

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

**FEFLAG** (rcvd on pull list)  
 FE case flagged for CGPI review / scoring?  
 0. No  
 1. Yes

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

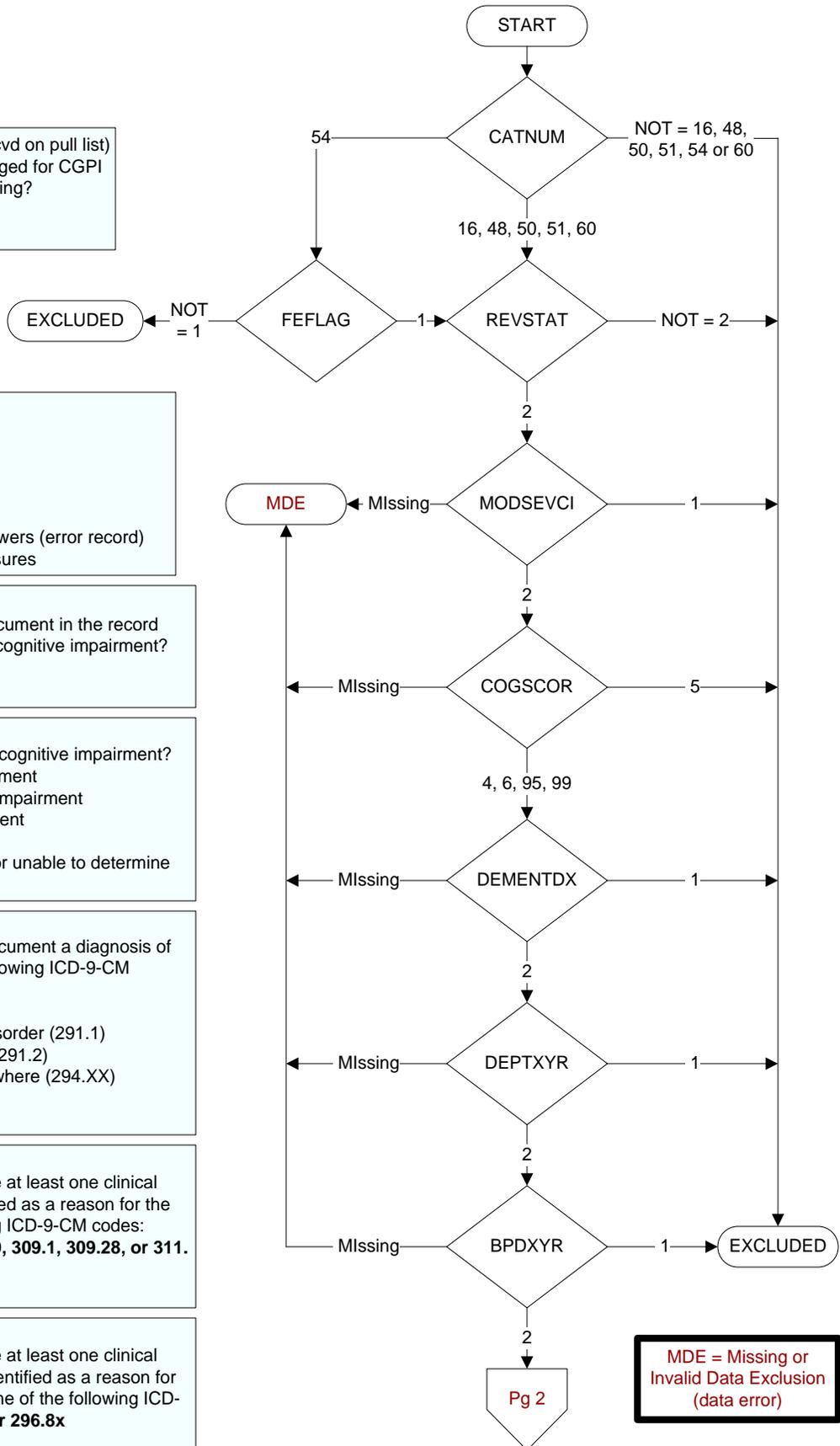
**MODSEVCI** (MH)  
 During the past year, did the clinician document in the record that the patient has moderate or severe cognitive impairment?  
 1. Yes  
 2. No

**COGSCOR** (MH)  
 What was the outcome of the screen for cognitive impairment?  
 4. Score indicated mild cognitive impairment  
 5. Score indicated moderate to severe impairment  
 6. Score indicated no cognitive impairment  
 95. Not applicable  
 99. No score documented in the record or unable to determine outcome

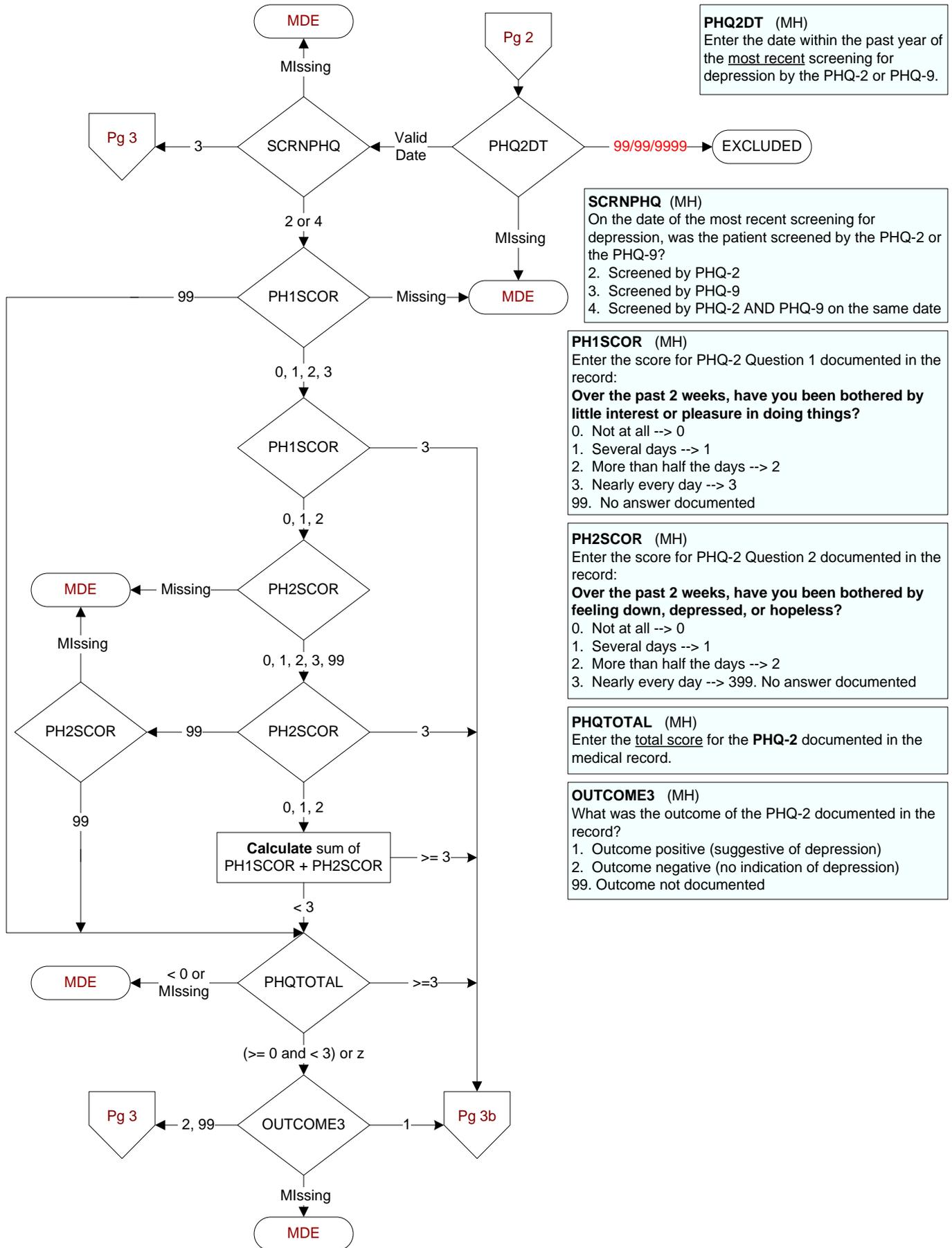
**DEMENTDX** (MH)  
 During the past year, does the record document a diagnosis of dementia as evidenced by one of the following ICD-9-CM codes?  
 -- Dementia (290.XX)  
 -- Alcohol-induced persisting amnesic disorder (291.1)  
 -- Alcohol-induced persisting dementia (291.2)  
 -- Dementia in conditions classified elsewhere (294.XX)  
 1. Yes  
 2. No

**DEPTX1R** (MH)  
 Within the past year, did the patient have at least one clinical encounter where depression was identified as a reason for the visit as evidenced by one of the following ICD-9-CM codes:  
**296.2-296.3, 298.0, 300.4, 301.12, 309.0, 309.1, 309.28, or 311.**  
 1. Yes  
 2. No

**BPD1R** (MH)  
 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, 296.7x, or 296.8x**  
 1. Yes  
 2. No



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



**PHQ2DT (MH)**  
Enter the date within the past year of the most recent screening for depression by the PHQ-2 or PHQ-9.

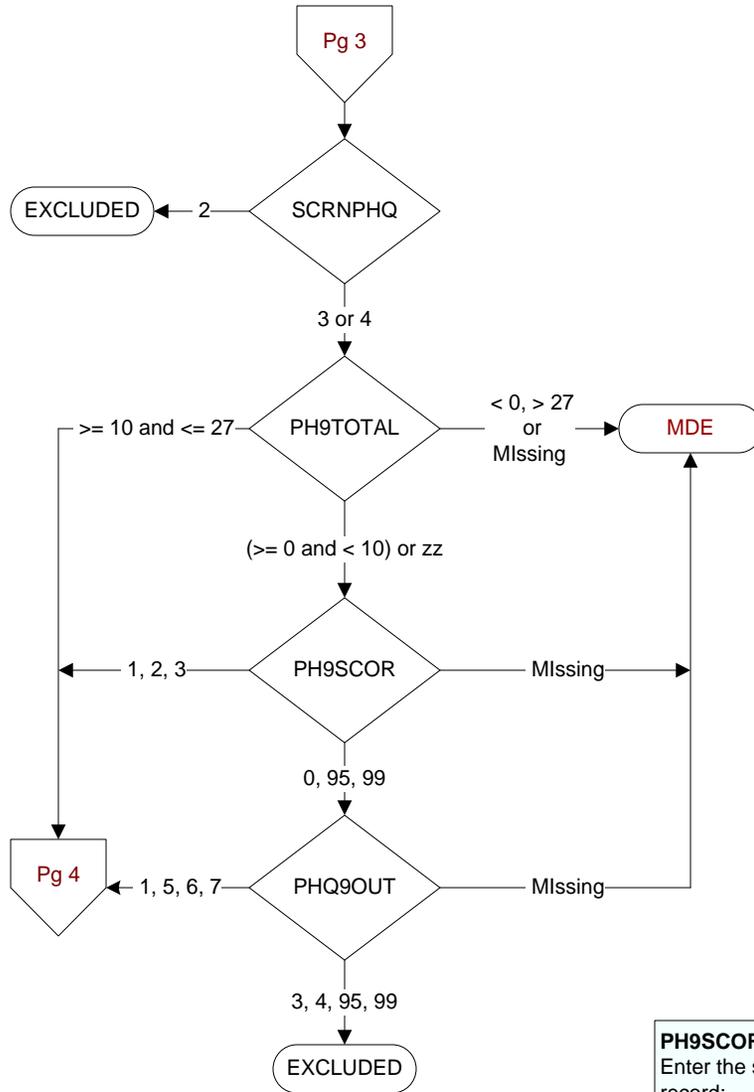
**SCRNPHQ (MH)**  
On the date of the most recent screening for depression, was the patient screened by the PHQ-2 or the PHQ-9?  
2. Screened by PHQ-2  
3. Screened by PHQ-9  
4. Screened by PHQ-2 AND PHQ-9 on the same date

**PH1SCOR (MH)**  
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

**PH2SCOR (MH)**  
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

**PHQTOTAL (MH)**  
Enter the total score for the **PHQ-2** documented in the medical record.

**OUTCOME3 (MH)**  
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



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

**PH9SCOR (MH)**  
Enter the score for PHQ-9 Question 9 documented in the record:  
**Over the last 2 weeks, how often have you been bothered by thoughts that you would be better off dead, or of hurting yourself in some way?**  
0. Not at all --> 0  
1. Several days --> 1  
2. More than half the days --> 2  
3. Nearly every day --> 3  
95. Not applicable  
99. No answer documented

**PHQ9OUT (MH)**  
Was the outcome of the PHQ-9 documented in the medical record?  
1. Outcome positive  
3. Score suggestive of no depression  
4. Score suggestive of mild depression  
5. Score suggestive of moderate depression  
6. Score suggestive of moderately severe depression  
7. Score suggestive of severe depression  
95. Not applicable  
99. No documentation of outcome

**DEPEVAL (MH)**  
 Following the positive PHQ-2 or PHQ-9 or affirmative answer to PHQ-9 question 9, did the provider document the patient needed further intervention?  
 1. Yes, documented further intervention needed  
 2. Documented no further intervention needed  
 99. No documentation regarding further intervention

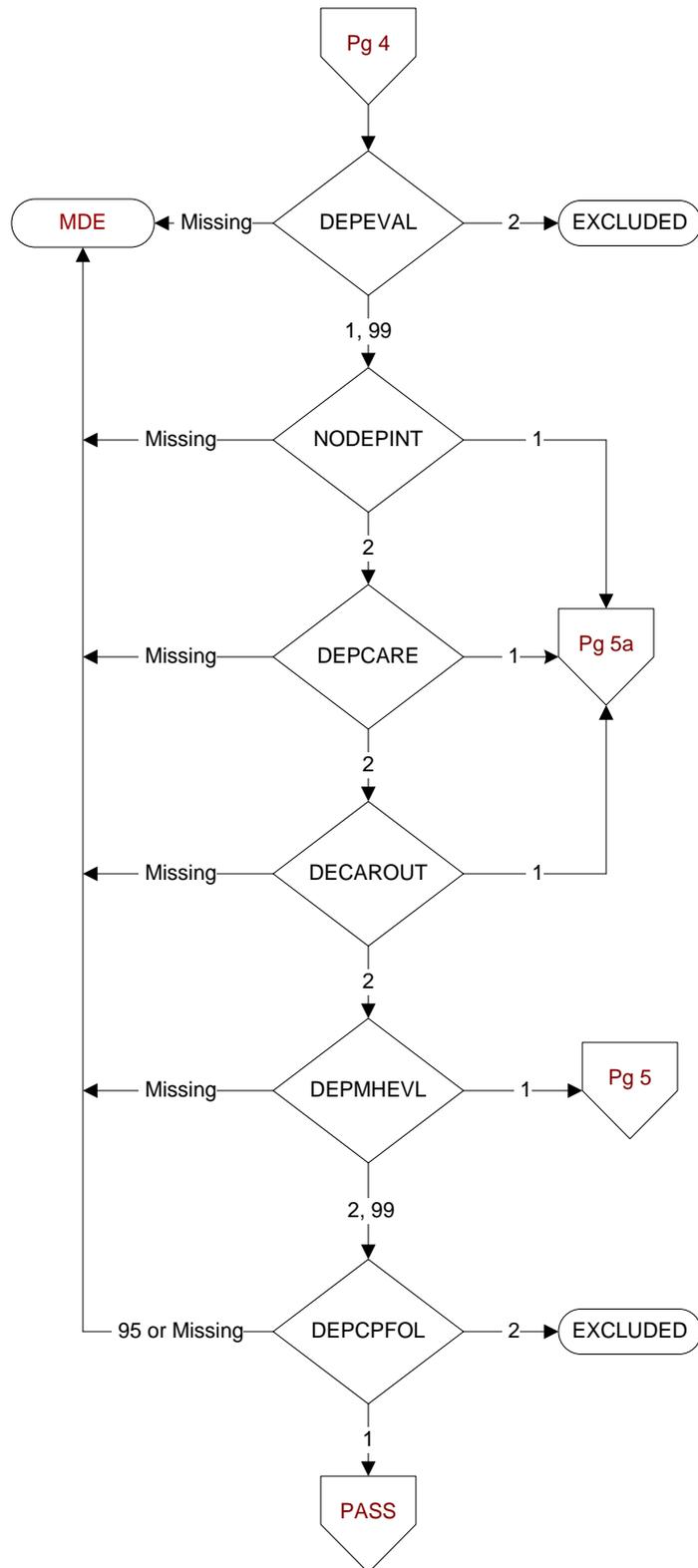
**NODEPINT (MH)**  
 Following the positive PHQ-2 or PHQ-9 or affirmative answer to PHQ-9 question 9, did the provider document the patient refused further evaluation/treatment for depression?  
 1. Yes  
 2. No

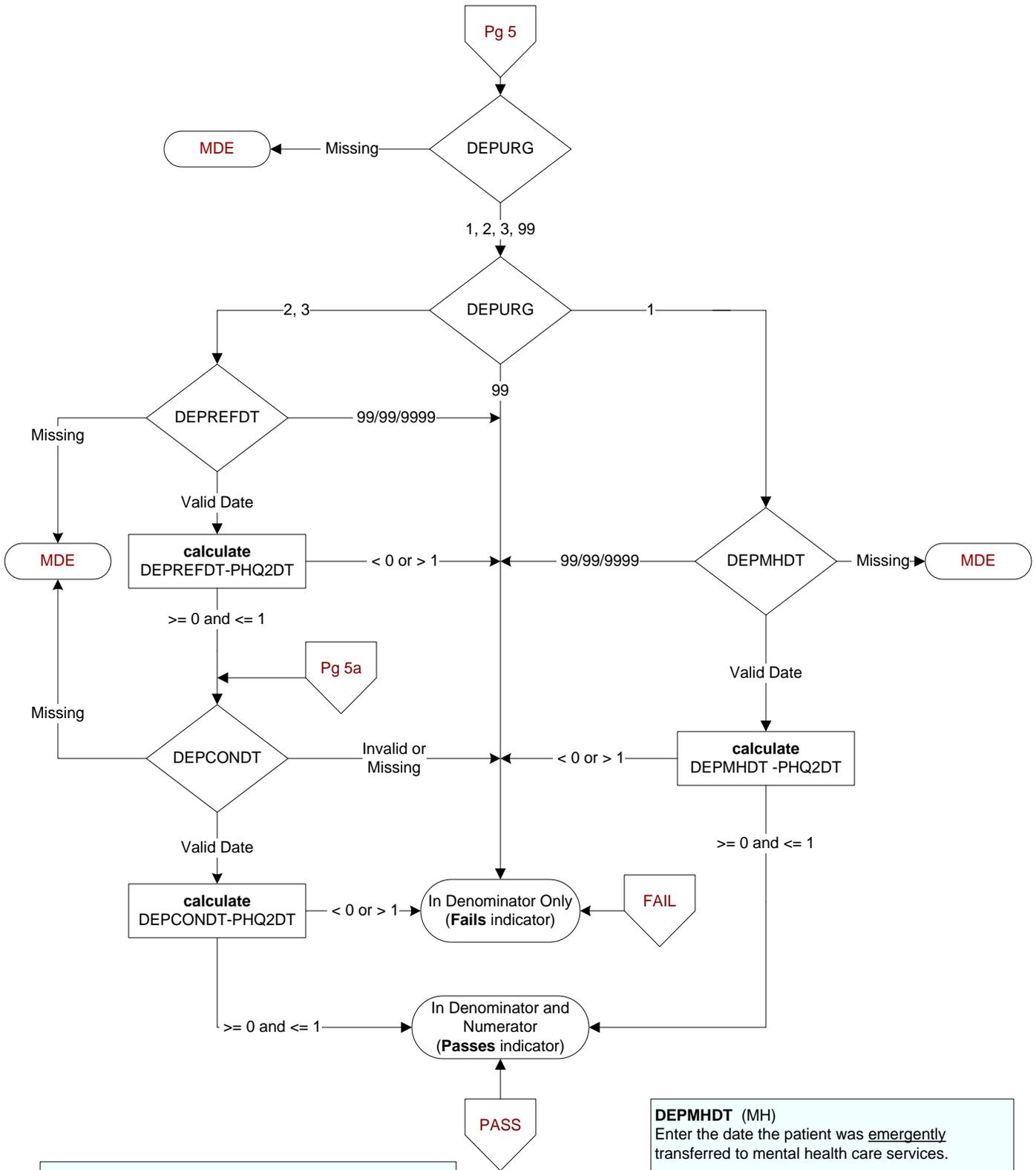
**DEPCARE (MH)**  
 Following the positive PHQ-2 or PHQ-9 or affirmative answer to PHQ-9 question 9, did the provider document the patient was already receiving recommended care for depression?  
 1. Yes  
 2. No

**DECAROUT (MH)**  
 Following the positive PHQ-2 or PHQ-9 or affirmative answer to PHQ-9 question 9, did the provider document the patient was to receive care for depression outside this VA?  
 1. Yes  
 2. No

**DEPMHEVL (MH)**  
 Following the positive PHQ-2 or PHQ-9 or affirmative answer to PHQ-9 question 9, did the provider document that the patient needed a mental health evaluation?  
 1. Yes, mental health evaluation needed  
 2. No mental health evaluation needed  
 99. No documentation regarding mental health evaluation

**DEPCPFOL (MH)**  
 Following the positive PHQ-2 or PHQ-9 or affirmative answer to PHQ-9 question 9, did the provider document that the patient will follow-up with a primary care provider?  
 1. Yes  
 2. No  
 95. Not applicable





**DEPURG (MH)**  
 Following the positive PHQ-2 or PHQ-9 or affirmative answer to question 9, did the provider document the urgency of the mental health evaluation?  
 1. Immediate/emergent mental health evaluation needed  
 2. Urgent mental health evaluation needed  
 3. Non-urgent mental health evaluation needed  
 99. No documentation of urgency of care

**DEPMHDT (MH)**  
 Enter the date the patient was emergently transferred to mental health care services.

**DEPREFDT (MH)**  
 Enter the date the mental health consult was placed.

**DEPCONDT (MH)**  
 Enter the date the provider documented contact information was provided to the patient.