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| **[Link to Mnemonics and Questions](https://secure.wvmi.org/QUESTIONS/Specifications/Mnemonics%20and%20Questions/fy2025q4/MnemonicQuestions2025q4.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  **Oracle Health 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, Problem List (found in Patient Summary) |

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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.  In order to answer “1,” the documentation must clearly indicate the severity of dementia was assessed using one of the specified tools, the date the assessment was completed, and the results of the assessment.  **If the severity of dementia was not assessed during the past year using one of the specified tools, enter 99.c** |
| 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.** * Other acceptable documentation includes:   + 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.”**   + The Form Browser for mental health screening in Oracle Health allows providers to establish this exclusion by checking the box to indicate **“Unable to Screen Due to Permanent, Major Neurodegenerative Disorder.”** * 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.** * Other acceptable documentation includes: * 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.”** * The Form Browser for mental health screening in Oracle Health allows providers to establish this exclusion by checking the box to indicate **“Unable to Screen Due to Permanent, Major Neurodegenerative Disorder.”** * 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 or Concise 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?”  **Note: E-s**creening for alcohol misuse by the AUDIT-C Concise tool is acceptable. The displayed results may not include the complete question; however, the question intent, responses and scoring are the same as the AUDIT-C.  **Acceptable setting for alcohol screening:** outpatient encounter, screening by telephone, and clinical video telehealth (CVT), inpatient hospitalization, e-screening (a screen performed asynchronously by email or text to the patient)  **Oracle Health 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.  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.  **Oracle Health 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.**  The date refers to the date of the signature on the encounter note.  **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.   **Oracle Health 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.   **Oracle Health Suggested Data Sources:** Search Diagnoses & Problems for applicable diagnosis code, verify use within appropriate timeframe in Coding Summary found in Documentation, Problem List (found in Patient Summary) |
| 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:  **F25.0, 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:**   * **F25.0, 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.   **Oracle Health 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, Problem List (found in Patient Summary) |
| 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 scrnphq9 | **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 timeframe (i.e., over the past 2 weeks) in the questions is not required at this time. * **Note:** E**-**screening for depression is acceptable. The displayed results may not include the complete questions; however, the question intent, responses and scoring are the same as the PHQ-2.   **Acceptable setting for depression screening: outpatient** encounter, screening by telephone, and clinical video telehealth (CVT), inpatient hospitalization, e-screening (a screen performed asynchronously by email or text to the patient)  **Oracle Health 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. |
| 27 | scrnphq9 | During the past year was the patient screened for depression by the **PHQ-9**?  1.Yes  2.No  98. Patient refused depression screening by the PHQ-9 | 1,2,98  If 2 or 98, go to ptsdx | **PHQ-9 = Patient Health Questionnaire (9 questions - scaled)** “Over the past two weeks, have you often been bothered by any of the following problems?”   1. Little interest or pleasure in doing things 2. Feeling down, depressed, or hopeless 3. Trouble falling 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. Thoughts that you would be better off dead, or of hurting yourself 10. If you checked off *any* problems, how *difficult* have these problems made it for you to do work, take care of things at home, or get along with other people?   **Note:** E**-**screening for depression is acceptable. The displayed results may not include the complete questions; however, the question intent, responses and scoring are the same as the PHQ-9.  **Acceptable setting for depression screening: outpatient** encounter, screening by telephone, and clinical video telehealth (CVT), inpatient hospitalization, e-screening (a screen performed asynchronously by email or text to the patient)  **Oracle Health Suggested Data Sources**: Form browser and select depression screening |
| 28 | 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.** |
| 29 | phq9dt | Enter the date of the most recent screening for depression by the PHQ-9. | 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** |
| 30 | ph9total | Enter the total score of the PHQ-9 documented in the record. | \_\_\_  Whole numbers only  0 to 27  Abstractor can enter zz  If >=3, go to depeval; else go to ptsdx | The total score for PHQ-9 questions must be documented in the medical record. The abstractor may NOT enter the total score if it is not documented in the record, even if all 9 questions have been answered and the total is evident.  The total score may range from 0 to 27.   |  |  | | --- | --- | | Total Score | Depression Severity | | 1-4 | Minimal depression | | 5-9 | Mild depression | | 10-14 | Moderate depression | | 15-19 | Moderately severe depression | | 20-27 | Severe depression |   **If total score is not documented in the record, enter default zz.** |
|  |  | Depression Disposition |  |  |
| 31 | depeval | On (if scrnph2=1, computer to display phq2dt; else computer to display phq9dt), 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.” |
| 32 | depfolint1  depfolint2  depfolint3  depfolint4  depfolint5  depfolint7  depfolint99 | On (if depeval=1, computer to display phq2dt; else phq9dt), 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. |

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|  |  | Screening for PTSD |  |  |
| 33 | 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.   **Oracle Health 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, Problem List (found in Patient Summary) |
| 34 | 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 end**   |  | | --- | | < = 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. |
| 35 | 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. |
| 36 | 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. |
| 37 | 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   **Oracle Health Suggested Data Sources**: Joint Longitudinal Viewer (JLV) then demographics widget and select Military Service link for date of separation (DOS) |
| 38 | pcptsd5 | During the time frame from (computer to display stdybeg – 5 years to stdyend), 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**   **Note: Due to an issue with the PC-PTSD5 screen clinical reminder**, **the lead in traumatic event question may include “IN THE PAST MONTH” at the beginning or end of the question AND/OR a different term to describe the event.**For example, documentation of either of the following is acceptable:  “IN THE PAST MONTH, have you ever had any experience that was so frightening, horrible or traumatic” OR “Have you ever had any experience that was so frightening, horrible or upsetting that, IN THE PAST MONTH, you”.  **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?  **Cont’d next page**   * **NOTE:** “In the past month” may precede each question. * **The PC-PTSD5 screen must be documented in a clinic/progress note.** * **Note:** E**-**screening for PTSD is acceptable. The displayed results may not include the complete questions; however, the question intent, responses and scoring are the same as the PC-PTSD5   **Acceptable setting for PTSD screening: outpatient** encounter, screening by telephone, and clinical video telehealth (CVT), inpatient hospitalization, e-screening (a screen performed asynchronously by email or text to the patient)  **Oracle Health Suggested Data Sources**: Form browser and select VA PC-PTSD-5 |
| 39 | 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   |  | | --- | | <= 5 years prior to or = stdybeg 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. |
| 40 | scrptsd5i9 | During the time frame from (computer to display stdybeg – 5 years 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 end; 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, e-screening (a screen performed asynchronously by email or text to the patient) |
| 41 | pcptsd5dt | Enter the date of the most recent screen for PTSD using the PC-PTSD5+ I9. | mm/dd/yyyy   |  | | --- | | <= 5 years prior to or = stdybeg 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. |
| 42 | 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 end | **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”.** |
| 43 | 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.**  **Note: “In the past month” may precede each question.**  **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 | 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**  **end** | * **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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| 45 | ptsdeval | On (if pcptsd5dt and pcptsd5dt2 are valid, computer to 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 end | **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 pcptsd5dt and pcptsd5dt2 are valid, computer to 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   |  | | --- | | 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. |