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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. Yes2. No | 1\*,2\*If 1, go out of module If 2, go to fluvac15 | A “yes” answer to this question will exclude the case from the PI and Mental Health modules.Although all noted conditions may be applicable to the case, only one is necessary for exclusion from the PI and Mental Health Modules.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. |

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|  |  | Immunizations |  |  |
| 2 | fluvac15 | During the period 7/01/2015 to 3/31/2016, did the patient receive influenza vaccination?1. received vaccination from VHA1. 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

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| **Warning if 4, 98, or 99 and ImmFlag = 1:** Please review all pertinent data sources for documentation of influenza immunization on (ImmDate).  |

**If 4, go to pnumovac****If 98 or 99, go to allerflu**  | **Acceptable 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 patient 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.
6. Documentation in the Immunization Health Summary (under the reports tab in CPRS) that the vaccine was provided by Walgreens, which will be noted as the facility. The month and year must be known.

**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”
4. Documentation of the vaccine in the Immunization Health Summary, **WITHOUT** verification in a progress note that the vaccine was actually given (with the only exception of Walgreens as noted above).

**Cont next page** |
|  |  |  |  | **Cont from previous page****Additional guidelines:****Value 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 7/01/15 – 3/31/16 was on 8/26/15. Facility did not receive vaccine until 9/05/15. Enter response #4.) **Value 98 (Patient refusal) = during the vaccination season, when flu shot was offered, patient stated he did not wish to receive flu vaccination****Value 99 = For patients who had no visits at all during immunization season and did not receive vaccine at this VAMC or elsewhere, answer “99.”**  |
| 3 | fluvacdt | Enter the date influenza vaccination was given. | mm/dd/yyyy

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| > = 7/01/2015 and < = 3/31/2016 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.** |

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| 4 | lfluvac1dfluvac1lfluvac2dfluvac2lfluvac3dfluvac3lfluvac4dfluvac4lfluvac5dfluvac5lfluvac6dfluvac6lfluvac7dfluvac7 | Select the location where the influenza immunization was found in the medical record and enter the date of the documentation.

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| **Location**1 (yes), 2 (no)Must start with #1; if response = 2, auto-fill dfluvac as 99/99/9999, and go to next question  | **Date**If valid date, go to pnumovac

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| >= fluvacdt and<= stdyend |

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| 1. PCE Immunization |  |
| 2. BCMA/MAR |  |
| 3. Immunization Health Summary |  |
| 4. Health Factors/Clinical Reminder |  |
| 5. Clinic/progress/immunization note  |  |
| 6. Scanned notes |  |
| 7. Other |  |

 | 1,2Must answer in the order listedIf location source (e.g., lfluvac1) = 1, date must be enteredIf valid date, go to pnumovac | **NOTE:** **The intent of this question is to verify whether influenza immunization documentation is located in the data source. The priority list of data sources is not representative of abstraction guidelines (i.e., Verify influenza immunization documentation found in clinical reminders/health factors/health summary in the medical record.).**Starting with location #1, PCE Immunization, check to see if documentation of influenza immunization is found in this data source. If yes, enter the date of documentation. The date of documentation may differ from the date the influenza immunization was administered. For example, Prevention note on 3/01/2016 documents influenza immunization was given in private sector by Dr. XYZ’s office on 12/01/2015 (date entered in fluvacdt). Enter 03/01/2016.).  |

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| 5 | 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. Yes2. No | 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.”**  |
| 6 | 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 pneumococcal vaccination from VHA
2. received pneumococcal vaccination from private sector provider

98. patient refused pneumococcal vaccination99. no documentation patient received pneumococcal vaccination | 1,3,98,99If 98 or 99, auto-fill pnuvacdt as 99/99/9999 and go to notobuse as applicable  | Documentation of either PPSV23 or PCV13 is acceptable.Acceptable documentation: * At a minimum the year of pneumococcal vaccination must be documented.
* 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  |
| 7 | pnuvacdt | Enter the date of the most recent pneumococcal vaccination. | mm/dd/yyyyIf pnumovac = 98 or 99, will be auto-filled as 99/99/9999

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| 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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| **If catnum = 61 AND (seenyr = 2 or specvst = 1), go to colondx as applicable; else go to notobuse** |
|  |  | **Screening for Tobacco Use** |  |  |
| 8 | 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. Yes2. No | 1,2If 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, and go to colondx as applicable | 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. |
| 9 | tobscrdt | Enter the most recent date within the past year that the patient was screened for tobacco use. | mm/dd/yyyy

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| < = 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, and go to colondx as applicable** | Review ALL notes and enter date of most recent screening.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.  |
| 10 | 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  | 1,2,95If 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.”

**Exclude:** Documentation of electronic cigarette (e-cigarette) use only |
| 11 | 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 | 1,2,95If 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, and go to colondx as applicable**

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| 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.”
* **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.**
* 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. Answer “1.”) 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.

**Exclude:** Documentation of electronic cigarette (e-cigarette) use only |
| 12 | tuconsel | Within the past year, was the patient provided with direct brief counseling to quit using tobacco? 1. Yes
2. No
3. Not applicable
 | 1,2,95Will 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 VA Quitline, 1-855-QUIT-VET. The VA Quitline 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.**
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| 13 | tucnsldt | Enter the date brief direct tobacco use counseling was provided. | mm/dd/yyyyWill be auto-filled as 99/99/9999 if tuconsel = 2

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| < = 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. |
| 14 | tucrefer | Within the past year, was the patient offered referral for individual intervention or to a tobacco use cessation program?1. Yes
2. No

95. Not applicable | 1,2,95Will 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 the VA Quitline, 1-855-QUIT-VET, as appropriate.If documentation indicates the program was offered, answer “1” even if the patient refused to enroll or participate. |
| 15 | tucrefdt | Enter the date the patient was offered referral for individual intervention or to a tobacco use cessation program. | mm/dd/yyyyWill be auto-filled as 99/99/9999 if tucrefer = 2

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| < = 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. |
| 16 | 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 provider4. No offer of medication documented95. Not applicable | 2,3,4,95Will be auto-filled as 95 if notobuse = 1, or tobscrdt = 99/99/9999, or tobnow = 2 and tobuseyr = 2If 4, auto-fill tucmedt as 99/99/9999, ptreqrx as 95, and go to colondx as applicable | 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 onlyOral medications: Bupropion (Zyban, Wellbutrin), varenicline (Chantix) - Rx only |
| 17 | tucmedt | Enter the date the patient was offered medication to assist in tobacco use cessation. | mm/dd/yyyyWill be auto-filled as 99/99/9999 if offtucrx = 4If offtucrx = 2, auto-fill ptreqrx as 95, and go to colondx as applicableIf offtucrx = 3, go to ptreqrx

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| < = 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. |
| 18 | ptreqrx | Did the non-prescribing provider who offered tobacco cessation medication document that the patient requested tobacco cessation medication?1. Yes2. No95. Not applicable98. Patient refused tobacco cessation medication | 1,2,95,98Will be auto-filled as 95 if offtucrx = 2 or 4  | 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. |
| **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.** |

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|  |  | Colorectal Cancer Screening |  |  |
| 19 | colondxp61h | Does the patient have a diagnosis of one of the following:1. Colon cancer2. Total colectomy1. Neither of these diagnoses
 | 1,2,99If 1 or 2, go to testpapIf 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** |
| 20 | prevcolnp61h | Does the medical record contain the report of a colonoscopy performed within the past ten years? 1. Colonoscopy performed by VHA2. Colonoscopy performed by a private sector provider98. Patient refused colonoscopy 99. No documentation of colonoscopy performed  within the past ten years | 1,2,98,99If 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 databaseIf 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. |
| 21 | coln10dt | Enter the date of the most recent colonoscopy performed within the past 10 years.  | mm/yyyyIf prevcoln = 98 or 99, will be auto-filled as 99/9999 **\*If prevcoln = 1 or 2, go to testpap as applicable**

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| <= 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.  |
| 22 | gfecalbldp61h | 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 VHA4. Three-card guaiac FOBT by private sector provider99. No result of three-card guaiac FOBT done within past year | 3,4, 99If 99, auto-fill 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.  |
| 23 | occblddt | Enter the date of the laboratory report for most recent three-card serial screening for colorectal cancer by gFOBT. | mm/dd/yyyyIf gfecalbld = 99, will be auto-filled as 99/99/9999If gfecalbld = 3 or 4, go to testpap as applicable.

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| < = 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. |
| 24 | ifobtstp61h | 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, 99If 99, auto-fill ifobtdt as 99/99/9999, and go to sigmoid5 | * 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.**
 |
| 25 | 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/yyyyWill be auto-filled as 99/99/9999 if ifobtst = 99 If ifobtst = 3 or 4, go to testpap as applicable

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| < = 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. |

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| 26 | sigmoid5p61h | Does the medical record contain the report of a flexible sigmoidoscopy performed within the past five years?1. Sigmoidoscopy performed by VHA2. Sigmoidoscopy performed by a private sector provider98. 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 ctcolon as applicable** | **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.** |
| 27 | sig5dt | Enter the date of the most recent flexible sigmoidoscopy performed within the past five years. | mm/yyyyIf sigmoid5 = 98 or 99, will be auto-filled as 99/9999 **If sigmoid5 = 1 or 2, go to testpap as applicable**

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| < = 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.  |
| **If [(prevcoln, gfecalbld, AND sigmoid5 = 98 or 99) AND (ifobtst = 99)], go to ctcolon; else go to testpap as applicable** |
| 28 | ctcolon | Does the medical record contain the report of a CT colonography performed within the past five years? 1. CT colonography performed by VHA2. CT colonography performed by a private sector provider99. No documentation of CT colonography performed  within the past five years | 1,2,99If 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 databaseIf 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.** |
| 29 | ctcolndt | Enter the date of the most recent CT colonography performed within the past five years. | mm/yyyyWill be auto-filled as 99/9999 if ctcolon = 99If ctcolon = 1 or 2, go to testpap as applicable

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| < = 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.  |
| 30 | sdnatestp61h | 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 VHA2. Stool-based DNA test performed by a private sector provider99. No documentation of stool-based DNA test performed in the past year | 1,2, 99If 99, auto-fill sdnadt as 99/99/9999, and go to nocrcscr  | 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.** |
| 31 | sdnadt | Enter the date of the most recent stool-based DNA test performed within the past year. | mm/dd/yyyyWill be auto-filled as 99/99/9999 if sdnatest = 99If sdnatest = 1 or 2, go to testpap as applicable

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| < = 1 year prior or = stdybeg and < = stdyend |

 | Enter the exact date. The use of 01 to indicate missing month or day is not acceptable. |
| 32 | nocrcscrp61h | During the past five years, did the patient’s primary care physician/APN/PA document that he/she does not believe that this patient will experience a net-benefit from colorectal cancer screening because of one or both of the following:* Patient’s life expectancy is < 5 years because of diagnoses or clinical factors (as specified in the progress note)
* Patient could not tolerate the further work-up or treatment (if the colorectal cancer screen was positive) because of co-morbidities (as specified in the progress note)

1. Yes2. No | 1,2 | In order to answer “1”, the patient’s PCP must document in a progress note that he/she does not believe that this patient will experience a net-benefit from colorectal cancer screening, i.e. no benefit is expected or benefits are not expected to outweigh harms because of one or both of the following: * Life expectancy is less than 5 years because of diagnoses or clinical factors that are specified in the progress note ; AND/OR
* Patient could not tolerate the further work-up or treatment (if the screen was positive) because of co-morbidities that are also specified in the progress note.
 |
| **If the patient is male, the computer program will end.** **If patient is female and age > 64, go to mamgram2; else go to testpap.** |
| 33 | testpapp41hp42p43h | Does the medical record contain the report of a Pap test performed for this patient within the past five years?1. Pap test performed by VHA1. Pap test performed by private sector provider
	1. Hysterectomy (with no residual cervix) or congenital absence of a cervix
	2. **All** Pap test reports within the past five years note sample was inadequate or that "no cervical cells were present"

98. Patient refused all Pap tests99. No documentation Pap test performed | 1,3,6,7,98,99**If 6,98, or 99, auto-fill papdt as 99/99/9999, paprptdt as 99/99/9999, paplab as 95, papreslt as 95, hpvtest as 95, hpvtstdt as 99/99/9999, hpvrptdt as 99/99/9999, AND if age > = 40, go to mamgram2****If 99 and age < 40, go to nocascrn** **If 6 or 98, 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 five 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. The hysterectomy operative report does not have to be present in the medical record; however, **documentation of hysterectomy in the medical record must indicate no residual cervix (i.e., “complete”, “total”, or “radical” abdominal or vaginal hysterectomy).** **The following are also acceptable:**Documentation of a “vaginal pap smear” in conjunction with documentation of “hysterectomy”.Documentation of hysterectomy in combination with documentation the patient no longer needs pap testing/cervical cancer screening.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.** |
| 34 | papdtp41hp42 | Enter the collection date of the most recent Pap test performed during the past five years. | mm/dd/yyyyIf testpap = 6,98, or 99, will be auto-filled as 99/99/9999

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| < = 5 years prior or = stdybeg and < = stdyend |

 | Enter the collection date of the most recent pap test performed during the past five years. Collection date can be found on the pap test report. 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 TESTPAP = 6, 98, or 99, PAPDT will be auto-filled as 99/99/9999.  |
| 35 | paprptdt | Enter the report date of the most recent Pap test performed during the past five years | mm/dd/yyyyAbstractor can enter 99/99/9999If testpap = 6,98, or 99, will be auto-filled as 99/99/9999If testpap = 7 and age >= 40, go to mamgram2; else if 7, go to end

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| >= papdt and <= pulldt |

 | Enter the report date of the most recent pap test performed during the past five years. If ALL pap reports within the past five years note sample was inadequate or that “no cervical cells were present”, enter the date of the most recent report.If the pap test report date is after pull list date, abstractor may enter 99/99/9999.If TESTPAP = 6, 98, or 99, will be auto-filled as 99/99/9999.  |
| 36 | paplab | Were the results of the pap test found in the laboratory package?1. Yes2. No95. Not applicable | 1,2,95Will be auto-filled as 95 if testpap = 6,98,or 99If 2, go to hpvtest  | **Only answer “1” if the pap test results are documented in the laboratory package. Do not include scanned reports located in VISTA imaging.**  |
| 37 | papreslt | What results for the pap test were documented? 3. Normal4. Abnormal95. Not applicable99. Unable to determine | 3,4,95,99Will be auto-filled as 95 if testpap = 6,98,or 99 | **Only use the pap test report to answer this question.** Documentation of pap test results may include but are not limited to: **Normal** = negative findings, no cell abnormalities, negative for intraepithelial lesion or malignancy, benign cellular changes**Abnormal** = atypical squamous cells of undetermined significance, atypical squamous cells cannot exclude a high-grade squamous intraepithelial lesion, low grade squamous intraepithelial lesions, high grade squamous intraepithelial lesions, squamous cell carcinoma, atypical glandular cells, endocervical adenocarcinoma in situ, adenocarcinoma**Value 99 should only be selected if the results of the pap test are not clearly documented as normal or abnormal.** |
| 38 | hpvtestp41hp43h | During the timeframe from (computer to display papdt – 4 days to papdt + 4 days), does the medical record document a cervical human papillomavirus (HPV) test was performed for this patient? 1. HPV test performed by VHA3. HPV test performed by private sector provider95. Not applicable99. No documentation HPV test performed | 1,3,95,99Will be auto-filled as 95 if testpap = 6,98,or 99If 99, auto-fill hpvtstdt as 99/99/9999, hpvrptdt as 99/99/9999 and go to mamgram2 as applicable | A HPV test is usually performed in conjunction with a pap test. For the purpose of this question, an HPV test may be obtained during the timeframe of 4 days prior and up to 4 days after the pap test date. HPV tests may be performed by the VHA or sent to non-VHA lab. Look at cervical cytology reports first because even if HPV is noted as a chemistry test, the report may be added to the cytology report.  Then, if HPV test not found, do a search on the lab tab under selected lab tests and see if HPV or Human Papillomavirus is listed. 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 HPV test is known. Patient self-report of the result of a HPV test done outside the VHA is not acceptable.**Results of HPV test 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 HPV test was done by another VAMC or private sector provider, the abstractor must be certain the HPV test was accomplished. The date is documented closely enough to be able to compute if the HPV test were accomplished within the accepted time window. Clinically relevant documentation must also include findings, e.g., “positive”. **Suggested data sources: cytology reports, lab reports** |
| 39 | hpvtstdtp41hp43h | Enter the date of the most recent cervical HPV test performed.  | mm/dd/yyyyWill be auto-filled as 99/99/9999 if testpap = 6,98, or 99 or hpvtest = 99

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| <= 4 days prior to or = papdt and <= 4 days after papdt |

 | Enter the date the most recent cervical HPV test was performed (i.e., collected or obtained).Although the day may be entered as day = 01 if the specific date is unknown, the exact month and year must be entered accurately. |
| 40 | hpvrptdt | Enter the date the HPV test result was reported. | mm/dd/yyyyWill be auto-filled as 99/99/9999 if testpap = 6,98, or 99 or hpvtest = 99Abstractor can enter 99/99/9999

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| >= hpvtstdt and <= 45 days after hpvtstdt and <= pulldt or (<= stdyend if stdyend > pulldt) |

 | HPV report date is the date on which the results were completed by the lab and could be reported to the clinician if he/she called to ask for the results. If the HPV report date cannot be entered (date is after pull list date or after study end when study end date is greater than pull list date), enter 99/99/9999. |
| **If female patient age > = 40, go to mamgram2; if female patient age < 40 and (testpap = 99 or hpvtest = 99), go to nocascrn; if female patient age < 40 and (testpap = 99 = 99, go to nocascrn;ap = <> 99), go to end** |

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|  |  | Screening for Breast Cancer |  |  |
| 41 | mamgram2p31h | Does the medical record contain the report of a mammogram performed for this patient during the timeframe from (computer to display stdybeg – 27 months to stdyend)?1. Yes2. No98. Patient refused to have mammogram performed | 1,2,98If 1, auto-fill nomammo as 95If 2 or 98, auto-fill mammdt as 99/99/9999, mamperva2 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 27 months, 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. |
| 42 | mamperva2 | Was the mammogram performed by the VHA?3. Mammogram performed at a VAMC4. Mammogram performed outside VHA, fee basis5. Mammogram performed private sector, not fee basis95. Not applicable  | 3,4,5,95Will be auto-filled as 95 if mamgram2 = 2 or 98 | Value 3 = mammogram was performed at a VAMC.Value 4 = mammogram performed outside VHA, **fee basis**, may be determined by checking to see if mammogram was ordered by and consult placed by VHA. If the mammogram was ordered by VHA and performed outside VHA, enter 4.Value 5 = mammogram performed private sector, **not fee basis**, includes documentation the mammogram was performed outside VHA such as patient self-report documented by VHA staff or outside mammogram report without evidence it was ordered by VHA. |
| 43 | mammdt | Enter the date of the most recent mammogram performed during the past 27 months. | mm/dd/yyyyIf mamgram2 = 2 or 98, will be auto-filled as 99/99/9999If mamperva2 = 5 and (testpap = 99 or hpvtest = 99), go to nocascrn; else if mamperva2 = 5, go to bmdtdt as applicable

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| < = 27 months 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. |
| 44 | mamrptdt | Enter the report date of the most recent mammogram performed during the past 27 months. | mm/dd/yyyyAbstractor can enter 99/99/9999

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| >= mammdt and <= pulldt or (<= stdyend if stdyend > pulldt |

 | Enter the report date of the most recent mammogram performed during the past 27 months. If the mammogram report date is after pull list date, abstractor may enter 99/99/9999. |
| 45 | mamrad | Were the results of the mammogram documented in the radiology package?1. Yes2. No95. Not applicable | 1,2,95Will be auto-filled as 95 if mamgram2 = 2 or 98 If 1, go to biradcodIf 2, auto-fill biradcod as 95 AND (if testpap = 99 or hpvtest = 99, go to nocascrn); else go to bmdtdt as applicable | **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.  |
| 46 | biradcod | What BI-RAD code was documented in the mammogram report?0. 01. 12. 23. 34. 45. 56. 695. Not applicable99. No documentation of BI-RAD code | 0,1,2,3,4,5,6,95,99Will be auto-filled as 95 if mamgram2 = 2 or 98, or mamrad = 2If testpap = 99 or hpvtest = 99, go to nocascrn If mamrptdt = 99/99/9999 or if testpap <> 99, go to bmdtdt as applicable  | 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.  |
| 47 | nomammop31h | Does the record document the patient had a bilateral mastectomy or gender alteration in the past?1. Yes2. No95. Not applicable | 1,2,95Will be auto-filled as 95 if mamgram2 = 1If 2, go to nocascrnIf 1 and (testpap = 99 or hpvtest = 99), go to nocascrn; else if 1, to bmdtdt as applicable | Documentation the patient had two unilateral mastectomies on different dates of service, with service dates at least 14 or more days apart, is acceptable to answer “1”.Example: If first unilateral mastectomy was 2/1/20xx, service date for second unilateral mastectomy must be on or after 2/15/20xx.Patients are considered to be the gender documented in the record **unless** there is evidence of a gender change procedure in the record. |
| 48 | nocascrnp31hp41hp42p43h | During the past five years, did the patient’s primary care physician/APN/PA document that he/she does not believe that this patient will experience a net-benefit from cancer screening (breast or cervical), because of one or both of the following:* Patient’s life expectancy is < 5 years because of diagnoses or clinical factors (as specified in the progress note)
* Patient could not tolerate the further work-up or treatment (if the screen was positive) because of co-morbidities (as specified in the progress note)

1. Yes2. No | 1,2 | In order to answer “1”, the patient’s PCP must document in a progress note that he/she does not believe that this patient will experience a net-benefit from breast and/or cervical cancer screening, i.e. no benefit is expected or benefits are not expected to outweigh harms because of one or both of the following: * Life expectancy is < 5 years because of diagnoses or clinical factors that are specified in the progress note ; AND/OR
* Patient could not tolerate the further work-up or treatment (if the screen was positive) because of co-morbidities that are also specified in the progress note.
 |
| **If female patient age is < = 64, go out of module. If age > 64, go to bmdtdt.** |
| 49 | bmdtdt | Enter the date of the patient’s most recent bone mineral density test. | mm/dd/yyyyAbstractor can enter 99/99/9999 if no BMDT doneIf 99/99/9999, auto-fill skelsite as 95

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| 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 documentedEnter 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. |
| 50 | 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

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| 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 streamsQuantitative 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.  |
| 51 | skelsite1skelsite2skelsite3skelsite4skelsite95skelsite99 | What was the skeletal site of testing?**Indicate all that apply:**1. Hip2. Forearm3. Lumbar spine4. Calcaneus95. Not applicable99. Site not documented | 1,2,3,4,95,99If 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 densityHip 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.”  |