories may complete a CSRE with appropriate co-signature.   **Note:** RNs are *not* an acceptable provider. Nor is LPN, Addiction Therapist, Peer Support Specialist, or Unlicensed Assistive Personnel, including Health Tech, Medical Assistant and Nursing Assistant. |
|  |  | Interventions cont’d  1. Discussion with Veteran to continue to see assigned Primary Care Provider for medical care 2. Discussion with Veteran regarding enhancement of a sense of purpose and meaning 3. Educate Veteran on smartphone VA applications (e.g. Virtual Hope Box, PTSD Coach) 4. Conduct medication reconciliation 5. Involve family/support system in Veteran’s care 6. Provide Opioid Overdose Education and Naloxone Distribution (OEND) 7. Provide resources/contacts for benefits information 8. Provide Veteran with phone number for Veteran's Crisis Line: 1-800-273-8255 (press 1) 9. Other/Comments: [text box] 10. Obtain consultation from Suicide Risk Management Consultation Program on ways to address Veteran’s risk by sending a request for consultation by email to: Email (Left Click and Allow)   99. No interventions documented by the provider |  |  |