

**CATNUM**

Sample category  
16. AMI - Outpatient visit  
36. SCI Dx  
48. Female, age 20-69  
50. Random Sample  
51. Random Sample MH  
54. Frail/Elderly  
60. DM Outpatient  
61. Inpatient SC  
68. Contract CBOC

**REVSTAT**

REVIEW STATUS (not abstracted)  
0. Abstraction has not begun  
1. Abstraction in progress  
2. Abstraction completed w/o errors  
3. TVG failure (exclusion)  
4. Record contains missing required answers (error record)  
5. Administrative exclusion from all measures

**FEFLAG** (rcvd on pull list)  
FE case flagged for CGPI review / scoring?

0. No  
1. Yes

**DOCHOSPCE** (PI module)

Is one of the following documented in the medical record:  
- the patient is enrolled in a VHA or community-based Hospice program  
- the patient has a diagnosis of cancer of the liver, pancreas, or esophagus  
- on the problem list it is documented the patient's life expectancy is less than 6 months?

1. Yes  
2. No

**DEMENTDX2** (MH)

During the past year, does the record document a diagnosis of dementia/neurocognitive disorder as evidenced by one of the following:

**ICD-9-CM codes (Prior to 10/01/15):**

046.11, 046.19, 046.3, 290.0, 290.10, 290.11, 290.12, 290.13, 290.20, 290.21, 290.3, 290.40, 290.41, 290.42, 290.43, 291.2, 292.82, 294.10, 294.11, 294.8, 331.0, 331.11, 331.19, 331.2, 331.7, 331.82, 331.89, 331.9, 333.0 or 333.4

**ICD-10-CM codes (On or after 10/01/15):**

A8100, A8101, A8109, A812, A8189, A819, Primary I60xx – I69xx + Secondary F0150 or F0151, F0390, F0391, any Primary xxx.xx + Secondary F0280 or F0281, F0390, F0391, F1027, F1997, G231, G300, G301, G308, G309, G3101, G3109, G3183, G903

1. Yes  
2. No

**DEMSEV** (MH)

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

**COGSCOR2** (MH)

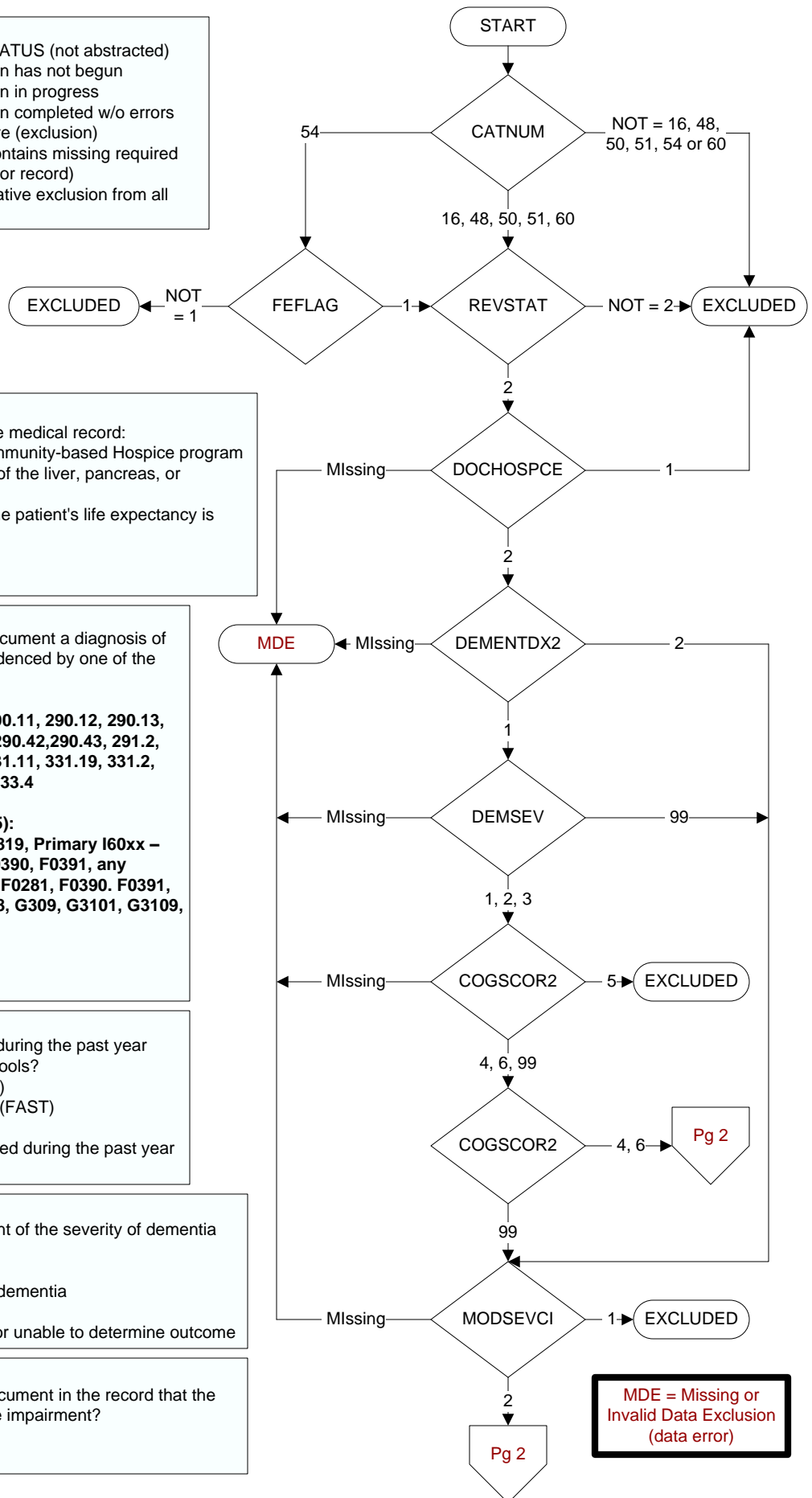
What was the outcome of the assessment of the severity of dementia assessment?

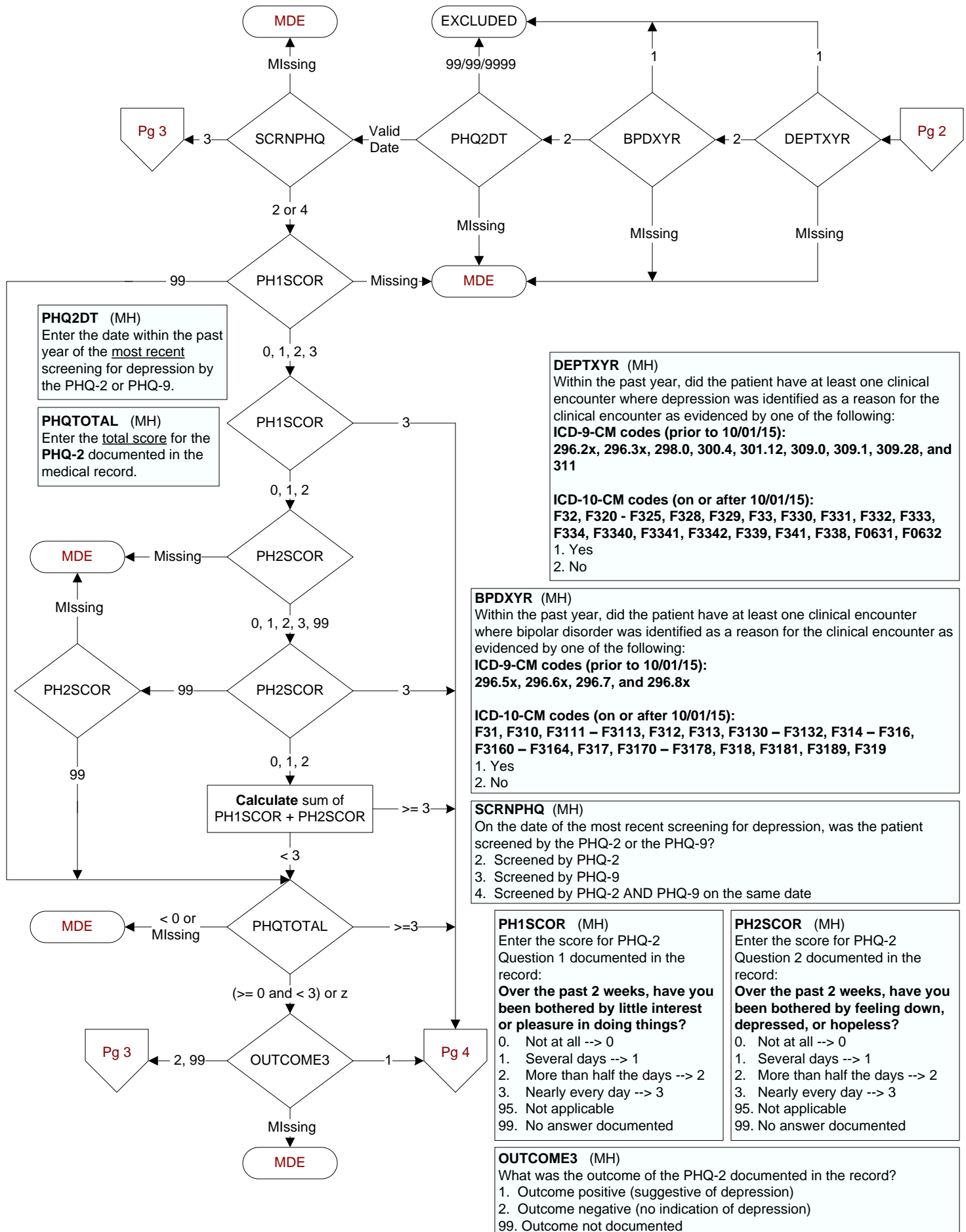
4. Score indicated mild dementia  
5. Score indicated moderate to severe dementia  
6. Score indicated no dementia  
99. No score documented in the record or unable to determine outcome

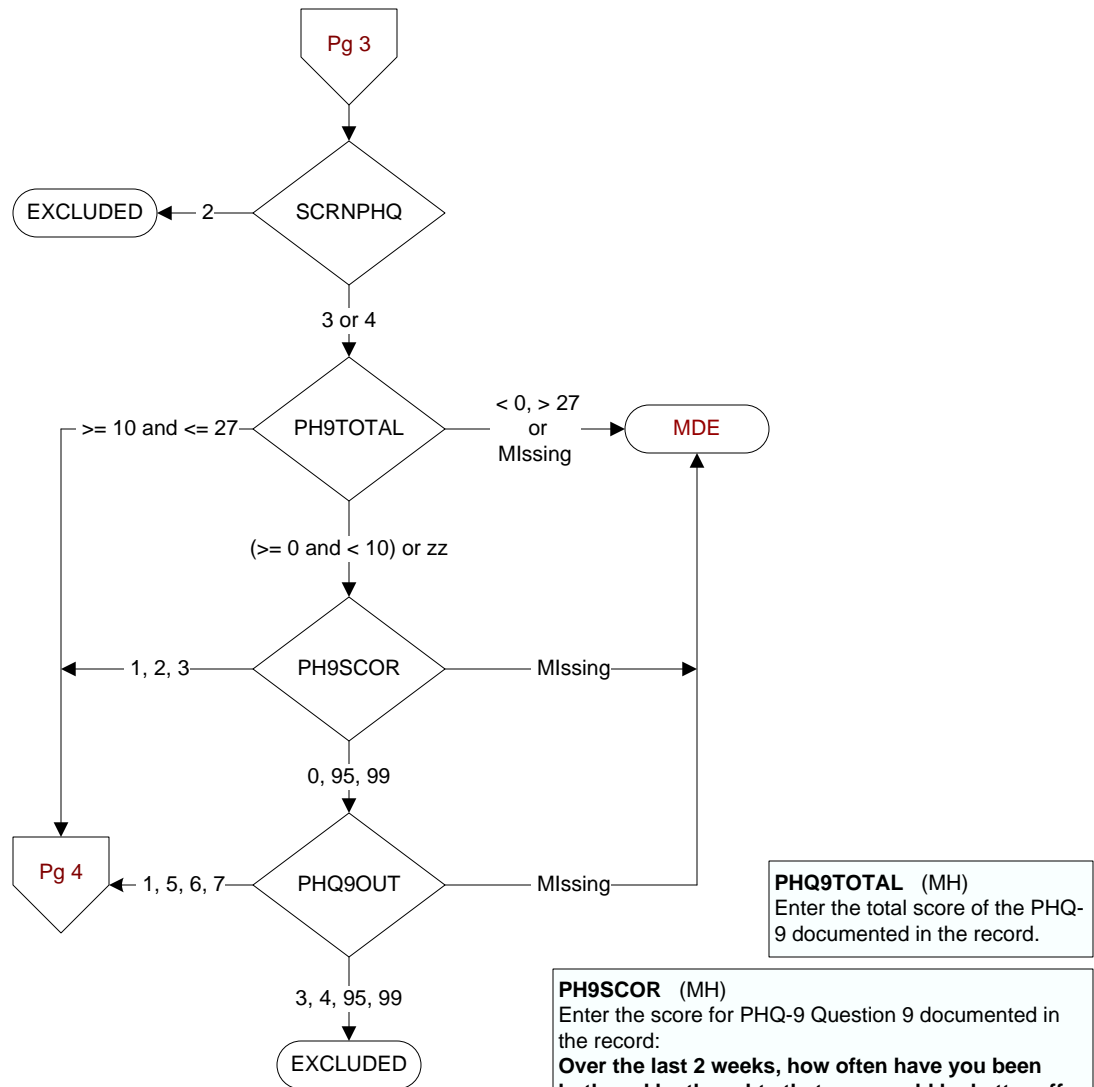
**MODSEVCI** (MH)

During the past year, did the clinician document in the record that the patient has moderate or severe cognitive impairment?

1. Yes  
2. No







**PHQ9TOTAL (MH)**  
Enter the total score of the PHQ-9 documented in the record.

**PH9SCOR (MH)**  
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

**PHQ9OUT (MH)**  
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  
95. Not applicable  
99. No documentation of outcome

**DEPEVAL (MH)**

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

**NODEPINT (MH)**

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

**DEPCARE (MH)**

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

**DECAROUT (MH)**

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

**DEPMHEVL (MH)**

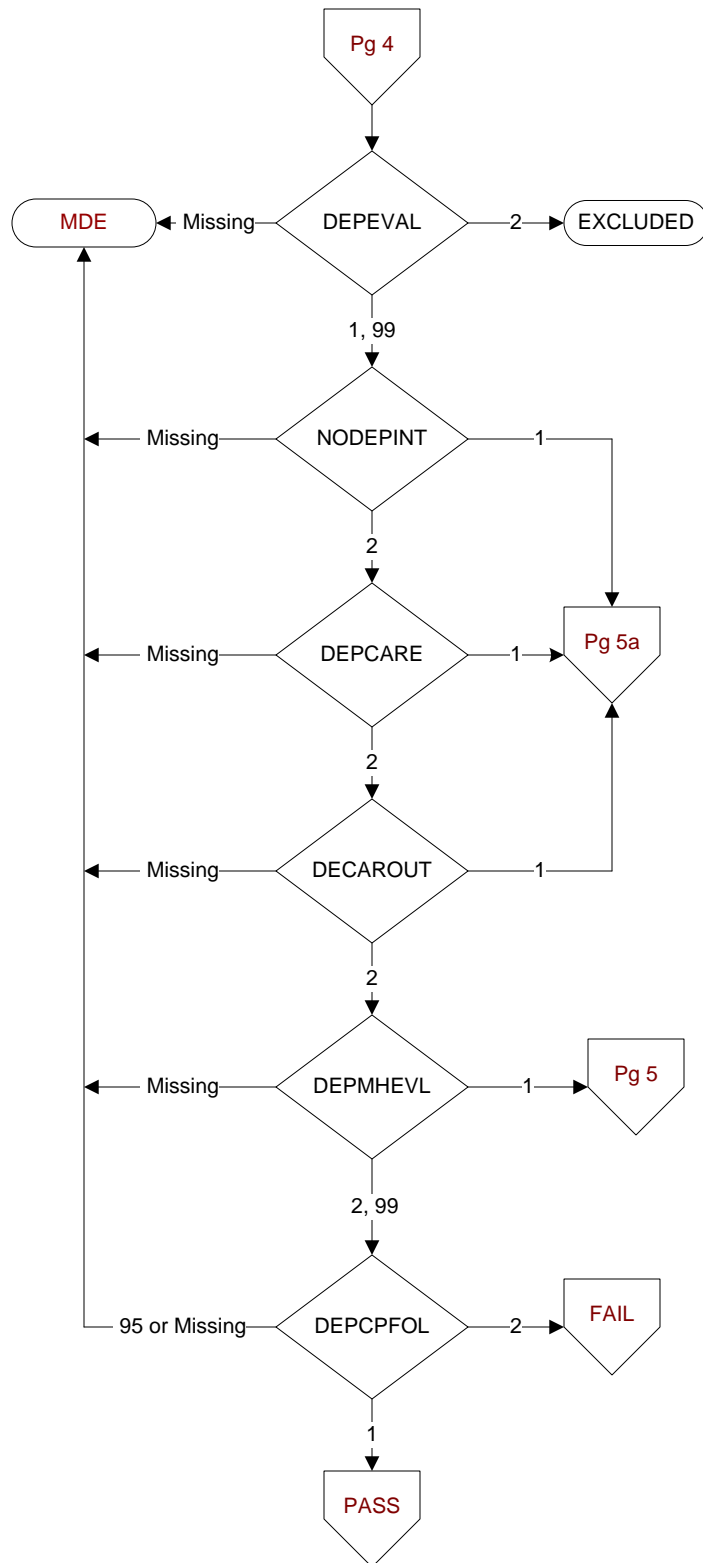
Following the positive PHQ-2 or PHQ-9 or affirmative answer to PHQ-9 question 9, did the provider document that the patient needed a mental health evaluation?

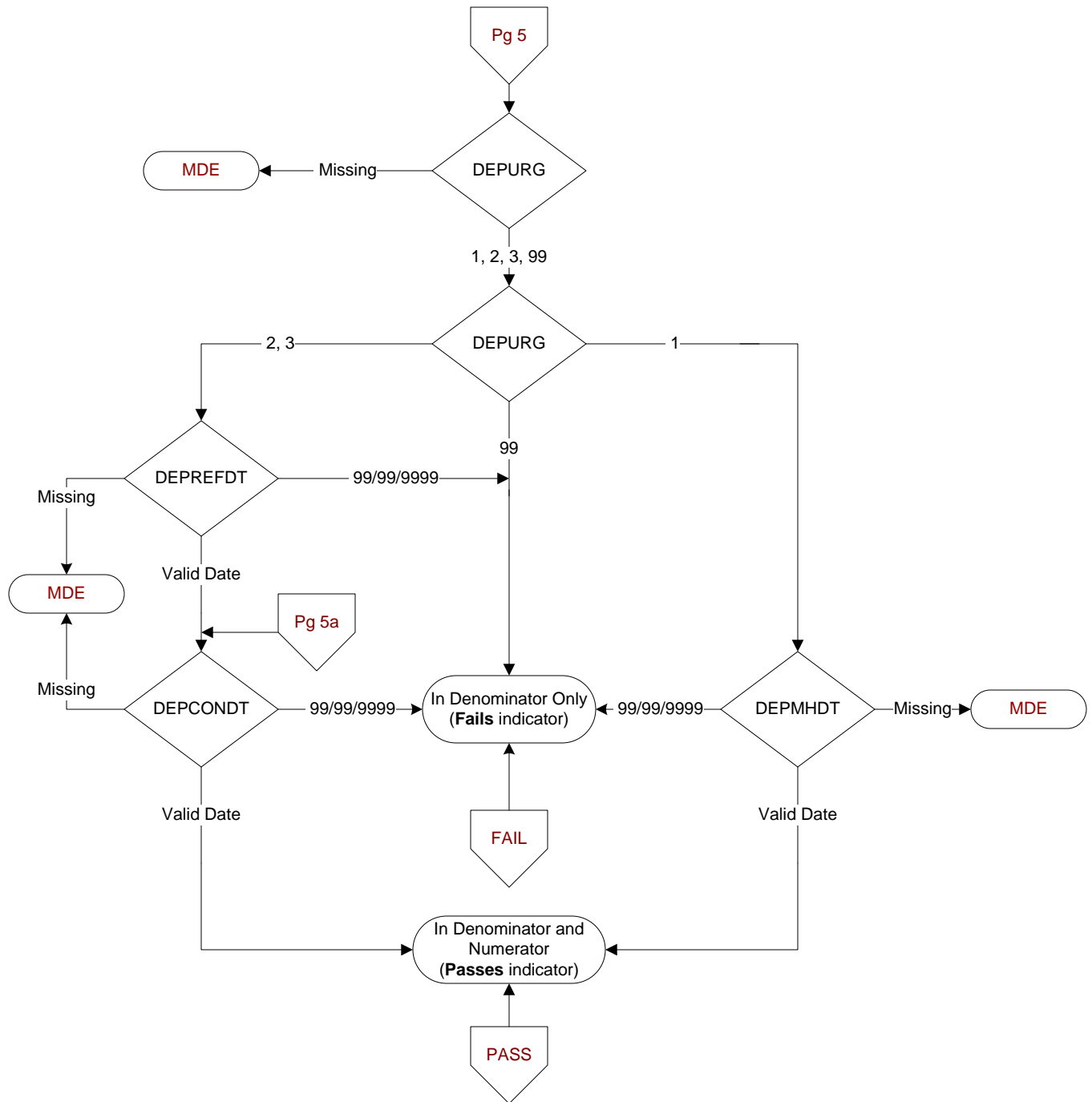
1. Yes, mental health evaluation needed
2. No mental health evaluation needed
99. No documentation regarding mental health evaluation

**DEPCPFOL (MH)**

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



**DEPURG (MH)**

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

**DEPMHDT (MH)**

Enter the date the patient was emergently transferred to mental health care services.

**DEPREFDT (MH)**

Enter the date the mental health consult was placed.

**DEPCONDT (MH)**

Enter the date the provider documented contact information was provided to the patient.