

**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

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

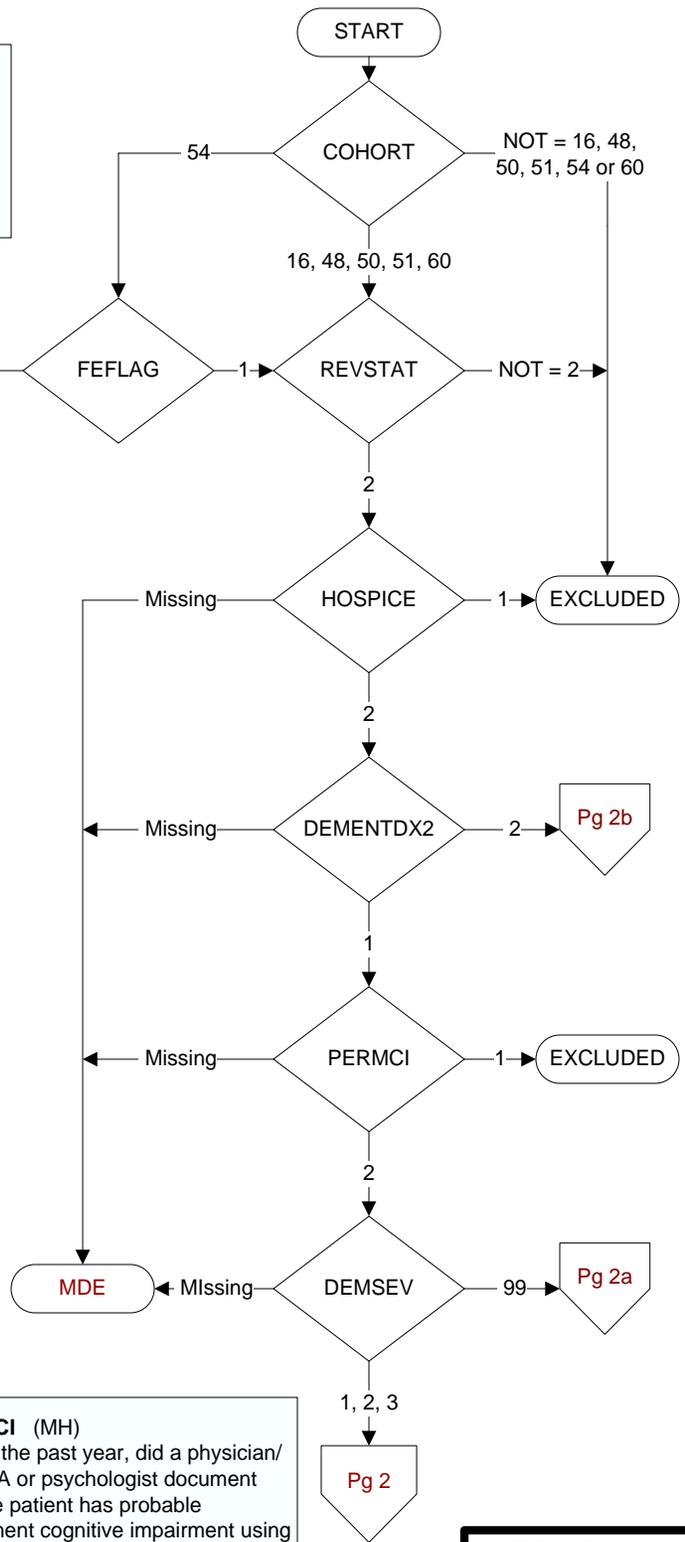
**REVSTAT**  
 REVIEW STATUS (not abstracted)  
 0. Abstraction has not begun  
 1. Abstraction in progress  
 2. Abstraction completed w/o errors  
 3. TVG failure (exclusion)  
 4. Record contains missing data  
 5. Administrative exclusion

**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

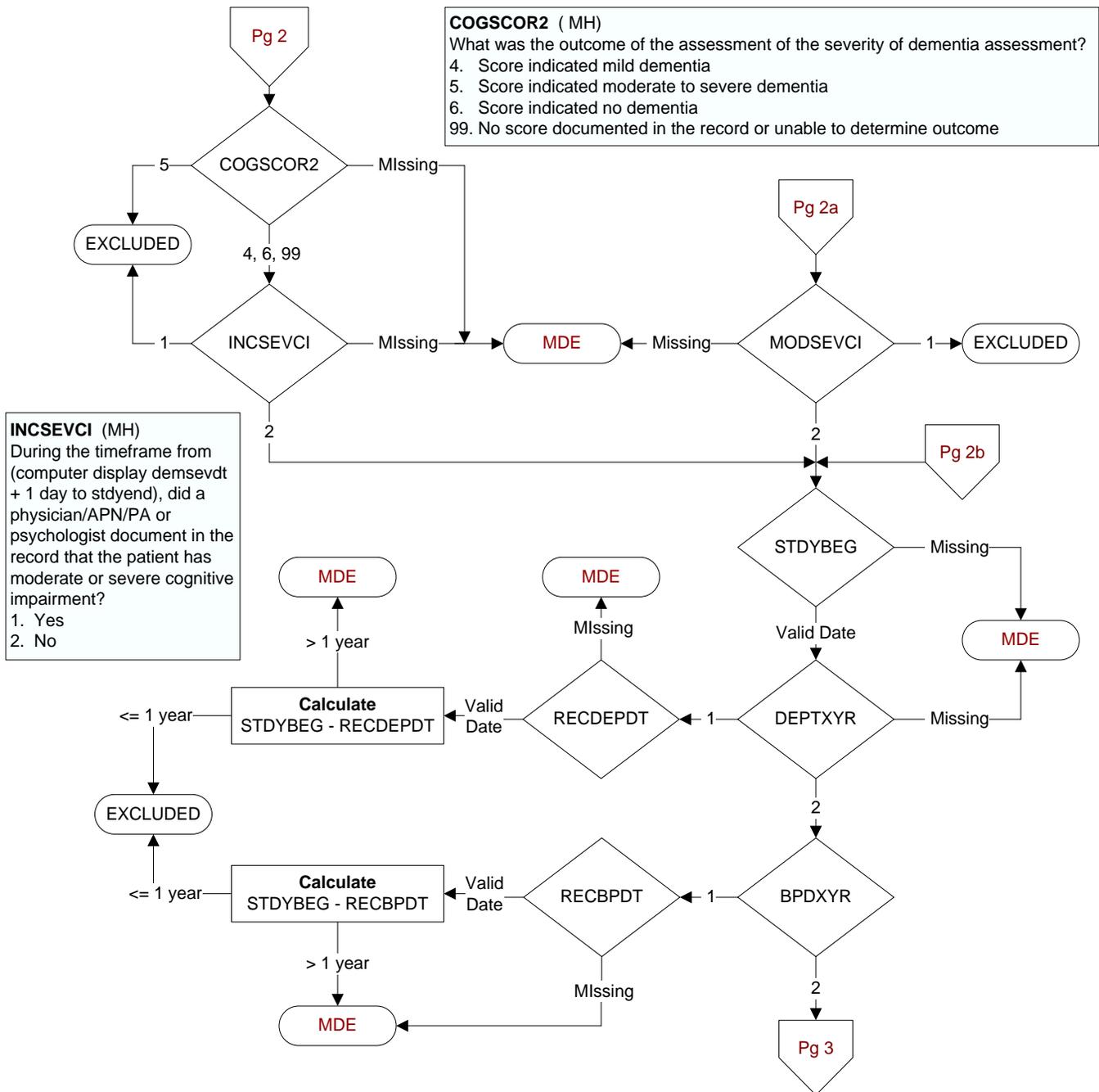
**DEMENTDX2** (MH)  
 During the past year, does the record document a diagnosis of dementia/neurocognitive disorder as evidenced by one of the following ICD-10-CM diagnosis codes:  
**A81.00, A81.01, A81.09, A81.2, A81.82, A81.89, A81.9, F01.50, , F01.511, F01.518, F01.52 – F01.54, F01.A0, F01.A11, F01.A18, F01.A2 – F01.A4, F01.B0, F01.B11, F01.B18, F01.B2 – F01.B4, F01.C0, F01.C11, F01.C18, F01.C2 – F01.C4, F02.80, , F02.811, F02.818, F02.82 – F02.84, F02.A0, F02.A11, F02.A18, F02.A2 – F02.A4, F02.B0, F02.B11, F02.B18, F02.B2 – F02.B4, F02.C0, F02.C11, F02.C18, F02.C2 – F02.C4, F03.90, , F03.911, F03.918, F03.92 – F03.94, F03.A0, F03.A11, F03.A18, F03.A2 – F03.A4, F03.B0, F03.B11, F03.B18, F03.B2 – F03.B4, F03.C0, F03.C11, F03.C18, F03.C2 – F03.C4, 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

**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

**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



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



**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

**INCSEVCI (MH)**  
 During the timeframe from (computer display demsevd + 1 day to stdyend), did a physician/APN/PA or psychologist document in the record that the patient has moderate or severe cognitive impairment?  
 1. Yes  
 2. No

**MDE**  
 > 1 year

**MDE**  
 Missing

Pg 2a

**MDE**

**EXCLUDED**

**MDE**  
 > 1 year

Pg 3

**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, F32.A, F33.0 - F33.3, F33.40 - F33.42, F33.8, F33.9, F34.1, F34.81, F34.89, F43.21, F43.23, F53.0, F53.1, O90.6, O99.340 – O99.345**  
 1. Yes  
 2. No

**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

**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

**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.

**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.

**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.

