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

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

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

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?

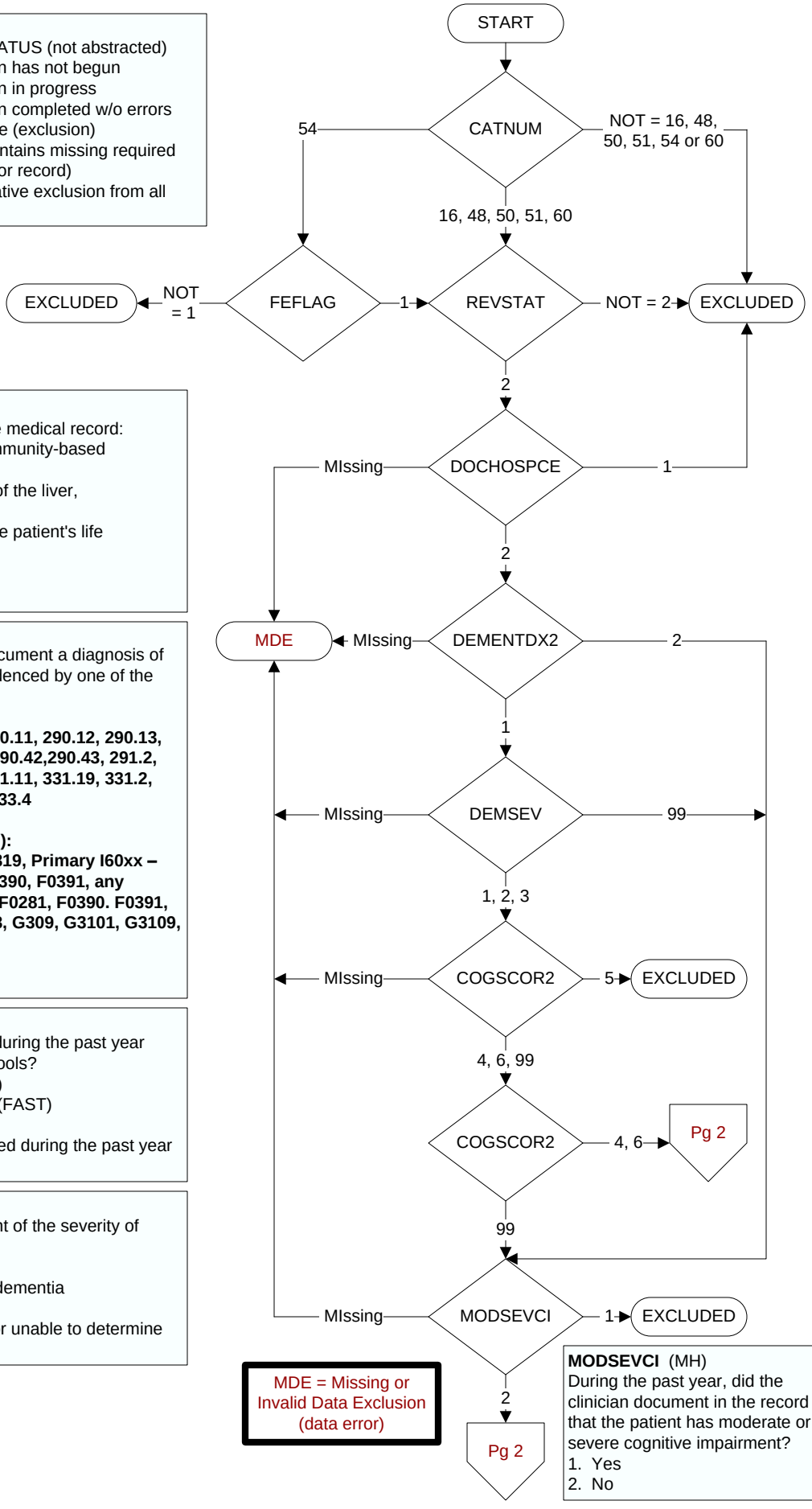
1. Yes
2. No

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

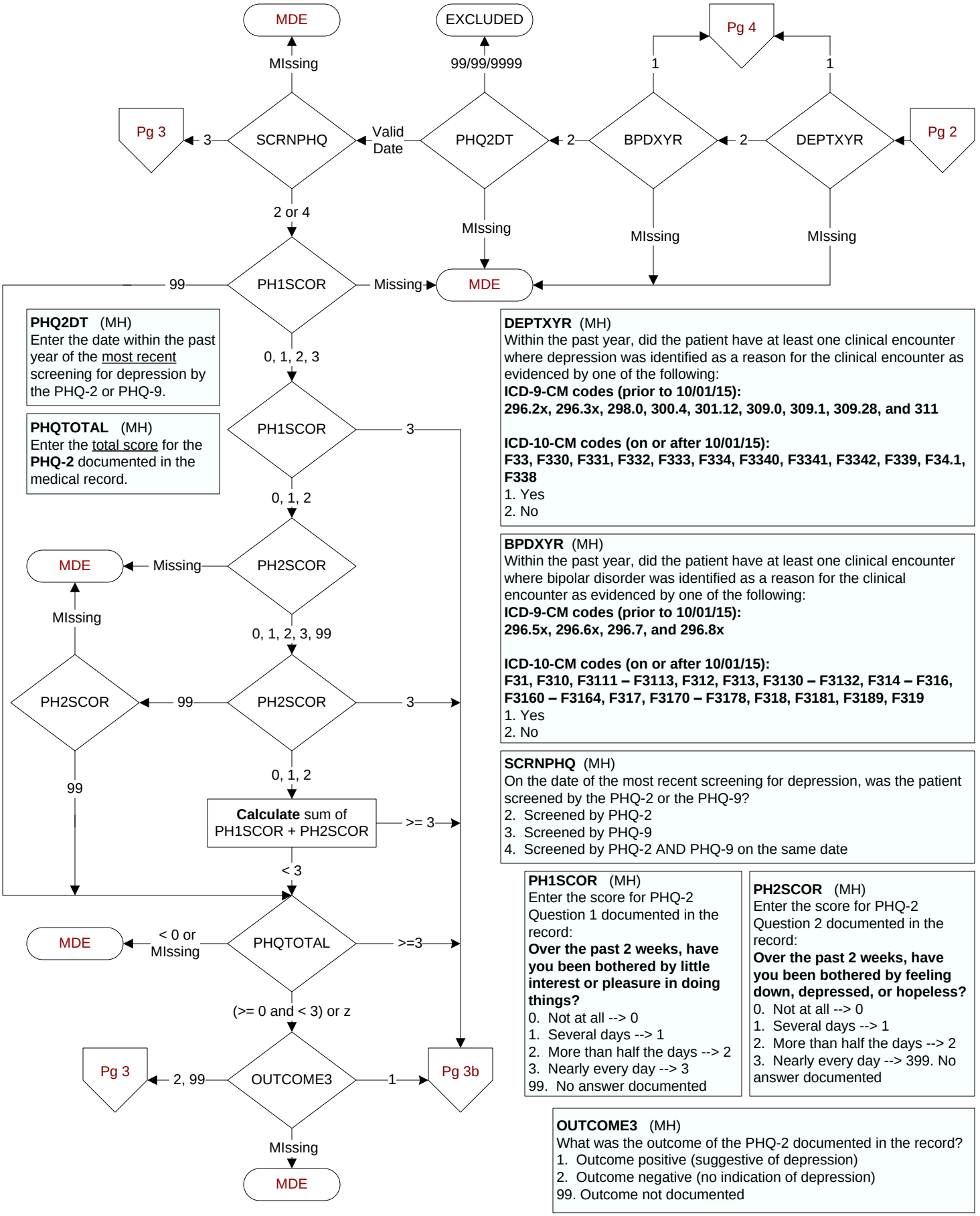
DEMSEV (MH)
Was the severity of dementia assessed during the past year using one of the following standardized tools?
1. Clinical Dementia Rating Scale (CDR)
2. Functional Assessment Staging Tool (FAST)
3. Global Deterioration Scale (GDS)
99. Severity of dementia was not assessed during the past year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



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

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

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-9-CM codes (prior to 10/01/15):
296.2x, 296.3x, 298.0, 300.4, 301.12, 309.0, 309.1, 309.28, and 311

ICD-10-CM codes (on or after 10/01/15):
F33, F330, F331, F332, F333, F334, F3340, F3341, F3342, F339, F34.1, F338
1. Yes
2. No

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-9-CM codes (prior to 10/01/15):
296.5x, 296.6x, 296.7, and 296.8x

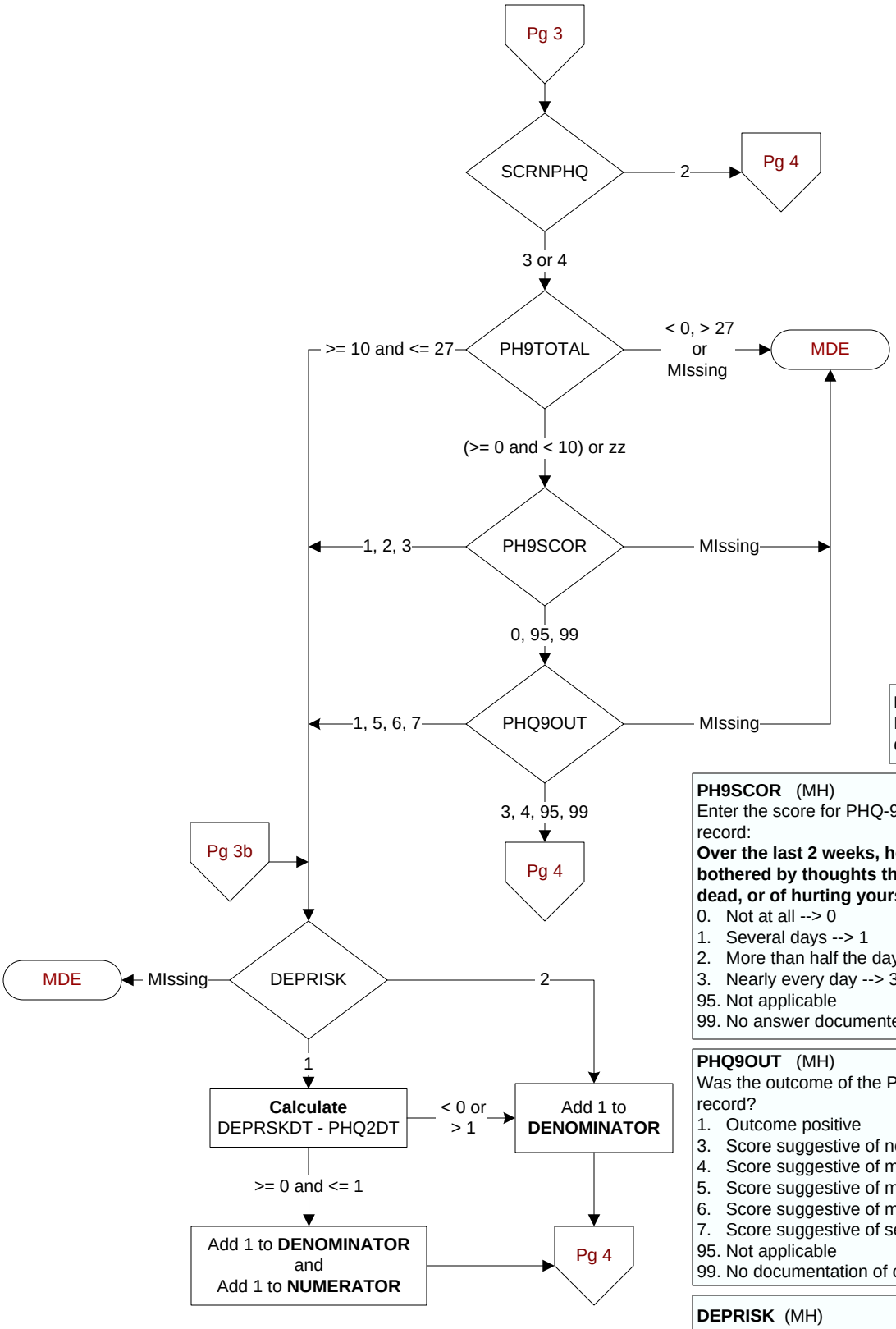
ICD-10-CM codes (on or after 10/01/15):
F31, F310, F3111 – F3113, F312, F313, F3130 – F3132, F314 – F316, F3160 – F3164, F317, F3170 – F3178, F318, F3181, F3189, F319
1. Yes
2. No

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 --> 399. No answer documented

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

DEPRISK (MH)
Following the positive PHQ-2 or PHQ-9 depression screen or affirmative answer to PHQ-9 question 9, did the provider document a suicide ideation/behavior evaluation?
1. Yes
2. No

DEPRSKDT (MH)
Enter the date of the suicide ideation/ behavior evaluation.

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

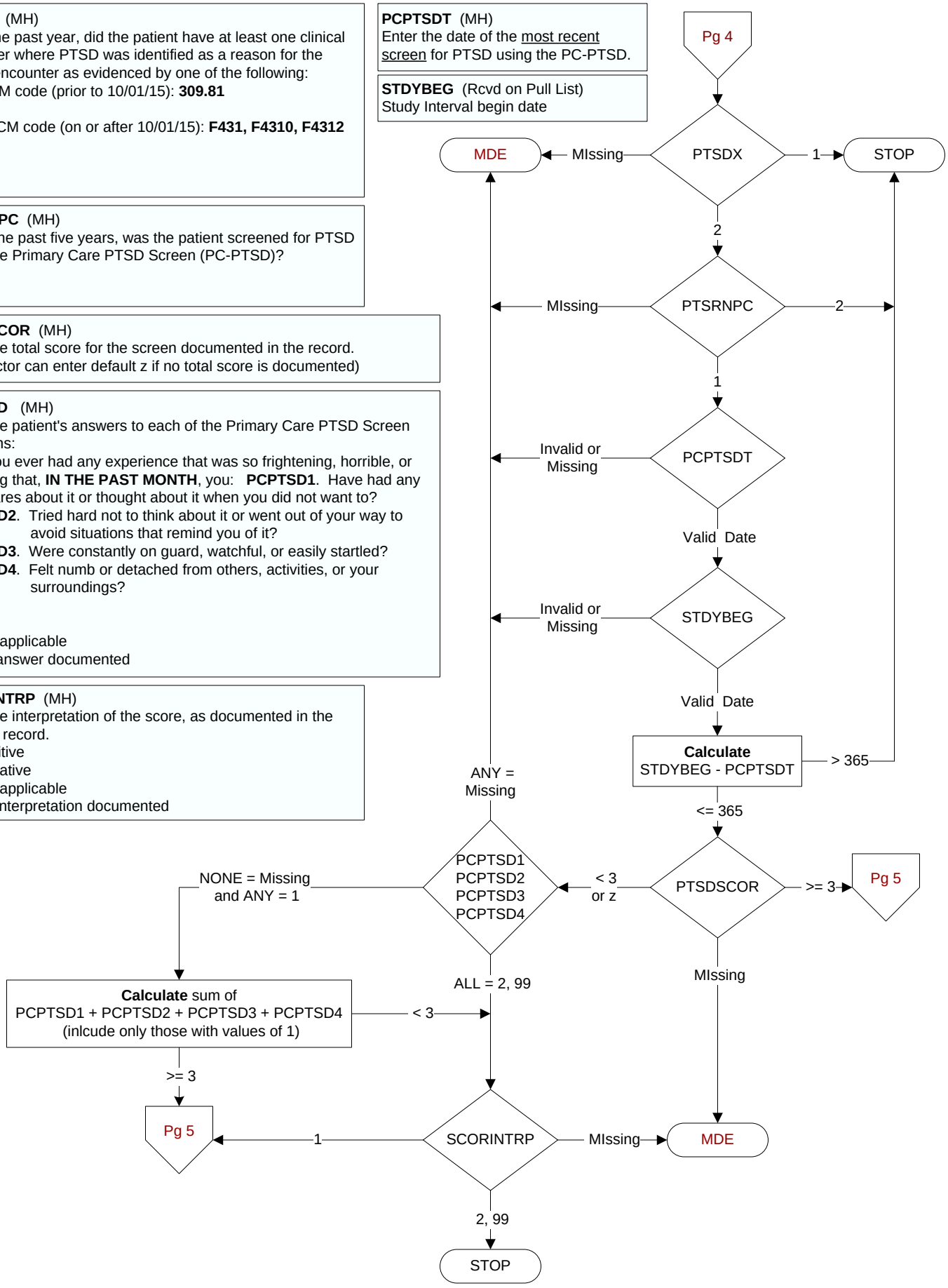
PTSDSCOR (MH)
Enter the total score for the screen documented in the record.
(Abstractor can enter default z if no total score is documented)

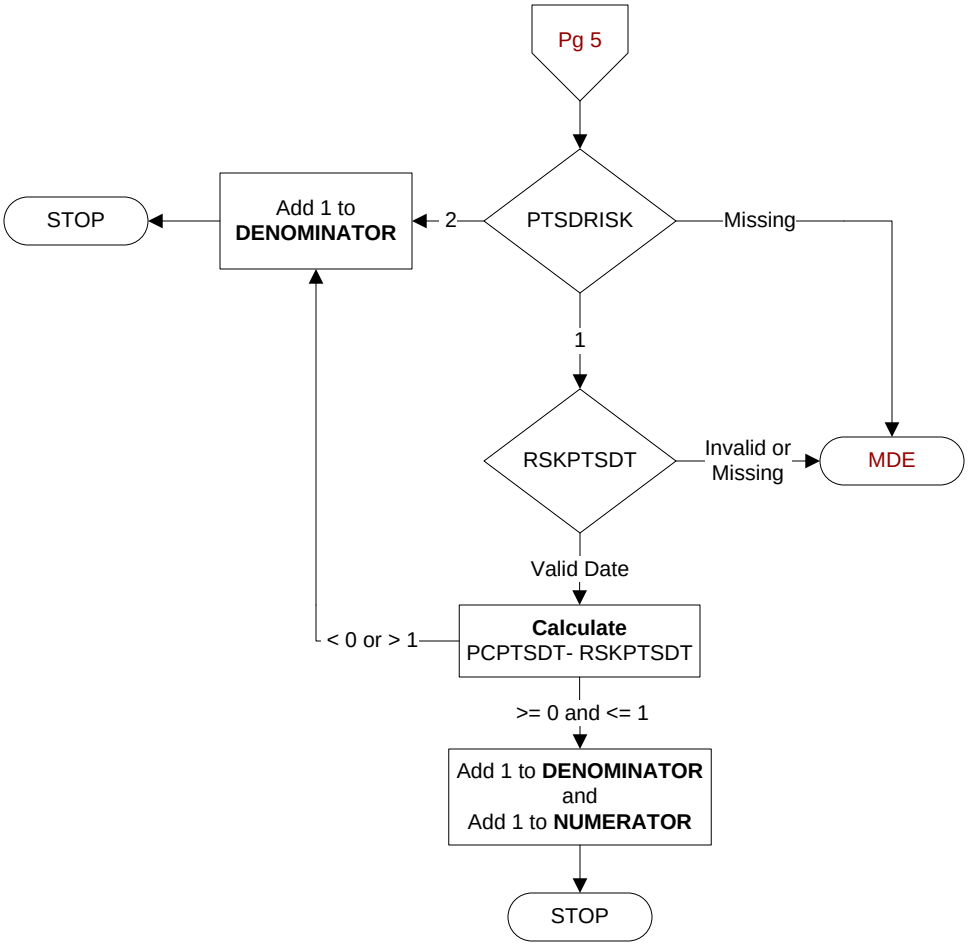
PCPTSD (MH)
Enter the patient's answers to each of the Primary Care PTSD Screen questions:
Have you ever had any experience that was so frightening, horrible, or upsetting that, **IN THE PAST MONTH**, you: **PCPTSD1**. Have had any nightmares about it or thought about it when you did not want to?
PCPTSD2. 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

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

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

STDYBEG (Rcvd on Pull List)
Study Interval begin date





PTSDRISK (MH)
Following the positive PC-PTSD screen, did the licensed independent provider document a suicide ideation/behavior evaluation?
1. Yes
2. No

RSKPTSDT (MH)
Enter the date of the suicide ideation/behavior evaluation.