EPRP UPDATE

4Q FY2018

Presentation Objectives

- The purpose of this presentation is to:
  - Highlight changes to existing questions
  - Discuss new questions and associated rules
  - Note new measures and changes to existing measures
- As always it is important to review the data collection questions sent to you by email in addition to reading these slides

GLOBAL MEASURES

EPRP INPATIENT INSTRUMENTS

Rule Changes

- The changes to the Global Instruments are basically rule changes
- There are no new or deleted questions
- *** Note that these changes are effective with discharges>=7/1/2018.

tobstatus2, auditc

- There are some changes for tobstatus2 and auditc that pertain to the rules around screening patients with cognitive impairment within the first day of admission
  - If there is documentation within the first day of admission **(by end of Day 1)** that the patient was psychotic, **symptoms of psychosis**, (e.g., hallucinating, non-communicative, catatonic, etc.), must also be documented for the patient to be considered cognitively impaired.
  - Documentation of "rule out" conditions, e.g. rule out psychosis, must also include documentation of symptoms in order to select value 97

notobmed, notobrxdc,

- "Patient is pregnant" has been added to the list of reasons for not prescribing one of the FDA-approved tobacco cessation medications during the hospital stay and at discharge
- Any documentation in the medical record indicating the patient is pregnant is sufficient to answer yes to notobmed and notobrxdc
  - Documentation of pregnancy does not have to be by a physician/APN/PA or pharmacist

tobmedc

- If nicotine replacement therapy (NRT) or a prescribed FDA-approved tobacco cessation medication is listed as a discharge medication but there is also documentation of refusal by the patient at discharge, **select Value "98."**

Inpatient Medication Reconciliation

- There are no changes to the Inpatient Medication Reconciliation module

Delirium Risk Module

- The only changes are to the examples of acceptable documentation in the definition/decision rules for q4 docorient
- **Examples of acceptable physician/APN/PA documentation of a current problem of disorientation include but are not limited to:**
  - A&O x 2
  - Oriented to self and place but not year
  - Disoriented

Global Measures Exit Report and Scoring

- The scoring check for a code on TJC Table 12.3 (pregnancy) has been removed from tob20 and tob40 effective with discharges >= 7/1/2018 (8/20/18 pull list)
  - As noted in a previous slide, pregnancy is now an acceptable reason for not prescribing an FDA-approved tobacco cessation medication during the hospital stay and/or at discharge and is captured in the applicable questions. The scoring will now check that instead of the code
- The discharge date parameter for all Global measures was extended to 12/31/2018

HBIPS

HBIPS

- There are several modifications to HBIPS for 4Q although most are minor.
- Most of the changes will be effective starting with abstraction of the 7/9 pull list and will be reflected in the "pre" HBIPS data collection questions
- A few changes in the restraint and seclusion rules will only be effective with discharges >= 7/1/2018 which you will see on the 8/20/2018 pull list

Substance use amount and frequency

- There is clarification (not new) to the rules for the question drugamt
  - If documentation indicates the patient was asked about the amount of substance use, but the patient is unable to quantify the amount, i.e., states, "I don't know how much"; it is acceptable to answer "Yes".
- The same clarification (not new) applies to the question drugfreq
  - If documentation indicates the patient was asked about the frequency of substance use, but the patient is unable to quantify the frequency, i.e., states, "I don't know how often"; it is acceptable to answer "Yes".

Alcohol Use Screening

- The following was added to the rules for pauditc for clarification
  - **All components of the screen for alcohol use must be documented in ONE note.**
- **Again, this is not a change to the rules, but was added for emphasis**

Alcohol Use Screening

- **Please note the following from the 4Q FAQs regarding the AUDIT-C**
  - Q: Can the nurse complete the AUDIT-C and the information then be imported into another note such as the H&P for the provider to assess type and problems due to past alcohol use in order to ensure that all elements of the HBIPS ips1 Alcohol Use Components are documented in one note?
  - A: Yes, as long as it is clearly documented which note the data is coming from; that is, the provider must at the very least state the note title, date, time and AUDIT-C score in order to receive credit.
  - Also, the original source must include the AUDIT-C questions, be completed within the required timeframe, and at a minimum have been completed by a Registered Nurse (RN).
  - Another option would be to copy and paste the AUDIT-C screening from the original source in its entirety, but again, a reference to that source must be clearly documented.

harmself

- The following rule was **deleted** from the question harmself
  - If the patient is admitted to psychiatric care for violence risk to self (e.g., suicidal thoughts) AND assessment of any of the components are documented, select value "1" for that component.
- Admission for suicidal thoughts is no longer a consideration when looking for documentation of the components of the harmself question
- You will need to look for documentation of screening for all the components with the past 6 month timeframe

Restraint and Seclusion Changes

- There are some minor wording changes in the rules for question 33 resevent
  - Mittens to prevent intentional self-harm (examples of physical restraints)
  - Methods that involve the physical holding of a patient to conduct routine physical examinations or tests and Restraint uses that are forensic or correctional restrictions applied and used by designated hospital security personnel to transport the patient to court off the locked unit. (Not included as restraints)
- Again, these changes will be noted beginning with July discharges

HBIPS Exit Report and Scoring Changes

- The only change to HBIPS scoring is to change the end discharge date parameter to 12/31/2018

VTE

VTE Changes

- There are multiple changes to the VTE instrument including changes to existing questions and rules and new questions
- Please read all highlighted areas carefully as some changes may not be covered in this presentation
- *** Note that these changes are effective with discharges>=7/1/2018.

arrvtedx

- Please review the changes to the definition/decision rules for arrvtedx
  - Examples of both acceptable and unacceptable documentation of VTE present on hospital arrival are included
  - Also, examples of acceptable and unacceptable orders for VTE diagnostic tests are in the rules

vtetest

- The timeframe for a diagnostic test has changed in q12 vtetest
  - Is there documentation that a diagnostic test for VTE was performed on the day of arrival or anytime during the hospitalization?
    - Previously the timeframe included 4 days prior to arrival
- Additional acceptable tests were also added to the bullet points in the question

posvte

- There are also extensive changes to q14 posvte
- The timeframe of 4 days prior to arrival was also deleted from this question and now is: **the day of arrival to anytime during hospitalization**
- The question now specifies a ***new/acute*** VTE
  - In cases where VTE is documented in a defined location, consider it a new or acute VTE unless described as otherwise, e.g., chronic. The terms "new" or "acute" do not need to be explicitly documented to select "Yes."

posvte

- More defined locations were added to pulmonary emboli
  - **pulmonary artery embolism**
  - **pulmonary trunk embolism,**
  - **saddle embolism**
- More defined DVT locations were added:
  - Intrahepatic IVC
  - Saphenofemoral junction WITH extension into the common femoral vein
  - Tumor thrombus in the IVC or another defined location
- Don't forget to review the examples in the definition/decision rules
  - There is also a list of VTE locations that are not included

vteproadm

- The timeframe in q16 vteproadm for administration of mechanical and/or pharmacological VTE prophylaxis has changed to:
  - between arrival date and the day before the VTE diagnostic test order date
  - In past quarters, the time period started with the hospital admission date
- Was mechanical and/or pharmacological VTE prophylaxis administered **between the arrival date** and the day before the VTE diagnostic test order date?
- The definition/decision rules also reflect this change

Reason For No **Mechanical** VTE Prophylaxis

- Questions 17-21 all address documentation of reasons for not administering mechanical prophylaxis for VTE
  - Specific reason(s)
  - Location of documentation in record of reason(s)

nomecpro

- Q17 has also changed with regard to the timeframe and now reads as follows:
- Is there physician/APN/PA or pharmacist documentation why mechanical VTE prophylaxis was not administered on the day**(s)** between arrival and the **day before** the VTE diagnostic test **order date?**

nomecpro rules

- There are also some important changes to the definition/decision rules regarding the exceptions to documentation of reasons for no mechanical VTE prophylaxis by a physician/APN/PA or pharmacist
  - **A validated risk assessment may be documented by a nurse, but should be documented within the same timeframe as the reason for no administration of VTE prophylaxis.**
  - For patients receiving anticoagulant therapy, including **continuous** IV heparin **infusion**, the day before the VTE diagnostic test order date, select "Yes." **Disregard IV heparin administered to flush/maintain patency of a line or dialysis equipment and IV heparin administered during an interventional procedure, e. g., cardiac catheterization**

nomecpro rules

- Please review the changes with regard to the rules about validated risk assessments
  - **Documentation of a low risk score without a copy of the validated risk assessment is acceptable, *if* the validated risk assessment tool used is mentioned in the note. See Inclusion Guidelines for Abstraction.**
  - **Documentation of low risk or no risk without mention of a score and the validated risk assessment tool, select "No."**

Validated Risk Assessments

- Low risk scores for included validated risk assessments have been added to the rules for nomecpro
  - **Caprini score of 0 (zero) – no need for prophylaxis.**
  - **Padua score of less than 4 (0-3)**
  - **IMPROVE score of 0 (zero) or 1 (one); or a probability of less than 1.5%**
- Risk assessment tools other than the three above are not to be considered in answering this question

Reason for no mechanical prophylaxis

- **Question 18 is new** and asks you to abstract all documented reasons for not administering mechanical VTE prophylaxis: rsnomec
- On the day(s) between arrival and the day before the VTE diagnostic test order date, what reason for not administering mechanical VTE prophylaxis is documented?

Select all that apply:

  - 1. Low risk score on a validated risk assessment tool (Caprini, Padua, IMPROVE)
  - 2. Explicit reason documented by physician, APN, PA or pharmacist
  - 3. Patient on anticoagulant therapy
  - 95. Not applicable
  - 98. Patient/family refusal of mechanical VTE prophylaxis

rsnomec

- Reasons must be mentioned in the context of a reason for not administering VTE prophylaxis
- The rules for question 18 include suggested data sources for this documentation
- If you select value 2 (explicit reason documented by physician/APN/PA or pharmacist), you will enter the reason in a free text box (q19 rsndomec)

Location of Reason

- Q20 is also new
- Select the location(s) where documentation of a reason for not administering mechanical VTE prophylaxis was found in the medical record.
  - **Select all that apply:**
  - 1. Consultation Note
  - 2. Discharge Summary
  - 3. Emergency Department Record
  - 4. History and Physical
  - 5. Medication Administration Record
  - 6. Nurses Notes
  - 7. Physician Orders
  - 8. Physician Progress Note
  - 9. Transfer form
  - 10.Validated Risk Assessment form
  - 11.Clinical Reminder
  - 12.Other

Location of Reason

- Be sure to select **ALL** locations where you found a reason for not administering mechanical VTE prophylaxis.
- If you select value 12 (other) you will need to enter the name of that location in q21 in a free text box

No **Pharmacological** VTE Prophylaxis

- Questions 22-26 are about reasons for no pharmacological VTE prophylaxis
- These questions mirror questions 17-21 except for the obvious difference in focus on pharmacological vs. mechanical
- It is important to read through each question and the rules carefully

VTE Exit Report and Scoring

- The only change you will note on the exit report format and to the scoring of vte6 is that the end discharge date parameter changed from 6/30/2018 to 12/31/2018.

EPRP OUTPATIENT INSTRUMENTS

HOP

HOP

- There are no changes to the 4Q HOP instrument, exit report, or scoring

CGPI

4QFY2018 CGPI Changes

- There are multiple changes to the CGPI data collection questions
- Most of the changes are in the Mental Health module
- Modules with *no* changes:
  - Validation
  - CVD
  - Diabetes
  - Shared

CGPI Core Module Changes

- Instructions regarding Telehealth blood pressure monitoring have been added to the definition/decision rules of Core Module question 1 (vhabps/vhabpd)
  - **Telehealth BP Monitoring**: Remote monitoring device blood pressure readings directly transmitted to a clinician or directly observed by a clinician through video conferencing, may be included in the CPRS vital signs package.
  - Documentation in the medical record note **must state that the reading was taken by a VA issued electronic device; transmitted directly to a clinician or directly observed by a clinician through video conferencing and the results are interpreted by a clinician**.
  - **NOTE: Telehealth BP Monitoring is not the same as Care Coordination (CC/H) electronic capture of BP.**
    - **BP captured by CC/H will be entered in a subsequent question**

Outpatient Medication Reconciliation

- There is a skip change in the OP Medication Reconciliation module
- If none of the essential medication list components are documented (i.e. optmed1-6 all = 2) you will go to the question opmedlst2
- In this scenario you will skip the location question and the question about patient/caregiver involvement

Location of List

- Q3 has been renamed opmedloc
- The list of data sources now is the same as the priority list in the question optmed
  - 1. Medication Reconciliation or Medication Review Note
  - 2. Essential Medication List for Review Note (EMLR)
  - 3. Clinical Pharmacy or Pharmacy Note
  - 4. Provider Note
  - 5. Nursing Note
  - 6. Other

Prevention Module

- The validation/location questions for documentation of hospice have been removed
- Hospice care will no longer be flagged on the pull list

Mental Health Module

- There are major changes to depression and PTSD screening
- Several new questions have been added
- Please review all highlighted sections in the data collection questions document carefully as well as this presentation
- The new questions and changes will be reflected in new measures

Depression Screening

- This section has major changes and new questions
- We will start by reviewing the questions related to the PHQ-2
- After completing that path, the slides will continue with the PHQ-2 + i9

Depression Screening

- Q21 (scrphq2) is a new question, although it collects familiar information
  - During the past year was the patient screened for depression by the PHQ-2?
    - 1. Yes
    - 2. No
- The rules for abstracting the PHQ-2 haven't changed BUT there is an important new NOTE
  - **For depression screening completed on or after 10/01/2018, the VHA will only accept screening completed with the PHQ-2 +I9**
  - ***Please be sure your facility liaison is aware of this upcoming change!***

PHQ-2

- If the patient was screened using the PHQ-2 you will enter the patient's responses in questions 25 and 26, total score in q27 and the outcome in q28
- This is not a change

Outcome3

- Q28 (outcome3) has some wording changes but is capturing the some information as before, i.e. you are looking for documentation of the interpretation of the score, i.e. positive or negative
  - 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 in the record, enter "99."

Suicide Risk Assessment

- You will get question 31(deprisk) about a Suicide Risk Evaluation (SRE) if the patient was screened with the **PHQ-2** and
  - the score of either question was 3 or
  - the total score documented in the record is =>3
  - or the outcome is documented as positive

deprisk

- The current rules for q31 (deprisk) have not changed
- The rules for acceptable provider documentation remain the same as in previous quarters
- **Acceptable Provider Documentation of Suicide Risk Evaluation:**
  - 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 the suicide risk evaluation was completed. 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.
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deprisk (cont.)

- However there are important additions to the rules for deprisk
  - **On or after 10/01/18, suicide risk assessment must be completed on the same calendar date as the PHQ-2 + I 9**
  - **Completion of the Columbia-Suicide Severity Rating Scale (C-SSRS) screener is also acceptable when completed by an acceptable provider**
    - **The definition/decision rules display the questions of the C-SSRS**
    - **As with any standardized instrument, it is important to be sure it is documented correctly in order to be acceptable**

PHQ-2 + I9

- If the patient was not screened with the PHQ-2 in the past year, **Q23 (scrphqi9)** asks if the patient was screened with the **PHQ-2 +I9** during the past year
- **PHQ-2 +I9 = Patient Health Questionnaire (2 questions - scaled) plus item 9 of the PHQ-9**
  - 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?".
  - **Item 9 question:** 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?
- **Item 9 must be included as part of the PHQ-2 + I9 tool. Do not accept screening for depression by the PHQ-9 or stand-alone item 9 to answer scrphqi9**

PHQ2 = I9 (continued)

- Documentation of the stem time frame (i.e., over the past 2 weeks) in the questions is not required at this time.
- **PHQ-2 +I9 completed during inpatient hospitalization is not acceptable.**
- **Acceptable setting for depression screening:**
  - outpatient encounter
  - screening by telephone and
  - televideo (real time) with face-to-face encounter between the provider and patient
- You will enter the date within the past year of the most recent screening for depression by the PHQ-2+I9 in question 24

Depression Screening

- Please note that some facilities may not yet be using the PHQ-2 + I9 for depression screening. Please be sure to abstract carefully and answer the scrphq2 and scrphqi9 questions correctly based on the documentation

Item 9

- Q29 will capture the patient's response to item9 when screened with the PHQ-2 + I9
- Enter the score for item 9/question #3 of the PHQ-2 + I9 screen 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
  - 99. No answer documented
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Item 9 (continued)

- **Rules for answering ph9scor:**
  - 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 item 9/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

Interpretation item 9

- You will enter the interpretation of item9/question 3 of the PHQ-2 + I9 in Q30 (outcomei9)
  - **The interpretation (positive or negative) of item9/question #3 in the PHQ2 + I9 screen score must be documented in the record**
  - **If the record contains both a 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**

SRE for positive PHQ-2 +I9

- If the outcome of screening with the PHQ-2 + I9 is positive and/or ph9scor=1, 2, or 3, you will go to question 33 (cssrs)
- On (computer to display **phqi9dt),** the day of the positive **I 9**, did the acceptable provider complete the Columbia-Suicide Severity Rating Scale (C-SSRS) Screener?
  - 1. Yes
  - 2. No
  - 98. Patient refused to complete the C-SSRS screener
- The questions for the C-SSRS are included in the definition/decision rules
- **The C-SSRS screener must be completed on the same calendar date as the positive I9**

C-SSRS

- In questions 34-41 you will enter the score (patient's responses) for the questions of the Columbia screener as applicable
- As always, software skips will take you to appropriate questions based on previous answers

Columbia Interpretation

- In q42 (outcome4) you will enter the interpretation of the C-SSRS screener as documented in the record (i.e. positive or negative)
- Any of the following would result in a positive Columbia Screen.
  - YES to Question 3: Have you been thinking about how you might do this? (Time period over the past month) OR
  - YES to Question 4: Have you had these thoughts and had some intention of acting on them? (Time period over the past month) OR
  - YES to Question 5: Have you started to work out or worked out the details of how to kill yourself? (Time period over the past month) OR
  - YES to Question 8: Was this within the past 3 months?

VA CSRA

- Q43 (vacsra)
- On (computer to display **phqi9dt),** the same calendar day as the positive C-SSRS and positive I9, is there evidence of **a signed VA Comprehensive Suicide Risk Assessment (CSRA)** in the record?
  - 1. Yes
  - 2. No
  - 98. Patient refused to complete CSRA
- Hint: The title of the note with documentation of this assessment likely will be: Suicide Risk Assessment-Comprehensive

VA CSRA

- **The Comprehensive Suicide Risk Assessment must be completed *and signed* on the same calendar date as the positive I9 and the C-SSRS screener**
- The CSRA is a 21 page template and must be completed by an acceptable provider
- For a "provider" to be deemed acceptable for the CSRA he/she must be an MD, DO, PhD or PsyD Psychologist, LCSW, LCSW-C, LMSW, LISW, LMFT, LPMHC, APN, PA, or clinical pharmacist (RPH/PharmD).
  - Trainee in ANY of these categories may complete a suicide risk evaluation *with appropriate co-signature*.
  - Note: RNs are *not* an acceptable provider for the CSRA

CSRA

- CSRA can be performed **face-to-face, by telemedicine, or by telephone** as long as the acceptable provider – patient exchange is documented in the medical record and accurately reflects the encounter

CLINICAL IMPRESSION OF ACUTE RISK

- Q44 (vacsraacu)
- Enter the Clinical Impression of Acute Risk as documented in the medical record:
  - 1. High Risk - (as evidenced by):
  - 2. Intermediate Risk – (as evidenced by):
  - 3. Low Risk – (as evidenced by):
  - 99. Acute risk not documented
- Only one risk level is selected by the acceptable provider and an explanation is provided in the "as evidenced by section" for that risk level.
  - Note: This item must be completed and cannot be left blank.

CLINICAL IMPRESSION OF CHRONIC RISK

- Q45 (vacsrachr)
- Enter the Clinical Impressions of Chronic Risk as documented in the medical record:
  - 1. High Risk - (as evidenced by):
  - 2. Intermediate Risk – (as evidenced by):
  - 3. Low Risk – (as evidenced by):
  - 99. Chronic risk not documented
- Only one risk level is selected by the acceptable provider and an explanation is provided in the as evidenced by section for that risk level.
  - Note: This item must be completed and cannot be left blank

CSRA Interventions

- Q46 vacsraint
- If a signed CRSA was completed, you will answer q46 by **selecting all interventions** documented by the acceptable provider in the VA-CSRA template
- The provider may add additional comment/interventions as needed as indicated by [text box].
  - If the provider does not have any documentation in the text box for the applicable options, do not select that option as an intervention
  - For example, if there is nothing in the text box after follow up appointments, do not select that as an intervention

Depression Disposition

- Q47 (depeval) will likely seem familiar to you from past quarters
- On (computer to display phq2dt or phqi9dt), did the provider document the patient needed further intervention for the positive depression screen?
  - 1. Yes, documented further intervention needed
  - 2. Documented no further intervention needed
  - 98. Documented patient refused further intervention for positive depression screen
  - 99. No documentation regarding further intervention
- See the definition/decision rules for acceptable providers who can document the need for further intervention

Further Interventions

- If the answer to depeval=1 you will go to q48 (depfolint) where you will indicate all interventions documented by an acceptable 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
  - 6. Documented provider contact information was provided to the patient
  - 7. Documented emergency contact information was provided to the patient
  - 99. None of the above documented

PTSD

- There are changes in the PTSD series of questions that mirror those in the depression screening questions
- The PC-PTSD tool is currently acceptable for screening, but
- **For PTSD screening completed on or after 10/01/2018, the VHA will only accept screening completed with the PC-PTSD5+I9.**
- **Again, it is important to share this information with your facility liaison and refer them to the data collection questions available on the Quality Insights website**

PC-PTSD+I9

- **The PC-PTSD5 +I9 is a five item screen plus item 9 of the PHQ-9**
- **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.**

PC-PTSD+I9

- **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?

PC-PTSD+I9

- **Item 9 (or question 6) must be included as part of the PC-PTSD5 + I9 tool**
  - **Do not accept screening for PTSD by a stand-alone item 9**
- **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?
- A PC-PTSD5 +I9 completed during an inpatient hospitalization is not acceptable.
- **Acceptable setting for PTSD screening:**
  - outpatient encounter
  - screening by telephone and
  - televideo (real time) with face-to-face encounter between the provider and patient

SRE

- The PTSD series of questions also includes use of the Columbia screener for follow up of positive screens as well as the CSRA and the follow up intervention questions
- Since all questions follow the same pattern as the depression screening series, details will not be repeated here
- **Please note: If the patient has a positive PHQ-2+I9 and a positive PC-PTSD5 +I9 on the same day, you should only expect to see the C-SSRS and the CSRA once on that day**

CGPI Exit Report and Scoring

- Changes to the CGPI exit report all are related to the changes in the Mental Health module
- There are 7 new **pilot** measures:
  - sui40: Primary suicide risk screening while screening for depression
  - sui51: Primary suicide risk screening while screening for PTSD
  - sui2: Timely secondary suicide risk screening
  - csra1: Timely VA comprehensive suicide risk assessment
  - csra2: Evidence of clinical impression of acute risk on VA CSRA
  - csra3: Evidence of clinical impression of chronic risk on VA CSRA
  - csra4: Evidence of risk mitigation on VA CSRA
- Please see the 4Q Exit Report Guide for scoring information

CGPI Exit Report and Scoring

- There are also changes to 4 existing measures due to new questions
  - ptsd51: Screened for PTSD at required intervals with PC-PTSD
  - ptsd52: Positive PC-PTSD screen with timely suicide evaluation
  - mdd40: Screened for depression with PHQ-2
  - mdd41: Positive depression screen with timely suicide evaluation
- Changes will be reflected in the 4QFY2018 CGPI Exit Report Guide

HBPC

Q15 newmedrx

- The definition/decision rules for question 15 (newmedrx) have been updated with an exclusion note
- **Exclude: medications noted as prescribed, added or identified as a result of an inpatient admission**

Home Oxygen Safety Risk Assessment

- Some additional changes and a new question have been added to the home oxygen series of questions
  - The goal is to increase the reliability of the questions
  - There is no change to question intent
- Q35 asesoxydt asks you to enter the date of the most recent home oxygen safety risk assessment that was documented by an HBPC team member during a face to face encounter
  - The date may <=30 days prior to or = to the date of HBPC admission and <= 30 days after HBPC admission
- The date that you enter in q35 will then be displayed in q36 (oxyedu) as the date you are looking for education on home oxygen safety

Recommended Interventions

- Q37(oxyrec): Examples of recommended interventions to address identified oxygen safety risks have been placed under the question for easier reference
  - The same examples are bolded in the definition/decision rules
- Remember these are only examples, but should help guide you re: acceptable documentation for this data element

Response to Interventions

- Q38 (oxyrecres): As with q37, examples of response to interventions have been placed under this question for easier reference

Depression Screening

- There are changes to the depression screening series of questions
- The changes mirror those in CGPI although not all the new CGPI questions are included in HBPC
- The same important note is included in the scrphq2
  - **For depression screening completed on or after 10/01/2018, the VHA will only accept screening completed with the PHQ-2 +I9**
- Also in deprisk
  - **On or after 10/01/18, suicide risk assessment must be completed on the same calendar date as the PHQ-2 + I9 (positive I9) depression screen.**

SRE

- The **Columbia-Suicide Severity Rating Scale (C-SSRS)** screener has also been added to the HBPC question deprisk as acceptable for suicide risk evaluation

Follow Up Evaluation

- Q57 deplan
- Be sure to follow the guidance in the definition/decision rules when looking for documentation of follow up **related to the positive PHQ-2**
- Suggested data sources have been added to the rules

Screening for PTSD

- Q61 (ptsrnpc) includes an important note; please be sure facility staff are aware
  - **For PTSD screening completed on or after 10/01/2018, VHA will only accept screening completed with the PC-PTSD5 +I9**
- Q66 (ptsdrisk) includes the same guidance regarding the Columbia-Suicide Severity Rating Scale (C-SSRS) as previously noted in deprisk

HBPC Exit Report and Scoring

- There are no changes to the HBPC exit report
- The only scoring change is to include the new question scrphq2 in scoring hc38, 39 and 40 instead of phq2dt

Wrap Up

- We can't emphasize enough the importance of studying the question and scoring changes
- Remember that the facility liaisons have access to this presentation on the Quality Insights website but you may need to remind them of this
- It is also important for you to review the significant changes with facility staff during the 1st exit conference of each quarter
- Ask questions as needed!
- Thanks for your good work!