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

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

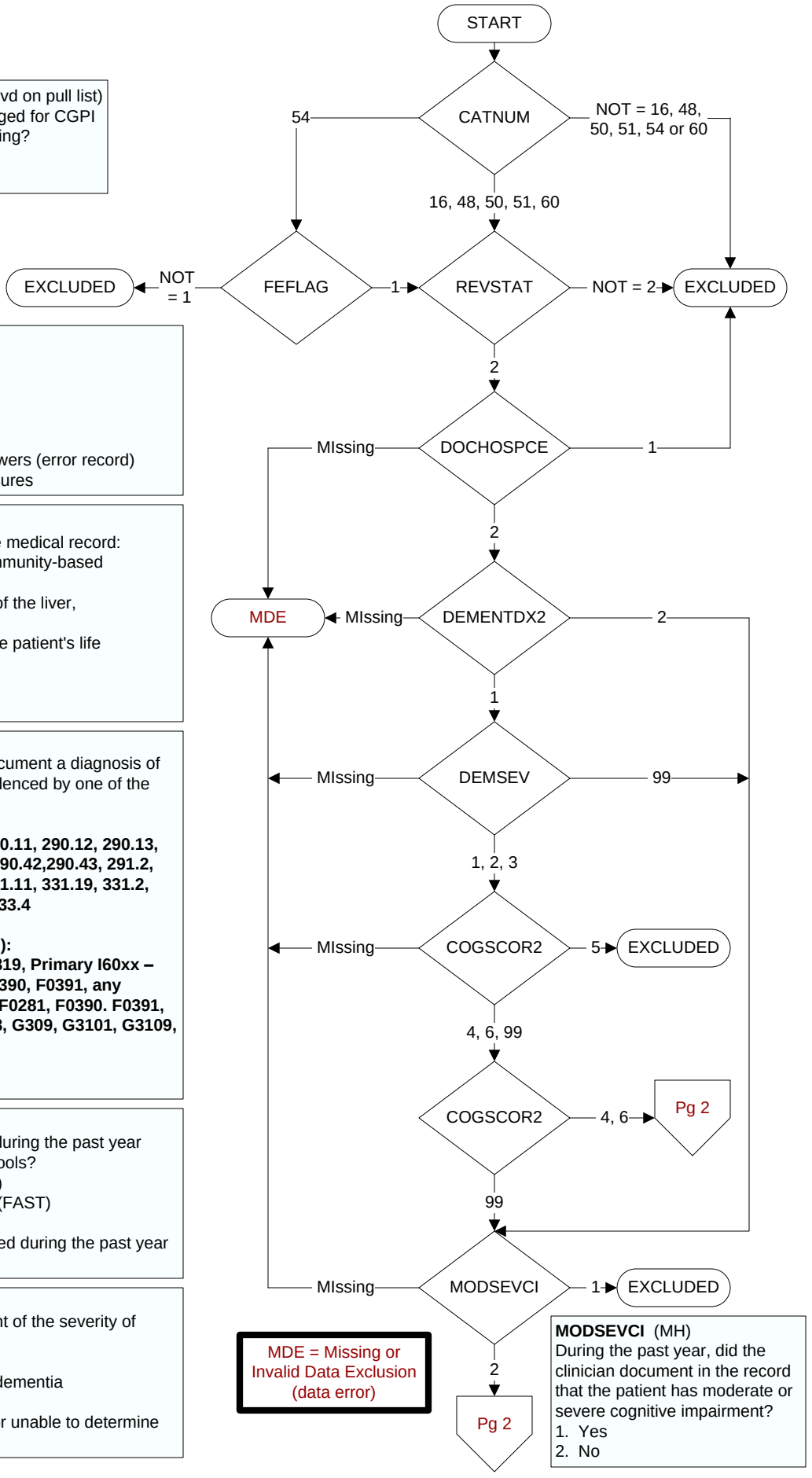
1. Yes
2. No

DEMENTDX2 (MH)
During the past year, does the record document a diagnosis of dementia/neurocognitive disorder as evidenced by one of the following:
ICD-9-CM codes (Prior to 10/01/15):
046.11, 046.19, 046.3, 290.0, 290.10, 290.11, 290.12, 290.13, 290.20, 290.21, 290.3, 290.40, 290.41, 290.42,290.43, 291.2, 292.82, 294.10, 294.11, 294.8, 331.0, 331.11, 331.19, 331.2, 331.7, 331.82, 331.89, 331.9, 333.0 or 333.4

ICD-10-CM codes (On or after 10/01/15):
A8100, A8101, A8109, A812, A8189, A819, Primary I60xx – I69xx + Secondary F0150 or F0151, F0390, F0391, any Primary xxx.xx + Secondary F0280 or F0281, F0390. F0391, F1027, F1997, G231, G300, G301, G308, G309, G3101, G3109, G3183, G903
1. Yes
2. No

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

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



MDE = Missing or Invalid Data Exclusion (data error)

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

PTSDX (MH)
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-9-CM code (prior to 10/01/15): **309.81**

ICD-10-CM code (on or after 10/01/15): **F431, F4310, F4312**

1. Yes
2. No

PTSRNPC (MH)
Within the past five years, was the patient screened for PTSD using the Primary Care PTSD Screen (PC-PTSD)?
1. Yes
2. No

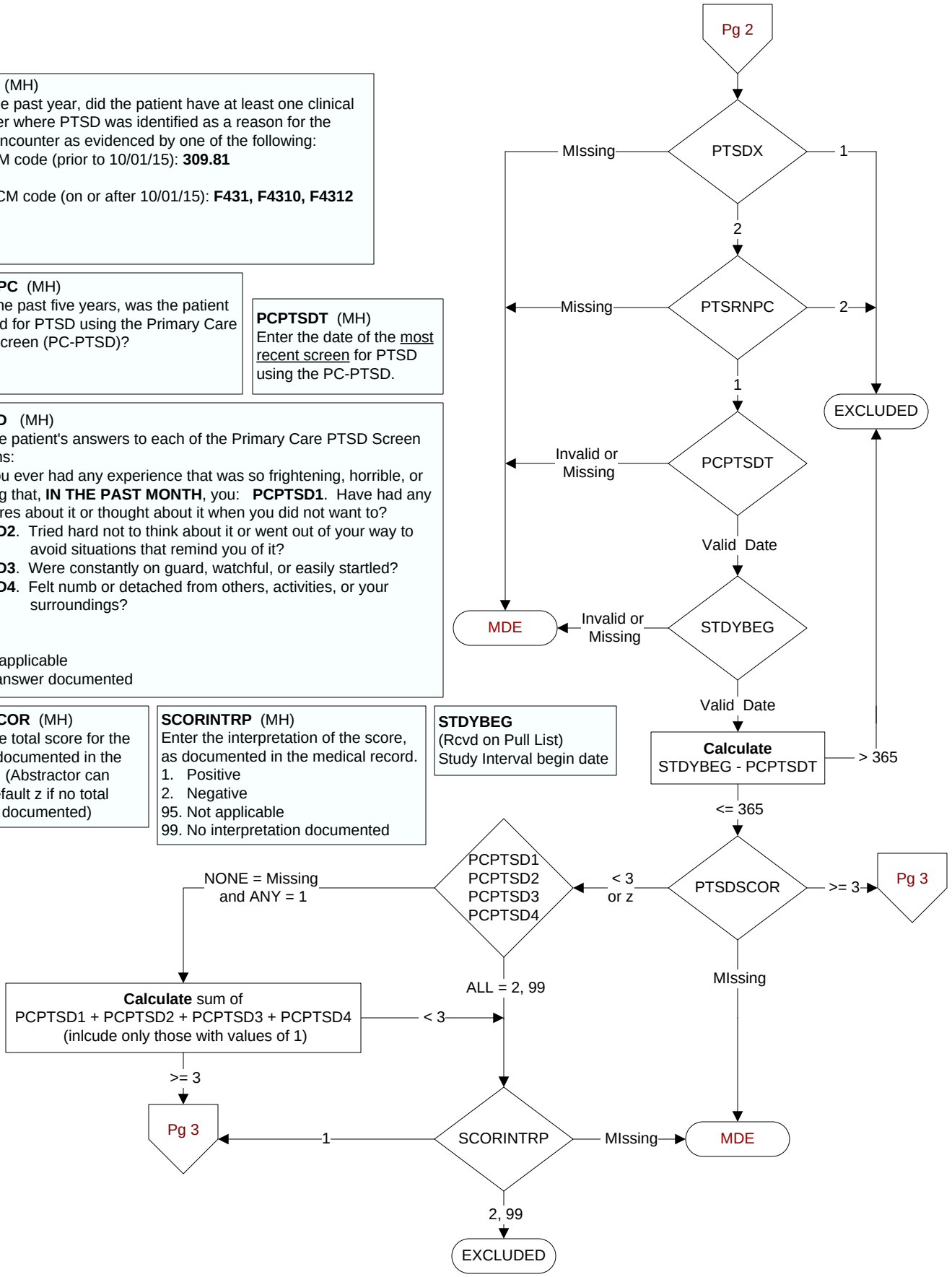
PCPTSDT (MH)
Enter the date of the most recent screen for PTSD using the PC-PTSD.

PCPTSD (MH)
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: **PCPTSD1**. Have had any nightmares about it or thought about it when you did not want to?
PCPTSD2. Tried hard not to think about it or went out of your way to avoid situations that remind you of it?
PCPTSD3. Were constantly on guard, watchful, or easily startled?
PCPTSD4. Felt numb or detached from others, activities, or your surroundings?
1. Yes
2. No
95. Not applicable
99. No answer documented

PTSDSCOR (MH)
Enter the total score for the screen documented in the record. (Abstractor can enter default z if no total score is documented)

SCORINTRP (MH)
Enter the interpretation of the score, as documented in the medical record.
1. Positive
2. Negative
95. Not applicable
99. No interpretation documented

STDYBEG
(Rcvd on Pull List)
Study Interval begin date



PTSDEVAL (MH)
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

NOPTSINT (MH)
Did the provider document the patient refused further evaluation/treatment for PTSD?
1. Yes
2. No

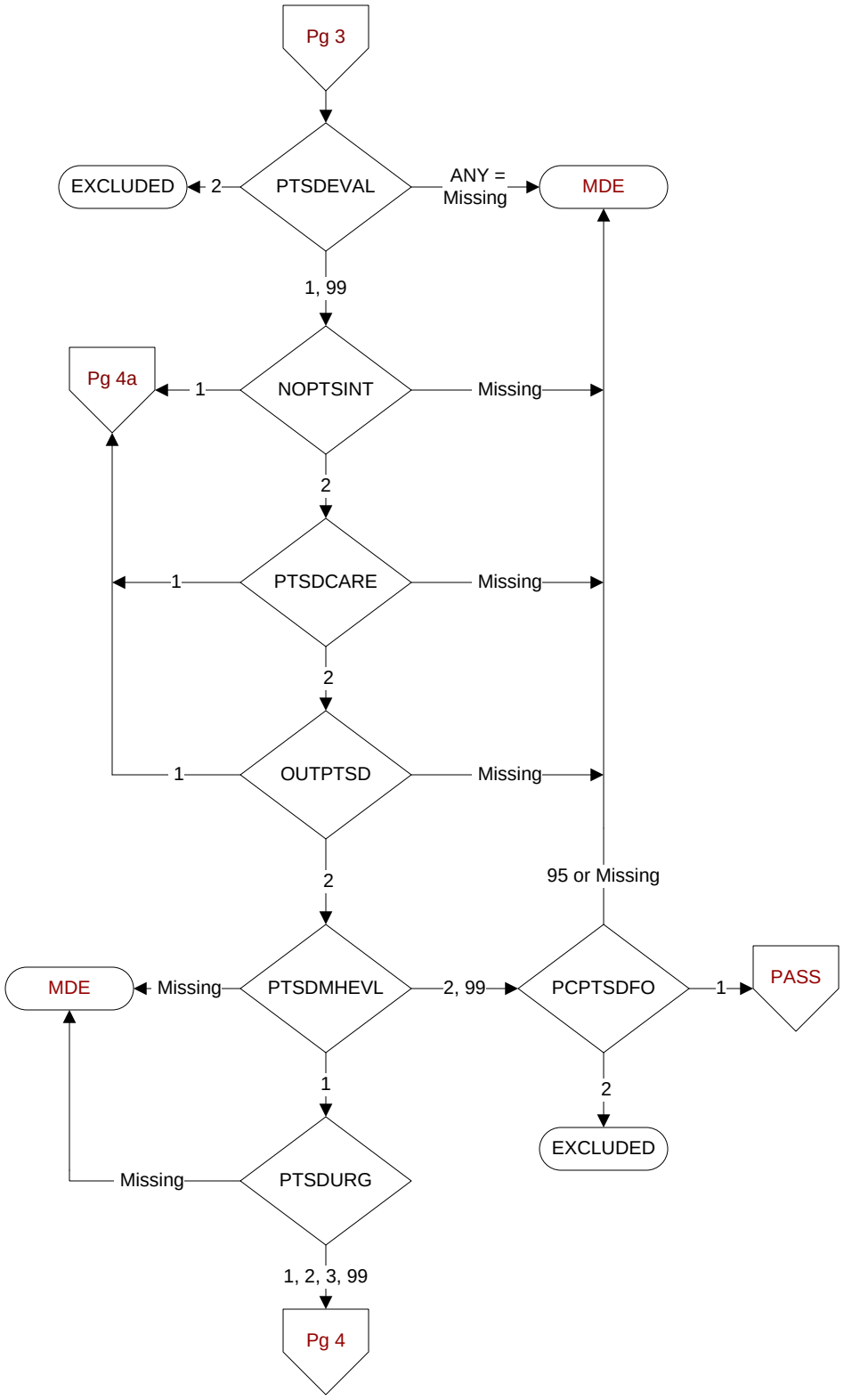
PTSDCARE (MH)
Did the provider document the patient was already receiving recommended care for PTSD?
1. Yes
2. No

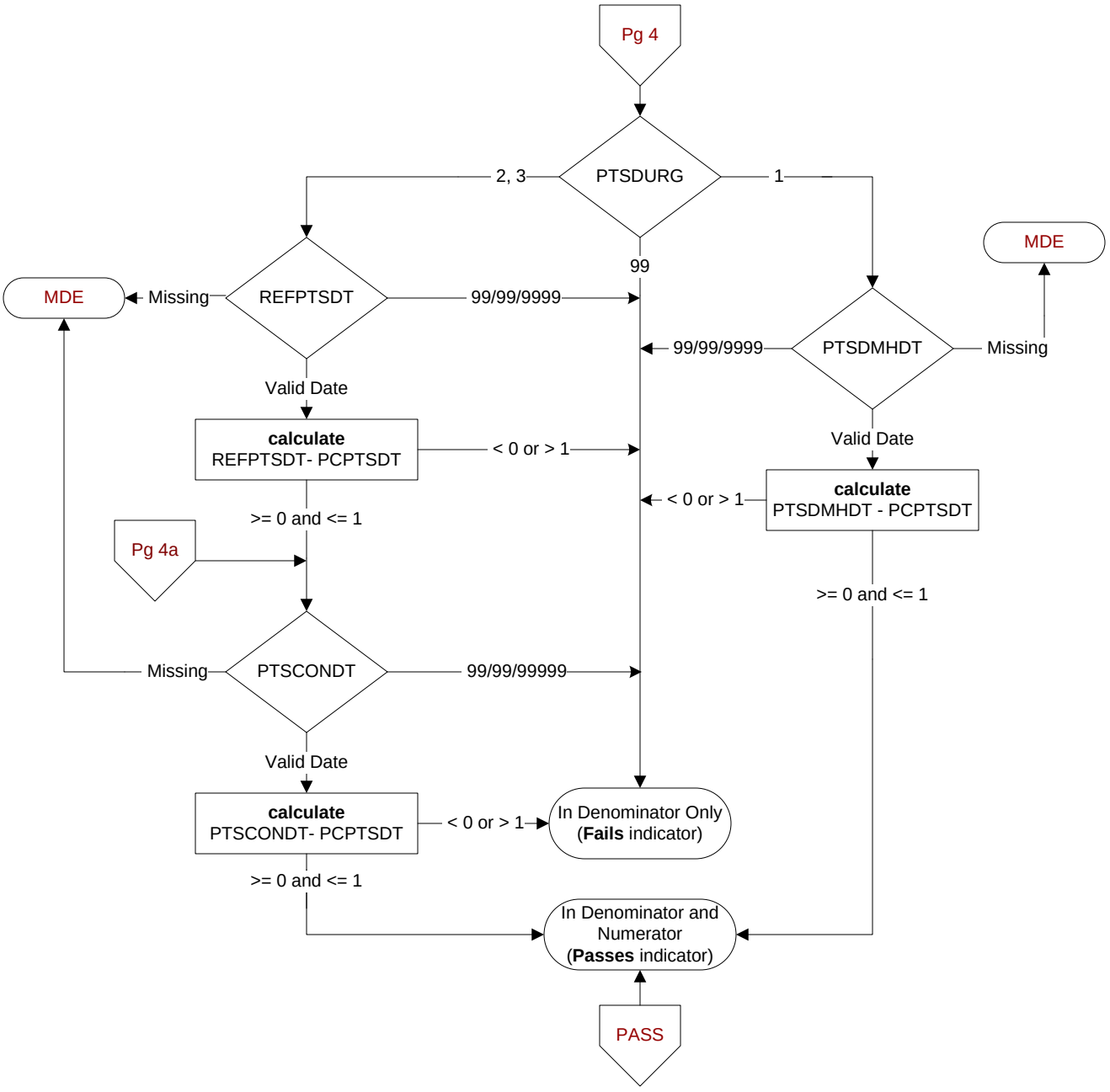
OUTPTSD (MH)
Did the provider document the patient was to receive care for PTSD outside this VA?
1. Yes
2. No

PTSDMHEVL (MH)
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

PCPTSDFO (MH)
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

PTSDURG (MH)
Following the positive 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





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

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

PTSCONDT (MH)
Enter the date the licensed independent provider documented that contact information was provided to the patient.