

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

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

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 data
 5. Administrative exclusion

FEFLAG (rcvd on pull list)
 FE case flagged for CGPI
 0. No
 1. Yes

HOSPICE (Validation)

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

DEMENTDX2 (MH)

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

A81.00, A81.01, A81.09, A81.2, A81.82, A81.89, A81.9, F01.50, F01.51, F02.80, F02.81, F03.90, F03.91, F10.27, F10.97, F13.27, F13.97, F18.17, F18.27, F18.97, F19.17, F19.27, F19.97, G23.1, G30.0, G30.1, G30.8, G30.9, G31.01, G31.09, G31.83, G90.3

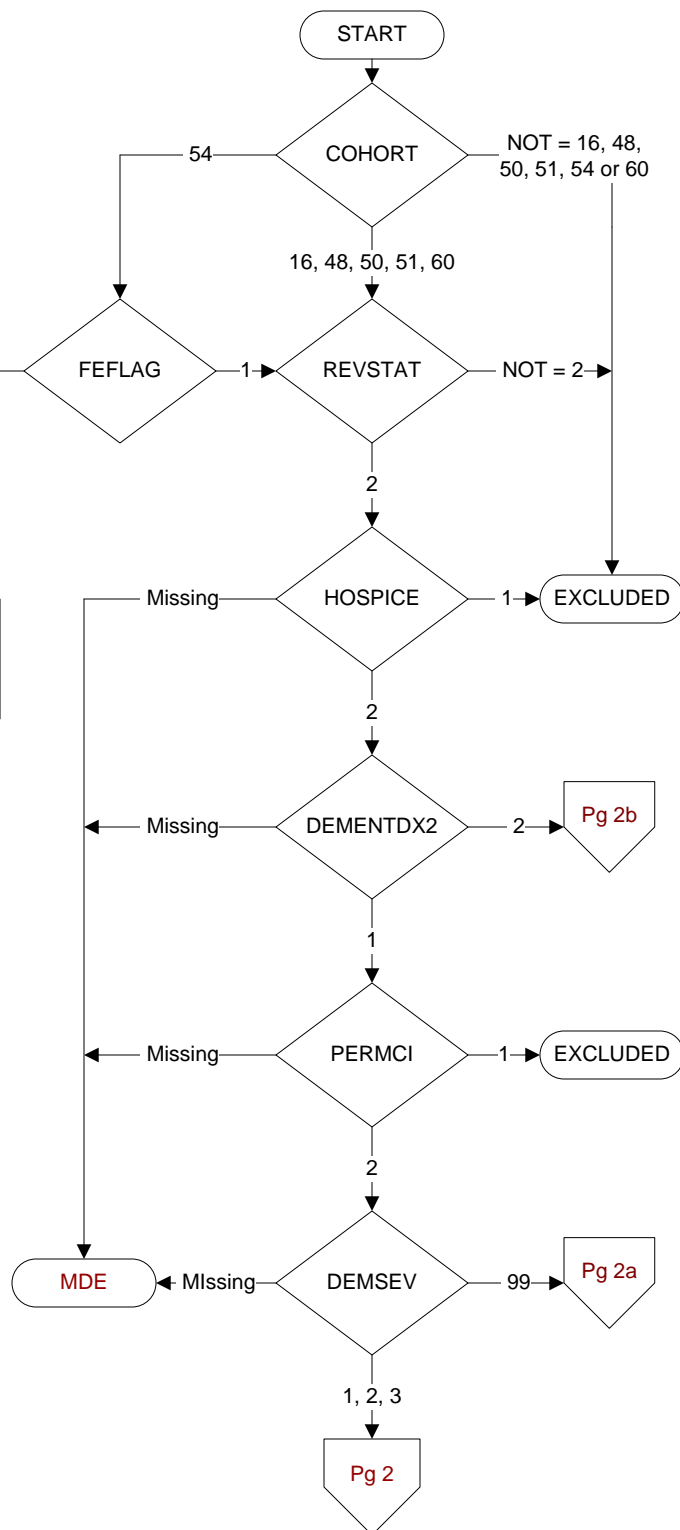
1. Yes
 2. No

PERMCI (MH)

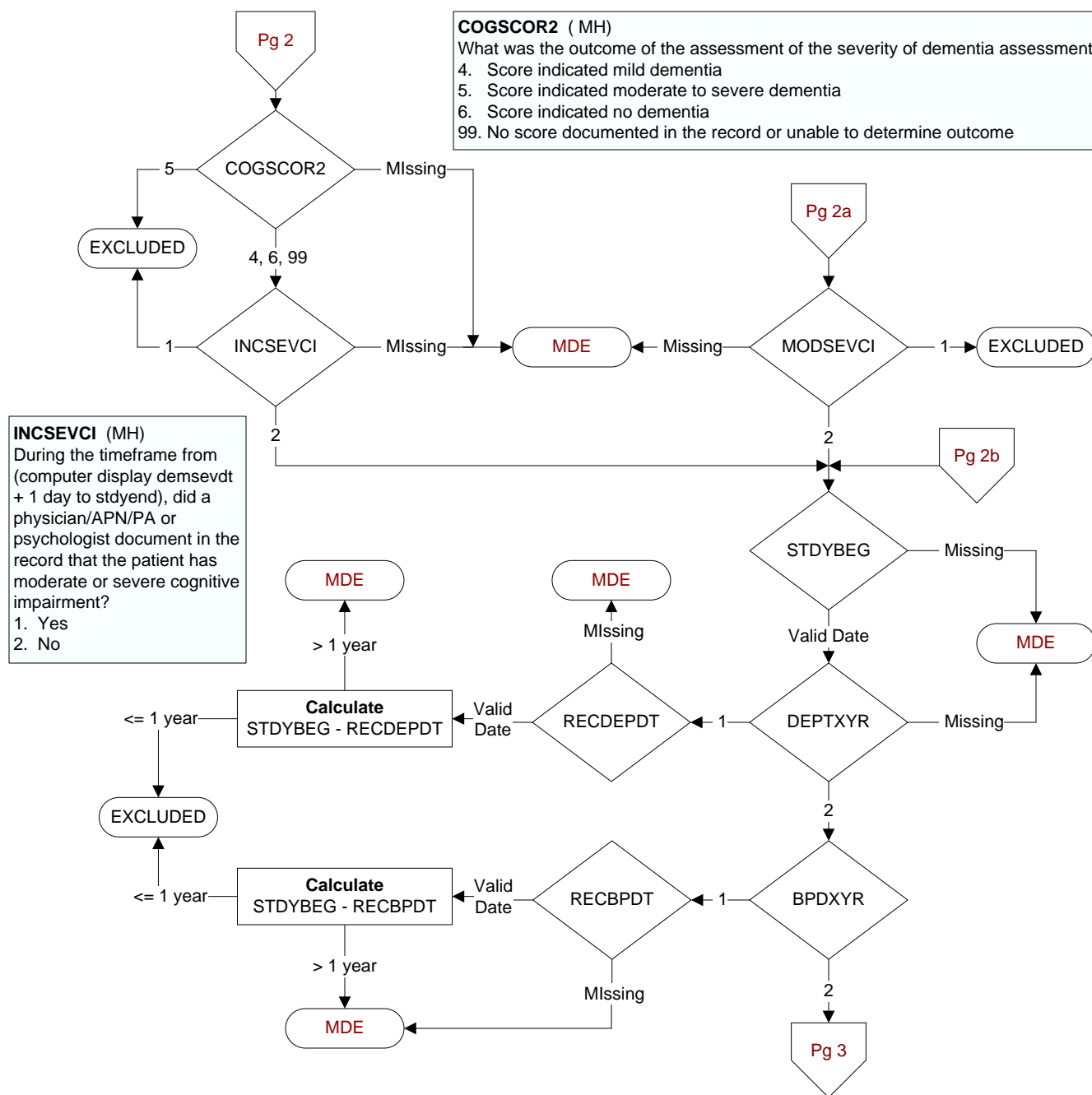
During the past year, did a physician/APN/PA or psychologist document that the patient has probable permanent cognitive impairment using a Clinical Reminder?
 1. Yes
 2. No

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



MDE = Missing or Invalid Data Exclusion (data error)



DEPTXYR (MH)

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, F33.0
- F33.3, F33.42, F33.9, F34.1, F43.21, F43.23**

1. Yes
2. No

RECDEPDT (MH)

Enter the date within the past year of the most recent clinical encounter where depression was identified as a reason for the clinical encounter.

MODSEVCI (MH)

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

RECBPDT (MH)

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.

BPDXYR (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-10-CM diagnosis codes:

**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

SCRPHQ2 (MH)
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

PHQ2DT (MH)
Enter the date of the most recent screening for depression by the PHQ-2.

PHQ1SCOR (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

PHQ2SCOR (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 questions documented in the medical record.

