CSP575B Chart Review Guide

Introduction

InfoPath forms will be used to electronically capture key information from patient chart reviews in order to (1) test the ability of the algorithm to identify "caseness", (2) measure inter-reviewer reliability and (3) locate records that may be useful for applying natural language processing (NLP) methods during a later phase of phenotype development. The data from InfoPath is directed to an Access database that updates each time an InfoPath form is submitted. MAVERIC staff will also be able to track changes in the data using this tool.

Privacy and Data Security

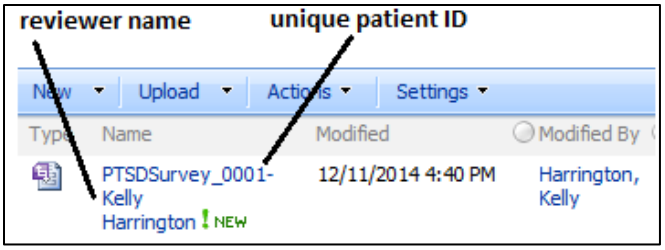
When conducting chart reviews, maintaining Veterans' privacy and data security is of primary importance. You will be asked to record Protected Health Information (PHI) such as patient diagnostic information, visit dates, and test results on the InfoPath forms saved in SharePoint. SharePoint is a secure environment for hosting PHI. However, it is essential that you do NOT record any Personally Identifiable Information (PII) on the InfoPath forms. PII is VA sensitive information and refers to information about a specific person, such as patient or provider name; social security number; date of birth; HIV status; or education, criminal, and employment histories. A unique Study ID has been assigned to each patient selected for chart review to protect their privacy.

If you have questions regarding the chart review process, please be sure that you do NOT communicate any PHI or PII via email to fellow chart reviewers or study team members. It is OK to refer to a patient by the unique Study ID (e.g., 0001) in an email as long as you do not include any other information that could be linked to a specific patient. It is also acceptable to ask general questions (i.e., without any patient specific information) about conducting chart reviews via email. If you have a question during the chart review process which requires discussion of specific patient identifiers, please email or call Kelly Harrington to set up a time to talk by phone.

I. Location of Documents for Chart Review

1. Location of InfoPath Forms
    a. InfoPath forms are stored in a document library named "Chart Review" on the CSP 575B SharePoint site. The location of each chart reviewer's document library will be sent at the time of chart review assignment.

    b. Each reviewer has their own folder (labeled by last name) containing InfoPath forms to use for chart review. Each InfoPath form corresponds to a specific patient and is labeled with the reviewer's name and unique Study ID, see example below:

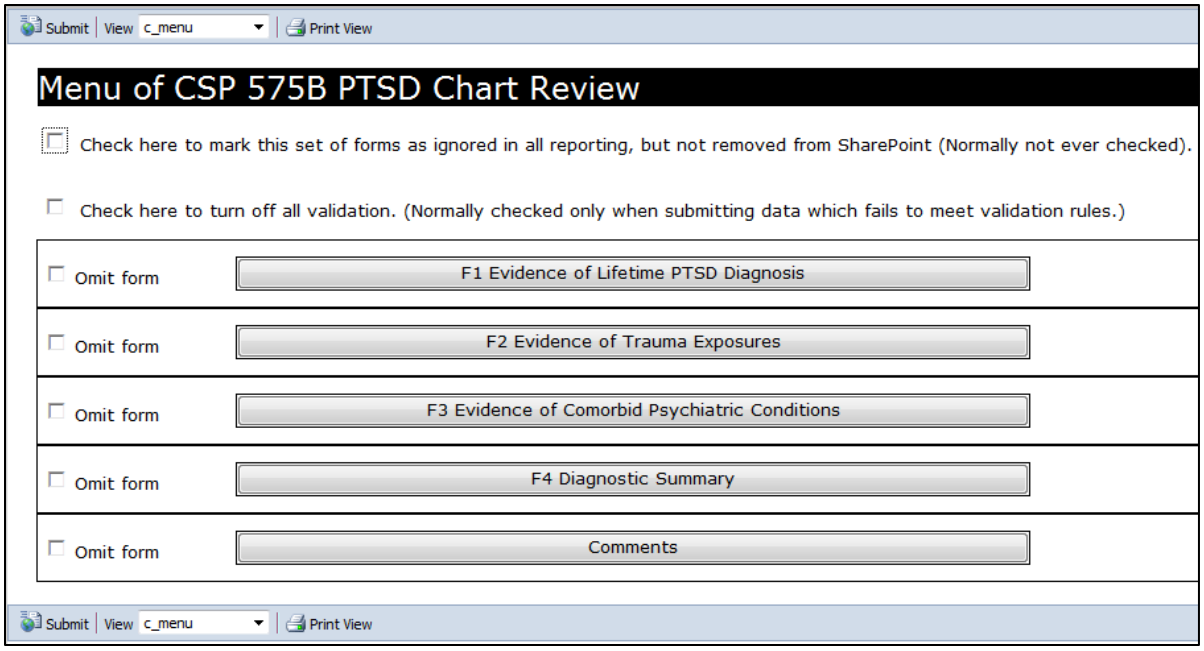


   c. The InfoPath forms are uploaded by the team at MAVERIC. The unique Study ID is also generated at MAVERIC and only will be used for the purposes of chart review.

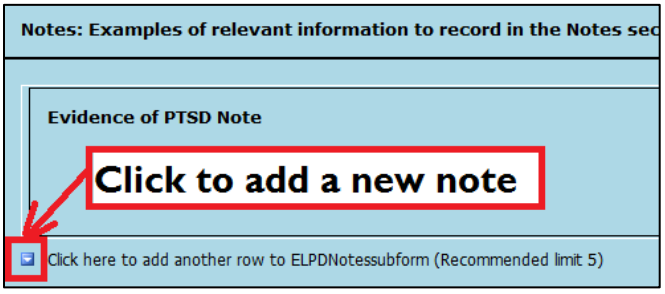
2. Location of Chart Review Form
   a. The current Microsoft Word version of the chart review form is located in the appendix for your reference; this might be easier to follow than the InfoPath form as you are getting oriented to the chart review process.
3. Location of Crosswalk File
   a. Login to VINCI to access the crosswalk file (see Appendix for instructions regarding how to log on to VINCI).
   b. Each reviewer will have their own folder and crosswalk file with their case assignments. The crosswalk file contains the unique Study ID, real SSN, and patient's primary VA facility.
   c. In order to access a patient's record in CAPRI, first you will need to refer to the crosswalk file to look up the real SSN and primary VA facility corresponding to the unique Study ID.

II. Overview of the InfoPath Forms

1. Main Menu
   a. The Main Menu appears once you click on the InfoPath link in SharePoint. The InfoPath form pack is divided into 5 forms for data entry.



2. Form 1: Evidence of Lifetime PTSD Diagnosis
    a. The purpose of this form is to mark whether each record type provided evidence of a lifetime PTSD diagnosis. Search for each record type in CAPRI and mark:
        i. "**Yes**" if the form was found and there is evidence of PTSD
        ii. "**No**" if the form was found and there is no evidence of PTSD
        iii. "**Record not found**" if you were unable to locate the record type in CAPRI
    b. All questions must be answered on this form with the exception of "*Question: Other PTSD Assessment Note (if yes please specify kind below)"* and the *"Notes"* free text section.
    c. Please add a new note field for distinct comments or note types



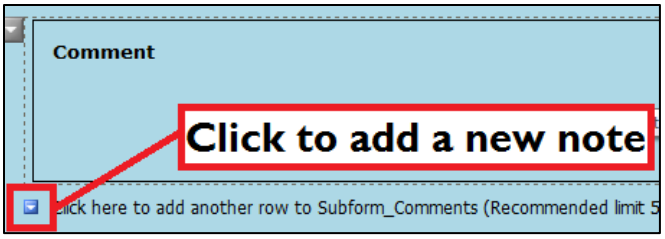
3. Form 2: Evidence of Trauma Exposure
    a. The purpose of this form is to collect evidence of trauma exposure and to document where it was found (i.e., the associated visit date, provider type, and record type).
    b. Only answer subsequent questions if first question is answered "Yes".
    c. Note: the following records are most likely to contain detailed information about a patient's history of trauma exposure: Initial Compensation & Pension Exam for

PTSD, or a Mental Health Consultation Note or Intake Note (particularly if completed by the PTSD Clinical Team).

   d. When completing questions related to a patient's history of combat trauma or exposure to a war-zone on Forms 2 and 4, documentation of <u>any traumatic event generally related to military experience</u> should be classified as "combat trauma" with the exception of military sexual trauma (MST) which is categorized separately.

4. Form 3: Evidence of Comorbid Psychiatric Conditions
   a. The purpose of this form is to track the location of notes that provide evidence of other psychiatric conditions.
   b. Do not spend extra time searching for these conditions, only note if you found them during your review of PTSD notes.
   c. Only answer subsequent questions if first question is answered "Yes".
   d. Note: The study team made a decision not to record evidence of 'Tobacco Use Disorder' under the 'Substance Use Disorder' section of this form.
5. Form 4: Diagnostic Summary
   a. The purpose of this form is for the reviewer to mark their classification of the patient as a Likely PTSD case, Possible PTSD case, or Likely Not PTSD case and to document the patient's history of trauma exposure.
   b. History of trauma exposure is broken into three categories: (1) Combat Trauma (including any traumatic event generally related to military experience except for MST), (2) MST, and (3) Other Potentially Traumatic Events which encompasses all other types of adulthood or childhood trauma identified on Form 2.
   c. For each of the three types of trauma described in 5b, the response options include yes, no, and unsure. Note: "no" should be reserved for clear documentation that the patient does not have exposure to a given type of trauma, whereas "unsure" is more appropriate when an adequate assessment of trauma exposure was not found in the medical record.
   d. The comments section (titled "Other Important Notes about your Diagnostic Impressions") is not required to be completed. Examples of appropriate comments include noting conflicting information about a patient's primary mental health diagnosis, noting when Axis II psychopathology was documented, and providing a brief rationale for your classification of the patient.

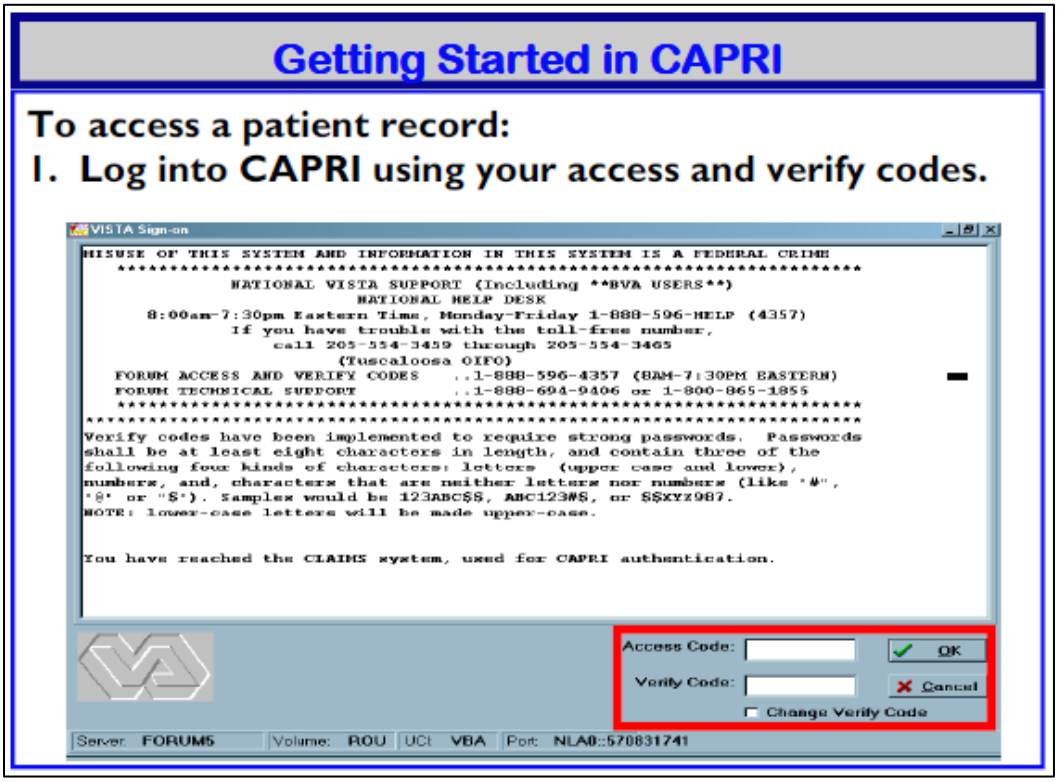
6. Comments
   a. The comments field is only necessary to complete if there is additional data or an unusual circumstance which you would like to record.
   b. Please add a new note field for distinct comments or note types

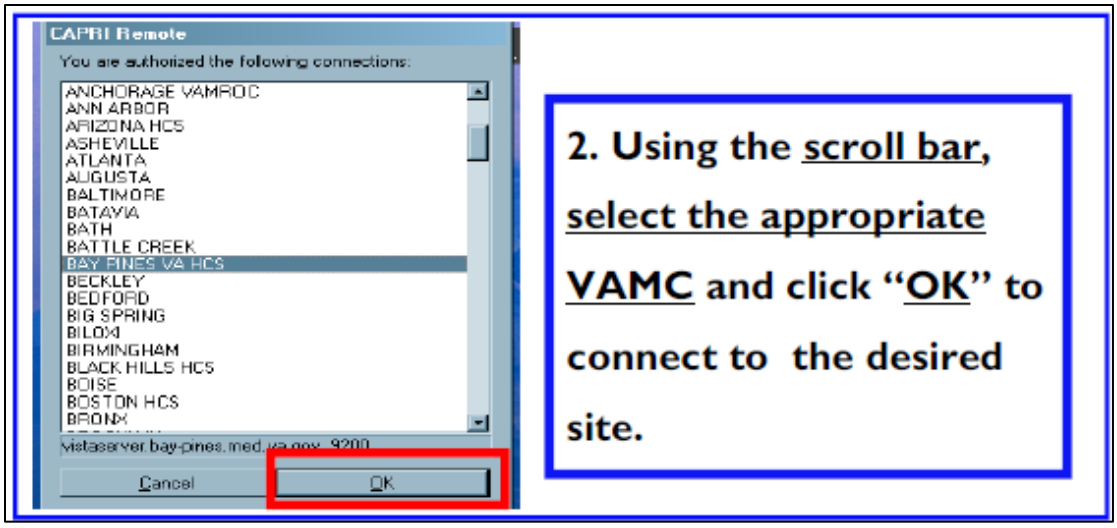


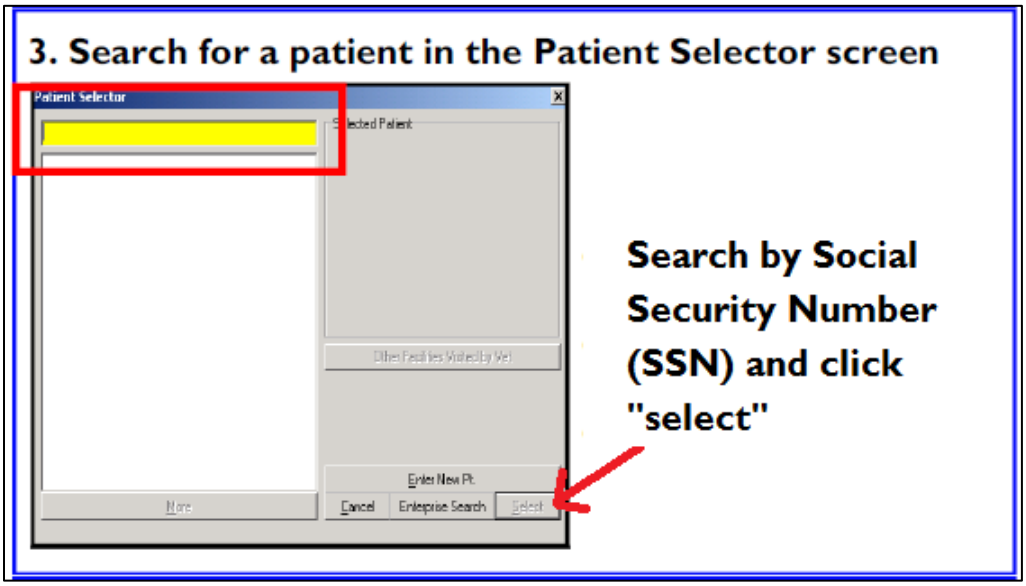
Screenshots of the forms are provided in the appendix.

III. Tips for Using CAPRI

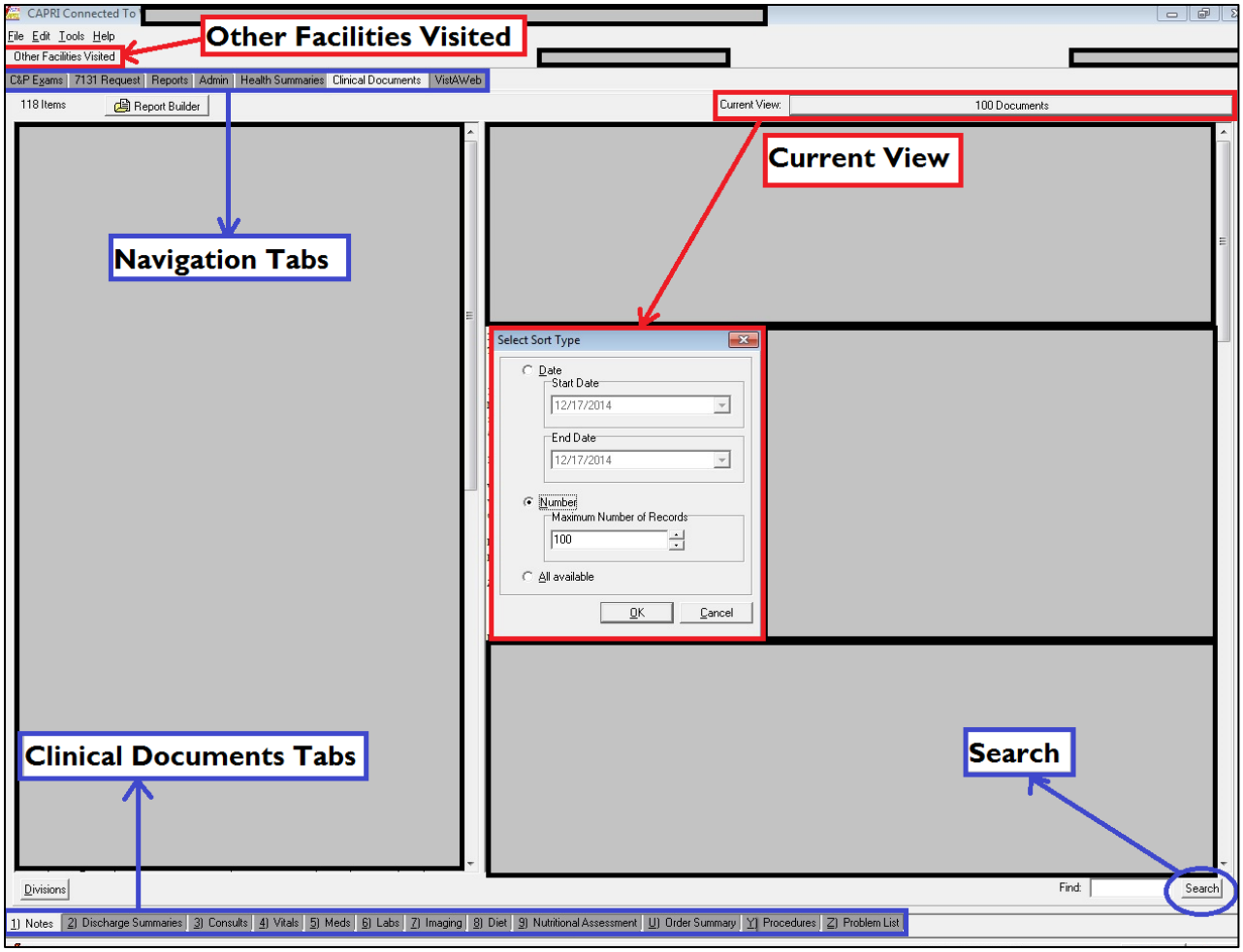
- Instructions for getting started in CAPRI (more information here: http://vaww.va.gov/hia/Forms/capri-tri.pdf)



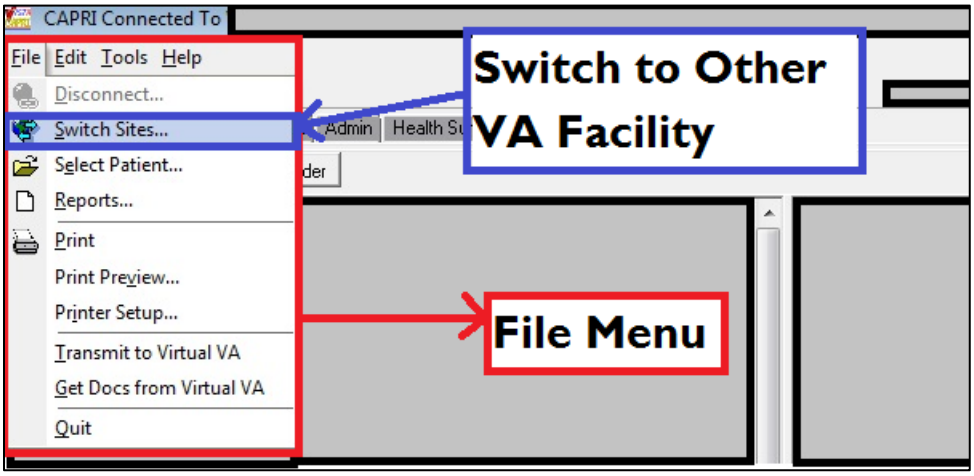




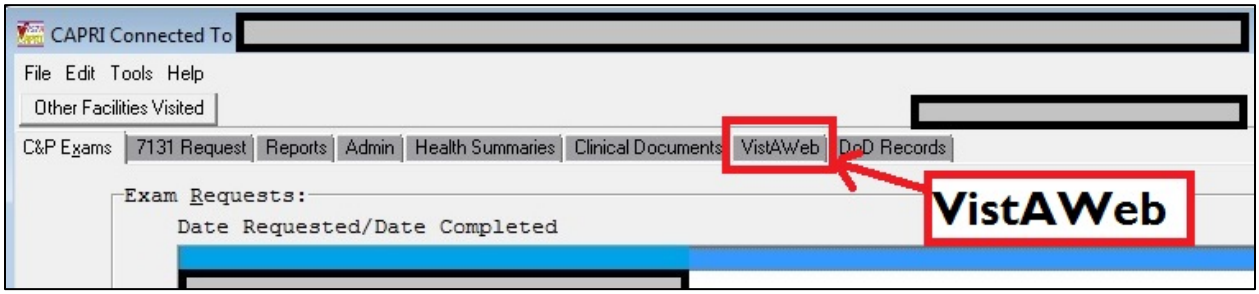
- **Reminder: You must login to CAPRI at least once every 30 days to prevent your account from being temporarily disabled due to inactivity.**
- Strategy: Remember to try to gather multiple pieces of information from each note that you review. For example, if you are reading an Initial Compensation & Pension Exam for PTSD and you find a detailed trauma history, you may want to skip ahead to Form 2 to record this information. Note: before moving to another page, we recommend that you submit data on the current form to prevent losing data (see section IV, "Timeouts" for more information).
- Current View: for searching by date range, number of documents, or all documents
- Search: on word/phrase. When found, the word/phrase is highlighted in the progress note. Searching is not case-sensitive. You can use partial words for a wider search. For example, using "psych" as the search term will find all permutations, such as "psychology", "psychiatry", etc.
- Other Facilities Visited: Click here to view other VA facilities where the patient has received services



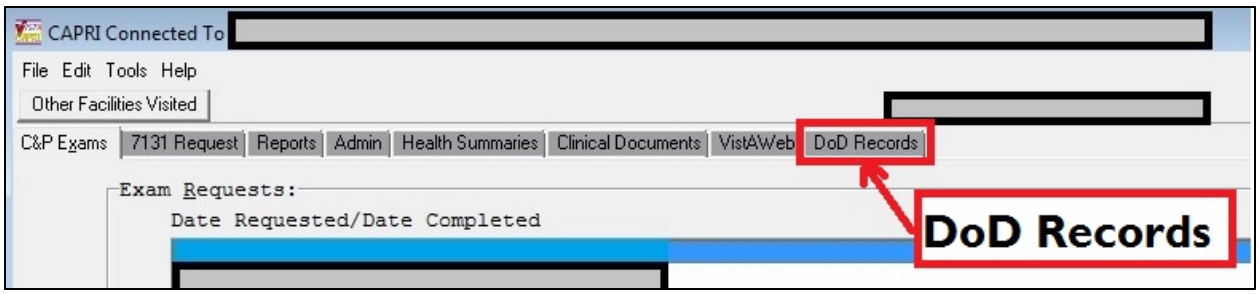
- Switching facilities in CAPRI
    - Click on “File”>”Switch Sites” to change the VA facility



- Accessing VistAWeb from CAPRI
    - VistAWeb is an intranet web portal, similar to CAPRI, where you can read through patient EHR notes. However, this site is setup different from CAPRI. VistAWeb provides a consolidated view of EHR data from all VA sites, instead of showing site specific data like CAPRI.
    - VistAWeb may be helpful in order to view visit notes for a patient who was seen at many VA sites. It is also the best way to obtain information about a patient's Problem List (see **Section V. Information to Look for in CAPRI** for details).
    - To access VistAWeb from CAPRI, click on the icon to the right of the clinical documents tab:



- Accessing DoD records
    - It is possible that there will not be any VHA records for some patients. The DoD tab can be a useful resource for these cases.
    - The DoD tab which is located on the top far right of the screen in CAPRI when available. Sometimes DoD records, such as Post-deployment Health Assessments, may be available and include questions about mental health symptoms, TBI, combat exposure, # of deployments, etc. You could record this information under "Other PTSD Assessment Note" on form #1 (lifetime PTSD form).



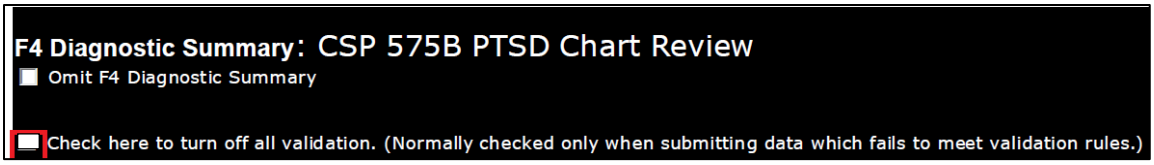
- General Tips and Guidelines
    - Compensation and pension exam is not the final word – consider all sources of data when classifying a patient's PTSD diagnostic status.
        - Ex: if the patient is rejected for PTSD service connection, that doesn't mean they don't have PTSD
    - For the purposes of this chart review, a traumatic event generally related to military experience will be considered combat trauma with the exception of military sexual

trauma. Note that MST is distinguished as a separate category of trauma exposure on Forms 2 and 4.
    - Once you find confirmatory evidence for a record type, move on to the next record type after recording the date of the note that provides confirmatory evidence
    - A general approach for searching notes is to look at the notes in the past year or two and then look back at the start of the record. The goal is to try to develop diagnostic impressions of a patient's current as well as lifetime psychiatric history.
    - Make sure to change the "Current View" to "All available" in order to be able to see all progress notes entered in CPRS over time

- Tips for Charts with Records from Multiple VA Facilities:
    - When you access a patient's records for the first time in CAPRI, view "Other Facilities Visited" to determine whether the Veteran has received services from multiple VA facilities.
        - If you click on the "Other Facilities Visited" tab, the following information will be displayed: Station Number, VA Facility Name, and Date Last Seen.
        - If a Veteran has only received services at a single VA facility, this feature will not be available.
    - If a Veteran has received services at more than one site, begin your review by looking at the records for the VA facility where the patient was most recently seen.
    - Proceed with your review by navigating to each type of medical record and searching for evidence of lifetime PTSD, trauma exposure, and comorbid psychiatric conditions.
    - Once you find confirmatory evidence for a given record type, move on to the next record type.
    - If you find sufficient evidence for each record type during your review of notes from the VA facility where the Veteran was most recently seen, it is not necessary to conduct a thorough review of notes from the other facilities visited.
        - However, it is always a good idea to at least check the following record types for **all sites visited**: (1) Comp & Pen Exams for PTSD, (2) Psychiatric Inpatient Discharge Summaries, and (3) Problem List
    - If you do not find each record type during your review of the most recent VA facility (e.g., a MH intake note), switch to the first VA facility visited to continue your review.

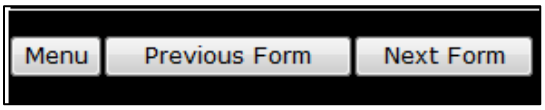
IV. Tips for Using the InfoPath Form

- During your first few chart reviews, we recommend that you follow along with the Word version of the chart review form while looking at the InfoPath form on SharePoint.
- Validation and Data Entry Errors
    - The default for the forms is an unchecked box here which indicates that the validation function is turned on.

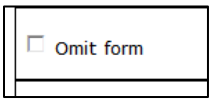


  - When the validation function is 'on', you will be alerted if there are any data entry errors before you submit the InfoPath form; validation errors are indicated by a red box or red asterisk (*) on the form.
  - If a validation error is detected, you may need to scan each page to find the source of the error(s) and fix each issue.
  - If you need to save and submit a form before you have completed your review, you can check this box to temporarily turn off validation. However, please be sure to uncheck the box before submitting your finalized form to allow the system to check for errors (e.g., a missing field or a comment that exceeds the word limit).

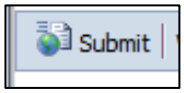
- Navigation
  - Use the following buttons at the top of the page to navigate through the forms:



  - There is no reason to select "omit form" during chart review. This is located on the main menu



- Hiding
  - There are some conditional questions that can only be answered when "Yes" is selected
- Blanks
  - The "blank" response signifies the default answer
  - It is appropriate to leave "blank" selected for certain questions when answering "Yes" is not applicable
- Time Outs
  - If the form is open for an extended period of time, you may not be able to save it
  - To prevent losing data, click on "Submit" after you complete each form or if you are taking an extended period of time on a form (greater than 10 minutes)
    - "Submit" is located at the bottom left corner of the form



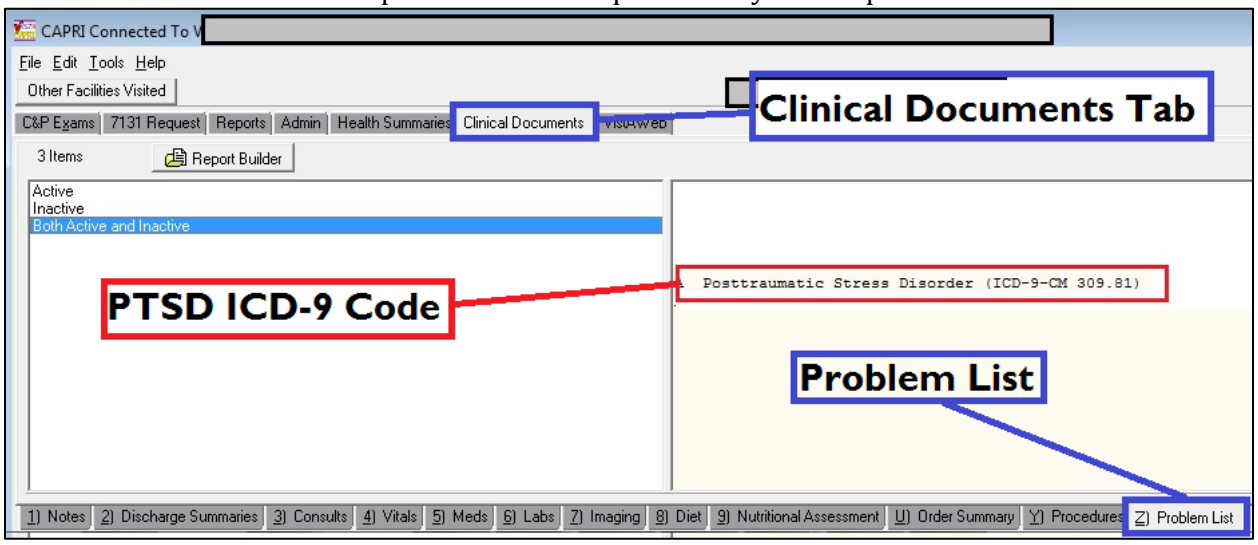
  - It is not problematic to submit multiple times – your updated data will be sent to the Access database each time and replace the data that was there previously
- Free text sections
  - Text entered in the note section will also be sent to the database. It is not required to enter data here, but it can be helpful for clarifying an unusual situation. Try to be brief, but also informative.

- The maximum number of characters for comment fields is 255
- The notes section is not an appropriate place to provide comments on issues with the form; the data here should be patient specific
- NEVER enter a provider name in the notes
- DO NOT copy and paste CAPRI text into the notes, this creates a risk of including PII in this field
- MAVERIC personnel will check fields for PII (names, SSN, etc)

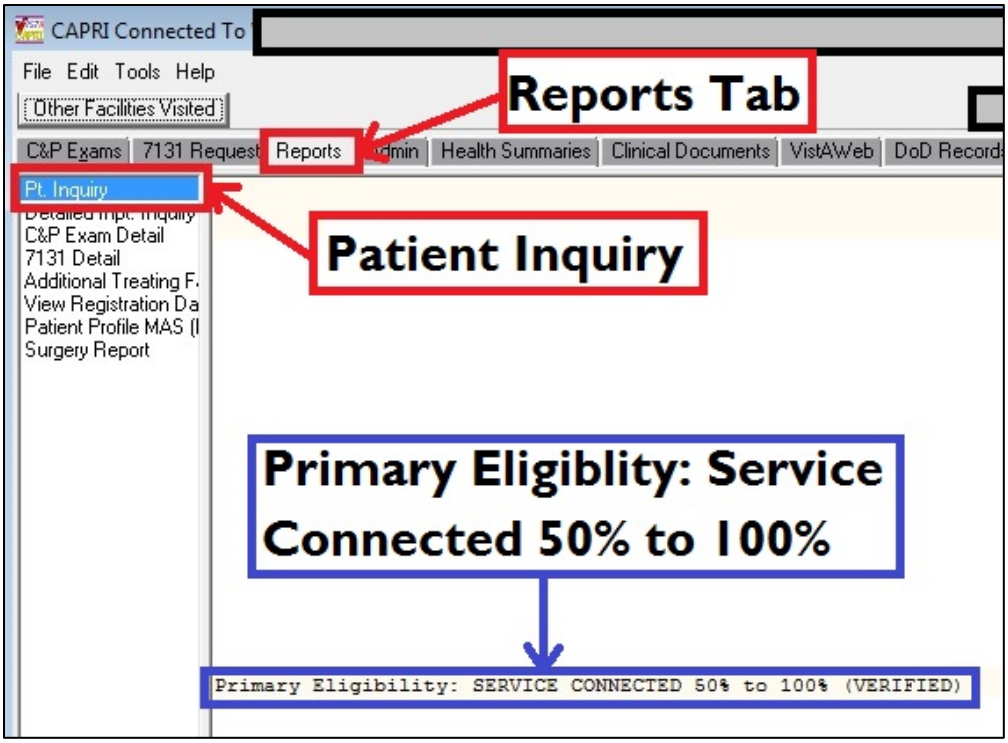
V. Information to Look For in CAPRI

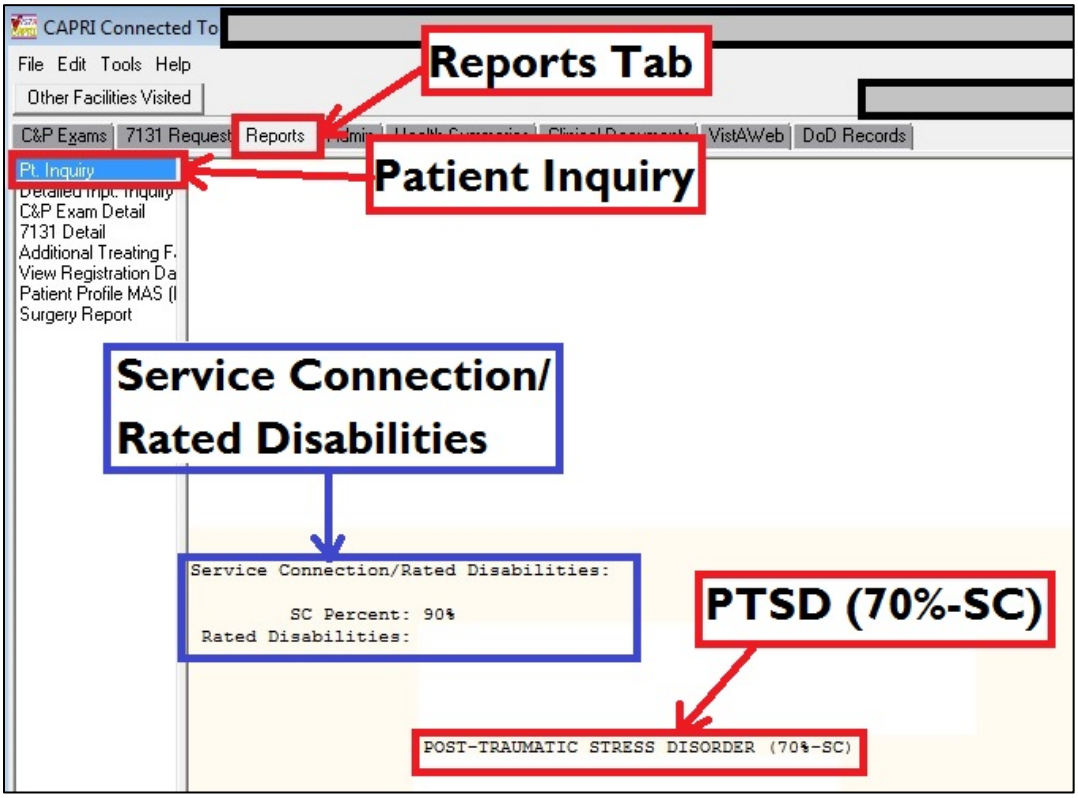
The following locations should be reviewed in the patient chart if available.

1. Problem List
    a. The 'Problem List' section (Z) appears at the bottom of the 'Clinical Documents' tab.
    b. If PTSD (ICD-9 code 309.81) is listed in a patient's Problem List, you will need to look elsewhere for the date it was entered or last modified.
    c. **The best place to find the date when PTSD was entered on the Problem List is to look in the Problem List section of VistAWeb** (see p. 9 for how to access VistAWeb).
        i. To quickly locate PTSD on the Problem List within VistAWeb, click on the "Description" header to alphabetically sort all problems.



2. Service Connected Disability
    a. Click on the 'Reports' tab and then the 'Pt. Inquiry' record.
    b. Look here for service connected disability status. If a patient is not service connected, you will see 'Primary Eligibility: NSC'.

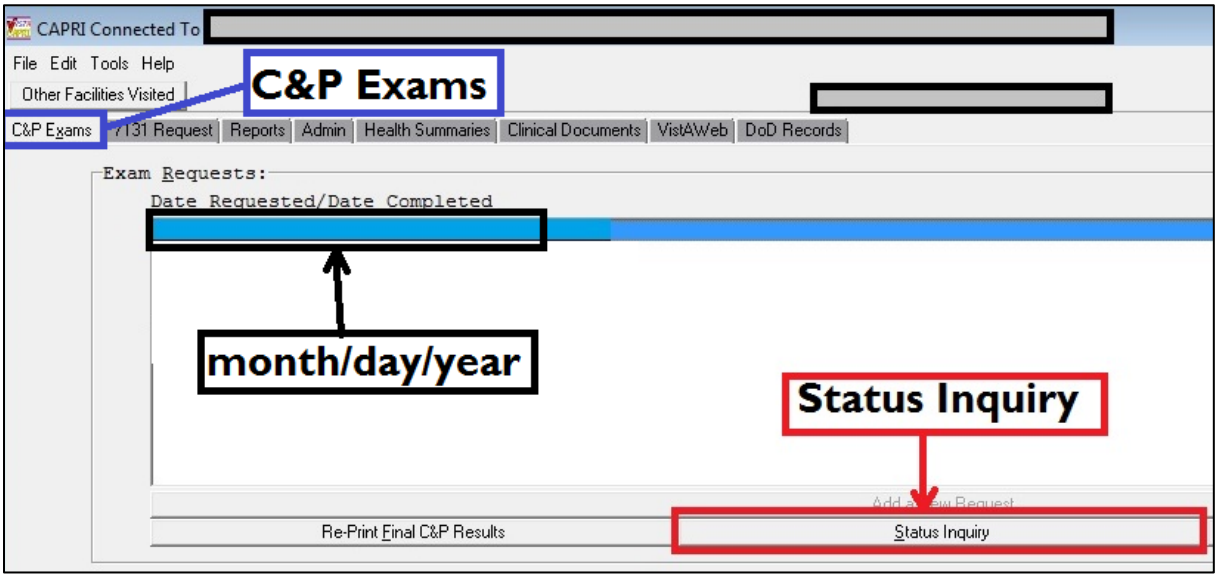


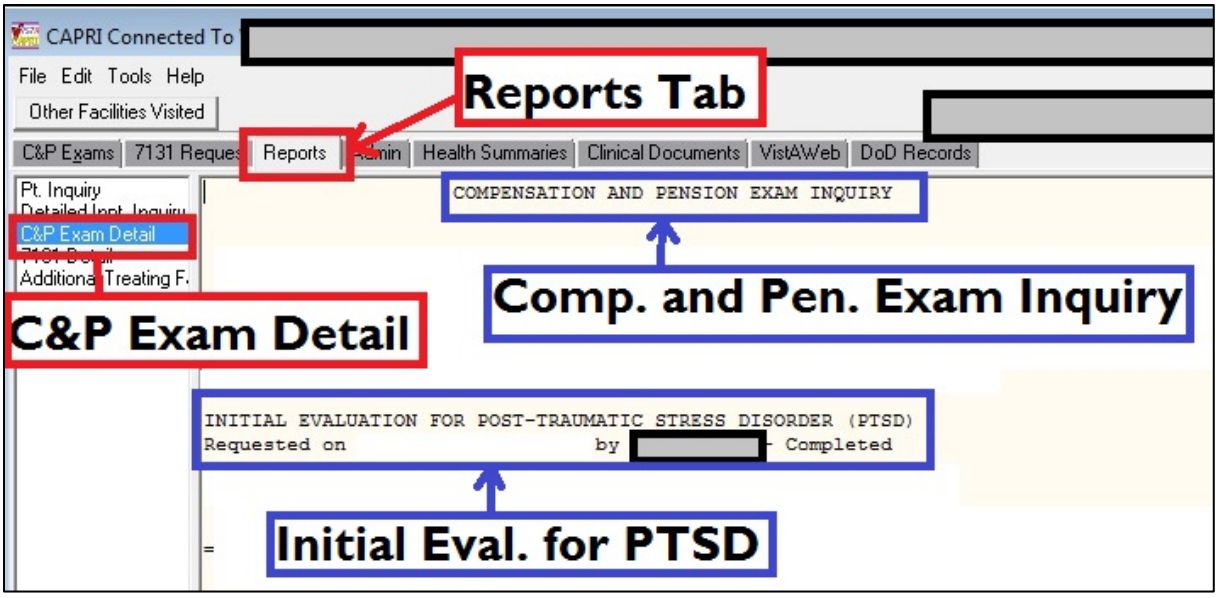


3. Compensation and Pension Exams
    a. Click on the 'C&P Exams' tab.
    b. You will see the 'Date Requested/Date Completed' for existing C&P Exams. This section should be blank if a patient has never requested a C&P Exam since the existence of the EHR. However, sometimes the C&P Exams tab will be blank even

though there is a C&P Exam report found elsewhere in the patient's record (e.g., in the 'Notes' section of the 'Clinical Documents' tab).

c. To discover which conditions/areas of disability were assessed in a given C&P Exam, select a date and click on the 'Status Inquiry' tab at the bottom of the screen. You should be able to tell whether PTSD was being evaluated.
d. The full C&P Report might be available in the C&P Exams tab.
    i. To check, double click on the line corresponding to the 'Date Requested/Date Completed' of interest which will pull up a 'View C&P Exam' window. Look in the 'Exams Requested' section and you may find a completed 'C&P Exam for PTSD' record. Double click on this entry to view the complete report.
e. Other strategies for locating C&P reports:
    i. A record such as 'C&P Exams Listed' might be found in the 'Health Summaries' section
    ii. Sometimes there will be a 'C&P Exam' section included in the Health Summaries documents
        1. Note: the 'Health Summaries' tab has a field at the top called 'HS component'. Clicking on the drop down arrow reveals subject headings such as 'C&P Exams and allows you to navigate directly to that section.
    iii. Manually search in the 'Notes' section (1) of the 'Clinical Documents' tab by the date when C&P Exam was completed.
    iv. Use the Search function in the 'Notes' section (previously described) to search for key words such as "C&P Exam"

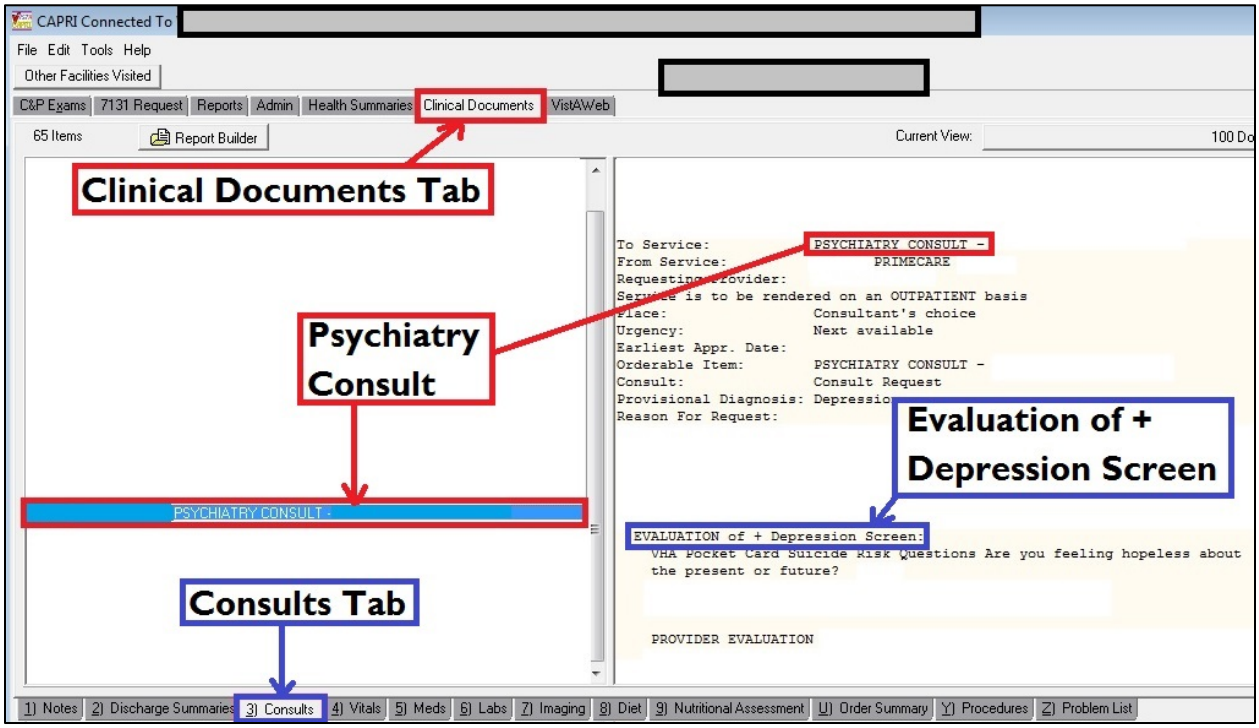




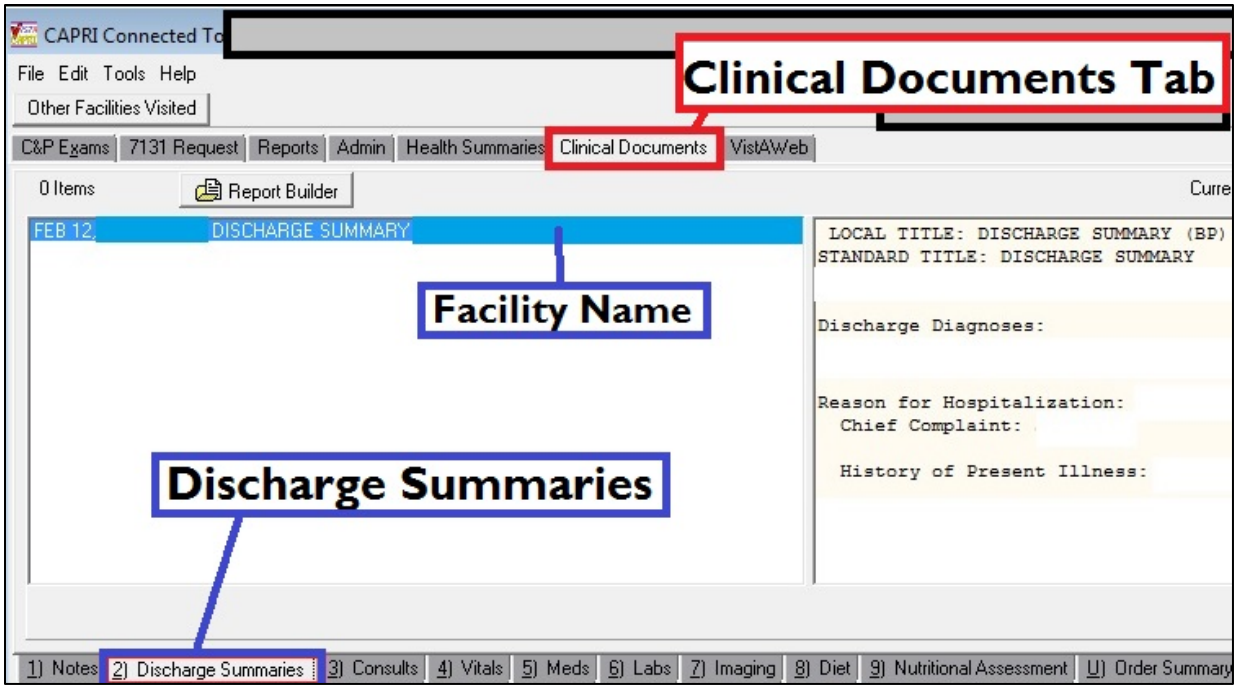
4. Mental Health Intake Note
    a. Search in the 'Notes' section (1) of the 'Clinical Documents' tab for intakes or initial assessments conducted in any mental health clinic (e.g., PTSD Clinical Team, Psychology, Psychiatry, General Mental Health, MH, etc.).
        i. **To help improve inter-rater reliability when reviewing the 'Notes' section in CAPRI, we have made it standard practice to search for the following key words:**
            1. **PTSD**
            2. **Combat**
            3. **MST**
            4. **Abuse**
        ii. **Note: it will not be necessary to search for all four key words in every case if you have found relevant confirmatory evidence for PTSD, combat trauma, MST, and/or other traumatic events earlier in your record review.**
    b. Ideally, intake notes will include a section at the bottom which lists Mulitaxial Diagnostic Impressions.
    c. The note titles can vary considerably across VA facilities, but you can typically distinguish mental health notes from other disciplines. However, it is less likely that the note title will explicitly state 'Initial Assessment' or 'Intake'. You will probably need to click on a note that looks promising and scan the header (or introductory paragraph) in the body of the note to identify whether it was an initial evaluation with the provider.
    d. When completing Form 1 (Evidence of Lifetime PTSD Diagnosis), the "Mental Health Intake Note" section includes a free text field to specify the "Local Title of Note". This will allow for more precise tagging of notes that could be beneficial for relocating a specific note manually as well as by natural language processing techniques.

i. Note: visit dates and local note titles are clearly displayed in the index of the Notes tab of CAPRI.

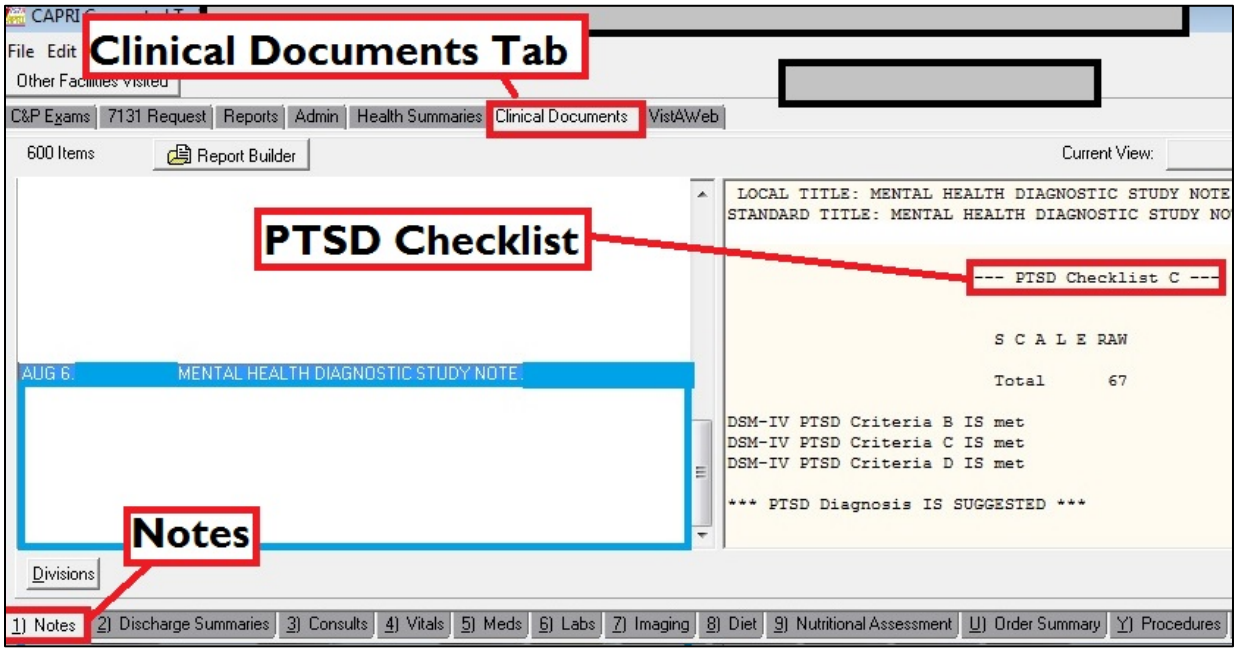
5. Mental Health Consultation Note
    a. The 'Consults' section (3) appears at the bottom of the 'Clinical Documents' tab.
    b. Look here for any mental health consults that have been requested by a provider (e.g., Psychology, Psychiatry, PTSD Clinical Team, General Mental Health Clinic, etc.).
    c. Sometimes the completed psychological assessment report will be appended to the initial consult note. If not, you should be able to tell if and when the consult was completed. Use the date the consult was completed to look for the full report in the 'Notes' section (1) of the 'Clinical Documents' tab.



6. Psychiatric Inpatient Discharge Summary Diagnosis
    a. The 'Discharge Summaries' section (2) appears in the 'Clinical Documents' tab. Look here to see if the patient has ever had an inpatient hospitalization.
    b. Typically the chief complaint or reason for admission will be listed at the top of a discharge summary to get a sense of whether this was a psychiatric hospitalization.
    c. The discharge diagnoses should also be listed near the top of the note. Look to see whether PTSD was listed as one of the Discharge Diagnoses.
    d. If there is not a psychiatric inpatient discharge note, you would enter "record not found" on Form 1. If you found a psychiatric inpatient discharge note without a PTSD diagnosis, you would enter "no".



7. PTSD Checklist
    a. PTSD Checklists may appear as a separate note in the 'Notes' section (1) of the 'Clinical Documents' tab (as shown in the example below) or within a Compensation & Pension Exam.
    b. Sometimes searching the Notes section using key words such as 'PTSD Checklist' will be successful in locating a PCL score.



8. Other PTSD Assessment Notes

a. If you find other informative PTSD assessment notes during your review of required source documents, you may record such information in this section.
b. Otherwise you can leave this section blank.

VI. Handling Discrepancies

1. Overview
    a. To ensure consistency between reviewers, 25% of charts will be assigned to 2 reviewers – these are referred to as "reliability cases".
    b. Periodic inter-rater reliability checks at MAVERIC will notify the team of discrepancies between reviewers. Before we can test the efficacy of the algorithm, any discrepancies between chart reviewers must be resolved.
2. Chart Review Summary Sheets
    a. The MAVERIC analyst will report discrepancies between reliability cases and compile them into a "Chart Review Summary Sheet".
    b. The Summary Sheet reports the following:
        i. Status of assigned cases by reviewer
        ii. All inter-rater discrepancies for classifying patients (PTSD diagnosis, trauma exposure and comorbid diagnoses)
        iii. Sources of evidence for PTSD when raters disagree about PTSD diagnosis
        iv. Nature of discrepancy when raters disagree about trauma exposure
3. Inter-rater Reliability Calls
    a. MAVERIC will schedule periodic calls with all reviewers based on the number of discrepancies reported. The "Chart Review Summary Sheet" will guide the session.
    b. To resolve a discrepancy, at least 3 reviewers must be present: the two reviewers that performed the reliability review and a third reviewer to act as a tie-breaker.
    c. The focus of the inter-rater reliability calls will be to resolve discrepancies pertaining to PTSD caseness and trauma exposure. Each reviewer should be prepared to provide a summary of the evidence that led them to their decision and the group must come to a consensus about the final classification.
    d. For co-morbid conditions, if one reviewer found evidence of a co-morbid condition, this will provide sufficient evidence to resolve the discrepancy.

Appendix

CSP575B Chart Review Form v5

How to Log onto VINCI

InfoPath Screen Shots

Quick Guide: Classifying Patients by Chart Review v3

CSP575B Chart Review Classification Guidance v2

Study ID: _____

Reviewer: _____

1. Evidence of Lifetime PTSD Diagnosis :

Source: Record Type/Note Title	Evidence of PTSD Diagnosis	Visit Date/ Date of Note	Provider Type
Problem List	• Yes • No	mmddyyyy	**N/A**
Service Connected Disability (PTSD) **If service connected for PTSD, enter disability rating (0-100%)**	• Yes • No Numeric	N/A	N/A
Initial Compensation and Pension Exam for PTSD	• Yes • No • Record not found	mmddyyyy	• Clinical psychologist • Psychiatrist • Nurse practitioner/ Nurse • Social worker • Primary care physician • Other
Last Compensation and Pension Exam for PTSD	• Yes • No • Record not found	mmddyyyy	*Same as above*
Mental Health Intake Note **If Yes, specify Local Title of Note:**	• Yes • No • Record not found	mmddyyyy	*Same as above*
Mental Health Consultation Note	• Yes • No • Record not found	mmddyyyy	*Same as above*
Psychiatric Inpatient Discharge Summary Diagnosis	• Yes • No • Record not found	mmddyyyy	*Same as above*

PTSD Checklist (e.g., from Mental Health Assistant Package) **If PTSD Checklist present, enter PCL score:**	• Yes • No • Record not found Numeric – range: 0-85	mmddyyyy	*Same as above*
Other PTSD Assessment Note (*please specify*):	• Yes • No	mmddyyyy	*Same as above*

Notes [1]

[1] *Examples of relevant information to record in the Notes section include: PTSD listed as primary vs. secondary diagnosis, new or ongoing PTSD diagnosis, significant diagnostic discrepancies across providers, etc.*

2. Evidence of Trauma Exposure:

In your review of this patient's chart, did you find any evidence of trauma exposure?

☐ **No**
☐ **Yes** – if yes, then answer all applicable fields below:

Type of Traumatic Event	Visit Date	Provider Type	Source: Record Type / Note Title
Combat Trauma /Exposure to a War-zone	mmddyyyy	• Clinical psychologist • Psychiatrist • Nurse practitioner/ Nurse • Social worker • Primary care physician • Other	• Initial Compensation and Pension Exam for PTSD • Last Compensation and Pension Exam for PTSD • Mental Health Intake Note • Mental Health Consultation Note • Inpatient Discharge Summary Diagnosis • Primary Care Physician Note • Other PTSD Assessment Note
Military Sexual Trauma	mmddyyyy	*Same as above*	*Same as above*

Other Adulthood Trauma (*please specify*):	mmddyyyy	*Same as above*	*Same as above*
Child Sexual Abuse	mmddyyyy	*Same as above*	*Same as above*
Child Physical Abuse	mmddyyyy	*Same as above*	*Same as above*
Other Childhood Trauma (*please specify*):	mmddyyyy	*Same as above*	*Same as above*

3. Evidence of Comorbid Psychiatric Conditions:

In your review of this patient's chart, did you find any evidence of comorbid psychiatric conditions?

☐ **No**
☐ **Yes** – if yes, then answer all applicable fields below:

Condition	Visit Date	Provider Type	Source: Record Type / Note Title
Schizophrenia	mmddyyyy	• Clinical psychologist • Psychiatrist • Nurse practitioner/ Nurse • Social worker • Primary care physician • Other	• Initial Compensation and Pension Exam for PTSD • Last Compensation and Pension Exam for PTSD • Mental Health Intake Note • Mental Health Consultation Note • Inpatient Discharge Summary Diagnosis • Primary Care Physician Note • Other PTSD Assessment Note
Bipolar Disorder	mmddyyyy	*Same as above*	*Same as above*
Depressive Disorder	mmddyyyy	*Same as above*	*Same as above*
Alcohol Use Disorder	mmddyyyy	*Same as above*	*Same as above*
Substance Use Disorder (*if yes, please specify drug type/class below)*	mmddyyyy	*Same as above*	*Same as above*
Anxiety Disorder	mmddyyyy	*Same as above*	*Same as above*

Traumatic Brain Injury	mmddyyyy	*Same as above*	*Same as above*

4. Diagnostic Summary

Posttraumatic Stress Disorder *(check the box that best applies)*

On the basis of your chart review, what is the best classification of this patient?

Likely PTSD ☐ (Patient shows significant evidence of a lifetime PTSD diagnosis)

Possible PTSD ☐ (Patient shows some (weak or indeterminate) evidence of a lifetime PTSD diagnosis or presents with subclinical level of PTSD symptomatology)

Likely Not PTSD ☐ (Patient does not show any evidence of a lifetime PTSD diagnosis)

Insufficient Data Available ☐ (There is inadequate information in the medical record to classify this patient)

History of Trauma Exposure

1. Does the patient show evidence of exposure to combat trauma?

   Yes ☐ (Medical record documents exposure of combat or war-zone trauma)

   No ☐ (Medical record documents no history of combat or war-zone exposure)

   Unsure ☐ (Assessment of exposure to combat trauma was not found)

2. Does the patient show evidence of exposure to military sexual trauma (MST)?

   Yes ☐ (Medical record documents exposure of MST)

   No ☐ (Medical record documents no history of MST)

   Unsure ☐ (Assessment of MST was not found)

3. Does the patient show evidence of exposure to other potentially traumatic event(s)?

Yes ☐ (Medical record documents exposure of other potentially traumatic events, consistent with DSM Criterion A)

No ☐ (Medical record documents no history of other potentially traumatic events)

Unsure ☐ (Assessment of other trauma exposure was not found)

<u>Other Important Notes about your Diagnostic Impressions</u>:

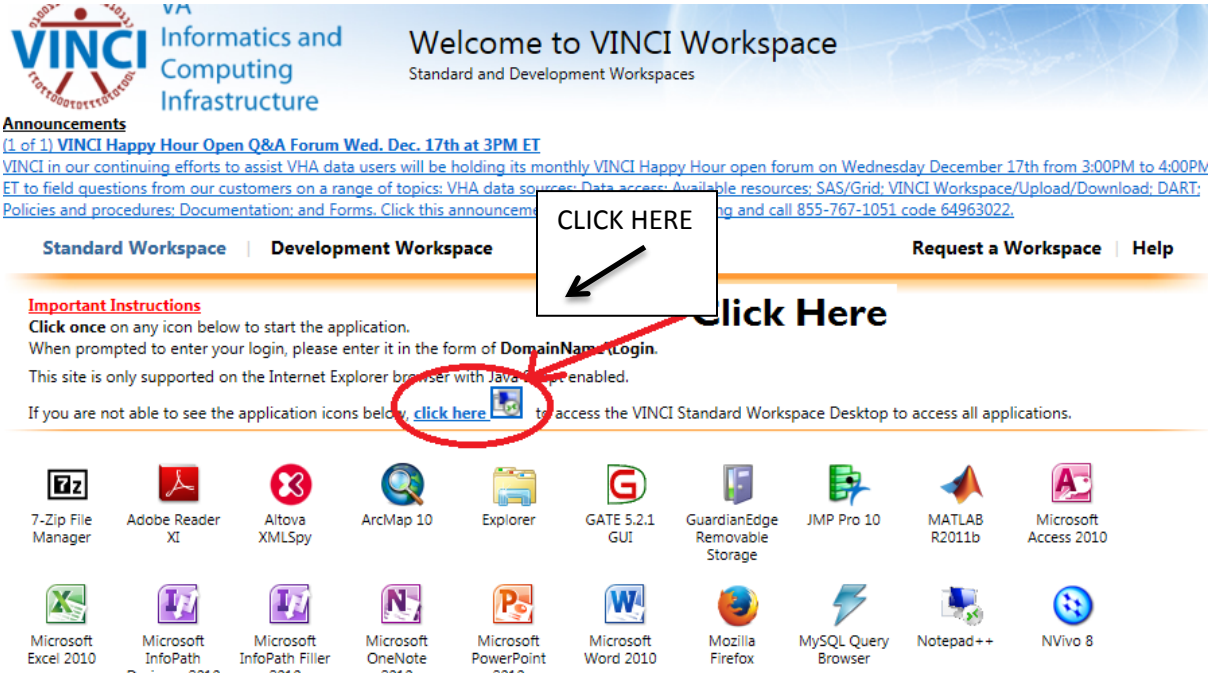
_____
_____
_____
_____

How to Log onto VINCI

1. Go to http://vaww.vinci.med.va.gov/vincicentral/default.aspx

2. Click “Launch the VINCI Workspace”

3. Click on the “click here” link within the Important Instructions



4. a) You can click open to use once

b) To create a shortcut on your desktop (preferable) click the down arrow next to the save button and save as. Save VINCI on your desktop.

5. Enter in your password, click ok. If username did not automatically populate, use domain name (e.g. VHA01) "\" then username.

6. Once you have accessed the VINCI Workspace, double click on the yellow folder ('Libraries') at the bottom of the screen.

7. Double click on the computer icon (on the left hand side of the folder) to expand options.

8. Double click on the 'Projects' icon.

9. You should see a project folder called "ORD_Stein_201408074D". When you open this folder, there will be a subfolder called "Chart Review Documents" that contains the crosswalk file.

F1 Evidence of Lifetime PTSD Diagnosis: CSP 575B PTSD Chart Review

☐ Omit F1 Evidence of Lifetime PTSD Diagnosis

☑ Check here to turn off all validation. (Normally checked only when submitting data which fails to meet validation rules.)

Study ID:

Reviewer:

Question: Problem List

- ◉ Blank
- ○ Yes
- ○ No

Visit Date: Problem List

Question: Service Connected Disability (PTSD)

- ◉ Blank
- ○ Yes
- ○ No

Score: If service connected for PTSD, enter disability rating (0-100% please enter only integer without percent sign)

Question: Initial Compensation and Pension Exam for PTSD

- ◉ Blank
- ○ Yes
- ○ No
- ○ Record not found

Visit Date: Initial Compensation and Pension Exam for PTSD

Provider Type: Initial Compensation and Pension Exam for PTSD

- ◉ Blank
- ○ Clinical psychologist
- ○ Psychiatrist
- ○ Nurse practitioner/ Nurse
- ○ Social worker
- ○ Primary care physician

Other (indicate below)

Other Provider Type: Initial Compensation and Pension Exam for PTSD

Question: Last Compensation and Pension Exam for PTSD

- (•) Blank
- ( ) Yes
- ( ) No
- ( ) Record not found

Visit Date: Last Compensation and Pension Exam for PTSD

Provider Type: Last Compensation and Pension Exam for PTSD

- (•) Blank
- ( ) Clinical psychologist
- ( ) Psychiatrist
- ( ) Nurse practitioner/ Nurse
- ( ) Social worker
- ( ) Primary care physician
- ( ) Other (indicate below)

Other Provider Type: Last Compensation and Pension Exam for PTSD

Question: Mental Health Intake Note

- (•) Blank
- ( ) Yes
- ( ) No
- ( ) Record not found

Visit Date: Mental Health Intake Note

Local Title of Note: Mental Health Intake Note

Provider Type: Mental Health Intake Note

- (•) Blank
- ( ) Clinical psychologist
- ( ) Psychiatrist
- ( ) Nurse practitioner/ Nurse
- ( ) Social worker
- ( ) Primary care physician
- ( ) Other (indicate below)

Other Provider Type: Mental Health Intake Note

Question: Mental Health Consultation Note

- (•) Blank
- ( ) Yes
- ( ) No
- ( ) Record not found

Visit Date: Mental Health Consultation Note

Provider Type: Mental Health Consultation Note

- (•) Blank
- ( ) Clinical psychologist
- ( ) Psychiatrist
- ( ) Nurse practitioner/ Nurse
- ( ) Social worker
- ( ) Primary care physician
- ( ) Other (indicate below)

Other Provider Type: Mental Health Consultation Note

Question: Psychiatric Inpatient Discharge Summary Diagnosis

- (•) Blank
- ( ) Yes
- ( ) No
- ( ) Record not found

Visit Date: Psychiatric Inpatient Discharge Summary Diagnosis

Provider Type: Psychiatric Inpatient Discharge Summary Diagnosis

- (•) Blank
- ( ) Clinical psychologist
- ( ) Psychiatrist
- ( ) Nurse practitioner/ Nurse
- ( ) Social worker
- ( ) Primary care physician
- ( ) Other (indicate below)

Other Provider Type: Psychiatric Inpatient Discharge Summary Diagnosis

Question: PTSD Checklist (e.g., from Mental Health Assistant Package)

- (•) Blank
- ( ) Yes
- ( ) No
- ( ) Record not found

Score: If PTSD Checklist present, enter PCL score (0-85).

Visit Date: PTSD Checklist (e.g., from Mental Health Assistant Package)

Provider Type: PTSD Checklist (e.g., from Mental Health Assistant Package)

- (•) Blank
- ( ) Clinical psychologist
- ( ) Psychiatrist
- ( ) Nurse practitioner/ Nurse
- ( ) Social worker
- ( ) Primary care physician
- ( ) Other (indicate below)

Other Provider Type: PTSD Checklist (e.g., from Mental Health Assistant Package)

Question: Other PTSD Assessment Note (if yes please specify kind below)

- (•) Blank
- ( ) Yes

Kind: Other PTSD Assessment Note

Visit Date: Other PTSD Assessment Note

Provider Type: Other PTSD Assessment Note

- (•) Blank
- ( ) Clinical psychologist
- ( ) Psychiatrist
- ( ) Nurse practitioner/ Nurse
- ( ) Social worker
- ( ) Primary care physician
- ( ) Other (indicate below)

Other Provider Type: Other PTSD Assessment Note

Notes: Examples of relevant information to record in the Notes section include: PTSD listed as primary vs. secondary diagnosis, new or ongoing PTSD diagnosis, significant diagnostic discrepancies across providers, etc.

1

Evidence of PTSD Note

F2 Evidence of Trauma Exposures: CSP 575B PTSD Chart Review

☐ Omit F2 Evidence of Trauma Exposures

☑ Check here to turn off all validation. (Normally checked only when submitting data which fails to meet validation rules.)

Study ID:

Reviewer:

Question: In your review of this patient's chart, did you find any evidence of trauma exposure? (if yes, then answer all applicable questions below:)

- ◉ Blank
- ○ Yes
- ○ No

Question: Combat Trauma or Exposure to a War-zone

- ◉ Blank
- ○ Yes

Visit Date: Combat Trauma or Exposure to a War-zone

Provider Type: Combat Trauma or Exposure to a War-zone

- ◉ Blank
- ○ Clinical psychologist
- ○ Psychiatrist
- ○ Nurse practitioner/ Nurse
- ○ Social worker
- ○ Primary care physician
- ○ Other (indicate below)

Other Provider Type: Combat Trauma or Exposure to a War-zone

Source: Combat Trauma or Exposure to a War-zone

- ◉ Blank
- ○ Initial Compensation and Pension Exam for PTSD
- ○ Last Compensation and Pension Exam for PTSD
- ○ Mental Health Intake Note
- ○ Mental Health Consultation Note
- ○ Psychiatric Inpatient Discharge Summary Diagnosis
- ○ Primary Care Physician Note
- ○ Other PTSD Assessment Note (indicate below)

Other Source: Combat Trauma or Exposure to a War-zone

Question: Military Sexual Trauma

- (•) Blank
- ( ) Yes

Visit Date: Military Sexual Trauma

Provider Type: Military Sexual Trauma

- (•) Blank
- ( ) Clinical psychologist
- ( ) Psychiatrist
- ( ) Nurse practitioner/ Nurse
- ( ) Social worker
- ( ) Primary care physician
- ( ) Other (indicate below)

Other Provider Type: Military Sexual Trauma

Source: Military Sexual Trauma

- (•) Blank
- ( ) Initial Compensation and Pension Exam for PTSD
- ( ) Last Compensation and Pension Exam for PTSD
- ( ) Mental Health Intake Note
- ( ) Mental Health Consultation Note
- ( ) Psychiatric Inpatient Discharge Summary Diagnosis
- ( ) Primary Care Physician Note
- ( ) Other PTSD Assessment Note (indicate below)

Other Source: Military Sexual Trauma

Question: Other Adulthood Trauma (if yes please specify kind below)

- (•) Blank
- ( ) Yes

Kind: Other Adulthood Trauma

Visit Date: Other Adulthood Trauma

Provider Type: Other Adulthood Trauma

- (•) Blank
- ( ) Clinical psychologist
- ( ) Psychiatrist

- Nurse practitioner/ Nurse
- Social worker
- Primary care physician
- Other (indicate below)

Other Provider Type: Other Adulthood Trauma

Source: Other Adulthood Trauma

- Blank
- Initial Compensation and Pension Exam for PTSD
- Last Compensation and Pension Exam for PTSD
- Mental Health Intake Note
- Mental Health Consultation Note
- Psychiatric Inpatient Discharge Summary Diagnosis
- Primary Care Physician Note
- Other PTSD Assessment Note (indicate below)

Other Source: Other Adulthood Trauma

Question: Child Sexual Abuse

- Blank
- Yes

Visit Date: Child Sexual Abuse

Provider Type: Child Sexual Abuse

- Blank
- Clinical psychologist
- Psychiatrist
- Nurse practitioner/ Nurse
- Social worker
- Primary care physician
- Other (indicate below)

Other Provider Type: Child Sexual Abuse

Source: Child Sexual Abuse

- Blank
- Initial Compensation and Pension Exam for PTSD
- Last Compensation and Pension Exam for PTSD
- Mental Health Intake Note
- Mental Health Consultation Note
- Psychiatric Inpatient Discharge Summary Diagnosis
- Primary Care Physician Note

- Other PTSD Assessment Note (indicate below)

Other Source: Child Sexual Abuse

Question: Child Physical Abuse

- Blank
- Yes

Visit Date: Child Physical Abuse

Provider Type: Child Physical Abuse

- Blank
- Clinical psychologist
- Psychiatrist
- Nurse practitioner/ Nurse
- Social worker
- Primary care physician
- Other (indicate below)

Other Provider Type: Child Physical Abuse

Source: Child Physical Abuse

- Blank
- Initial Compensation and Pension Exam for PTSD
- Last Compensation and Pension Exam for PTSD
- Mental Health Intake Note
- Mental Health Consultation Note
- Psychiatric Inpatient Discharge Summary Diagnosis
- Primary Care Physician Note
- Other PTSD Assessment Note (indicate below)

Other Source: Child Physical Abuse

Question: Other Childhood Trauma (if yes please specify kind below)

- Blank
- Yes

Kind: Other Childhood Trauma

Visit Date: Other Childhood Trauma

Provider Type: Other Childhood Trauma

- (•) Blank
- ( ) Clinical psychologist
- ( ) Psychiatrist
- ( ) Nurse practitioner/ Nurse
- ( ) Social worker
- ( ) Primary care physician
- ( ) Other (indicate below)

Other Provider Type: Other Childhood Trauma

Source: Other Childhood Trauma

- (•) Blank
- ( ) Initial Compensation and Pension Exam for PTSD
- ( ) Last Compensation and Pension Exam for PTSD
- ( ) Mental Health Intake Note
- ( ) Mental Health Consultation Note
- ( ) Psychiatric Inpatient Discharge Summary Diagnosis
- ( ) Primary Care Physician Note
- ( ) Other PTSD Assessment Note (indicate below)

Other Source: Other Childhood Trauma

F3 Evidence of Comorbid Psychiatric Conditions: CSP 575B PTSD Chart Review

☐ Omit F3 Evidence of Comorbid Psychiatric Conditions

☑ Check here to turn off all validation. (Normally checked only when submitting data which fails to meet validation rules.)

Study ID:

Reviewer:

Question: In your review of this patient's chart, did you find any evidence of comorbid psychiatric conditions? (if yes, then answer all applicable questions below:)

- ◉ Blank
- ○ Yes
- ○ No

Question: Schizophrenia

- ◉ Blank
- ○ Yes

Visit Date: Schizophrenia

Provider Type: Schizophrenia

- ◉ Blank
- ○ Clinical psychologist
- ○ Psychiatrist
- ○ Nurse practitioner/ Nurse
- ○ Social worker
- ○ Primary care physician
- ○ Other (indicate below)

Other Provider Type: Schizophrenia

Source: Schizophrenia

- ◉ Blank
- ○ Initial Compensation and Pension Exam for PTSD
- ○ Last Compensation and Pension Exam for PTSD
- ○ Mental Health Intake Note
- ○ Mental Health Consultation Note
- ○ Psychiatric Inpatient Discharge Summary Diagnosis
- ○ Primary Care Physician Note
- ○ Other PTSD Assessment Note (indicate below)

Other Source: Schizophrenia

Question: Bipolar Disorder

- (•) Blank
- ( ) Yes

Visit Date: Bipolar Disorder

Provider Type: Bipolar Disorder

- (•) Blank
- ( ) Clinical psychologist
- ( ) Psychiatrist
- ( ) Nurse practitioner/ Nurse
- ( ) Social worker
- ( ) Primary care physician
- ( ) Other (indicate below)

Other Provider Type: Bipolar Disorder

Source: Bipolar Disorder

- (•) Blank
- ( ) Initial Compensation and Pension Exam for PTSD
- ( ) Last Compensation and Pension Exam for PTSD
- ( ) Mental Health Intake Note
- ( ) Mental Health Consultation Note
- ( ) Psychiatric Inpatient Discharge Summary Diagnosis
- ( ) Primary Care Physician Note
- ( ) Other PTSD Assessment Note (indicate below)

Other Source: Bipolar Disorder

Question: Depressive Disorder

- (•) Blank
- ( ) Yes

Visit Date: Depressive Disorder

Provider Type: Depressive Disorder

- (•) Blank
- ( ) Clinical psychologist
- ( ) Psychiatrist

- Nurse practitioner/ Nurse
- Social worker
- Primary care physician
- Other (indicate below)

Other Provider Type: Depressive Disorder

Source: Depressive Disorder

- Blank
- Initial Compensation and Pension Exam for PTSD
- Last Compensation and Pension Exam for PTSD
- Mental Health Intake Note
- Mental Health Consultation Note
- Psychiatric Inpatient Discharge Summary Diagnosis
- Primary Care Physician Note
- Other PTSD Assessment Note (indicate below)

Other Source: Depressive Disorder

Question: Alcohol Use Disorder

- Blank
- Yes

Visit Date: Alcohol Use Disorder

Provider Type: Alcohol Use Disorder

- Blank
- Clinical psychologist
- Psychiatrist
- Nurse practitioner/ Nurse
- Social worker
- Primary care physician
- Other (indicate below)

Other Provider Type: Alcohol Use Disorder

Source: Alcohol Use Disorder

- Blank
- Initial Compensation and Pension Exam for PTSD
- Last Compensation and Pension Exam for PTSD
- Mental Health Intake Note
- Mental Health Consultation Note
- Psychiatric Inpatient Discharge Summary Diagnosis
- Primary Care Physician Note

Other PTSD Assessment Note (indicate below)

Other Source: Alcohol Use Disorder

Question: Substance Use Disorder (if yes, please specify drug type/class below)

- (•) Blank
- ( ) Yes

Drug type/class: Substance Use Disorder

Visit Date: Substance Use Disorder

Provider Type: Substance Use Disorder

- (•) Blank
- ( ) Clinical psychologist
- ( ) Psychiatrist
- ( ) Nurse practitioner/ Nurse
- ( ) Social worker
- ( ) Primary care physician
- ( ) Other (indicate below)

Other Provider Type: Substance Use Disorder

Source: Substance Use Disorder

- (•) Blank
- ( ) Initial Compensation and Pension Exam for PTSD
- ( ) Last Compensation and Pension Exam for PTSD
- ( ) Mental Health Intake Note
- ( ) Mental Health Consultation Note
- ( ) Psychiatric Inpatient Discharge Summary Diagnosis
- ( ) Primary Care Physician Note
- ( ) Other PTSD Assessment Note (indicate below)

Other Source: Substance Use Disorder

Question: Anxiety Disorder

- (•) Blank
- ( ) Yes

Visit Date: Anxiety Disorder

Provider Type: Anxiety Disorder

- (•) Blank
- ( ) Clinical psychologist
- ( ) Psychiatrist
- ( ) Nurse practitioner/ Nurse
- ( ) Social worker
- ( ) Primary care physician
- ( ) Other (indicate below)

Other Provider Type: Anxiety Disorder

Source: Anxiety Disorder

- (•) Blank
- ( ) Initial Compensation and Pension Exam for PTSD
- ( ) Last Compensation and Pension Exam for PTSD
- ( ) Mental Health Intake Note
- ( ) Mental Health Consultation Note
- ( ) Psychiatric Inpatient Discharge Summary Diagnosis
- ( ) Primary Care Physician Note
- ( ) Other PTSD Assessment Note (indicate below)

Other Source: Anxiety Disorder

Question: Traumatic Brain Injury

- (•) Blank
- ( ) Yes

Visit Date: Traumatic Brain Injury

Provider Type: Traumatic Brain Injury

- (•) Blank
- ( ) Clinical psychologist
- ( ) Psychiatrist
- ( ) Nurse practitioner/ Nurse
- ( ) Social worker
- ( ) Primary care physician
- ( ) Other (indicate below)

Other Provider Type: Traumatic Brain Injury

Source: Traumatic Brain Injury

- (•) Blank
- ( ) Initial Compensation and Pension Exam for PTSD
- ( ) Last Compensation and Pension Exam for PTSD
- ( ) Mental Health Intake Note
- ( ) Mental Health Consultation Note
- ( ) Psychiatric Inpatient Discharge Summary Diagnosis
- ( ) Primary Care Physician Note
- ( ) Other PTSD Assessment Note (indicate below)

Other Source: Traumatic Brain Injury	

Menu | Previous Form | Next Form | Check here to turn off all validation. (Normally checked only when submitting data which fails to meet validation rules.)

Form 4

Study ID: *

Reviewer: *

Posttraumatic Stress Disorder: On the basis of your chart review, what is the best classification of this patient? (check the box that best applies)

- (•) Blank
- ( ) Likely PTSD (Significant evidence of a lifetime PTSD diagnosis)
- ( ) Possible PTSD (Weak or indeterminate evidence of a lifetime PTSD diagnosis or presents with subclinical level of PTSD symptomatology)
- ( ) Likely Not PTSD (No evidence of a lifetime PTSD diagnosis)
- ( ) Insufficient Data Available (There is inadequate information in the medical record to classify this patient)

History of Trauma Exposure: 1. Does the patient show evidence of exposure to combat trauma?

- (•) Blank
- ( ) Yes (Medical record documents exposure of combat or war-zone trauma)
- ( ) No (Medical record documents no history of combat or war-zone exposure)
- ( ) Unsure (Assessment of exposure to combat trauma was not found)

History of Trauma Exposure: 2. Does the patient show evidence of exposure to military sexual trauma (MST)?

- (•) Blank
- ( ) Yes (Medical record documents exposure of MST)
- ( ) No (Medical record documents no history of MST)
- ( ) Unsure (Assessment of MST was not found)

History of Trauma Exposure: 3. Does the patient show evidence of exposure to other potentially traumatic event(s)?

- (•) Blank
- ( ) Yes (Medical record documents exposure of other potentially traumatic events, consistent with DSM Criterion A)
- ( ) No (Medical record documents no history of other potentially traumatic events)
- ( ) Unsure (Assessment of other trauma exposure was not found)

Other Important Notes about your Diagnostic Impressions:

Comments: CSP 575B PTSD Chart Review

☐ Omit Comments

☑ Check here to turn off all validation. (Normally checked only when submitting data which fails to meet validation rules.)

Study ID:

Reviewer:

1

Comment

2

Comment

3

Comment

Quick Guide:

Summary of Team Decisions related to Classifying Patients for CSP 575B Chart Reviews

- A major objective of CSP 575B chart reviews is to reliably identify PTSD Cases and non-PTSD Controls.
- Towards that end, we must strive to standardize our classifications of patients into Likely PTSD, Possible PTSD, and Likely Not PTSD. Most importantly, we are working to define the gold standard PTSD case.
- Different pieces of evidence in CAPRI give us varying degrees of confidence in a PTSD diagnosis, for example:
    - PTSD in the Problem List alone gives us low certainty in the diagnosis
    - Multiple instances of PTSD diagnosis in ICD-9 codes gives us greater certainty
    - Review of the clinical notes (e.g., documentation of patient's ongoing engagement in treatment for PTSD) gives us the most confidence in classifying PTSD

Team Decisions related to Evidence of a **Lifetime PTSD Diagnosis**

- PTSD Treatment
    - **Decision**: Treatment for PTSD provides evidence of lifetime PTSD history (for detailed information, see "Chart Review Classification Guidance" in Appendix)
- PTSD screens
    - **Decision**: 2 or more positive screens (e.g., PC-PTSD) alone would only suggest Possible PTSD; additional evidence of PTSD is needed to move to Likely PTSD category
- C&P Exam
    - **Decision:** The C&P exam (single evaluation) is not the gold standard when there are multiple notes available from routine providers.
- Service connection for PTSD
    - **Decision**: Higher percentage of service connection should be weighted more in judgement of PTSD caseness. Even in the absence of a C&P exam record, we should give considerable weight to 100% service connection.
        - **Try out this guideline during upcoming reviews**: Mark patients with ≥ 50% service connection as "Likely PTSD".
        - **Caveat**: It is still important to weigh all sources of evidence of PTSD and use your clinical judgment to arrive at the final PTSD classification for each subject.
- "Rule out" PTSD
    - **Issue:** If "rule out PTSD" is noted in a patient's chart but there is no diagnosis or assessment, should the patient be classified as possible PTSD?
    - **Decision:**
        - 1) If "rule out PTSD" is noted in a patient's chart and there is confirmatory evidence of PTSD, mark the patient as Likely PTSD
        - 2) If "rule out PTSD" is noted in a patient's chart and there is NO confirmatory evidence of PTSD, mark the patient as Possible PTSD

Team Decisions related to Evidence of a **Lifetime Trauma Exposure**

- Assessment of Trauma History
    - **Decision**: Any documentation of trauma history is enough to provide evidence – the patient does not need a formal trauma assessment to show evidence of trauma
    - **Decision:** If a patient has no screening/assessment information regarding combat exposure, mark combat status as "unsure". Overall, combat exposure must have been assessed in some manner in order to confirm evidence of combat exposure ("yes") or disconfirm evidence of combat exposure ("no").
    - **Decision**: Documentation of any traumatic event generally related to military experience should be classified as "combat trauma" with the exception of military sexual trauma (MST) which is categorized separately for this study.

Team Decisions related to Evidence of a **Lifetime Comorbid Psychiatric Condition**

- Comorbid Psychiatric Conditions
    - **Decision:** Any evidence of a comorbid psychiatric condition is sufficient to label the patient as having it.
        - The threshold for diagnosis of comorbid conditions is lower than the threshold for PTSD for the purposes of our study.
    - **Decision**: Many comorbid psychiatric conditions are episodic in nature. If one reviewer finds any evidence of a comorbid diagnosis, the final classification of the patient will be affirmative for that condition.
    - **Decision**: We are not recording evidence of 'Tobacco Use Disorder' under the 'Substance Use Disorder' section of the comorbidity form.
- Alcohol Use Disorder
    - **Decision**: Notes should give evidence of the disorder (i.e., ongoing problematic pattern of alcohol use over a 12-month period), not subclinical alcohol use.
        - Ex: A mention of "heavy drinking" or a single instance of alcohol detox does not meet the criteria.
- Traumatic Brain Injury (TBI)
    - **Decision:** Do not rely on a clinician diagnosis to mark a patient as having experienced a TBI. It is sufficient to use information about the injury and symptoms to label the patient as having a TBI.
        - Documentation of a concussion can qualify as TBI (concussion = mild TBI).
        - The threshold for diagnosis of TBI is lower than the threshold for PTSD for the purposes of our study; for TBI, the minimum threshold is documentation of exposure rather than diagnosis
        - Remember: we are looking at lifetime exposure to TBI.

CSP575B Chart Review: Guidance for PTSD Classification

	Likely PTSD	Possible PTSD	Likely Not PTSD	Insufficient Data
Problem List		PTSD in the Problem List alone gives us low certainty in the diagnosis.		
Rule-Out PTSD	If "rule out PTSD" is noted in a patient's chart and there is confirmatory evidence of PTSD,* mark the patient as **Likely PTSD**.	If "rule out PTSD" is noted in a patient's chart and there is NO confirmatory evidence of PTSD,* mark the patient as **Possible PTSD**.		
Service Connection for PTSD	Higher percentage of service connection should be weighted more in judgement of PTSD caseness. Even in the absence of a C&P exam record, we should give considerable weight to 100% service connection. ***Note:*** *"0% service-connected for PTSD" means a disability exists and is related to the veteran's service but it's not so disabling that it entitles the veteran to compensation payments.*			
PTSD Diagnosis	More instances of PTSD diagnoses in notes from multiple MH providers give greater confidence in **Likely PTSD** diagnosis. The presence of one or more comprehensive PTSD assessments (e.g., DSM criteria are listed and linked to traumatic stressor) concluding with a PTSD diagnosis move patients along the continuum towards **Likely PTSD**. *Note: repeated copying and pasting a PTSD diagnosis across notes should not necessarily suggest* ***Likely PTSD*** *in the absence of other evidence of PTSD.*			
PTSD Treatment – individual psychotherapy	Clear documentation of PTSD- or trauma-focused therapy provides evidence of **Likely PTSD**.	If a patient has been diagnosed with multiple psychiatric disorders (including PTSD) and there is no evidence that treatment has addressed PTSD symptoms specifically, this would suggest **Possible PTSD** in the absence of other evidence of PTSD.		

PTSD Treatment – groups	Clear documentation of PTSD- or trauma-focused group therapy (e.g., group CPT or group exposure therapy), provides evidence of **Likely PTSD**.	If a patient has only received PTSD treatment in a psychoeducation group (e.g., PTSD support group or stress management group), this would suggest **Possible PTSD** in the absence of other evidence of PTSD.		
PTSD Treatment – medication	Clear documentation of a psychotropic medication being prescribed to treat PTSD specifically provides evidence of **Likely PTSD**.	If a patient is prescribed a psychotropic medication but it is not clearly linked to the treatment of PTSD, this would suggest **Possible PTSD** in the absence of other evidence of PTSD.		
Primary Care PTSD Screener (PC-PTSD)		2 or more positive screens (e.g., PC-PTSD) alone would only suggest **Possible PTSD**.	In order to say **Likely Not PTSD** (vs. **Insufficient Data**), we would like to see at least one negative PTSD screen OR another type of mental health screening or assessment OR evidence veteran has received regular/ongoing care in VHA system (ideally at least multiple visits spanning over several years).	
PTSD Checklist (PCL)		PCL score ≥ 50 alone would only suggest **Possible PTSD**.		

* = There are two primary types of confirmatory evidence for "Rule-Out PTSD": (1) documentation of a PTSD diagnosis in at least one independent assessment note and/or (2) documentation of treatment for PTSD (as defined in the PTSD treatment rows of the table).

General Guidance/ Rules of Thumb

3 scenarios where it is appropriate to assign the Possible PTSD category:

1. **Weak OR indeterminate OR ambiguous evidence of lifetime PTSD diagnosis**: There may be a few mentions of PTSD, but not enough information to feel confident in classifying the patient as **Likely PTSD**. Patient probably has had very little contact with mental health or perhaps even primary care. In other cases, there may be ambiguous or conflicting information presented by various providers which precludes classifying the patient as **Likely PTSD** or **Likely Not PTSD**.

2. **Subthreshold PTSD**: There is documentation of PTSD symptoms in the patient's record, but clear evidence of a PTSD diagnosis is lacking. For example, a provider's note shows that a rule-out of PTSD was considered but a final diagnosis was not indicated.
3. When the group is struggling to reach consensus about the final PTSD classification (e.g., high degree of uncertainty and/or lack of corroborating evidence), it seems most appropriate to label the patient as **Possible PTSD**.

Likely Not PTSD vs. Insufficient Data Available:

- If a patient has interacted with various providers across various disciplines over multiple years with no mention of posttraumatic stress, then you might feel fairly confident in classifying him/her as **Likely Not PTSD**.
- On the other hand, if the patient has had minimal interactions with VA providers, it might be more appropriate to label him/her as **Insufficient Data**.

Final determination about PTSD caseness:

This guidance document is not intended to be prescriptive; rather it was created to help document several key considerations when classifying a patient's PTSD status based on information reviewed in the medical record. Ultimately, a final determination about PTSD caseness should be reached after considering all sources of PTSD evidence in their totality.