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| 1 | dochospce | Is one of the following documented in the medical record:the patient is enrolled in a VHA or community-based Hospice programthe patient has a diagnosis of cancer of the liver, pancreas, or esophaguson the problem list it is documented the patient’s life expectancy is less than 6 months? | 1\*,2  \*If 1, go to modsevci  If 2, go to fluhirsk | A “yes” answer to this question will exclude the case from the PI module.  Although all noted conditions may be applicable to the case, only one is necessary for exclusion from the PI Module.  The stage of cancer of the liver, esophagus, or pancreas is not applicable. Even if the patient is newly diagnosed, the case is excluded.  Patient’s life expectancy of less than six months must be documented on the problem list or in the computer field “health factors,” without exception.  **Acceptable:** Enrollment in a VHA or community-based Hospice  **Unacceptable:** Enrollment in a VHA Palliative Care program or HBPC. | |
|  |  | Immunization |  |  | |
| 2 | fluhirsk1  fluhirsk2  fluhirsk3  fluhirsk4  fluhirsk5  fluhirsk6  fluhirsk9  fluhirsk10  fluhirsk99 | Was the patient in one or more of the following influenza high-risk categories?  **Indicate all that apply:**   1. resident of chronic care facility, to include a Domiciliary 2. chronic cardiopulmonary disorder 3. metabolic disease (including diabetes mellitus) 4. hemoglobinopathy 5. immunosuppression   6. renal dysfunction   1. pregnancy during immunization period 2. neurological or neuromuscular condition that could compromise respiratory function, handling of respiratory secretions, or increase risk of aspiration   99. none of the above | 1,2,3,4,5,6,9,10,99   |  | | --- | | Warning if fluhirsk= 2 and selcopd = F or selchf = F.  Warning if fluhirsk  = 3 and seldm = F  Warning if fluhirsk = 6 and selckd = F |  |  | | --- | | Cannot enter 9 if sex = 1 or 3 |  |  | | --- | | 99 cannot be  entered with any other number | | Groups at Increased Risk for Complications from Influenza:  1. Residents of nursing homes and other chronic-care facilities that house persons who have chronic medical conditions 2. Chronic disorders of the pulmonary or cardiovascular system, i.e., COPD, CHF, cor pulmonale, and including asthma, aortic stenosis, mitral valve regurgitation 3. Diabetes Mellitus, Metabolic disease: Cushing’s Syndrome, Graves disease, myxedema, Addison’s disease 4. Hemoglobinopathy: Sickle cell anemia, polycythemia, thalassemia 5. Immunosuppression: AIDS, chemotherapy, organ transplant 6. Renal dysfunction: chronic renal failure, nephrotic syndrome 7. Pregnancy during immunization period = September 1, 2011 – March 31, 2012 8. Neurological or neuromuscular condition (e.g., cognitive dysfunction, spinal cord injuries, seizure disorders, or other neuromuscular disorders) that can compromise respiratory function or the handling of respiratory secretions or that can increase the risk for aspiration   99. Patient has none of these conditions documented in record | |
| 3 | allerflu | Does the patient have known allergy to eggs or other flu vaccine components, a history of Guillain-Barre Syndrome, a bone marrow transplant within the past 12 months? | 1,2 | “Inactivated influenza vaccine should not be administered to persons known to have anaphylactic hypersensitivity to eggs or other components of the influenza vaccine.”  **Allergy to eggs or other flu vaccine component must be documented in the paper or electronic record. Notation does not have to state “anaphylactic.” If the facility is using single dose syringes and the veteran has a documented latex allergy, answer “yes.”** |
| 4 | fluvac11 | During the period 9/01/2011 to 3/31/2012, did the patient receive influenza vaccination?  1. received vaccination from VHA   1. received vaccination from private sector provider 2. patient’s only visit during immunization period preceded availability of vaccine   98. patient refused vaccination  99. no documentation patient received  vaccination | 1,3, 4, 98,99  **If 4, 98 or 99, auto-fill fluvacdt as 99/99/9999** | **To enter response #4, the abstractor must see the pharmacy record stating the date the vaccine arrived on station (shipping slip, inventory record, etc.) The patient’s only visit during the immunization period must have occurred prior to receipt of the facility’s flu vaccine. (Example: patient’s only visit during immunization season of 9/01/11 – 3/31/12 was on 9/14/11. Facility did not receive vaccine until 9/21/11. Enter response #4.)**  **For patients who had no visits at all during immunization season and did not receive vaccine at this VAMC or elsewhere, answer “99.”**  **Acceptable as documentation of influenza immunization:**   1. Notation of “flu shot given” entered in paper or electronic record. The month and year (or the fact it was flu vaccination season) when the pt received the vaccine must be known. 2. Influenza vaccine given in another setting, i.e., acute care, NHCU, etc., and the month and year are known 3. Patient self-report of flu shot at community facility if month and year are known and documented. 4. Checkmark on a checklist, if there is a month and year, and the checkmark is accompanied by the clinician’s signature or initials. The patient must have had a clinic visit or visit to a vaccination clinic on the date indicated on the checklist. 5. **Historical information obtained by telephone by a licensed member of the healthcare team and entered in a CPRS progress note is acceptable.**   Cont’d on next page |
|  |  |  |  | **Influenza vaccination cont’d**  **Unacceptable documentation:**   1. Patient is told to return later for flu vaccine. 2. “Shortfall” of flu vaccine, unless nationally publicized shortage 3. Documented assumption “patient gets annual flu shot or vaccination”   **Patient refusal = during the vaccination season, when flu shot was offered, patient stated he did not wish to receive flu vaccination** |
| 5 | fluvacdt | Enter the date influenza vaccination was given. | mm/dd/yyyy   |  | | --- | | > = 9/01/2011 and  < = 3/31/2012 and  (< = pulldt or < = stdyend if > pulldt) | | Although the day may be entered as day = 01, if the specific date is unknown, the exact month and year must be entered accurately.  **If the exact month is unknown, but there is documentation the patient received the flu vaccine in fall or winter, enter “10” as the default month.** |
| 6 | pnuhirsk1  pnuhirsk2  pnuhirsk3  pnuhirsk4  pnuhirsk5  pnuhirsk7  pnuhirsk8  pnuhirsk99 | Was the patient in one or more of the following pneumococcal pneumonia high-risk categories?  **Indicate all that apply:**   1. institutional resident age 50 or older, including Domiciliary 2. diabetes mellitus 3. chronic cardiac disease (past MI, CHF, or cardiomyopathy) 4. chronic pulmonary disease (COPD or emphysema) 5. anatomic asplenia (includes sickle cell disease or splenectomy)   7. HIV positive  8. Immunocompromised patients  99. none of the above | 1,2,3,4,5,7,8,99   |  | | --- | | Disable pnuhirsk1 if pt age < 50  Hard edit on pnuhirsk2: seldm = T must =T  Warning on pnuhirsk3 if selmi or selchf=F  Warning on pnuhirsk4 if selcopd=F  Cannot enter 99 with any other number  **Enable seldm in Validation Module if pnuhirsk2 = T.**  **Enable selcopd in Validation Module if pnuhirsk = 4.** | | **High Risk Groups for Which Vaccination is Recommended**  1 = resident of long-term care facility, Domiciliary, etc.  3= includes past MI, congestive heart failure and cardiomyopathies  4 = includes COPD and emphysema  5 = includes sickle cell disease and splenectomy  8 = immunocompromised patients with chronic illnesses specifically associated with increased risk from pneumococcal infection (e.g., persons with Hodgkin's disease, lymphoma, multiple myeloma, chronic renal failure, nephrotic syndrome, or conditions such as organ transplantation associated with immunosuppression) |
| 7 | pnumovac | At any time, not later than the study end date, did the veteran receive pneumococcal vaccination, either as an inpatient or outpatient?   1. received vaccination from VHA 2. received vaccine from private sector provider   98. patient refused vaccination  99. no documentation patient received vaccine | 1,3,98,99 If 98 or 99, auto-fill pnuvacdt as 99/99/9999 | Acceptable: Documentation that patient had pneumovax if year is known. It is preferable to know the month and year of pneumococcal vaccination: however, this data is not always available.  Historical information obtained by telephone by a licensed member of the healthcare team and entered in a CPRS progress note is acceptable.  Unacceptable: Notation in the record that patient has had pneumococcal vaccination if year of administration is not documented.  Patient refusal = each time it was offered, patient stated he/she states he does not want pneumococcal vaccination |
| 8 | pnuvacdt | Enter the date of the most recent pneumococcal vaccination. | mm/dd/yyyy  If pnumovac = 98 or 99, will be auto-filled as 99/99/9999   |  | | --- | | Warning if > 15 years prior to stdybeg and < = stdyend | | Notation in the record that patient has had pneumococcal vaccination is not acceptable unless, at a minimum, year is documented. If more than one pneumococcal vaccination, use the most recent date.  Enter the year if that is the only information known, with 01 for month and day. |

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|  |  | **Hepatitis C** |  |  |
| 9 | testhcv | Within the past two years, was the veteran tested for HCV antibodies?  1. Yes  2. No  3. Vet diagnosed with Hep-C prior to past two years  98. Patient refused to be tested | 1,2,3,98  **If 2,3, or 98, auto-fill the following:**  **hcvtstdt as 99/99/9999, poshcv as 95, tstposdt as 99/99/9999, hcvconf as 95, hcvcondt as 99/99/9999, informpt as 95, informdt as 99/99/9999, hcvtxref as 95, disrefdt as 99/99/9999, and go to notobuse as applicable** | Tests for HCV Antibodies: Anti-Hep C Virus Ab (EIA or ELISA)  **Anti-Hep C Virus Ab tests (EIA or ELISA) are used to detect the presence of antibody to hepatitis C virus (anti-HCV). These tests do not confirm active HepC.**  The question applies to testing at this or another VAMC or in the private sector. If patient was tested at another VAMC or in the private sector, the date and the test results must be known to answer yes.  Patient refusal documented in record = during a patient encounter, when testing for Hepatitis-C offered or recommended, the patient stated he/she does not wish to be tested. |
| 10 | hcvtstdt | Enter the date of the most recent HCV antibody test done within the past two years. | mm/dd/yyyy  Will be auto-filled as 99/99/9999 if testhcv = 2,3, or 98   |  | | --- | | < = 2 years prior to or = stdybeg and < = stdyend | | If the laboratory date is not available, use the date of documentation in the record that the test was done.  At a minimum the month and year should be documented and entered accurately. If the day is unknown, enter 01 as the default. |
| 11 | poshcv | Within the two-year period, was any the Anti-Hep C Virus Ab (EIA or ELISA)test positive?   1. Yes 2. No 3. Not applicable | 1,2,95  Will be auto-filled as 95 if testhcv = 2,3, or 98  **If 2, auto-fill tstposdt as 99/99/9999, hcvconf as 95, hcvcondt as 99/99/9999, informpt as 95, informdt as 99/99/9999, hcvtxref as 95, disrefdt as 99/99/9999, and**  **go to notobuse as applicable** | If more than one Anti-Hep C Virus Ab (EIA or ELISA) test was performed during the two-year period, the results may differ. If any HCV antibody test result was positive within the past two years, answer “1.”  Patient self-report is not acceptable. |
| 12 | tstposdt | Enter the date of the first positive test for Anti-Hep C Virus Ab (EIA or ELISA). | mm/dd/yyyy  Will be auto-filled as 9/99/9999 if  testhcv = 2,3, or 98,  or poshcv = 2   |  | | --- | | < = 2 years prior to or = stdybeg and < = stdyend | | If more than one Anti-Hep C Virus Ab (EIA or ELISA) test was performed, enter the date of the first Anti-Hep C Virus Ab test with a positive result. Use the laboratory report date. If the lab report date is not available, use the date the clinician documented that results were positive.  At a minimum the month and year should be documented and entered accurately. If the day is unknown, enter 01 as the default. |
| 13 | hcvconf | Following the positive test for HCV antibodies, was further testing for active HCV performed?   1. HCV RNA test done, results positive 2. HCV RNA test done, results negative 3. RIBA test done, results negative 4. Not applicable 5. Patient refused further testing for HCV 6. Further testing for HCV not documented | 1,2,3,95,98,99  Will be auto-filled as 95 if testhcv = 2,3, or 98, or poshcv = 2  **If 98 or 99, auto-fill hcvcondt as 99/99/9999, informpt as 95, informdt as 99/99/9999, hcvtxref as 95, disrefdt as 99/99/9999,**  **and go to notobuse as applicable** | **Tests for assessment of active HCV:**  HCV RNA Qualitative (RT-PCR)  HCV RNA Qualitative (bDNA)  HCV RNA Quantitative (RT-PCR)  HCV RNA Quantitative (bDNA)  HCV genotype result (expressed as 1, 1a, 1b, 2, 3, or other number)  **Exclusion test for active HCV:**  Option #3 = Recombinant immunoblot assay (RIBA) – **only enter “3” if RIBA test was performed and the RIBA results were negative.** If RIBA test was positive, a RNA test must be done to confirm (or exclude) active HCV infection. **If RIBA test was positive but HCV RNA test was not done, enter “99.”**  This question applies to testing at this or another VAMC or in the private sector. If patient was tested at another VAMC or in the private sector, the date and the outcome must be known to answer yes.  Patient refusal documented in record = during a patient encounter, when further testing for active Hepatitis-C offered or recommended, the patient stated he/she does not wish to be tested. |
| 14 | hcvcondt | Enter the date the test for assessment of active HCV was performed. | mm/dd/yyyy  Will be auto-filled as 99/99/9999 if  testhcv = 2,3, or 98,  or poshcv = 2, or hcvconf = 98 or 99  **If hcvconf = 2 or 3, auto-fill informpt as 95, informdt as 99/99/9999, hcvtxref as 95, disrefdt as 99/99/9999, and go to notobuse as applicable**   |  | | --- | | > = tstposdt and  < = stdyend | | Use the laboratory report date. If the lab report date is not available, use the date the clinician documented the test results.  **Tests for assessment of active HCV:**  HCV RNA Qualitative (RT-PCR)  HCV RNA Qualitative (bDNA)  HCV RNA Quantitative (RT-PCR)  HCV RNA Quantitative (bDNA)  HCV genotype result (expressed as 1, 1a, 1b, 2, 3, or other number)  RIBA (if negative)  Enter the exact date. The use of 01 to indicate missing month or day is not acceptable. |
| 15 | informpt | Was the patient notified of the positive HCV confirmatory test result?  1. Yes  2. No  3. No, positive test result was reported less than 60 days prior to the study end date  95. Not applicable | 1,2,3,95  Will be auto-filled as 95 if testhcv = 2,3, or 98, or poshcv = 2 or hcvconf = 2, 3, 98 or 99   |  | | --- | | **Cannot enter 3 if hcvcondt > = 60 days prior**  **to stdyend** |   **If 2 or 3, auto-fill informdt as 99/99/9999, hcvtxref as 95, disrefdt as 99/99/9999,**  **and go to notobuse as applicable** | **Confirmatory HCV test = definitive test performed to confirm active HCV infection**  **This question refers to the HCV RNA test date entered in HCVCONDT.**  **Examples of notification of the patient of the positive HCV confirmatory test result include, but are not limited to:**   * Hepatitis C mentioned in progress note (lab result or other note) indicating the information was shared with the patient. * The patient was informed of the reason (positive test result) for referral to a liver specialist, GI specialist, or Hepatitis C service. * Documentation in a clinic note that a letter was sent to the patient regarding the test results. * Physician or other provider states in a clinic note, “Talked to patient by phone and discussed HCV test results” or other similar statement.   **Only answer “3” if the patient was not notified of the HCV test results AND the positive confirmatory test result was reported from the lab less than 60 days prior to the study end date.** |
| 16 | informdt | Enter the date the patient was notified of positive HCV confirmatory test result. | mm/dd/yyyy  Will be auto-filled as 99/99/9999 if  testhcv = 2,3, or 98,  or poshcv = 2, or  hcvconf =2,3, 98, or 99, or informpt = 2 or 3   |  | | --- | | > = hcvcondt and  < = stdyend | | If more than one form of notification is applicable, use the date of the event occurring earliest in time. (Example: clinician writes in progress note of 11/10/08 that patient was notified of test result. On 11/21/08, the clinician discusses referral to a liver specialist with the patient. Use the 11/10/08 date.)  Enter the exact date. The use of 01 to indicate unknown month or day is not acceptable |
| 17 | hcvtxref | Within 3 months of the positive HCV RNA confirmatory test result, does the record document discussion of HCV treatment options with the patient or referral to a specialty clinic?  1. Discussion of HCV treatment options by primary care or mental health provider  2. Referral to a specialty clinic by primary care or mental health provider  3. Both 1 and 2  4. Positive HCV RNA confirmatory test result was reported less than 3 months prior to the study end date  95. Not applicable  98. Patient refused referral to specialty clinic  99. None of the above | 1,2,3,4,,95,98,99  Will be auto-filled as 95 if testhcv = 2,3, or 98, or poshcv = 2, or  hcvconf =2, 98, or 99, or informpt = 2 or 3   |  | | --- | | **Cannot enter 4 if hcvcondt > = 3 months prior to stdyend** |   If 4, 98, or 99, auto-fill disrefdt as 99/99/9999, and go to **notobuse as applicable** | **This question refers to the HCV RNA test date entered in HCVCONDT.**  **Discussion of HCV treatment options with the patient by the primary care or mental health provider:**   * **Decreasing (or stopping) alcohol use may be the most important initial treatment for Hepatitis C; thus, discussion of referral to substance abuse or Mental Health is a treatment option.** * Other treatment options may include discussion of: anti-viral therapy (alpha interferon, Peginterferon, with or without Ribavirin)   **Specialty clinic = Hepatitis C service, Gastroenterologist, (GI service), Liver specialist, Infectious disease, Hepatitis C nurse coordinator, HCV education coordinator**   * Documentation that a referral was placed to a specialty clinic for management of the positive HCV test results is sufficient to answer “2” (or “3” as applicable). There does not need to be documentation that the patient was seen by the specialty clinic. * **If referral to a specialty clinic was discussed and the patient refused referral, answer “98.”**   **Only answer “4” if HCV treatment options were not discussed or the patient was not referred to a specialty clinic** within 3 months of the positive HCV RNA test **AND the positive HCV RNA confirmatory test result was reported from the lab less than 3 months prior to the study end date.** |
| 18 | disrefdt | Enter the date of the first discussion of treatment options with the patient or of referral to a specialty clinic. | mm/dd/yyyy  Will be auto-filled as 99/99/9999 if  testhcv = 2,3, or 98,  or poshcv = 2, or  hcvconf =2, 3, 98, or 99, or informpt = 2 or 3, or if hcvtxref= 4, 98, or 99   |  | | --- | | >= hcvcondt and <= 3 months after hcvcondt and  < = stdyend | | Discussion may include the benefits and risks of anti-viral therapy, or referral to a specialist or Hepatitis C service. **Discussion of referral to substance abuse or Mental Health is a treatment option.**  If both treatment options were discussed and referral was made, enter the earliest date of the interventions.  Enter the exact date. The use of 01 to indicate unknown month or day is not acceptable |
| **If catnum = 61 AND (seenyr = 2 or specvst = 1), go to smokcigs; else go to notobuse** | | | | |
|  |  | **Screening for Tobacco Use** |  |  |
| 19 | notobuse | Is there evidence in the record the patient is a lifetime non-user of tobacco, or has not used tobacco for the past 7 years? | 1,2 If 1, auto-fill tobscrdt as 99/99/9999, tobnow as 95, tobuseyr as 95, tuconsel as 95, tucnsldt as 99/99/9999, tucrefer as 95, tucrefdt as 99/99/9999, offtucrx as 95, tucmedt as 99/99/9999, ptreqrx as 95, offmedrx as 95, tucrxdt as 99/99/9999, tucmedrx as 95, and clinone as 95, and go to vascdis1 | Tobacco use: cigarettes, cigars, pipe smoking, snuff, and chewing tobacco. Information may be taken from inpatient or outpatient record.  Patient need not report specifically that he/she has not used tobacco for 7 or more years.  Acceptable documentation = denies history of tobacco use, lifetime non-tobacco user; never used tobacco; no history of tobacco use; tobacco use history negative, has not used tobacco for 20+ years, quit tobacco in 1985, etc.  Documentation that the patient is a lifetime non-user or quit > 7 years ago may be obtained from information entered in the record prior to the past year, if the information does not conflict with more recent data. |
| 20 | tobscrdt | Enter the most recent date within the past year that the patient was screened for tobacco use. | mm/dd/yyyy   |  | | --- | | < = 1 year prior to or = stdybeg and < = stdyend |   If notobuse = 1, will be auto-filled as 99/99/999  **Abstractor may enter 99/99/9999 if the patient was not screened within the past year**  **If 99/99/9999, auto-fill tobnow as 95, tobuseyr as 95 tuconsel as 95, tucnsldt as 99/99/9999, tucrefer as 95, tucrefdt as 99/99/9999, offtucrx as 95, tucmedt as 99/99/9999, ptreqrx as 95, offmedrx as 95, tucrxdt as 99/99/9999, tucmedrx as 95, clinone as 95, and go to vascdis1** | Most recent date: the date most immediately prior to or during the study interval when the patient was asked whether he/she was a current tobacco user. May be by direct question to the patient or completion of a patient questionnaire form.  If the patient was not screened for tobacco use within the past year, enter default date 99/99/9999.  Most recent date may be taken from either the inpatient or outpatient record. Date must be specific. Use of default 01 is not acceptable. |
| 21 | tobnow | At the most recent screening for tobacco use, did the patient report he/she is a current tobacco user?   1. Reported he/she is a current tobacco user 2. Reported he/she is not a current tobacco user   95. Not applicable | 1,2,95  If notobuse = 1 or tobscrdt = 99/99/9999, will be auto-filled as 95 | **This question refers to the most recent screening for tobacco use that occurred on the date entered in TOBSCRDT. There must be documentation in the record of the patient’s response to the question of whether he/she is a current tobacco user at the most recent screening for tobacco use.**  **If the patient’s response is ambiguous, or documentation is conflicting (patient states to clinic intake clerk that he “has an occasional cigarette,” but states to MD that he does not use tobacco), consider that the patient uses tobacco and answer “1.”** |
| 22 | tobuseyr | Did the patient use tobacco any time during the year prior to the most recent Nexus clinic visit?   1. Yes 2. No   95. No applicable | 1,2,95  If notobuse = 1, or tobscrdt = 99/99/9999, will be auto-filled as 95  **If 2, and tobnow = 2, auto-fill tuconsel as 95, tucnsldt as 99/99/9999, tucrefer as 95, tucrefdt as 99/99/9999, offtucrx as 95, tucmedt as 99/99/9999, ptreqrx as 95, offmedrx as 95, tucrxdt as 99/99/9999, tucmedrx as 95, clinone as 95, and go to vascdis1**     |  | | --- | | If tobnow = 1, cannot enter 2 | | **“During the year prior to the most recent Nexus clinic visit” = from the visit or encounter date to the same date exactly one year previously.**  If documentation in the record is non-specific as to the time period the patient has not used tobacco (example: “patient doesn’t smoke”), consider the veteran a tobacco user and answer “1.”  If there is conflicting information in the record regarding the patient’s tobacco use, consider the patient uses tobacco (e.g., inpatient H&P states “current smoker” but clinic note states “quit 2 years ago.”) Answer that the patient used tobacco.  There must be a documented 12-month history of non-use of tobacco to answer “no.” (Example: if there is an entry in the record six months ago that the patient quit smoking five months previously, but there is no further entry, the abstractor cannot know the patient has not used tobacco within the past year – he may have resumed smoking in the interim.) If there is a subsequent entry that indicates the patient is still not smoking, and a total of 12 months without tobacco use can be determined, answer “2” to the question.  To answer “no,” medical record documentation must convey to the abstractor the certainty that the veteran has not used tobacco within the past 12 months. |
| 23 | tuconsel | Within the past year, was the patient provided with direct brief counseling to quit using tobacco?   1. Yes 2. No 3. Not applicable | 1,2,95  Will be auto-filled as 95 if notobuse = 1, or tobscrdt = 99/99/9999, or tobnow = 2 and tobuseyr = 2  **If 2, autofill tucnsldt as 99/99/9999** | Within the past year: from the first day of the study interval to the first day of the same month one year previously. Counseling done from the first day of the study interval to the study end date is also acceptable.  **In order to answer “1,” the direct brief counseling must include at least three points on how to quit tobacco.**  Documentation of direct brief counseling should indicate general guidance on elements such as:   * advising the patient to set a quit date when ready to quit * identify reasons for and benefits of quitting * remove all tobacco products from home and work settings * identify and plan ahead for challenges to quitting * get support from family, friends, and co-workers * communicate support and encouragement   The provider should communicate support and encouragement to the patient.  The provider should advise total abstinence from tobacco use, should encourage use of pharmacotherapy, and help provide information about potential resources such as the national number linking to any state telephone counseling quitline, 1-800-QUIT-NOW. (1-800-Quit Now is a program outside VHA, and while it may be used as a patient resource, it does not replace the responsibility to provide counseling.) Provision of brief counseling must be documented.   * **Any provider who is able to refer is able to provide brief counseling and/or refer for individual intervention or specialty smoking cessation clinic, including physicians, APN, PA, RN, LPN, pharmacists, social workers, psychologists, dentists, and substance abuse counselors.** * **Provider documentation of direct brief counseling to quit using tobacco via telephone is acceptable.** * **Provision of a brochure or pamphlet to the patient without documented direct discussion of how to quit is NOT acceptable.** |
| 24 | tucnsldt | Enter the date brief direct tobacco use counseling was provided. | mm/dd/yyyy  Will be auto-filled as 99/99/9999 if tuconsel = 2   |  | | --- | | < = 1 year prior to or = stdybeg and < = stdyend | | Exact date must be entered. The use of 01 to indicate missing day or month is not acceptable. |
| 25 | tucrefer | Within the past year, was the patient offered referral for individual intervention or to a tobacco use cessation program?   1. Yes 2. No 3. Not applicable | 1,2,95  Will be auto-filled as 95 if notobuse = 1, or tobscrdt = 99/99/9999, or tobnow = 2 and tobuseyr = 2  **If 2, auto-fill tucrefdt as 99/99/9999** | Any provider who is able to refer is able to provide brief counseling and/or refer for individual intervention or to a specialty smoking cessation clinic, including physicians, APN, PA, RN, LPN, pharmacists, social workers, psychologists, dentists, and substance abuse counselors. The referral should inform the patient of services available through a VA smoking or Tobacco Use Cessation Specialty Clinic or VA providers who are local specialists in evidence-based smoking cessation care. If the patient cannot or will not attend a VA clinic, the provider can also offer to refer the patient to a local smoking cessation program in the community, such as the American Lung Association, the American Cancer Society, or a state telephone counseling quitline, through the national portal number, 1-800-QUIT-NOW, as appropriate.  If documentation indicates the program was offered, answer “1” even if the patient refused to enroll or participate. |
| 26 | tucrefdt | Enter the date the patient was offered referral for individual intervention or to a tobacco use cessation program. | mm/dd/yyyy  Will be auto-filled as 99/99/9999 if tucrefer = 2   |  | | --- | | < = 1 year prior to or = stdybeg and < = stdyend | | Exact date must be entered. The use of 01 to indicate missing day or month is not acceptable. |
| 27 | offtucrx | Within the past year, was the patient offered medication to assist in tobacco use cessation by a provider?  2. Yes, medication offered by a prescribing provider  3. Yes, medication offered by non-prescribing provider  4. No offer of medication documented  95. Not applicable | 2,3,4,95  Will be auto-filled as 95 if notobuse = 1, or tobscrdt = 99/99/9999, or tobnow = 2 and tobuseyr = 2  If 4, auto-fill tucmedt as 99/99/9999, ptreqrx as 95, **offmedrx as 95, tucrxdt as 99/99/9999,** tucmedrx as 95, and go to clinone, else go to tucmedt | Prescribing provider = includes, but may not be limited to, MD/DOs, dentists, APNs, PAs, and PharmDs. Facilities may have local policies in place allowing other providers to prescribe over-the-counter nicotine replacement therapy.  Non-prescribing provider = This includes, but may not be limited to, pharmacists, psychologists, RNs, LPNs, social workers, and substance abuse counselors.  If there is documentation the patient was currently on a tobacco cessation medication at the time of the most recent tobacco screening, answer “2.”  Referral to a smoking cessation program does not meet the measure for offering medications.  If a non-prescribing provider has been authorized by the facility to prescribe OTC nicotine replacement therapy (e.g. RN) and there is documentation the non-prescribing provider offered and prescribed the OTC nicotine replacement product, select “2.”  Examples of tobacco cessation products and medications such as:  **Nicotine replacement products (OTC)**  Nicotine patch (Nicoderm CQ, Habitrol)  Nicotine gum (Nicorette)  Nicotine lozenges (Commit)  **Nicotine replacement products prescription**  Nicotine inhaler (Nicotrol inhaler) - prescription only  Nicotine nasal spray (Nicotrol) - prescription only  Oral medications: Bupropion (Zyban, Wellbutrin), varenicline (Chantix) - Rx only |
| 28 | tucmedt | Enter the date the patient was offered medication to assist in tobacco use cessation. | mm/dd/yyyy  Will be auto-filled as 99/99/9999 if  offtucrx = 4  If offtucrx = 2, auto-fill ptreqrx as 95, **offmedrx as 95, tucrxdt as 99/99/9999,** and go to tucmedrx  If offtucrx = 3, go to ptreqrx   |  | | --- | | < = 1 year prior to or = stdybeg and < = stdyend | | Exact date must be entered. The use of 01 to indicate missing day or month is not acceptable. |
| 29 | ptreqrx | Did the non-prescribing provider who offered tobacco cessation medication document that the patient requested tobacco cessation medication?  1. Yes  2. No  95. Not applicable  98. Patient refused tobacco cessation medication | 1,2,95,98  Will be auto-filled as 95 if offtucrx = 2 or 4  If 2, auto-fill offmedrx as 95 and tucrxdt as 99/99/9999, and go to tucmedrx  If 98, auto-fill offmedrx as 95,tucrxdt as 99/99/9999, tucmedrx as 95, and go to clinone | If a non-prescribing provider offers the tobacco cessation medication as part of counseling and the patient reports that he or she would like to receive such assistance, the non-prescribing provider is responsible for documenting this in the chart and communicating the patient request to a provider who can prescribe medications. For example, social worker notes, “talked to patient about tobacco cessation medication. Patient interested in bupropion.” Enter “1.”  If the non-prescribing provider who offered tobacco cessation medication does not document whether the patient is interested in receiving tobacco cessation medication, enter “2.” For example, LPN notes, “discussed/offered tobacco cessation medications.”  If the non-prescribing provider who offered tobacco cessation medication documented that the patient declined or refused tobacco cessation medication, enter “98.”  Non-prescribing provider = This includes, but may not be limited to, pharmacists, psychologists, RNs, LPNs, social workers, and substance abuse counselors. |
| 30 | offmedrx | On or after the date when the patient was offered tobacco cessation medication, was tobacco cessation medication prescribed by the provider?  1. Yes  2. No  95. Not applicable | 1,2,95  Will be auto-filled as 95 if ptreqrx = 2 or 98  If 2, auto-fill tucrxdt as 99/99/9999 and go to tucmedrx | Provider = includes, but may not be limited to, MD/DOs, APNs, PAs, and PharmDs.  **Tobacco cessation medication prescribed =** Prescribing clinician entered an order or wrote a prescription for tobacco cessation medication.  Examples of tobacco cessation medications such as:  **Nicotine replacement products prescription**  Nicotine inhaler (Nicotrol inhaler) - prescription only  Nicotine nasal spray (Nicotrol) - prescription only  **Oral medications: Bupropion (Zyban, Wellbutrin), varenicline (Chantix) - Rx only** |
| 31 | tucrxdt | Enter the date the tobacco cessation medication was prescribed. | mm/dd/yyyy  Will be auto-filled as 99/99/9999 if  ptreqrx = 2 or 98 or offmedrx = 2  If offmedrx = 1, auto-fill tucmedrx as 95, and go to clinone   |  | | --- | | > = tucmedt or = tucmedt and <= stdyend | | Enter the exact date. The use of 01 to indicate missing month or day is not acceptable. |
| 32 | tucmedrx | Within the past year, was the patient prescribed medication to assist in tobacco use cessation by a provider?   1. Yes 2. No 3. Not applicable   98. Patient refused tobacco cessation medication | 1,2,95,98  Will be auto-filled as 95 if notobuse = 1, or tobscrdt = 99/99/9999, or tobnow = 2 and tobuseyr = 2, offtucrx = 4, ptreqrx = 98, or offmedrx = 1 | Provider = includes, but may not be limited to, MD/DOs, APNs, PAs, and PharmDs.  **Tobacco cessation medication prescribed =** Prescribing clinician entered an order or wrote a prescription for tobacco cessation medication.  Examples of tobacco cessation medications such as:  **Nicotine replacement products prescription**  Nicotine inhaler (Nicotrol inhaler) - prescription only  Nicotine nasal spray (Nicotrol) - prescription only  Oral medications: Bupropion (Zyban, Wellbutrin), varenicline (Chantix) - Rx only |
| 33 | clinone | During at least one outpatient encounter in the past year, did a clinician provide direct counsel to the patient regarding tobacco use cessation?   1. Yes 2. No 3. Not applicable | 1,2,95  Will be auto-filled as 95 if notobuse = 1, or tobscrdt = 99/99/9999, or tobnow = 2 and tobuseyr = 2  If ipadm = 1, go to smokcigs, else go to vascdis | Clinician = MD, APN, PA, or Psychologist  Clinician counseling: direct discussion between clinician and patient, or direct advice provided to patient to stop using tobacco, or direct warning to patient of the risks associated with tobacco use. Referral by the clinician to a tobacco use cessation program is acceptable.  Counseling provided by telephone is acceptable. |
| 34 | smokcigs | Did the adult patient smoke cigarettes any time during the year prior to hospital arrival?   1. Yes 2. No or unable to determine from medical record documentation | 1,2  **If 2, auto-fill tobcess as 95, and go to vascdis** | This question refers only to smoking cigarettes and is not pertinent to other forms of tobacco**. If the record documents “tobacco use” or “+smoker” but the type of product is not specified, assume this refers to** **cigarette smoking unless documentation in another Only Acceptable Source suggests that the tobacco product is pipe, cigar, or chewing tobacco.**  If there is definitive documentation anywhere in the **ONLY ACCEPTABLE SOURCES** that the patient either currently smokes or is an ex-smoker that quit less than one year prior to hospital arrival, select “yes,” **regardless of whether or not there is conflicting documentation.**  If there is documentation of a history of smoking and that the patient quit “several months ago,” select “yes.”  Examples of smoking within the past year include, but are not limited to:  “Former smoker. Quit recently.”  “History – quit smoking 7 months ago”  “Quit smoking several months ago”  “Social habits = current smoking”  “Tobacco history – current cigarette smoker”  **If there is NO definitive documentation of current smoking or smoking within one year prior to arrival in any of the ONLY ACCEPTABLE SOURCES select “No.”** The following examples would **not count** as inclusions (**select “No”**):   * “Smoked in the last year: ?” * “Probable smoker” * “Most likely quit 3 months ago”   Disregard documentation of smoking history or history of tobacco use if current smoking status or timeframe that patient quit is not defined (e.g., “20 pk/yr smoking history”, “History of tobacco abuse”).  Do not include documentation of smoking history referenced as a risk factor (e.g., “risk factor: tobacco,” “risk factor: smoking,”), where current smoking status is indeterminable.  **ONLY ACCEPTABLE SOURCES:** Emergency department record, history and physical, nursing assessment notes/nursing admission notes, respiratory therapy notes, smoking/tobacco use assessment forms  **Exclude:** Documentation from a transferring facility or a previous admission |
| 35 | tobcess | Did the patient/caregiver receive smoking/tobacco use cessation advice or counseling during the hospitalization?   1. Yes 2. No   95. Not applicable | 1,2,95  If smokcigs = 2, will be auto-filled as 95 | The caregiver is defined as the patient’s family or any other person (e.g., home health) who will be responsible for care of the patient after discharge.  **Adult Smoking Counseling:**  Documentation indicating the patient/caregiver received one of the following:   * Direct discussion with patient/caregiver to stop smoking (stop using tobacco) whether or not the patient is currently smoking * Viewing a smoking/tobacco use cessation video * Given brochure or handouts on smoking/tobacco use cessation * Referred to a smoking cessation class or clinic * Prescribed a smoking cessation aid, e.g., Habitrol, Nicoderm, Nicorette, Nicotrol, Prostep, Zyban, or Chantix during hospital admission or at discharge * Prescription of Wellbutrin/bupropion during hospital stay or at discharge, if specifically prescribed as a smoking cessation aid.   If the patient smoked within the year prior to arrival but does not currently smoke, they should still be advised not to smoke. Cessation counseling is still required.  Respond “1” if the patient/caregiver was given advice, a brochure, pamphlet, or video relative to smoking cessation even if the patient uses another form of tobacco.  If the patient refused smoking cessation advice or counseling during this hospital stay, answer “1.”  2 = advice/counseling not done, or unable to determine from medical record documentation  **Suggested Data Sources:** Consultation notes, Discharge instruction sheet, Discharge summary, ED record, H&P, Medication administration record, Nursing notes, Progress notes, Respiratory therapy notes, Teaching sheet  **Exclude:** Any documentation dated/timed after discharge, except discharge summary and operative/procedure/diagnostic test reports (from procedure done during hospital stay) |
| 36 | vascdis1  vascdis2  vascdis3  vascdis4  vascdis5  vascdis6  vascdis7  vascdis8  vascdis99 | Within the past two years, at any inpatient or outpatient encounter, did the patient have an active diagnosis of any of the following?  **Indicate all that apply:**   |  |  | | --- | --- | | 1. Coronary artery disease | 414.0x, 414.2, 414.8, 414.9, 429.2 | | 2. Angina | 411.xx, 413.xx | | 3. Lower extremity arterial disease/peripheral artery disease | 440.2, 440.4 | | 4. Transient cerebral ischemia | 435.xx | | 5. Stroke | 433.xx, 434.xx | | 6. Atheroembolism | 444.xx, 445.xx | | 7. Abdominal aortic aneurysm | 441.xx | | 8. Renal artery atherosclerosis | 440.1 | | 1. No ischemic vascular disease diagnosis |  | | 1,2,3,4,5,6,7,8,99   |  | | --- | | If 1 or 2 warning if selmi = F and selpci = F, and selcabg = F  Auto-fill 1 if selpci, selcabg or selmi = T | | **Within the past two years: from the first day of the study interval to the first day of the same month two years previously**   * **‘Active’ diagnosis = the condition was ever diagnosed and there is no subsequent statement, prior to the most recent outpatient visit, indicating the condition was resolved or is inactive.** * Include diagnoses noted in clinic notes or progress notes. Diagnoses documented on a problem list must be validated by a clinician diagnosis within the past 2 years. * Diagnoses may be taken from the inpatient or outpatient setting. The abstractor is not limited to the codes provided and may take diagnoses from clinician documentation even though an applicable code is not present. * Do not include diagnoses that occurred greater than two years in the past or are not active diagnoses**.** |
| 37 | famhx | Does the record document any one of the following:   1. patient has a family history of coronary events occurring prior to age 45 2. patient’s father or other male first-degree relative had a definite MI or sudden death before age 55 3. patient’s mother or other female first-degree relative had a definite MI or sudden death before age 65   99. none of these factors documented | 1,2,3,99 | **Definition of “family history” is the same as that for “first-degree relative,” i.e., father, mother, brother, or sister.**  **First-degree relative** = a natural (not adoptive) parent or sibling with whom an individual shares one-half of his/her genetic material, i.e., father, mother, brother, or sister  **Coronary events occurring before age 45** = acute myocardial infarction and unstable angina, conditions associated with stenosis within the coronary artery  **Sudden death before age 55** = death from cardiovascular disease, not as the result of an accident or other disease |

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **If the patient is male and <= age 50, the module will end.**  **If the patient is female and < age 51, the computer will go to question testpap.** | | | | | | | | | | |
|  |  | | Colorectal Cancer Screening | | |  | | |  | |
| 38 | colondx | | Does the patient have a diagnosis of one of the following:  1. Colon cancer  2. Total colectomy   1. Neither of these diagnoses | | | 1,2.99  If 1 or 2, go to testpap  If 99, go to prevcoln | | | Diagnosis of colon cancer=cancer of any part of the colon, including the rectum  **Total colectomy: Medical record documentation must clearly indicate a total lack of large bowel AND rectum** | |
| 39 | prevcoln | | Does the medical record contain the report of a colonoscopy performed within the past ten years?  1. Colonoscopy performed by VHA  2. Colonoscopy performed by a private sector provider  98. Patient refused colonoscopy  99. No documentation of colonoscopy performed  within the past ten years | | | 1,2,98,99  If 98 or 99, auto=fill coln10dt as 99/9999, and go to gfecalbld | | | Results of the colonoscopy must be in the medical record for those procedures performed by this VAMC. Entry in the computer package is acceptable, as long as the interpretation is present.  Sources: Progress notes, operative report, or electronic database  If the colonoscopy was performed by another VAMC or private sector provider, the abstractor must be certain the colonoscopy was accomplished. The year must be documented in order to be able to compute if the test was accomplished within the accepted time window.  Patient refused colonoscopy = during the visit when the colonoscopy was recommended, the patient stated he/she does not wish to perform this procedure.  If the record states only “refuses colon cancer screening,” with no other documentation, answer “98.” Note: spiral CT scan is not a substitute for colonoscopy and is not acceptable for colorectal cancer screening.  Patient self-report of result of colonoscopy done outside VHA is acceptable. | |
| 40 | coln10dt | | Enter the date of the most recent colonoscopy performed within the past 10 years. | | | mm/yyyy  If prevcoln = 98 or 99, will be auto-filled as 99/9999  **\*If prevcoln = 1 or 2, go to testpap as applicable**   |  | | --- | | <= 10 years prior to or = stdybeg and <= stdyend | | | | The year must be documented and entered accurately. If the month is not documented, enter the study month as the default. | |
| 41 | gfecalbld | | Does the medical record contain the results of a three-card guaiac fecal occult blood testing done within the past year?  3. Three-card guaiac FOBT done by VHA  4. Three-card guaiac FOBT by private sector provider 99. No result of three-card guaiac FOBT done within past year | | | 3,4, 99  If 4, auto-fill gfobths as 95, and go to occblddt  If 99, auto-fill gfobths as 95, occblddt as 99/99/9999, and go to ifobtst | | | * **Only screening by serial (three-card) stool sampling is acceptable as screening for colorectal cancer by guaiac fecal occult blood testing (gFOBT).** * If unable to determine whether the fecal occult blood testing was a gFOBT or immunochemical (iFOBT), consider as gFOBT. * Adequate screening requires three stool samples returned to the VAMC for gFOBT. Testing of the stool for occult blood may be done by the laboratory. The results of all three cards (three-card serial screening) should be reported within a 6 month timeframe. * Results of gFOBT must be in the medical record for those tests done by this VAMC. Entry in the computer package is acceptable, as long as the interpretation is present. * If gFOBT was done by another VAMC or private sector provider, documentation must indicate the result of the three-card serial test. Either the three-care serial gFOBT lab report or a report from the private sector provider containing the result of the three-card gFOBT must be documented in the record. The date must also be documented in sufficient detail to be able to compute if the test was accomplished within the accepted time window. * **Patient self-report of gFOBT result is NOT acceptable.**   A digital rectal exam is not screening for colon cancer. Digital rectal examination with hemetest of fecal matter is not acceptable as colorectal cancer screening by fecal occult blood testing. | |
| 42 | gfobths | | Is the gFOBT reported as a high sensitivity product?  1. Yes  2. No  95. Not applicable | | | 1,2,95  Will be auto-filled as 95 if gfecalbld = 4 or 99 | | | **If the gFOBT results are not reported as High Sensitivity (HS) as described below, assume the gFOBT is NOT a HS product and select “2.”**  The letters HS must be included as part of the name of the panel name: (OCCULT BLOOD GUAIAC-HS X3 SCREEN), test name (OCCULT BLOOD-HS#1 OCCULT BLOOD-HS#2 OCCULT BLOOD-HS#3), print name FOBHS#1 FOBHS#2 FOBHS#3) and test header (FOB-HS #1 FOB-HS #2 FOB-HS#3) | |
| 43 | occblddt | | Enter the date of the laboratory report for most recent three-card serial screening for colorectal cancer by gFOBT. | | | mm/dd/yyyy  If gfecalbld = 99, will be auto-filled as 99/99/9999  If gfecalbld = 3 or 4, go to prefobt4   |  | | --- | | < = 1 year prior or = stdybeg and < = stdyend | | | | Although the day may be entered as day = 01, if the specific date is unknown, the exact month and year should be retrievable and must be entered accurately.  If serial gFOBT performed on different days, enter the date of the first result as the screening date. The results of all three cards (three-card serial screening) should be reported within a 6 month timeframe. | |
| 44 | ifobtst | | Does the medical record contain the results of immunochemical fecal occult blood testing (iFOBT or FIT) done within the past year?   1. iFOBT/FIT performed by VHA 2. iFOBT/FIT performed by private sector provider  99. No result of iFOBT/FIT done within past year | | | 3,4, 99  If 4, auto-fill fitman as 95, fitmanum as z, fitrslt as z, fobtordr as 95, givcardt as 99/99/9999, and go to ifobtdt  If 99, auto-fill ifobtdt as 99/99/9999, fitman as 95, fitmanum as z, fitrslt as z, and go to fobtordr | | | * Fecal immunochemical testing of the stool for occult blood may be done by the laboratory. The results of all tests should be reported within a 6 month timeframe. Results of all required iFOBT must be in the medical record for those tests done by this VAMC. Entry in the computer package is acceptable as long as the interpretation is present. * If iFOBT/FIT was done by private sector provider, documentation must indicate the test results. Either the lab report or a report from the private sector provider containing the iFOBT/FIT results for at least one iFOBT/FIT vial must be documented in the record. The date must also be documented in sufficient detail to be able to compute if the test was completed within the acceptable timeframe. * **Patient self-report of iFOBT/FIT result is NOT acceptable.** | |
| 45 | ifobtdt | | Enter the date of the laboratory report for most recent screening for colorectal cancer by immunochemical fecal occult blood testing (iFOBT/FIT). | | | mm/dd/yyyy  Will be auto-filled as 99/99/9999 if  ifobtst = 99  If ifobtst = 4, go to prefobt4; else go to fitman   |  | | --- | | < = 1 year prior or = stdybeg and < = stdyend | | | | Although the day may be entered as day = 01, if the specific date is unknown, the exact month and year should be retrievable and must be entered accurately.  If serial iFOBT/FIT is performed on different days, enter the date of the first result as the screening date. The results of the required number of tests (one, two or three tests) should be reported within a 6 month timeframe. | |
| 46 | fitman | | Does the lab report document the number of immunochemical fecal occult blood tests/vials required by the manufacturer?  1. Yes  2. No  95. Not applicable | | | 1,2,95  Will be auto-filled as 95 if ifobtst = 4 or 99  If 2, auto-fill fitmanum as z, and go to fitreslt | | | **For immunochemical fecal occult blood tests performed within VHA, the lab report must indicate the number of tests that are required by the manufacturer along with the results of each of the required tests.**  **Specifically, results reporting for a FIT product that requires only 1 test should include the following information:**   * panel name: OCCULT BLOOD FIT X1 SCREEN * test name: OCCULT BLOOD (FIT) #1 OF 1 * print name: FIT1/1 * test header: FIT1/1   **Results reporting for a FIT product that requires two tests should include the following information:**   * panel name: OCCULT BLOOD FIT X2 SCREEN * test names: OCCULT BLOOD (FIT) #1 OF 2 OCCULT BLOOD (FIT) #2 OF 2 * print names: FIT1/2 FIT2/2 * test headers: FIT1/2 FIT2/2   Instructions for naming conventions which include the number of tests that are required is provided in the Laboratory Reporting of FOBT document available as part of the VHA Colorectal Cancer Screening Guidance Statement. | |
| 47 | fitmanum | | Enter the number of iFOBT/FIT tests/vials required by the manufacturer. | | | \_\_  Will be auto-filled as z if ifobtst = 4 or 99 or if fitman = 2   |  | | --- | | Whole numbers only 1 to 5 | | | | **For immunochemical fecal occult blood tests performed within VHA, the lab report must indicate the number of tests that are required by the manufacturer.** | |
| 48 | fitreslt | | Enter the number of iFOBT/FIT results reported in the record. | | | \_\_  **If fitreslt = 3 OR if fitreslt = fitmanum, go**  **to prefobt4, else go to sigmoid5**   |  | | --- | | Whole numbers only 1 to 5 | | | | **For immunochemical fecal occult blood tests performed within VHA, the panel name, test name, print name and test header should be used.**  **Specifically, results reporting for a FIT product that requires only 1 test should include the following information:**   * panel name: OCCULT BLOOD FIT X1 SCREEN * test name: OCCULT BLOOD (FIT) #1 OF 1 * print name: FIT1/1 * test header: FIT1/1   **Results reporting for a FIT product that requires two tests should include the following information:**   * panel name: OCCULT BLOOD FIT X2 SCREEN * test names: OCCULT BLOOD (FIT) #1 OF 2 OCCULT BLOOD (FIT) #2 OF 2 * print names: FIT1/2 FIT2/2 * test headers: FIT1/2 FIT2/2   For example, the lab report notes FIT X2 screen, but contains results for FIT1/2 only; enter “1.” | |
| 49 | fobtordr | | Within the past year, did the record document that guaiac or immunochemical fecal occult blood testing for colorectal cancer screening was ordered for or provided to the patient by the VA?  3. gFOBT or iFOBT ordered, but no tests returned  4. gFOBT or iFOBT ordered, but less than required number of tests returned  5. No documentation gFOBT or iFOBT was ordered or provided to the patient  95. Not applicable  98. Patient refused FOBT | | | 3,4,5,95, 98  Will be auto-filled as 95 if ifobtst = 3 or 4  If 5 or 98, auto-fill givcardt as 99/99/9999 and go to sigmoid5 | | | Review the orders and/or clinic notes for the past year to determine if gFOBT or iFOBT was ordered for colorectal cancer (CRC) screening or a FOBT CRC screening kit was given to the patient.  **Patient refused FOBT = during the visit when the test, using hemoccult cards, was recommended, the patient stated he/she does not wish to perform this procedure.**  **If the record states only “refuses colon cancer screening,” with no other documentation, answer “98.”** | |
| 50 | givcardt | | Enter the date the most recent gFOBT or iFOBT for CRC screening was ordered for or provided to the patient. | | | mm/dd/yyyy  Will be auto-filled as 99/99/9999 if  ifobtst = 3 or 4 OR if fobtordr = 5 or 98  **\*Go to sigmoid5**   |  | | --- | | <= 1 year prior to or = stdybeg and < = stdyend | | | | Enter the exact date. The use of 01 to indicate missing month or day is not acceptable. | |
| 51 | prefobt4 | | During the **4 years prior to the study year**, does the medical record contain the results of a three-card gFOBT or at least one iFOBT/FIT? 1. Yes 2. No | | | 1,\*2  **\*If 2, go to testpap as applicable** | | | **4 years prior to study year** = Count back 1 year prior to study begin date and from that date, subtract 4 years (e.g. If study begin date is 12/01/10, 1 year prior is 12/01/09 - timeframe would be 12/01/05 to 11/30/09).   * **Only screening by serial (three-card) stool sampling is acceptable as screening for colorectal cancer by guaiac fecal occult blood testing (gFOBT).** * **For purposes of this question only, if there is documentation of at least one iFOBT/FIT result, answer “yes.”** * Adequate screening requires three stool samples returned to the VAMC for gFOBT. Testing of the stool for occult blood may be done by the laboratory. The results of all three cards (three-card serial screening) should be reported within a 6 month timeframe. * Results of FOBT must be in the medical record for those tests done by this VAMC. Entry in the computer package is acceptable, as long as the interpretation is present. * If FOBT was done by another VAMC or private sector provider, documentation must indicate the result of the three-card serial test. Either the three-care serial FOBT lab report or a report from the private sector provider containing the result of the three-card FOBT must be documented in the record. The date must also be documented in sufficient detail to be able to compute if the test was accomplished within the accepted time window. * **Patient self-report of FOBT result is NOT acceptable.**   A digital rectal exam is not screening for colon cancer. Digital rectal examination with hemetest of fecal matter is not acceptable as colorectal cancer screening by fecal occult blood testing. | |
| 52 | fobtdt1 | | Starting with the most recent gFOBT or iFOBT, enter the date of the laboratory report for each three-card serial screening or at least one iFOBT performed **annually** during the 4 years prior to the study year.  **May enter up to 4 dates.**   |  | | --- | |  | | | | mm/dd/yyyy  **May enter up to 4 dates**  **\*Go to testpap as applicable**   |  | | --- | | > 1 year prior to stdybeg and  < = 5years prior to stdybeg | | | | If serial FOBT performed on different days, enter the date of the first result as the screening date. The results of all three cards (three-card serial screening) should be reported within a 6 month timeframe.  If more than one serial FOBT is performed during a year, enter the date of the most recent. .  Although the day may be entered as day = 01, if the specific date is unknown, the exact month and year should be retrievable and must be entered accurately. | |
| 53 | sigmoid5 | Does the medical record contain the report of a flexible sigmoidoscopy performed within the past five years?  1. Sigmoidoscopy performed by VHA  2. Sigmoidoscopy performed by a private sector provider  98. Patient refused sigmoidoscopy  99. No documentation of sigmoidoscopy  performed within last five years | | | 1,2,98,99  **If 98 or 99, auto-fill sig5dt as 99/9999, and go to dcbe** | | | **Results of the flexible sigmoidoscopy must be in the medical record for those procedures performed by this VAMC. Entry in the computer package is acceptable, as long as the interpretation is present.**  **If unable to determine whether the sigmoidoscopy was flexible or rigid, accept as flexible sigmoidoscopy.**  If the flexible sigmoidoscopy was performed by another VAMC or private sector provider, the abstractor must be certain the flexible sigmoidoscopy was accomplished. The year must be documented in order to be able to compute if the test was accomplished within the accepted time window.  **Patient refused sigmoidoscopy = during the visit when the sigmoidoscopy was recommended, the patient stated he/she does not wish to perform this procedure.**  **If the record states only “refuses colon cancer screening,” with no other documentation, answer “98.”**  **Note: spiral CT scan is not a substitute for flexible sigmoidoscopy and is not acceptable for colorectal cancer screening.**  **Patient self-report of result of sigmoidoscopy done outside VHA is acceptable.** | | |
| 54 | sig5dt | Enter the date of the most recent flexible sigmoidoscopy performed within the past five years. | | | mm/yyyy  If sigmoid5 = 98 or 99, will be auto-filled as 99/9999  **If sigmoid5 = 1 or 2, go to testpap as applicable**   |  | | --- | | < = 5 years prior or = stdybeg and < = stdyend | | | | The year must be documented and entered accurately. If the month is not documented, enter the study month as the default. | | |
| 55 | dcbe | Does the medical record contain the report of a double-contrast barium enema performed within the past five years and prior to 10/01/10?  1. DCBE performed by VHA  2. DCBE performed by a private sector provider  98. Patient refused DCBE  99. No documentation of DCBE  performed within last five years | | | 1,2,98,99  **If 98 or 99, auto-fill dcbedt as 99/9999, and**  **if prevcoln, gfecalbld, ifobtst, AND sigmoid5 = 98 OR 99, go to ctcolon; else go to testpap as applicable** | | | Record must document that a double-contrast barium enema was performed. A barium enema alone without double-contrast is not acceptable.  Double-contrast barium enema: imaging technique in which the bowel is filled with air or gas between the introduction of barium and radiographic imaging. This allows accurate visualization of the inner surface of the bowel.  If DCBE was done by another VAMC or private sector provider, documentation must indicate the test was accomplished. The year must be documented in order to be able to compute if the test was accomplished within the accepted time window.  **Patient refusal = at all encounters when DCBE recommended, he/she states he does not wish to undergo this test. If the record states only “refuses colon cancer screening,” with no other documentation, answer “98.”**  **Patient self-report of result of DCBE done outside VHA is acceptable.** | | |
| 56 | dcbedt | Enter the date of the most recent double-contrast barium enema performed within the past five years. | | | mm/yyyy  If dcbe = 98 or 99, will be auto-filled as 99/9999   |  | | --- | | < = 5 years prior to stdybeg and < = 9/30/10 | | | | The year must be documented and entered accurately. If the month is not documented, enter the study month as the default.  DCBEDT will be auto-filled as 99/9999 if DCBE = 98 or 99. | | |
| **If prevcoln, gfecalbld, ifobtst, sigmoid5, AND dcbe = 98 OR 99, go to ctcolon; else go to testpap as applicable** | | | | | | | | | | |
| 57 | ctcolon | | | Does the medical record contain the report of a CT colonography performed within the past five years?  1. CT colonography performed by VHA  2. CT colonography performed by a private sector provider  99. No documentation of CT colonography performed  within the past five years | | | 1,2,99  If 99, auto-fill ctcolndt as 99/9999, and go to sdnatest | | | CT colonography uses CT scanning to obtain an interior view of the colon (the large intestine) that is ordinarily only seen by endoscopy. CT of abdomen/pelvis is not a CT colonography. CT colonography may also be referred to as a virtual colonoscopy.  **Results of the CT colonography must be in the medical record for those procedures performed by this VAMC. Entry in the computer package is acceptable, as long as the interpretation is present.**  **Sources:** Progress notes, operative report, or electronic database  If the CT colonography was performed by another VAMC or private sector provider, the abstractor must be certain the CT colonography was accomplished**.** The year must be documented in order to be able to compute if the test was accomplished within the accepted time window.  **Patient self-report of result of CT colonography done outside VHA is acceptable.**  **This question is not enabled if the patient was screened for colorectal cancer by another accepted modality within the appropriate timeframe.** |
| 58 | ctcolndt | | | Enter the date of the most recent CT colonography performed within the past five years. | | | mm/yyyy  Will be auto-filled as 99/9999 if ctcolon = 99   |  | | --- | | < = 5 years prior or = stdybeg and < = stdyend | | | | The year must be documented and entered accurately. If the month is not documented, enter the study month as the default. |
| 59 | sdnatest | | | Does the medical record contain the report of a stool- based DNA test performed within the past year?  1. Stool-based DNA test performed by VHA  2. Stool-based DNA test performed by a private sector provider  99. No documentation of stool-based DNA test performed in the past year | | | 1,2, 99  If 2 or 99, auto-fill sdnadt as 99/99/9999  If ctcolon = 99 AND sdnatest = 99, go to nocrctst; else if sdnatest = 2 or 99, go to testpap | | | Stool-based deoxyribonucleic acid (DNA) testing (e.g. Pre-Gen Plus) is a noninvasive test that is intended to identify the presence of genetic mutations known to be associated with colorectal cancer (CRC).  **\*Patient self-report of result of stool based DNA test is NOT acceptable.**  **This question is not enabled if the patient was screened for colorectal cancer by another accepted modality within the appropriate timeframe.** |
| 60 | sdnadt | | | Enter the date of the most recent stool-based DNA test performed within the past year. | | | mm/dd/yyyy  Will be auto-filled as 99/99/9999 if  sdnatest = 2 or 99   |  | | --- | | < = 1 year prior or = stdybeg and < = stdyend | | | | Enter the exact date. The use of 01 to indicate missing month or day is not acceptable. |
| **If ctcolon and sdnatest = 99, go to nocrctst; else go to testpap as applicable** | | | | | | | | | | |
| 61 | nocrctst | | | During the past year, did the physician/APN/PA explicitly document a reason why colorectal cancer screening was not clinically indicated for this patient? | | | 1,2 | | | **In order to answer “1,” the documentation must reflect that in the physician/APN/PA’s judgment, colorectal cancer screening is not indicated for the patient for a clinical reason and at least one reason must be specified,**  **Examples include, but are not limited to:**   * Limited life expectancy * Medical co-morbidities that make the patient unable to tolerate further diagnostic testing and/or treatment if the screen was positive   For example, physician notes, “Patient has advanced COPD that precludes screening for CRC.”  **Note:** This information is being collected for information only. Provider documentation of a reason that CRC is not clinically indicated is NOT an exemption to the CRC performance measure at this time. |
| **If the patient is male, the computer program will end.**  **If patient is female and age > 64, go to mamord, else go to testpap.** | | | | | | | | | | |
| 62 | testpap | | Does the medical record contain the report of a Pap test performed for this patient within the past three years?  1. Pap test performed by VHA   1. Pap test performed by private sector provider    1. Hysterectomy or congenital absence of a cervix    2. **All** Pap test reports within the past three years note sample was inadequate or that "no cervical cells were present"   98. Patient refused all Pap tests  99. No documentation Pap test performed | | | 1,3,6,7,98,99  **If 3, auto-fill paplab**  **as 95**  **If 6, 98, or 99, auto-fill papdt as 99/99/9999, paplab as 95, and if age > = 40, go to mamord, else if 6, 98, or 99, and age < 40, go to end** | | | Historical information obtained by telephone by a licensed member of the healthcare team and entered in a CPRS progress note is acceptable, as long as the outcome of the test is known. Patient self-report of the result of a Pap test done outside the VHA is acceptable.  **Results of Pap smear must be in the medical record for those tests done by this VAMC. Entry in the computer package is acceptable, as long as the interpretation is present.**  If Pap test was done by another VAMC or private sector provider, the abstractor must be certain the Pap test was accomplished. The date is documented closely enough to be able to compute if the test was accomplished within the accepted time window. Clinically relevant documentation must also include findings, e.g., “normal.”  **If all pap test reports within the past three years note the sample was inadequate for evaluation, consists only of vaginal cells or that NO cervical cells (ectocervical or endocervical) were present, select “7.”**  **Note:** Lab results that indicate that the sample was adequate for evaluation but did not contain endocervical cells (e.g. “no endocervical cells”) may be used, provided a valid result was reported for the pap test.  (e.g., pap test pathology report noted, “Negative for intraepithelial lesion and malignancy, Specimen satisfactory for evaluation.  No endocervical component is identified” is acceptable.)  Do not count biopsies because they are diagnostic and therapeutic only and are not valid for primary cervical cancer screening.  Report of the hysterectomy does not have to be present in the medical record. Notation of past hysterectomy in clinic notes, progress notes, or other source is sufficient. Notation of whether cervix is or is not still present is not applicable. Documentation of hysterectomy is sufficient.  Cont’d next page | |
|  |  | |  | | |  | | | **Pap test cont’d**  **Congenital absence of a cervix** = female born without a uterus/cervix or gender change from male to female. Patients are considered to be the gender documented in the record **unless** there is evidence of a gender change procedure in the record.  **Patient refusal = during clinic visits, when Pap test recommended, the patient stated she does not wish to have this procedure performed.** | |
| 63 | papdt | | Enter date of the most recent Pap test performed during the past three years. | | | mm/dd/yyyy  If testpap = 6,98, or 99, will be auto-filled as 99/99/9999   |  | | --- | | < = 3 years prior or = stdybeg and < = stdyend | | | | Although the day may be entered as day = 01 if the specific date is unknown, the exact month and year must be entered accurately.  If ALL pap reports within the past three years note sample was inadequate or that "no cervical cells were present", enter the date of the most recent report.  If TESTPAP = 6, 98, or 99, PAPDT will be auto-filled as 99/99/9999. | |
| 64 | paplab | | Were the results of the pap test found in the laboratory package?  1. Yes  2. No  95. Not applicable | | | 1,2,95  Will be auto-filled as 95 if testpap = 3,6,98,or 99 | | | **Only answer “1” if the pap test results are documented in the laboratory package. Do not include scanned reports located in VISTA imaging.** | |
| **If female patient age > = 40, go to mamord, else if female patient age < 40, go to end** | | | | | | | | | | |
|  |  | | Screening for Breast Cancer | | |  | | |  | | |
| 65 | mamord | | Did the record document a mammogram was ordered by VHA within the past 2 years?  1. Yes  2. No | | | 1,2  If 2, auto-fill mamordt as 99/99/9999, and go to mamgram2 | | | Mammogram ordered = Clinician order for mammogram entered in CPRS | | |
| 66 | mamordt | | Enter the most recent date a mammogram was ordered by VHA within the past 2 years. | | | mm/dd/yyyy  Will be auto-filled as 99/99/9999 if  mamord = 2   |  | | --- | | <= 2 years prior to or = stdybeg and <= stdyend | | | | Enter the exact date. The use of 01 to indicate missing month or day is not acceptable. | | |
| 67 | mamgram2 | | Does the medical record contain the report of a mammogram performed for this patient within the past two years?  1. Yes  2. No  98. Patient refused to have mammogram performed | | | 1,2,98  If 1, auto-fill  nomammo as 95  If 2 or 98, auto-fill mammdt as 99/99/9999, mamperva as 95, mamrad as 95, biradcod as 95, and go to nomammo | | | * Historical information obtained by telephone by a licensed member of the healthcare team and entered in a CPRS progress note is acceptable, as long as the outcome of the test is known. * Results of mammogram must be in the medical record for those tests done by this VAMC. Entry in the computer package is acceptable, as long as the interpretation is present. * If mammogram was done by another VAMC or private sector provider, the abstractor must be certain the mammogram was accomplished. The date must be documented closely enough to be able to compute if the test was accomplished within the accepted time window. Clinically relevant documentation must also include the findings, e.g., “normal.” * Patient self-report of the result of a mammogram done outside the VHA is acceptable. * A diagnostic mammogram is used to evaluate signs or symptoms of breast cancer and is acceptable for breast cancer screening ONLY if the diagnostic mammogram evaluates both breasts or one breast if the patient has had a unilateral mastectomy. * If the appointment for a mammogram is scheduled for a later date, and the patient has not had a mammogram within the past two years, answer ‘99.’ * Patient refusal must be clearly documented in record.   **Sources:** Progress notes from General Medicine, Primary Care, or Women’s Health in paper record. Access VISTA Radiology or Selected Radiology or Procedures in CPRS. | | |
| 68 | mamperva | | Was the mammogram performed by the VHA?  1. Yes  2. No | | | 1,2,95  Will be auto-filled as 95 if mamgram2 = 2 or 98 | | | Mammogram performed by VHA includes fee based mammogram ordered by VHA. | | |
| 69 | mammdt | | Enter the date of the most recent mammogram performed during the past two years. | | | mm/dd/yyyy  If mamgram2 = 2 or 98, will be auto-filled as 99/99/9999   |  | | --- | | < = 2 years prior or = stdybeg and < = stdyend | | | | Although the day may be entered as day = 01, if the specific date is unknown, the exact month and year should be retrievable and must be entered accurately. | | |
| 70 | mamrad | | Were the results of the mammogram documented in the radiology package?  1. Yes  2. No  95. Not applicable | | | 1,2,95  Will be auto-filled as 95 if mamgram2 = 2 or 98  If 1, go to biradcod  If 2, auto-fill biradcod as 95 AND if  female patient age is  < = 64, go out of module; else if female age > 64, go to bonefx | | | **Do not include scanned reports located in VISTA imaging.**  **Only answer “1” if the mammogram results are documented in the radiology package.**  Documentation of the date of the mammogram with the BI-RAD results (e.g., Primary Diagnostic Code:  BI-RAD #2 - Benign Finding) in the radiology package is acceptable.  The BI-RAD categories are 0, 1, 2, 3, 4, 5, and 6. | | |
| 71 | biradcod | | What BI-RAD code was documented in the mammogram report?  0. 0  1. 1  2. 2  3. 3  4. 4  5. 5  6. 6  95. Not applicable  99. No documentation of BI-RAD code | | | 0,1,2,3,4,5,6,95,99  Will be auto-filled as 95 if mamgram2 = 2 or 98, or mamrad = 2  **If 0,1,2,3,4,5,6,or 99, and**  **female patient age is**  **< = 64, go out of module; else, if female age > 64, go to bonefx** | | | Documentation of the date of the mammogram with the BI-RAD results (e.g., Primary Diagnostic Code:  BI-RAD #2 - Benign Finding) in the radiology package is acceptable.  The BI-RAD categories are 0, 1, 2, 3, 4, 5, and 6. | | |
| 72 | nomammo | | Does the record document the patient had a bilateral mastectomy or gender alteration in the past?  1. Yes  2. No  95. Not applicable | | | 1,2,95  Will be auto-filled as 95 if mamgram2 = 1 | | | Patients are considered to be the gender documented in the record **unless** there is evidence of a gender change procedure in the record. | | |
| **If female patient age is < = 64, go out of module. If age > 64, go to bonefx.** | | | | | | | | | | | |
| 73 | bonefx | | Did the patient have a history of bone fracture within the past eighteen months? | | | 1,2  **If 2, auto-fill whenfrac as 99/99/9999, prevfx as 95, prevfxdt as 99/99/9999, prefxtst as 95, fxbmdt as 99/99/9999, and prefxmed as 95** | | | Past 18 months = from the first day of the study interval to the first day of the month 18 months previously  **Do not include fractures of the finger, toe, face, or skull**.  **If fracture occurred in any other bone, answer “yes.”** | | |
| 74 | whenfrac | | Enter the date the fracture occurred. (If more than one fracture, enter the date of the first fracture.) | | | mm/dd/yyyy  If bonefx = 2, will be auto-filled as 99/99/9999   |  | | --- | | < = 18 mos prior to or = stdybeg and < = stdybeg | | | | At a minimum, enter the month and year the fracture occurred. 01 may be used as default for day. If more than one fracture occurred during the period, enter the date of the first fracture. | | |
| 75 | prevfx | | Within 60 days prior to the date of the first fracture, did the record document a previous bone fracture?  1. Yes  2. No  95. Not applicable | | | 1,2,95  Will be auto-filled as 95 if bonefx = 2  If 2, auto-fill prevfxdt as 99/99/9999 | | | **Do not include fractures of the finger, toe, face, or skull**.  **If fracture occurred in any other bone, answer “yes.”** | | |
| 76 | prevfxdt | | Enter the date the previous fracture occurred. | | | mm/dd/yyyy  Will be auto-filled as 99/99/9999 if bonefx = 2 or prevfx = 2   |  | | --- | | < = 60 days prior to whenfrac and < whenfrac | | | | Enter the exact date. The use of 01 to indicate missing month and day is not acceptable. | | |
| 77 | prefxtst | | Within 365 days prior to the first fracture, did the patient have a bone mineral density test to screen for osteopenia or osteoporosis?  1. Yes  2. No  95. Not applicable  98. Patient refused bone mineral density test | | | 1,2,95,98  If 2 or 98, auto-fill fxbmdt as 99/99/9999  If bonefx = 2, will be auto-filled as 95 | | | Osteopenia = term is used to refer to any decrease in bone mass below the normal. Osteoporosis = a disease characterized by low bone mass and microarchitectural deterioration of bone tissue, leading to enhanced bone fragility and a consequent increase in fracture risk.  Bone mineral density test: DEXA is preferred test; other tests include Quantitative computed tomography (QCT), and calcaneal ultrasonography.  In order to answer “98,” there must be documentation by the provider that the patient refused to have a bone mineral density test performed. | | |
| 78 | fxbmdt | | Enter the date of the bone mineral density test done within 365 days prior to the first fracture. | | | mm/dd/yyyy  If bonefx = 2 or prefxtst = 2 or 98, will be auto-filled as 99/99/9999   |  | | --- | | < = 365 days prior to whenfrac and < whenfrac | | | | If exact date is unknown, 01 may be used as the default day; however, month and year must be known and entered accurately. | | |
| 79 | prefxmed | | Within 365 days prior to the first fracture, did the patient receive medication to treat or prevent osteopenia or osteoporosis?  1. yes  2. no  95. not applicable  98. Patient refused ALL medications to treat/prevent osteoporosis | | | 1,2,95,98  If bonefx = 2, will be auto-filled as 95 | | | Answer “1” if the patient received any of the following medications within 365 days prior to the first fracture:  alendronate, risedronate, calcitonin, raloxifene, estrogen, teriparatide  In order to answer “98,” there must be documentation by the provider that the patient refused ALL medications used to prevent or treat osteopenia or osteoporosis. | | |
| 80 | bmdtdt | | Enter the date of the patient’s most recent bone mineral density test. | | | mm/dd/yyyy  Abstractor can enter 99/99/9999 if no BMDT done  If 99/99/9999, auto-fill skelsite as 95, and bonefind as 95   |  | | --- | | Warn if < age 60 and < = study end date | | | | Bone mineral density test: DEXA (Dual-energy X-ray absorptiometry) is preferred test; other tests include Quantitative computed tomography (QCT), and calcaneal untrasonography.  Look back in the patient’s record to age 60 to determine whether BMDT was done and the date of screening is documented  Enter the exact date if possible. If exact date cannot be determined, enter month and year at a minimum.  Enter default date 99/99/9999 if no bone mineral density test can be found in the record. | | |
| 81 | bonescrn | | Was the patient screened by one of the following bone mineral density tests:   1. Dual-energy X-ray absorptiometry (DEXA) 2. Quantitative computed tomography (QCT) 3. Calcaneal ultrasonography 4. Other 5. Patient refused bone mineral density screening 6. No documentation of bone mineral density screening | | | 1,2,3,4,98,99   |  | | --- | | If bmdtdt = 99/99/9999, bonescrn can only = 98 or 99 | | | | Look back in the patient’s record to age 60 for BMDT.  Osteoporosis involves a gradual loss of calcium, causing bones to become thinner, more fragile, and more likely to break.  Dual-energy X-ray absorptiometry (DEXA) = DXA or DEXA is the established standard for measuring bone mineral density. The DEXA machine sends a thin, invisible beam of low-dose X-rays through the bones via two energy streams  Quantitative computed tomography = QCT of the spine utilizes a conventional CT scanner with a calibration phantom and special software to measure vertebral bone mass.  Calcaneal ultrasonography = less precise that DEXA scan but is portable and less expensive. Measurement based on two factors. i.e., broadband ultrasonic attenuation and speed of sound. | | |
| 82 | skelsite1  skelsite2  skelsite3  skelsite4  skelsite95  skelsite99 | | What was the skeletal site of testing?  **Indicate all that apply:**  1. Hip  2. Forearm  3. Lumbar spine  4. Calcaneus  95. Not applicable  99. Site not documented | | | 1,2,3,4,95,99  If bmdtdt = 99/99/9999 or bonescrn = 98 or 99, will be auto-filled as 95 | | | Central DEXA devices measure bone density in the hip and spine.  The term “hip” also includes the femoral neck. The term “proximal femur” is also acceptable. Documentation of “femur” alone is not sufficient to indicate hip was the site. Peripheral DEXA devices measure bone density in the wrist, heel, or finger. QCT measures vertebral mass of the spine and also peripheral sites. Calcaneal ultrasonography measures only calcaneus bone mineral density  Hip is the preferred skeletal site for testing. Always indicate this site if several body areas, including hip, have been tested.  Do not attempt to guess site from the test administered. If site is not documented, enter “99.” | | |
| 83 | bonefind | | What was the outcome of the bone mineral density screening?   1. Result normal 2. Result indicative of Osteopenia 3. Result indicative of Osteoporosis 4. Not applicable   99. No outcome documented | | | 1,2,3,95,99  If bmdtdt = 99/99/9999 or bonescrn = 98 or 99, will be auto-filled as 95 | | | T-Score WHO Criteria for Osteoporosis in Women   |  |  | | --- | --- | | Normal | BMD > -1.0 below young adult reference range | | Osteopenia | BMD is –1.0 - -2.5 SD below young adult reference range | | Osteoporosis | BMD < -2.5 SD below young adult reference range | | Severe Osteoporosis | BMD < -2.5 SD below young adult reference range and the patient has one or more fractures | | Patient self-report of BMDT done outside VHA is not acceptable. | | | | |
| 84 | osteotx | | Was the patient on medication to prevent or treat osteopenia or osteoporosis?   1. Bisphosphonate (Alendronate) (Risedronate) 2. Serum estrogen receptor modulator (SERM) (Raloxifene) 3. Parathyroid hormone (Calcitonin, Teriparatide) 4. Hormone therapy (estrogen) 5. Other agents (denosumab)   98. Patient refused ALL of the above medications  99. No documented medication for prevention or treatment of osteopenia/osteoporosis | | | 1,2,3,4, 5,98,99  If 98 or 99, auto-fill ostxdt as 99/99/9999 | | | FDA-Approved Osteoporosis Therapies  Bisphosphonate: alendronate (Fosamax) acts as a specific inhibitor of osteoclast-mediated bone reabsorption. Risedronate: (Actonel) inhibits osteoclast-mediated bone reabsorption and modulates bone metabolism  Serum estrogen receptor modulator (SERM): raloxifene (Evista)  Parathyroid hormone: Calcitonin a polypeptide hormone secreted by the parafollicular cells of the thyroid gland in mammals. Given in subcutaneous or intramuscular injection or in nasal spray.  Teriparatide (Forteo): recombinant human parathyroid hormone, given by injection  Hormone therapy; estrogen  To answer “4,” if the patient is taking estrogen, the abstractor must find documentation that estrogen was prescribed for osteopenia, or osteoporosis.  Other agents = denosumab  In order to answer “98,” there must be documentation by the provider that the patient refused ALL medications used to prevent or treat osteopenia or osteoporosis. | | |
| 85 | ostxdt | | Enter the treatment start date. | | | mm/dd/yyyy  Abstractor can enter 99/99/9999 if treatment start date not available.  If osteotx = 98 or 99, auto-fill as 99/99/9999   |  | | --- | | > = age 60 and < = stdyend  Warning if age < 60 at start date | | | | Check pharmacy records for start date of osteoporosis medication. If medication was prescribed by a private sector physician, look for approximate start date.  Enter a date as specific as possible. If exact day is unavailable, enter exact month and year at a minimum.  If treatment start date not available, enter 99/99/9999 | | |
| **Go to Shared Data Module** | | | | | | | | | | | |