

VHA EXTERNAL PEER REVIEW PROGRAM
MENTAL HEALTH MODULE
Third Quarter FY2014

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES																																										
1	dementdx2	<p>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? (046.1, 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)</p> <p>1. Yes 2. No</p>	<p>1, 2 If 2, go to modsevci</p>	<p>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. Dementia/neurocognitive disorder diagnosis recorded during an outpatient or inpatient encounter is acceptable.</p> <p>Each health factor should have an associated date that represents the date the health factor was recorded.</p> <p>For the purposes of this question, acceptable dementia diagnosis codes include:</p> <table><tr><th colspan="2">ICD-9 Diagnosis</th></tr><tr><td>046.1</td><td>Jakob-Creutzfeldt disease</td></tr><tr><td>046.11</td><td>Variant Jakob- Creutzfeldt disease</td></tr><tr><td>046.19</td><td>Other and unspecified Jakob- Creutzfeldt disease</td></tr><tr><td>046.3</td><td>Progressive multifocal leukoencephalopathy</td></tr><tr><td>290.0</td><td>Senile dementia uncomplicated</td></tr><tr><td>290.10</td><td>Presenile dementia uncomplicated</td></tr><tr><td>290.11</td><td>Presenile dementia with delirium</td></tr><tr><td>290.12</td><td>Presenile dementia with delusional features</td></tr><tr><td>290.13</td><td>Presenile dementia with depressive features</td></tr><tr><td>290.20</td><td>Senile dementia with delusional features</td></tr><tr><td>290.21</td><td>Senile dementia with depressive features</td></tr><tr><td>290.3</td><td>Senile dementia with delirium</td></tr><tr><td>290.40</td><td>Vascular dementia uncomplicated</td></tr><tr><td>290.41</td><td>Vascular dementia with delirium</td></tr><tr><td>290.42</td><td>Vascular dementia with delusions</td></tr><tr><td>290.43</td><td>Vascular dementia with depressed mood</td></tr><tr><td>291.2</td><td>Alcohol-induced persisting dementia</td></tr><tr><td>292.82</td><td>Drug-induced persisting dementia</td></tr><tr><td>294.10</td><td>Dementia in conditions classified elsewhere without behavioral disturbance</td></tr><tr><td>294.11</td><td>Dementia in conditions classified elsewhere with behavioral disturbance</td></tr></table>	ICD-9 Diagnosis		046.1	Jakob-Creutzfeldt disease	046.11	Variant Jakob- Creutzfeldt disease	046.19	Other and unspecified Jakob- Creutzfeldt disease	046.3	Progressive multifocal leukoencephalopathy	290.0	Senile dementia uncomplicated	290.10	Presenile dementia uncomplicated	290.11	Presenile dementia with delirium	290.12	Presenile dementia with delusional features	290.13	Presenile dementia with depressive features	290.20	Senile dementia with delusional features	290.21	Senile dementia with depressive features	290.3	Senile dementia with delirium	290.40	Vascular dementia uncomplicated	290.41	Vascular dementia with delirium	290.42	Vascular dementia with delusions	290.43	Vascular dementia with depressed mood	291.2	Alcohol-induced persisting dementia	292.82	Drug-induced persisting dementia	294.10	Dementia in conditions classified elsewhere without behavioral disturbance	294.11	Dementia in conditions classified elsewhere with behavioral disturbance
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#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
				<div> <div>294.8</div> <div>Other persistent mental disorders due to conditions classified elsewhere ["DEMENTIA NOS"]</div> </div> <div> <div>331.0</div> <div>Alzheimer's disease</div> </div> <div> <div>331.11</div> <div>Pick's disease</div> </div> <div> <div>331.19</div> <div>Other frontotemporal dementia</div> </div> <div> <div>331.2</div> <div>Senile degeneration of brain</div> </div> <div> <div>331.7</div> <div>Cerebral degeneration in diseases classified elsewhere</div> </div> <div> <div>331.82</div> <div>Dementia with lewy bodies</div> </div> <div> <div>331.89</div> <div>Other cerebral degeneration</div> </div> <div> <div>331.9</div> <div>Cerebral degeneration unspecified</div> </div> <div> <div>333.0</div> <div>Other degenerative diseases of the basal ganglia</div> </div> <div> <div>333.4</div> <div>Huntington's chorea</div> </div> <p>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</p>
2	demsev	<p>Was the severity of dementia assessed during the past year using one of the following standardized tools?</p> <p>1. Clinical Dementia Rating Scale (CDR)</p> <p>2. Functional Assessment Staging Tool (FAST)</p> <p>3. Global Deterioration Scale (GDS)</p> <p>99. Severity of dementia was not assessed during the past year using one of the specified tools</p>	<p>1, 2, 3, 99</p> <p>If 99, go to modsevci</p>	<p>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)</p> <p>Functional Assessment Staging Tool (FAST) = charts decline of patients with Alzheimer's Disease and is broken down into 7 stages.</p> <p>Global Deterioration Scale (GDS) = provides an overview of the stages of cognitive function and is broken down into 7 stages.</p>
3	demsevdt	Enter the date of the most recent assessment of the severity of dementia.	<p>mm/dd/yyyy</p> <div> <div><= 1 year prior to or</div> <div>= stdybeg and <=</div> <div>stdyend</div> </div>	Exact date must be entered. The use of 01 to indicate missing day or month is not acceptable.
		Assessment of Cognitive Function		

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4	cogscor2	<p>What was the outcome of the assessment of the severity of dementia assessment?</p> <p>4. Score indicated mild dementia</p> <p>5. Score indicated moderate to severe dementia</p> <p>6. Score indicated no dementia</p> <p>99. No score documented in the record or unable to determine outcome</p>	<p>4, *5, 6, 99</p> <p>If 4 or 6, go to scrnaudc</p> <p>*If 5, go out of module</p> <p>If 99, go to modsevc</p>	<p>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.</p> <p>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."</p> <p>Clinical Dementia Rating Scale: Score may range from 0 (normal) to 3 (severe dementia)</p> <p>Functional Assessment Staging Tool (FAST): Score may range from 1 (normal) to 7 (severe dementia)</p> <p>Global Deterioration Scale (GDS) : Score (stage) may range from 1 (no cognitive impairment) to 7 (very severe cognitive decline)</p> <p>For the above tools, scores indicating at least moderate degree of dementia are:</p> <ul style="list-style-type: none"> • FAST >= 5 • GDS >= 5 • CDR >= 2 <p>If documentation of the outcome of the assessment or the score of the standardized tool does not indicate the severity of dementia, enter "99."</p>
5	modsevc	<p>During the past year, did the clinician document in the record that the patient has moderate or severe cognitive impairment?</p> <p>1. Yes</p> <p>2. No</p>	<p>*1, 2</p> <p>If 2, auto-fill cogimpdt as 99/99/9999 and go to scrnaudc</p>	<p>Clinician = physician, APN, PA</p> <p>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.</p> <p>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.</p> <p>If the clinician documentation notes "mild cognitive impairment" or "cognitive impairment" without specifying severity, answer "2."</p> <p>Sources: Clinical Reminder for mental health screening, clinician notes.</p>

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6	cogimpdt	Enter the date of the most recent clinician documentation of moderate or severe cognitive impairment.	mm/dd/yyyy *If modsevc1 = 1, go out of module <div style="border: 1px solid black; padding: 2px; width: fit-content;"> < = 1 year prior to or = stdybeg and < = stdyend </div>	Enter the exact date. The use of 01 to indicate missing month or day is not acceptable.
		Screening for Alcohol Misuse		
7	scrnaudc	Within the past year, was the patient screened for alcohol misuse with the AUDIT-C? 1. Yes 2. No	1, 2 *If 2, go to deptxyr	Screening for alcohol misuse = the patient was screened within the past year using AUDIT-C questions OR AUDIT-C question # 1 alone if answer was "never" (audc1=0). Screening for alcohol use by telephone is acceptable. AUDIT-C completed during inpatient hospitalization is acceptable.
8	dtalscrn	Enter the <u>most recent date</u> of screening for alcohol misuse with the AUDIT-C.	mm/dd/yyyy If scrnaudc = 2, will be auto-filled as 99/99/9999 <div style="border: 1px solid black; padding: 2px; width: fit-content;"> < = 1 year prior to or = stdybeg and < = stdyend </div>	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.

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9	audc1	<p>Enter the score documented for AUDIT -C Question # 1 in the past year.</p> <p>"How often did you have a drink containing alcohol in the past year?</p> <p>0. Never</p> <p>1. Monthly or less</p> <p>2. Two to four times a month</p> <p>3. Two to three times a week</p> <p>4. Four or more times a week</p> <p>99. Not documented</p>	<p>0, 1, 2, 3, 4, 99</p> <p>If 0, auto-fill audc2 and audc3 as 95</p>	<p>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:</p> <p>Never → 0</p> <p>Monthly or less → 1</p> <p>Two to four times a month → 2</p> <p>Two to three times a week → 3</p> <p>Four or more times a week → 4</p> <p>Not documented → 99</p> <p>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.</p>
10	audc2	<p>Enter the score documented for AUDIT-C Question #2 in the past year.</p> <p>"How many drinks containing alcohol did you have on a typical day when you were drinking in the past year?"</p> <p>0. 0, 1 or 2 drinks</p> <p>1. 3 or 4</p> <p>2. 5 or 6</p> <p>3. 7 to 9</p> <p>4. 10 or more</p> <p>95. Not applicable</p> <p>99. Not documented</p>	<p>0, 1, 2, 3, 4, 95, 99</p> <p>Will be auto-filled as 95 if audc1 = 0</p>	<p>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:</p> <p>0 drinks → 0</p> <p>1 or 2 drinks → 0</p> <p>3 or 4 drinks → 1</p> <p>5 or 6 drinks → 2</p> <p>7 to 9 drinks → 3</p> <p>10 or more drinks → 4</p> <p>Not documented → 99</p> <p>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.</p>

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#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
11	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?" 0. Never 1. Less than monthly 2. Monthly 3. Weekly 4. 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.
12	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.
13	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.

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#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
14	alctxpy2	<p>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?</p> <p>5. Yes, in VHA 6. Yes, but <u>not</u> in VHA (includes AA) 99. No or unable to determine</p>	<p>5, 6, 99</p> <p>If 99, auto-fill inrecvdt as 99/99/9999 and sudclin as 95, and go to alcbac</p>	<p>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.</p> <p>5 Yes, specialty addictions or alcohol recovery program <u>in VHA</u> 6 Yes, but not in VHA, and can include support groups, e.g. AA 99 No documentation that the patient participated in a recovery program or unable to determine</p>
15	inrecvdt	<p>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.</p>	<p>mm/dd/yyyy</p> <p>Will be auto-filled as 99/99/9999 if alctxpy2 = 99</p> <p>If alctxpy2 = 5, go to sudclin1, else go to alcbac</p> <p>If alctxpy2 = 6, auto-fill sudclin as 95, and go to alcbac</p> <p>If unable to find month and year at a minimum, the abstractor may enter default 99/99/9999</p> <div style="border: 1px solid black; padding: 5px; margin-top: 5px;"> <p>If scrnaudc = 1, <= 1 year prior to or = dtalscrn and <= dtalscrn</p> <p>If scrnaudc = 2, <= 1 year prior to or = stdybeg and <= stdyend</p> </div>	<p>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.</p> <p>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.</p> <p>If the exact date cannot be found, month and year must be entered at a minimum.</p> <p>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.</p>

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#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
16	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 alctxpy2 = 6 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.

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#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
17	alcbac3 alba3dt alcbac6 alba6dt alcbac7 alba7dt alcbac8 alba8dt alcba95 alcba99	<p>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?</p> <p>Indicate all that apply and the date counseling was noted in the record:</p> <p>3. Advice to abstain</p> <p>6. Personalized counseling regarding relationship of alcohol to the patient's specific health issues</p> <p>7. General alcohol-related counseling (not linked to patient's issues)</p> <p>8. Explicitly advised patient to drink within recommended limits</p> <p>95. Not applicable</p> <p>99.No alcohol counseling documented</p>	<p>3, 6, 7, 8, 95, 99</p> <p>alcbac3 -1 or <> mm/dd/yyyy</p> <p>alcbac6 -1 or <> mm/dd/yyyy</p> <p>alcbac7 -1 or <> mm/dd/yyyy</p> <p>alcbac8 -1 or <> mm/dd/yyyy</p> <div style="border: 1px solid black; padding: 2px; width: fit-content; margin: 5px auto;"> >= dtalscrn and <= stdyend </div> <p>95, 99</p> <p>Will be auto-filled as 95 if scrnaudc = 2</p>	<p>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.</p> <p>Alcbac3 - Advice to abstain from alcohol</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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. 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.</p>
		Depression		

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#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
18	deptxvr	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 2, auto-fill recdepdt as 99/99/9999, and go to bpdxvr	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.
19	recdepdt	Enter the date within the past year of the <u>most recent</u> 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 deptxvr = 2 *If deptxvr = 1, go to leavduty <div style="border: 1px solid black; padding: 2px; width: fit-content;">< = 1 year prior to or = stdybeg and < = stdyend</div>	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.
20	bpdxvr	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 2 and deptxvr = 2, go to phq2dt; else if 2, go to leavduty	Bipolar disorder does not have to be listed as the only reason for the clinical encounter, but identified as one of the reasons for the clinical encounter as evidenced by any of the following ICD-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.

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21	recbpd	Enter the date within the past year of the <u>most recent</u> clinical encounter where bipolar disorder was identified as a reason for the clinical encounter.	mm/dd/yyyy If bpdxyr = 1, go to leavduty <div style="border: 1px solid black; padding: 2px; display: inline-block;">< = 1 year prior to or = stdybeg and < = stdyend</div>	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.
22	phq2dt	Enter the date within the past year of the <u>most recent</u> 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 scrnphq <div style="border: 1px solid black; padding: 2px; display: inline-block;">< = 1 year prior to or = stdybeg and < = stdyend</div>	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.
		Depression Screening		
23	erefphq	During the past year, is there documentation the patient refused screening for depression? 1. Yes 2. No	1, 2 If 1, go to leavduty	This question is informational only and does not impact current depression screening measures. Documentation from the inpatient or outpatient record during the past year that the patient refused screening for depression is acceptable.

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24	erenophq	<p>During the past year, is there physician/APN/PA documentation of a reason why depression screening was not performed?</p> <p>1. Yes 2. No</p>	<p>1, 2 If 1 or 2, go to leavduty</p>	<p>This question is informational only and does not impact current depression screening measures.</p> <p>Physician/APN/PA documentation must link the noted reason with not performing screening for depression.</p> <p>Examples: Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status.</p> <p>Situations where the patient's functional capacity or motivation to improve may impact the accuracy of results of standardized depression assessment tools (e.g, cases of delirium, certain court appointed cases)</p>

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#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
25	scrnphq	<p><u>On the date of the most recent screening for depression</u>, was the patient screened by the PHQ-2 or the PHQ-9?</p> <p>2. Screened by PHQ-2</p> <p>3. Screened by PHQ-9</p> <p>4. Screened by PHQ-2 AND PHQ-9 on the <u>same</u> date</p>	2, 3, 4	<p>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."</p> <p>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</p> <p>PHQ-2 = Patient Health Questionnaire (2 questions - scaled)</p> <p>Question 1: "Over the past two weeks, have you often been bothered by little interest or pleasure in doing things?"</p> <p>Question 2: "Over the past two weeks, have you often been bothered by feeling down, depressed, or hopeless?"</p> <p>Answers to PHQ-2 are scaled, ranging from "not at all" to "nearly every day."</p> <p>Patient Health Questionnaire (PHQ-9) asks:</p> <p>Over the last 2 weeks, how often have you been bothered by any of the following problems?</p> <ol style="list-style-type: none"> 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 <i>any</i> problems, how <i>difficult</i> have these problems made it for you to do work, take care of things at home, or get along with other people?

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#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
26	ph1scor	<p>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).</p> <p>Over the past 2 weeks, have you been bothered by little interest or pleasure in doing things?</p> <p>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</p>	0, 1, 2, 3, 99	<p>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.</p> <p>If the PHQ-2 and the PHQ-9 were administered on the same date, enter the response or score documented for the <u>PHQ-2</u> question 1.</p> <p>The questions displayed are the "Scaled PHQ-2" in which the answer key for Question 1 is as follows:</p> <p>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</p> <p>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.</p>
27	ph2scor	<p>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).</p> <p>Over the past 2 weeks, have you been bothered by feeling down, depressed, or hopeless?</p> <p>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</p>	<p>0, 1, 2, 3, 99</p> <p>If scrnphq = 3, go to phq9ques, else go to phqtotal</p>	<p>If the PHQ-2 and the PHQ-9 were administered on the same date, enter the response or score documented for the <u>PHQ-2</u> question 2.</p> <p>The questions displayed are the "Scaled PHQ-2" in which the answer key for Question 2 is as follows:</p> <p>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</p> <p>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.</p>

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#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
28	phqtotal	Enter the <u>total score</u> 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.
29	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."
30	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.

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#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES												
31	ph9total	Enter the total score of the PHQ-9 documented in the record.	<div>___ __ Whole numbers only 0 to 27 Abstractor can enter zz</div> <div>Warning if 0 AND ph1scor or ph2scor = 1, 2, or 3 OR if < sum of [ph1scor and ph2scor]</div>	<p>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.</p> <p>The total score may range from 0 to 27.</p> <table><tr><th>Total Score</th><th>Depression Severity</th></tr><tr><td>1-4</td><td>Minimal depression</td></tr><tr><td>5-9</td><td>Mild depression</td></tr><tr><td>10-14</td><td>Moderate depression</td></tr><tr><td>15-19</td><td>Moderately severe depression</td></tr><tr><td>20-27</td><td>Severe depression</td></tr></table> <p>If no total score is documented in the record, enter default zz.</p>	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
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															
32	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	<p>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</p> <p>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.</p>												

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#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
33	phq9out	<p>Was the outcome of the PHQ-9 documented in the medical record?</p> <p>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</p>	<p>1, 3, 4, 5, 6, 7, 95, 99</p> <p>If $ph9total \geq 10$, 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 $ph2scor$] $= \geq 3$, or $outcome3 =$ 1, go to deprisk, else go to leavduty</p>	<p>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.</p> <p>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.</p> <p>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.</p> <p>If the outcome of the PHQ-9 is documented as "negative," select "3."</p>

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#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
34	deprisk	<p>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?</p> <p>1. Yes 2. No</p>	<p>1, 2</p> <p>If 2, auto-fill deprskdt as 99/99/9999, and go to depeval</p>	<p>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.</p> <p>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).</p> <p>Acceptable Provider Documentation of Suicide Risk Evaluation:</p> <ul style="list-style-type: none"> 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 <u>the suicide risk evaluation was completed</u>. 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. <p>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.</p> <ul style="list-style-type: none"> 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, LMFT, LPMHC, APN, PA, or RN. Trainee in ANY of these categories may complete a suicide risk evaluation with appropriate co-signature. <p>Suggested sources: progress notes, ED notes, H&P, consultation, Clinical Reminder</p>

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#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
35	deprskdt	Enter the date the suicide ideation/behavior evaluation was completed.	mm/dd/yyyy <div style="border: 1px solid black; padding: 2px; width: fit-content;"> < = 1 day after or = phq2dt and < = 1 day after stdyend </div>	Enter the exact date. The use of 01 to indicate missing month or day is not acceptable.
36	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, LCSW-C, LMSW, LISW, LMFT, LPMHC, APN, PA or RN. Trainee in any of these categories with appropriate co-signature is acceptable. 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."
		Depression Triage		

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#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
37	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 <div style="border: 1px solid black; padding: 2px; display: inline-block;"> >= phq2dt and <= stdyend </div>	Enter the exact date. The use of 01 to indicate missing month and day is not acceptable.
38	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.
39	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."
40	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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#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
41	depmhv1	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, LCSW-C, LMSW, LISW, LMFT, LPMHC, APN, PA or RN. Trainee in any of these categories with appropriate co-signature is acceptable. 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."
42	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 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.
43	edeprx	On (computer display phq2dt), did the physician/APN/PA prescribe an anti-depressant medication for the patient? 1. Yes 2. No 98. Patient refused anti-depressant medication prescription	1, 2, 98 If 1, 2, or 98, go to leavduty	This question is informational only and does not impact current depression screening measures. There are multiple anti-depressant drug classes and many anti-depressant medications. Some examples are listed below (Please refer to a drug handbook for a more complete listing). Monoamine Oxidase Inhibitors (MAOI): phenelzine (Nardil), tranylcypromine (Parnate) Selective serotonin reuptake inhibitors (SSRI): citalopram (Celexa), escitalopram (Lexapro), fluoxetine (Prozac), paroxetine (Paxil), sertraline (Zoloft) Serotonin and Norepinephrine Reuptake Inhibitors (SNRI): desvenlafaxine (Pristiq), duloxetine (Cymbalta), venlafaxine (Effexor) Tricyclic antidepressants: amitriptyline, desipramine (Norpramin), doxepin (Sinequan), imipramine (Tofranil), Other anti-depressants: bupropion (Wellbutrin), mirtazapine (Remeron)

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#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
44	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 depmhdtd as 99/99/9999, and go to depmhref, else go to depmhdtd	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."
45	depmhdtd	Enter the date the patient was <u>emergently</u> transferred to mental health care services.	mm/dd/yyyy <div style="border: 1px solid black; padding: 2px; margin: 2px;"> > = phq2dtd and < = stdyend </div> *If <> 99/99/9999, go to leavduty 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.
46	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 deprefdtd 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."
47	deprefdtd	Enter the date the mental health consult was placed.	mm/dd/yyyy <div style="border: 1px solid black; padding: 2px; margin: 2px;"> > = phq2dtd and < = stdyend </div>	Enter the exact date. The use of 01 to indicate missing month or day is not acceptable.

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#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
48	deptcont	<p>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?</p> <p>1. Provider contact information provided 2. Emergency contact information provided 3. Both 1 and 2 99. None of the above documented</p>	<p>1, 2, 3, 99</p> <p>If 99, auto-fill depcondt as 99/99/9999 and go to leavduty</p>	<p>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</p> <p>Documentation that provider contact information or emergency contact information was provided to the patient is acceptable.</p> <p>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.</p>
49	depcondt	<p>Enter the date the provider documented contact information was provided to the patient.</p>	<p>mm/dd/yyyy</p> <p>Will be auto-filled as 99/99/9999 if deptcont = 99</p> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <p>If depevldt <> 99/99/9999, >= depevldt and <= stdyend</p> <p>If depevldt = 99/99/9999, >= phq2dt and <= stdyend</p> </div>	<p>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.</p>

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#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
50	leavduty	Enter the patient's <u>most recent</u> 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 <div style="border: 1px solid black; padding: 2px; width: fit-content;"> > = 01/01/1930 and < = stdyend </div>	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
		Screening for PTSD		
51	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 2, go to ptsrnp	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.
52	recptsdt	Enter the date within the past year of the <u>most recent</u> clinical encounter where PTSD was identified as a reason for the clinical encounter.	mm/dd/yyyy *If ptsdx = 1, go to end <div style="border: 1px solid black; padding: 2px; width: fit-content;"> < = 1 year prior to or = stdybeg and < = stdyend </div>	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.

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#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
53	ptsmpc	<p>Within the past five years, was the patient screened for PTSD using the Primary Care PTSD Screen (PC-PTSD)?</p> <p>1. Yes 2. No</p>	<p>1, *2</p> <p>*If 2, go to end</p>	<p>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.</p> <p>Have you ever had any experience that was so frightening, horrible, or upsetting that, IN THE PAST MONTH, you:</p> <p>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?</p> <p>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</p>
54	pcptsdt	Enter the date of the <u>most recent screen</u> for PTSD using the PC-PTSD.	<p>mm/dd/yyyy</p> <div style="border: 1px solid black; padding: 2px; width: fit-content;"> <p>< = 5 years prior or = stdybeg and < = stdyend</p> </div>	Enter the exact date. The use of 01 to indicate missing month or day is not acceptable.

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#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
55	pcptsd	<p>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:</p> <ol style="list-style-type: none"> 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? <p>1. Yes 2. No 99. No answer documented</p>	1, 2, 99	<p>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 <u>positive</u> 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."</p>
56	ptsdscor	Enter the total score for the PC-PTSD screen documented in the record.	<p style="text-align: center;">—</p> <p>Abstractor can enter default z if no total score is documented</p> <div style="border: 1px solid black; padding: 2px; width: fit-content; margin: 0 auto;"> <p>Whole numbers 0 - 4</p> </div>	<p>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 <u>positive</u> 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.</p>

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#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
57	scorintrp	Enter the interpretation of the PC-PTSD score, <u>as documented in the medical record.</u> 1. Positive 2. Negative 99. No interpretation documented	1, 2, 99 *If (pcptsdt <= 1 year prior to stdybeg and <= stdyend) AND (ptsdscor >= 3) or [sum (exclude values > 1) of pcptsd1 and pcptsd2 and pcptsd3 and pcptsd4 >= 3] or (scorintrp = 1), go to ptsdrisk; else go to end <div style="border: 1px solid black; padding: 5px; margin-top: 10px;">Warning window if ptsrnpc = 1, ptsdscor 3 or > and scorintrp = 2; or if ptsrnpc = 1, ptsdscor < 3 and scorintrp = 1</div>	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 <u>positive</u> 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."

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#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
58	ptsdrisk	<p>On the day of or the day after the positive PC-PTSD screen, did the provider document a suicide ideation/behavior evaluation?</p> <p>1. Yes 2. No</p>	<p>1, 2</p> <p>If 2, auto-fill rskptsdt as 99/99/9999, and go to ptsdeval</p>	<p>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.</p> <p>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).</p> <p>Acceptable Provider Documentation of Suicide Risk Evaluation:</p> <ul style="list-style-type: none"> 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 <u>the suicide risk evaluation was completed</u>. 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. <p>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.</p> <ul style="list-style-type: none"> 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, LMFT, LPMHC, APN, PA, or RN. Trainee in ANY of these categories may complete a suicide risk evaluation with appropriate co-signature. <p>Suggested sources: progress notes, ED notes, H&P, consultation, Clinical Reminder</p>

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#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
59	rskptsdt	Enter the date the suicide ideation/behavior evaluation was completed.	mm/dd/yyyy <div style="border: 1px solid black; padding: 2px; width: fit-content;"> < = 1 day after or = pcptsdt and < = 1 day after stdyend </div>	Enter the exact date. The use of 01 to indicate missing month or day is not acceptable.
60	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	<p>Acceptable Provider: MD, DO, PhD or PsyD Psychologist, LCSW, LCSW-C, LMSW, LISW, LMFT, LPMHC, APN, PA or RN. Trainee in any of these categories with appropriate co-signature is acceptable.</p> <p>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.</p> <p>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.</p> <p>If the provider documented that the patient needed further intervention for a positive PC-PTSD screen, select "1."</p> <p>For example, clinician documents, "PC-PTSD positive. Patient reports nightmares and anger outbursts. Needs mental health evaluation." Select "1."</p> <p>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."</p> <p>If there is no documentation by the provider regarding whether the patient needed further intervention, select "99."</p>

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#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
61	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.
62	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.
63	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."
64	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."

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#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
65	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, LCSW-C, LMSW, LISW, LMFT, LPMHC, APN, PA or RN. Trainee in any of these categories with appropriate co-signature is acceptable. 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."
66	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 Will be auto-filled as 95 if ptsdmhevl = 1 *If 1 or 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.
67	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."

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#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
68	ptsdmhdt	Enter the date the patient was <u>emergently</u> transferred to mental health care services.	mm/dd/yyyy <div style="border: 1px solid black; padding: 2px; margin: 2px;"> > = pcptsdt and < = stdyend </div> <p>If <> 99/99/9999, go to end Will be auto-filled as 99/99/9999 if ptsdurg = 2, 3, 99</p>	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.
69	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 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."
70	refptsdt	Enter the date the mental health consult was placed.	mm/dd/yyyy <div style="border: 1px solid black; padding: 2px; margin: 2px;"> > = pcptsdt and < = stdyend </div>	Enter the exact date. The use of 01 to indicate missing month or day is not acceptable.
71	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.

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#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
72	ptscondt	Enter the date the provider documented that contact information was provided to the patient.	<div>mm/dd/yyyy</div> <div> If evlptsdt < 99/99/9999, >= evlptsdt and <= stdyend If evlptsdt = 99/99/9999, >= pcptsdt and <= stdyend </div>	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.