

Document Links:[CGPI Validation Module](#)[CGPI MH Module](#)**COHORT**

16. AMI - Outpatient visit
 48. Female, age 20-69
 50. Random Sample
 51. Random Sample MH
 54. Frail/Elderly
 60. DM Outpatient

REVSTAT

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

HOSPICE (Validation)

During the past year is there documentation in the medical record the patient is enrolled in a VHA or community-based hospice program?
 1. Yes
 2. No

DEMENTDX2 (MH)

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

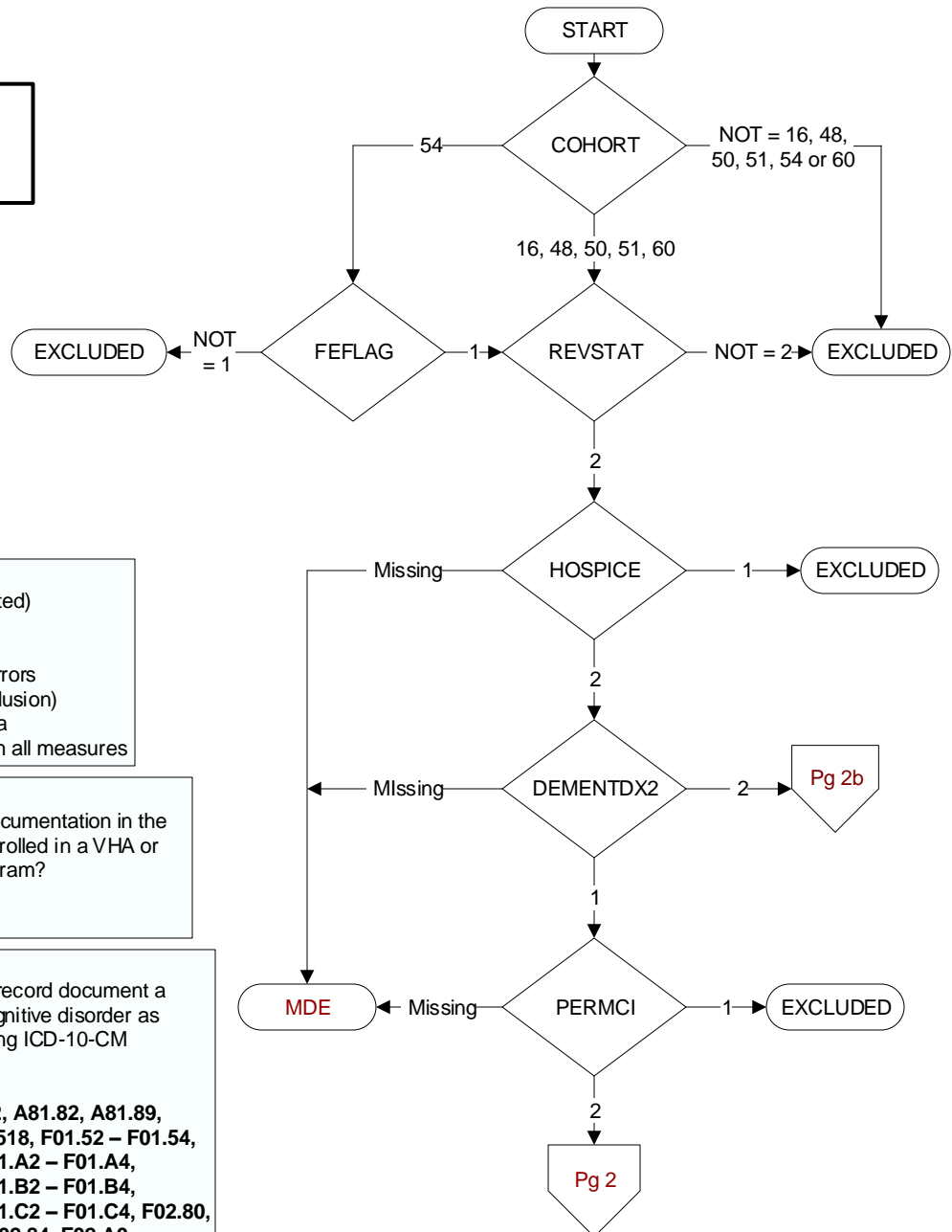
A81.00, A81.01, A81.09, A81.2, A81.82, A81.89, A81.9, F01.50, , F01.511, F01.518, F01.52 – F01.54, F01.A0, F01.A11, F01.A18, F01.A2 – F01.A4, F01.B0, F01.B11, F01.B18, F01.B2 – F01.B4, F01.C0, F01.C11, F01.C18, F01.C2 – F01.C4, F02.80, , F02.811, F02.818, F02.82 – F02.84, F02.A0, F02.A11, F02.A18, F02.A2 – F02.A4, F02.B0, F02.B11, F02.B18, F02.B2 – F02.B4, F02.C0, F02.C11, F02.C18, F02.C2 – F02.C4, F03.90, , F03.911, F03.918, F03.92 – F03.94, F03.A0, F03.A11, F03.A18, F03.A2 – F03.A4, F03.B0, F03.B11, F03.B18, F03.B2 – F03.B4, F03.C0, F03.C11, F03.C18, F03.C2 – F03.C4, F10.27, F10.97, F13.27, F13.97, F18.17, F18.27, F18.97, F19.17, F19.27, F19.97, G23.1, G30.0, G30.1, G30.8, G30.9, G31.01, G31.09, G31.83, G90.3

1. Yes
 2. No

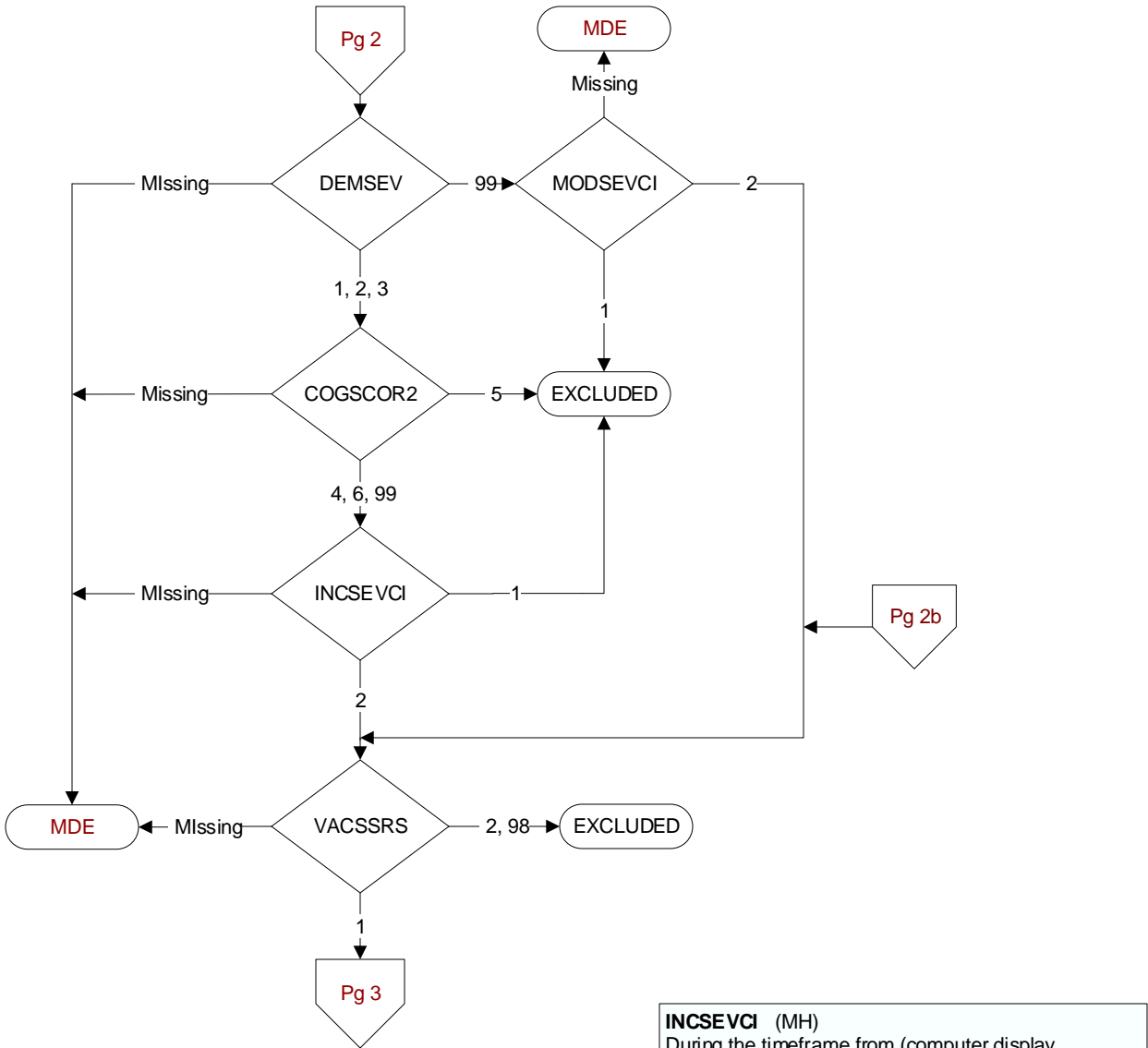
PERMCI (MH)

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



**MDE = Missing or
 Invalid Data Exclusion
 (data error)**



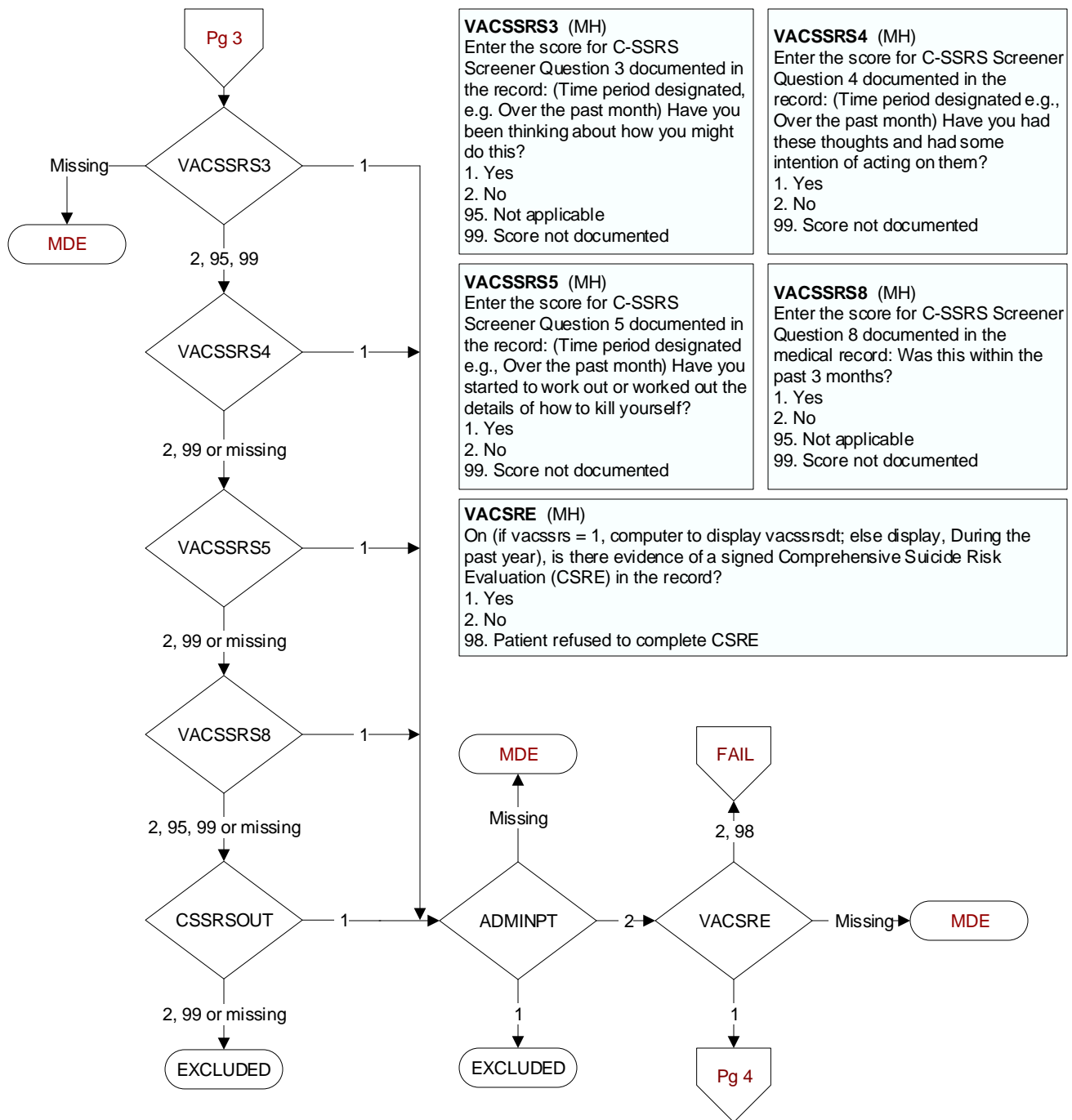
DEMSEV (MH)
Was the severity of dementia assessed during the past year using one of the following standardized tools?
1. Clinical Dementia Rating Scale (CDR)
2. Functional Assessment Staging Tool (FAST)
3. Global Deterioration Scale (GDS)
99. Severity of dementia was not assessed during the past year using one of the specified tools

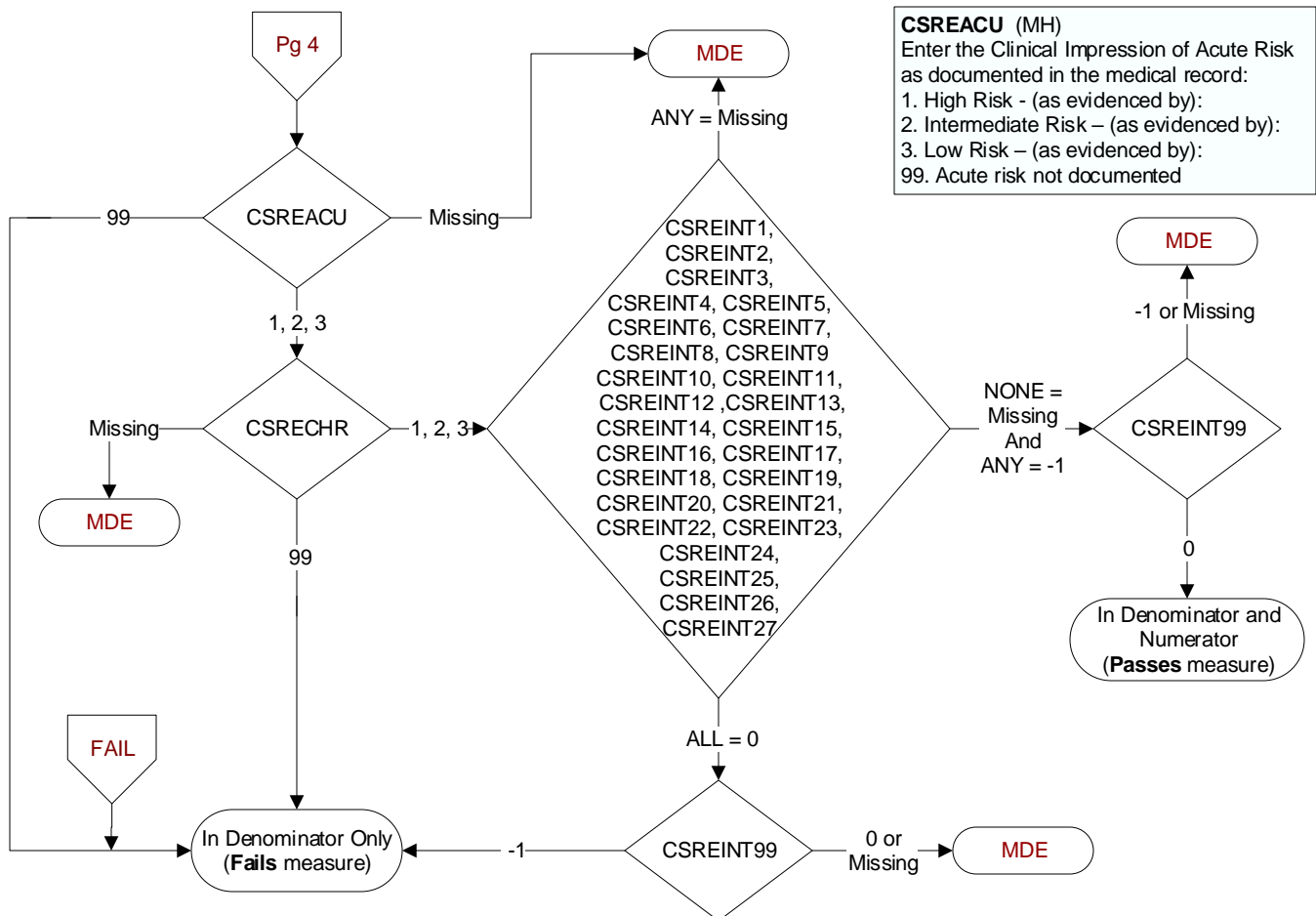
COGSCOR2 (MH)
What was the outcome of the assessment of the severity of dementia assessment?
4. Score indicated mild dementia
5. Score indicated moderate to severe dementia
6. Score indicated no dementia
99. No score documented in the record or unable to determine outcome

INCSEVCI (MH)
During the timeframe from (computer display demsevdt + 1 day to stdyend), did a physician/APN/PA or psychologist document in the record that the patient has moderate or severe cognitive impairment?
1. Yes
2. No

MODSEVCI (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

VACSSRS (MH)
During the past year, did an acceptable provider complete the Columbia-Suicide Severity Rating Scale (C-SSRS) Screener?
1. Yes
2. No
98. Patient refused to complete the C-SSRS Screener





(MH) 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:

CSREINT1. Alert Suicide Prevention Coordinator for consideration of a Patient Record Flag Category I High Risk for Suicide

CSREINT2. Complete or Update Veteran's Safety Plan

CSREINT3. Increased frequency of Suicide Risk Screening
[text box]

CSREINT4. Provide Lethal Means Safety Counseling (e.g., provision of gun locks)

CSREINT5. Obtain additional information from collateral sources
[Optional: comment]

CSREINT6. For prescribers only: Review of prescribed medications for risk for self-harm and/or new pharmacotherapy intervention to reduce suicide risk
[Optional: comment]

CSREINT7. Address barriers to treatment engagement by:
[text box]

CSREINT8. Address psychosocial needs by: [text box]

CSREINT9. Address medical conditions by: [text box]

CSREINT10. Consult/Referral to additional services and support:
[text box for options]

CSREINT11. Referral to evidence based psychotherapy

CSREINT12. Referral to psychiatry/medication assessment or management

CSREINT13. Referral to Chaplaincy/pastoral care

CSRECHR (MH)

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

CSREINT14. Referral to vocational rehabilitation/occupational rehabilitation services

CSREINT15. Referral for PRRC and/or ICMHR services

CSREINT16. Referral for residential mental health services

CSREINT17. Other Consult submitted to: [text box for user to enter a name]

CSREINT18. Discussion with Veteran to continue to see assigned Primary Care Provider for medical care

CSREINT19. Discussion with Veteran regarding enhancement of a sense of purpose and meaning

CSREINT20. Educate Veteran on smartphone VA applications (e.g. Virtual Hope Box, PTSD Coach)

CSREINT21. Conduct medication reconciliation

CSREINT22. Involve family/support system in Veteran's care

CSREINT23. Provide Opioid Overdose Education and Naloxone Distribution (OEND)

CSREINT24. Provide resources/contacts for benefits information

CSREINT25. Provide Veteran with phone number for V

Crisis Line: 1-800-273-8255 (press 1)

CSREINT26. Other/Comments: [text box]
CSREINT27. 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)

CSREINT99. No interventions documented by the provider