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| [**Link to Mnemonics and Questions**](https://secure.wvmi.org/QUESTIONS/Specifications/Mnemonics%20and%20Questions/fy2022q1/MnemonicQuestions1q22.xlsx) | | | | |
|  |  | Immunizations |  |  |
| 1 | fluvac21 | During the period from (computer display 7/01/2021 to (pulldt or <= stdyend if stdyend > pulldt)), did the patient receive influenza vaccination?  1. received vaccination from VHA   1. received vaccination from private sector provider   98. patient refused vaccination  99. no documentation patient received  vaccination | 1,3,98,99  **If 98 or 99, go to allerflu** | **Note: The intent is to look for influenza immunization administered during the current influenza immunization period (i.e. 7/01/2021 through 6/30/2022).** For the purposes of review, influenza immunization given up to the pull list date (unless the study end date is after the pull list date) is acceptable. For example, the pull list date is 11/02/2021 and medical record contains documentation the influenza immunization was administered on 11/01/2021, enter value “1”.  **Acceptable documentation of influenza immunization:**   1. Notation of “flu shot given” with month and year 2. Influenza vaccine given in another setting, i.e., acute care, NHCU, etc., with month and year documented 3. Patient self-report of flu shot at community facility with month and year documented. 4. Checkmark on a checklist, with month and year, clinician’s signature or initials and documentation of a clinic visit or vaccination clinic.   **Unacceptable documentation:**   1. Any documentation that does not indicate the vaccine was actually given and there is no month or year documented. 2. Documentation of the vaccine in the Immunization Health Summary, **WITHOUT** verification in a progress note that the vaccine was actually given.   **Additional guidelines:**  **To select value “98”, the documentation must indicate that the patient refused the flu vaccine during the vaccination season (7/01/2021 – 6/30/2022). For example, documentation from 8/23/2021 states “patient stated he did not wish to receive flu vaccination,” select value “98”.**  **Select value “99”for patients who had no visits at all during immunization season (7/01/2021 – 6/30/2022) and did not receive the influenza immunization at this VAMC or anywhere else during immunization season.** |
| 2 | fluvacdt | Enter the date influenza vaccination was given. | mm/dd/yyyy  If fluvac21 = 1 or 3, go to bnmrtrns   |  | | --- | | > = 7/01/2021 and  < = 6/30/2022 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.** |
| 3 | allerflu | Is one of the following documented in the medical record? Previous severe allergic reaction to any component of the influenza vaccine, or after a previous dose of any influenza vaccineHistory of Guillain-Barre Syndrome 1. Yes  2. No | 1,2 | **Severe allergic reaction to any influenza vaccine component must be documented in the medical record. Notation does not have to state “anaphylactic.”**   * A previous severe allergic reaction to influenza vaccine, regardless of the component suspected of being responsible for the reaction, is a contraindication to future receipt of the vaccine. * Signs of a severe allergic reaction can include: difficulty breathing, hoarseness or wheezing, swelling around the eyes or lips, hives, paleness, weakness, fast heart beat or dizziness * History of an allergy to eggs is no longer a contraindication to receiving the vaccine.   **History of Guillain-Barre Syndrome** - may be anytime in the patient’s history and must be documented in the medical record. |
| 4 | bnmrtrns | Is there documentation in the medical record the patient had a bone marrow transplant during the past year?  1. Yes  2. No | 1,2  If 1, go to tobscrn18 as applicable | **Bone marrow transplant - must be documented the procedure occurred during the past year.** |
| 5 | chemoexc | Is there documentation in the medical record the patient received chemotherapy during the past year?  1. Yes  2. No | 1, 2  If 1, go to tobscrn18 as applicable | **Documentation the patient received chemotherapy during the past year excludes the case from the pneumococcal measures.**  **Received chemotherapy:** the abstractor should look for evidence of a diagnosis of cancer and documentation that the patient received some type of chemotherapy for the cancer during the past year.  For example, a PCP note in the appropriate timeframe states “Patient is undergoing chemotherapy at XYZ Cancer Center.” or an Oncology note in the appropriate timeframe states: “Here today for IV chemo treatment.” |
| 6 | immcomp | At any time in the patient’s history through (computer to display stdyend), is there documentation of any of the following in the medical record?   * Immunocompromising conditions * Anatomic or functional asplenia * Sickle cell disease and HB-S disease * Cerebrospinal fluid leak(s) * Cochlear implant(s)   1. Yes  2. No | 1,2  If 1, go to tobscrn18 as applicable | **Individuals with immunocompromising conditions, anatomic or functional asplenia, cerebrospinal fluid leaks, or cochlear implants are excluded from the pneumococcal measures.**   * **Immunocompromising conditions may include but are not limited to:** immunoglobulin deficiencies, antibody deficiencies, other specified immune-deficiencies, graft-versus-host disease, end stage renal disease, organ transplants, transplant rejection/failure. (Refer to Table 1-Immunocompromising Conditions.) * **Anatomic or functional asplenia includes** congenital absence of the spleen, surgical removal of the spleen or diseases of the spleen. * **Sickle cell disease** isa group of disorders that affects hemoglobin. Individuals with this disorder have atypical hemoglobin molecules called hemoglobin S (or HB-S) which can distort red blood cells into a sickle shape.   **Suggested Data Sources:** History and Physical, Problem List |
| 7 | pcvvac | At any time, not later than the study end date, did the veteran receive the **PCV13** pneumococcal vaccination, either as an inpatient or outpatient?   1. received **PCV13** pneumococcal vaccination from VHA 2. received **PCV13** pneumococcal vaccination from private sector provider   98. patient refused **PCV13** pneumococcal vaccination  99. no documentation patient received **PCV13** pneumococcal vaccination | 1,3,98,99  If 98 or 99, go to ppsvvac | **There are two kinds of pneumococcal vaccines in the United States:**   * Pneumococcal conjugate vaccine (PCV 13 or Prevnar 13®) * Pneumococcal polysaccharide vaccine (PPSV23 or Pneumovax23®)   **The intent of this question is to determine if the patient received the PCV13 or** Prevnar 13® **pneumococcal vaccination. Only documentation of the PCV13 or** Prevnar 13®**vaccine is acceptable for this question.**   * At a minimum the year of the PCV13 vaccination must be documented. * Historical information obtained by telephone by a member of the healthcare team and entered in a CPRS progress note is acceptable.   Unacceptable:   * Notation in the record that patient has had a PCV13 vaccination if year of administration is not documented. * Documentation the patient received the PPSV23 vaccination * Documentation the patient received a pneumococcal vaccination, but type is unable to be determined   **Patient refusal** = each time it was offered, patient stated he/she states he does not want the **PCV13** vaccination |
| 8 | pcvdt | Enter the date of the PCV13 pneumococcal vaccination. | mm/dd/yyyy   |  | | --- | | Warning if >15 years prior to stdybeg and <= stdyend | | Notation in the record that patient has had the PCV13 pneumococcal vaccination is not acceptable unless, at a minimum, the year is documented.  Enter the year if that is the only information known, with 01 for month and day. |
| 9 | ppsvvac | At any time, not later than the study end date, did the veteran receive the **PPSV23** (or pneumococcal) vaccination, either as an inpatient or outpatient?   1. received **PPSV23** (or pneumococcal) vaccination from VHA 2. received **PPSV23** (or pneumococcal) vaccination from private sector provider   98. patient refused **PPSV23** (or pneumococcal) vaccination  99. no documentation patient received **PPSV23** (or pneumococcal) vaccination | 1,3,98,99  If 98 or 99, go to pneurxn | **The intent of this question is to determine if the patient received the PPSV23 (Pneumovax 23®, Pnu-Imune 23®) or pneumococcal (Pneumovax) vaccination.**   * **At a minimum the year of the PPSV23 (or pneumococcal) vaccination must be documented.** * Historical information obtained by telephone by a member of the healthcare team and entered in a CPRS progress note is acceptable.   Unacceptable:   * Notation in the record that patient has had a PPSV23 (or pneumococcal) vaccination if year of administration is not documented. * Documentation the patient received the PCV13 pneumococcal vaccination   **Patient refusal** = each time it was offered, patient stated he/she states he does not want the **PPSV23** (or pneumococcal ) vaccination |
| 10 | ppsvdt | Enter the date of the **PPSV23** (or pneumococcal) vaccination. | mm/dd/yyyy   |  | | --- | | Warning if >15 years prior to stdybeg and <= stdyend | | Notation in the record that patient has had the **PPSV23** (or pneumococcal) vaccination is not acceptable unless, at a minimum, year is documented.  Enter the year if that is the only information known, with 01 for month and day. |
| 11 | pneurxn | Is there documentation in the medical record of a prior anaphylactic reaction to a pneumococcal vaccine?  1. Yes  2. No | 1,2 | **Prior anaphylactic reaction to a pneumococcal vaccine must be documented in the medical record.**  **Anaphylactic reaction -** Sudden, potentially severe and life-threatening allergic reaction. Symptoms may start with a feeling of uneasiness, tingling sensations and dizziness and rapidly progress to generalized itching and hives, swelling, wheezing and difficulty breathing, and fainting. |
| **If [(dementdx2 = 1) AND (permci = 1)] OR [(demsev = 1, 2 or 3) AND (cogscor2=5)] OR (incsevci = 1) OR (modsevci=1)], go to colondx as applicable; else go to tobscrn18** | | | | |

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|  |  | **Screening for Tobacco Use** |  |  | |
| 12 | tobscrn18 | During the past year, was the patient screened for tobacco use by an acceptable provider using the **National Clinical Reminder for Tobacco Use**?  1. Yes  2. No  98. Patient declined to answer National Clinical Reminder for Tobacco Use screening questions | 1,2,98  If 2 or 98, go to colondx as applicable | **On or after 10/01/2018, tobacco screening must be completed by an acceptable provider using the National Clinical Reminder for Tobacco Use.**  Acceptable providers include: physicians, APN, PA, RN, LPN, pharmacists, social workers, psychologists, dentists, Addictions Therapists/substance abuse counselors, Licensed Professional Mental Health Counselors (LPMHC), and Marriage and Family Therapists.  Health/medical technicians or clerical staff are not acceptable providers to complete tobacco use screening or follow-up.  The first question of the National Clinical Reminder for Tobacco Use is:  Do you smoke cigarettes, or use tobacco every day, some days, or not at all?  🞎 Every Day  🞎 Some Days  🞎 Not at all  🞎 Declined to Answer  In order to answer “yes” to this question, the tobacco screening must be completed by an acceptable provider using the National Clinical Reminder for Tobacco Use with documentation of one of the responses as noted above such as “The patient uses tobacco every day”.  The questions will not appear in the documentation.  The lead in is Tobacco Use Screening, not the question.  Examples of documentation that may be seen in the medical record include:  **Tobacco Use Screening:**  **The patient uses tobacco every day.**  **OR**  **Tobacco Use Screening:**  **The patient uses tobacco some days.**  **OR**  **Tobacco Use Screening:**  **The patient is a former tobacco user.**  **The patient quit less than one year ago.**  Cont’d next page | |
|  |  |  |  | Tobacco Screening cont’d.  **OR**  **Tobacco Use Screening:**      The patient has never used tobacco.  In order to answer “98”, the documentation of refusal must be associated with the National Clinical Reminder for Tobacco Use. Refusal to answer other questions (e.g., Have you used tobacco in the past year; have you ever used tobacco?) is not acceptable.  An example of documentation that may be seen in the medical record includes:  **Tobacco Use Screening:**  **The patient declines to say if they use tobacco.**  **(FAILS – reminder reset)**  Tobacco use includes: cigarettes, cigars, pipe smoking, snuff, dip, or chewing tobacco (smokeless tobacco categories). Tobacco products do NOT include electronic cigarettes, vaping devices, or any electronic nicotine delivery system  Depending on the patient’s response, additional questions may be asked. | |
| 13 | tobscrndt | Enter the date of the most recent tobacco use screening by an acceptable provider using the National Clinical Reminder for Tobacco Use. | mm/dd/yyyy   |  | | --- | | <= 1 yr prior to stdybeg and <= stdyend | | Enter the exact date of the most recent tobacco use screening by an acceptable provider using the National Clinical Reminder for Tobacco Use. | |
| 14 | tobscrn1 | Enter the response to Tobacco Use Screening question #1 “Do you smoke cigarettes, or use tobacco every day, some days, or not at all?”  1. Every Day  2. Some Days  3. Not at all | 1,2,3  If 1 or 2, go to tobscrn2; else go to colondx as applicable | Enter the patient’s response to Tobacco Use Screening question #1 “Do you smoke cigarettes, or use tobacco every day, some days, or not at all?” documented in the medical record. | |
| 15 | tobscrn2 | Enter the response to the Tobacco Use Screening question “Do you smoke or use tobacco within 30 minutes of waking up?”  1. Yes  2. No  99. Not documented | 1,2,99 | Enter the patient’s response to the Tobacco Use Screening question “Do you smoke or use tobacco within 30 minutes of waking up?” documented in the medical record. | |
| 16 | tobscrn3 | Enter the response to the Tobacco Use Screening question “How long have you smoked or used tobacco?”  1. Less than 1 year  2. 1 year to less than 5 years  3. 5 years to 15 years  4. More than 15 years and less than 30 years  5. 30 years or more  99. Not documented | 1,2,3,4,5,99  If 1,2,3,4,5, or 99, go tuconsel2 | Enter the patient’s response to the Tobacco Use Screening question “How long have you smoked or used tobacco?” documented in the medical record.  This question is for informational purposes and is not used in scoring. | |
| 17 | tuconsel2 | During the past year was the patient advised to quit smoking or stop using tobacco using the National Clinical Reminder for Tobacco Use?  1. Yes  2. No | 1, 2  If 2, auto-fill tucnsldt2 as 99/99/9999 and go to tucrefer2 | For all patients screened for tobacco use on or after 10/01/2018, Advised to Quit must be documented using the National Clinical Reminder for Tobacco use which includes general guidance on elements such as:   * Quitting smoking or tobacco use is one of the most important things you can do to protect and improve your health and VA has the resources to support you. * Set a quit date when you are ready to quit. * Get support from your family and friends. * Review any past quit attempts- What helped? What didn't? * On the day you plan to quit, get rid of all cigarettes and tobacco products from your home, car or work. * Using a combination of behavioral counseling or other support strategies and FDA-approved cessation medications is the most effective way to ensure success in quitting. * Any provider who is able to screen for tobacco use is able to advise patient to quit and offer 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 advice 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. | |
| 18 | tucnsldt2 | Enter the date the patient was advised to quit smoking or stop using tobacco using the National Clinical Reminder for Tobacco Use. | mm/dd/yyyy  Will be auto-filled as 99/99/9999 if  tuconsel2 = 2   |  | | --- | | <= 1 year prior to stdybeg and <= stdyend | | Exact date must be entered. The use of 01 to indicate missing day or month is not acceptable.  All “Advice to Quit” guidance provided on or after 10/01/2018 must be documented using the National Clinical Reminder for Tobacco. | |
| 19 | tucrefer2 | During the past year, did the provider provide information about behavioral counseling or treatment options other than medication to assist patient with quitting smoking or using tobaccousing the National Clinical Reminder for Tobacco Use?   1. Yes 2. No | 1,2  If 2, auto-fill tucrefdt2 as 99/99/9999, and go to offtucrx2 | Any provider who is able to screen or advise to quit is able to provide information about behavioral counseling or treatment options other than medication to assist patient with quitting smoking or using tobacco including physicians, APN, PA, RN, LPN, pharmacists, social workers, psychologists, dentists, and substance abuse counselors.  Information about behavioral counseling/other options must be documented using the National Clinical Reminder for Tobacco Use, which includes:   * Behavioral counseling or other support strategies greatly increases your chances of successfully quitting smoking or tobacco use by helping you develop a quit plan and providing support and other strategies to make behavioral changes to help you quit. * VA has a number of behavioral counseling options to help you with quitting, including:   + Provide information about the facility smoking or tobacco use treatment options or clinics   + VA's national quitline, 1-855-QUIT-VET, with counseling available Monday-Friday   If documentation indicates the program was offered, answer “1” even if the patient refused to enroll or participate. | |
| 20 | tucrefdt2 | Enter the date the patient was offered information about behavioral counseling or treatment options other than medication for individual intervention or to a tobacco use cessation program using the National Clinical Reminder for Tobacco Use. | mm/dd/yyyy  Will be auto-filled as 99/99/9999 if  tucrefer2 = 2   |  | | --- | | <= 1 year prior to stdybeg and <= stdyend | | Exact date must be entered. The use of 01 to indicate missing day or month is not acceptable.  All “Information about Behavioral Counseling/Other Options” provided on or after 10/01/2018, must be documented using the National Clinical Reminder for Tobacco Use. | |
| 21 | offtucrx2 | During the past year, was the patient offered FDA approved medications by a provider to assist in tobacco use cessation using the National Clinical Reminder for Tobacco Use?  1. Yes  2. No | 1,2  If 2, go to colondx as applicable | **All “Offering of Medications” provided on or after 10/01/2018, must be documented using the National Clinical Reminder for Tobacco Use.**  Any provider who is able to screen or advise to quit is able to provide information about FDA approved medications to assist patient with quitting smoking or using tobacco including physicians, APN, PA, RN, LPN, pharmacists, social workers, psychologists, dentists, and substance abuse counselors.  Documentation of offer of FDA approved tobacco cessation medications using the National Clinical Reminder for Tobacco Use includes:  Medications for Nicotine replacement therapy such as the patch, gum or lozenge, and other medications such as varenicline or bupropion, can play an important role in the initial weeks and months after you quit smoking or tobacco use.  Medications help with cravings and withdrawal symptoms and they greatly increase your chances of successfully quitting.  If the provider offered tobacco cessation medication to the patient and the patient accepted or declined, enter “1”.  If there is no documentation the provider offered tobacco use cessation medication to the patient, enter “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) – prescription only | |
| 22 | tucmedt2 | Enter the date the patient was offered medication to assist with quitting smoking or to stop using tobacco using the National Clinical Reminder for Tobacco Use. | mm/dd/yyyy   |  | | --- | | <= 1 year prior to stdybeg and <= stdyend | | Exact date must be entered. The use of 01 to indicate missing day or month is not acceptable.  All “Information about Offering FDA Approved Medications” provided on or after 10/01/2018, must be documented using the National Clinical Reminder for Tobacco Use. | |
| 23 | ptreqrx2 | During the past year, did the provider document the patient was interested in a prescription for tobacco cessation medications?   1. Yes, patient is interested in a prescription for tobacco cessation medications 2. Yes, “non-prescribing provider” notified prescribing provider of patient’s interest in a prescription for tobacco cessation medications 3. No, documented patient was not interested in a prescription for tobacco cessation medications   99. No documentation if the patient was or was not interested in a prescription for tobacco cessation medications | 1,2, 3,99  If 3 or 99, go to colondx as applicable | Any provider who is able to screen or advise to quit is able to provide information about FDA approved medications to assist patient with quitting smoking or using tobacco including physicians, APN, PA, RN, LPN, pharmacists, social workers, psychologists, dentists, and substance abuse counselors.  **All “Offering of Medications” provided on or after 10/01/2018, must be documented using the National Clinical Reminder for Tobacco Use. The documentation must indicate if the patient was or was not interested in a prescription for tobacco cessation medication.**  **Discussion with the patient should include:**  Patient was offered FDA-approved cessation medications  Medications for Nicotine replacement therapy such as the patch, gum or lozenge, and other medications such as varenicline or bupropion, can play an important role in the initial weeks and months after you quit smoking or tobacco use.  Medications help with cravings and withdrawal symptoms and they greatly increase your chances of successfully quitting.  If the provider documents the patient was not interested in a prescription for tobacco cessation medication, enter “3”.  Non-prescribing provider = This includes, but may not be limited to pharmacists, psychologists, RNs, LPNs, social workers, and substance abuse counselors.  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. | |
| 24 | tobrxord | During the past year, is there documentation a tobacco use cessation medication was ordered for the patient?  1. Yes  2. No | 1,2  If 1 or 2, go to colondx as applicable | Please check clinic notes and physician orders to determine if a tobacco cessation medication was ordered for the patient.  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) - prescription only | |
| **If the patient is male and <= age 45, the module will end.**  **If the patient is female and <= age 45, the computer will go to question testpap.** | | | | |

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|  |  | Colorectal Cancer Screening |  |  |
| 25 | 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** |
| 26 | 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 procedures performed by any VAMC.**  **For colonoscopy performed by a community provider PRIOR to 10/01/2018:**   * Patient self-report of a colonoscopy done outside the VHA is acceptable * The medical record documentation must include the year the colonoscopy was performed and the results.   **For colonoscopy performed by a community provider ON or AFTER 10/01/2018:**   * **Patient self-report of a colonoscopy done outside the VHA is acceptable if the Primary Care Practitioner documentation clearly indicates that the colonoscopy was performed, the year and results.** * Primary care practitioner (PCP): A physician or non-physician (e.g., nurse practitioner, physician assistant) who offers primary care medical services. * Licensed practical nurses and registered nurses are not considered PCPs. * Nurse documentation of patient self-report is **NOT** acceptable.   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.  **Suggested Data Sources:** Anatomic Pathology (Lab Package), Consult notes, History and Physical, Progress notes, Operative report Procedure notes, Radiology notes |
| 27 | 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, go to testpap as applicable**  **If prevcoln = 2, go to pvtcolrpt**   |  | | --- | | <= 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. |
| 28 | pvtcolrpt | Is the actual report of the colonoscopy done by the private sector provider/outside the VHA found in the medical record?  1. Yes  2. No | 1,2  If 1, go to testpap as applicable | The intent of this question is to determine if the report of the colonoscopy performed by a private sector provider/outside the VHA is in the medical record. Reports from private sector providers may be scanned in to the electronic medical record.  **Suggested data sources:** VistA Imaging |
| 29 | colslfrpt | Does the documentation in the medical record indicate the result of the colonoscopy done by a private sector provider/outside the VHA was a self-report by the patient?  1. Yes  2. No  99. Unable to determine from documentation in the medical record | 1,2,99  If 1,2, or 99 go to testpap as applicable | The intent of this question is to determine if the source of the information about the colonoscopy report (e.g., where performed, date, result) was by patient self-report.   * If the documentation clearly indicates the report was a self-report by the patient, select “yes”. For example, in a clinic note: “Patient states he had a colonoscopy 5 years ago at XYZ Surgery Center and it was negative.” * If the documentation clearly indicates the report was obtained and noted in the record by a licensed member of the health care team, select “no”. For example, VHA provider notes, “Spoke with Dr. Smith at ABC gastro. Indicated colonoscopy was completed on 2/05/18 with benign findings.”   **If the abstractor is unable to determine if the documentation of the colonoscopy and result is a self-report, select “99”.** |
| 30 | 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 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-card 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 hematest of fecal matter is not acceptable as colorectal cancer screening by fecal occult blood testing. |
| 31 | 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 testpap as applicable.   |  | | --- | | < = 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. |
| 32 | 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 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.** |
| 33 | 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 = 3 or 4, go to testpap as applicable   |  | | --- | | < = 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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| 34 | 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 ctcolon as applicable** | | | **Results of the flexible sigmoidoscopy must be in the medical record for procedures performed by any VAMC.**  **If unable to determine whether the sigmoidoscopy was flexible or rigid, accept as flexible sigmoidoscopy.**  **For sigmoidoscopy performed by a community provider PRIOR to 10/01/2018:**   * Patient self-report of the result of a flexible sigmoidoscopy done outside the VHA is acceptable. * The medical record documentation must include the year the sigmoidoscopy was performed and the results   **For sigmoidoscopy performed by a community provider ON or AFTER 10/01/2018**   * **Patient self-report of a sigmoidoscopy done outside the VHA is acceptable if the Primary Care Practitioner documentation clearly indicates that the sigmoidoscopy was performed, the year and results.** * Primary care practitioner (PCP): A physician or non-physician (e.g., nurse practitioner, physician assistant) who offers primary care medical services. Licensed practical nurses and registered nurses are not considered PCPs. * Nurse documentation of patient self-report is **NOT** acceptable.   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.**  **Suggested Data Sources:** Anatomic Pathology (Lab Package), Consult notes, History and Physical, Progress notes, Operative report, Procedure notes, Radiology notes | | |
| 35 | 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, go to testpap as applicable**  **If sigmoid5 = 2, go to pvtsigrpt**   |  | | --- | | < = 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. | | |
| 36 | pvtsigrpt | Is the actual report of the sigmoidoscopy done by the private sector provider/outside the VHA found in the medical record?  1. Yes  2. No | | | 1,2  If 1, go to testpap as applicable | | | The intent of this question is to determine if the report of the sigmoidoscopy performed by a private sector provider/outside the VHA is in the medical record. Reports from private sector providers may be scanned in to the electronic medical record.  Suggested data sources; VistA Imaging | | |
| 37 | sigslfrpt | Does the documentation in the medical record indicate the result of the sigmoidoscopy done by a private sector provider/outside the VHA was a self-report by the patient?  1. Yes  2. No  99. Unable to determine from documentation in the medical record | | | 1,2,99  If 1,2, or 99 go to testpap as applicable | | | The intent of this question is to determine if the source of the information about the sigmoidoscopy report (e.g., where performed, date, result) was by patient self-report.   * If the documentation clearly indicates the report was a self-report by the patient, select “yes”. For example, in a clinic note: “Patient states he had a sigmoidoscopy 3 years ago at XYZ Surgery Center and it was negative.” * If the documentation clearly indicates the report was obtained and noted in the record by a licensed member of the health care team, select “no”. For example, VHA provider notes, “Spoke with Dr. Smith at ABC gastro. Indicated sigmoidoscopy was completed on 2/05/18 with benign findings.”   **If the abstractor is unable to determine if the documentation of the sigmoidoscopy and result is a self-report, select “99”.** | | |
| **If [(prevcoln, gfecalbld, AND sigmoid5 = 98 or 99) AND (ifobtst = 99)], go to ctcolon; else go to testpap as applicable** | | | | | | | | | | |
| 38 | 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 procedures performed by any VAMC.**  **For CT colonography performed by a community provider PRIOR to 10/01/2018:**   * Patient self-report of a CT colonography done outside the VHA is acceptable * The medical record documentation must include the year the CT colonography was performed and the results.   **For CT colonography performed by a community provider ON or AFTER 10/01/2018:**   * **Patient self-report of a CT colonography done outside the VHA is acceptable if the Primary Care Practitioner documentation clearly indicates that the CT colonography was performed, the year and results.** * Primary care practitioner (PCP): A physician or non-physician (e.g., nurse practitioner, physician assistant) who offers primary care medical services. Licensed practical nurses and registered nurses are not considered PCPs. * Nurse documentation of patient self-report is **NOT** acceptable   **This question is not enabled if the patient was screened for colorectal cancer by another accepted modality within the appropriate timeframe.**  **Suggested Data Sources:** Consult notes, History and Physical, Progress notes, Operative report, Procedure notes, Radiology notes |
| 39 | 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  If ctcolon = 1, go to testpap as applicable  If ctcolon = 2, go to pvtctrpt   |  | | --- | | < = 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. |
| 40 | pvtctrpt | | | Is the actual report of the CT colonography done by the private sector provider/outside the VHA found in the medical record?  1. Yes  2. No | | | 1,2  If 1, go to testpap as applicable | | | The intent of this question is to determine if the report of the CT colonography performed by a private sector provider/outside the VHA is in the medical record. Reports from private sector providers may be scanned in to the electronic medical record.  Suggested data sources; VistA Imaging |
| 41 | ctslfrpt | | | Does the documentation in the medical record indicate the result of the CT colonography done by a private sector provider/outside the VHA was a self-report by the patient?  1. Yes  2. No  99. Unable to determine from documentation in the medical record | | | 1,2,99  If 1,2, or 99 go to testpap as applicable | | | The intent of this question is to determine if the source of the information about the CT colonography report (e.g., where performed, date, result) was by patient self-report.   * If the documentation clearly indicates the report was a self-report by the patient, select “yes”. For example, in a clinic note: “Patient states he had a CT colonography 3 years ago at XYZ Surgery Center and it was negative.” * If the documentation clearly indicates the report was obtained and noted in the record by a licensed member of the health care team, select “no”. For example, VHA provider notes, “Spoke with Dr. Smith at ABC gastro. Indicated CT colonography was completed on 2/05/16 with benign findings.”   **If the abstractor is unable to determine if the documentation of the CT colonography and result is a self-report, select “99”.** |
| 42 | sdnatest | | | Does the medical record contain the report of a stool- based DNA (FIT-DNA) test performed within the past three years?  1. Stool-based DNA (FIT-DNA) test performed by VHA  2. Stool-based DNA (FIT-DNA) test performed by a private sector provider  99. No documentation of stool-based DNA (FIT-DNA) test performed in the past three years | | | 1,2, 99  If 99, auto-fill sdnadt as 99/99/9999, and go to nocrcscr | | | Stool-based deoxyribonucleic acid (DNA) (FIT-DNA) testing 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 (FIT-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.** |
| 43 | sdnadt | | | Enter the date of the most recent stool-based DNA (FIT-DNA) test performed within the past three years. | | | mm/dd/yyyy  Will be auto-filled as 99/99/9999 if  sdnatest = 99  If sdnatest = 1 or 2, go to testpap as applicable   |  | | --- | | < = 3 years prior or = stdybeg and < = stdyend | | | | Enter the exact date. The use of 01 to indicate missing month or day is not acceptable. |
| 44 | nocrcscr | | | 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. Yes  2. 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 mamgram3; else go to testpap.** | | | | | | | | | | |
| 45 | testpap | | 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 VHA   1. 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 tests  99. 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**  If 6, 98 or 99 andage <= 24, go to sxactv1  If 6 and age >= 40,  go to mamgram3;  else if 6 and age > 24 and < 40, go to end  If 98 or 99 and age  >= 30, go to hpvtest2; else if 98 and (age > 24 and < 30), go to end; else if 99 and (age > 24 and < 30), go to nocascrn | | | **Results of Pap test must be in the medical record for tests done by any VAMC.**  **For Pap tests performed by a community provider PRIOR to 10/01/2018:**   * Patient self-report of a Pap test done outside the VHA is acceptable * The medical record documentation must include the date the Pap test was performed and the results   **For Pap tests performed by a community provider ON or AFTER 10/01/2018:**   * **Patient self-report of a Pap test done outside the VHA is acceptable if the Primary Care Practitioner documentation clearly indicates that the Pap test was performed, the date and results.** * Primary care practitioner (PCP): A physician or non-physician (e.g., nurse practitioner, physician assistant) who offers primary care medical services. Licensed practical nurses and registered nurses are not considered PCPs. * Nurse documentation of patient self-report is **NOT** acceptable   **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.  **Cont’d next page** | |
|  |  | |  | | |  | | | **Pap test cont’d**  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.  **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.**  **Suggested Data Sources:** Consult notes, Cytology reports, Lab reports, History and Physical, Progress notes | |
| 46 | papdt | | Enter the collection date of the most recent Pap test performed during the past five years. | | | mm/dd/yyyy  If testpap = 6,98, or 99, will be auto-filled as 99/99/9999   |  | | --- | | < = 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. | |
| 47 | paprptdt | | Enter the report date of the most recent Pap test performed during the past five years | | | mm/dd/yyyy  Abstractor can enter 99/99/9999  If testpap = 6,98, or 99, will be auto-filled as 99/99/9999  If [testpap = 7 AND (age >= 30, go to hpvtest2) OR (age <= 24), go to sxactv1; else if 7, go to end   |  | | --- | | >= 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. | |
| 48 | 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 = 6,98,or 99  If 2 and testpap = 3, go to pvtpaprpt; else if 2, go to hpvtest2 | | | **Only answer “1” if the pap test results are documented in the laboratory package. Do not include scanned reports located in VISTA imaging.** | |
| 49 | papreslt | | What results for the pap test were documented?  3. Normal  4. Abnormal  95. Not applicable  99. Unable to determine | | | 3,4,95,99  Will be auto-filled as 95 if testpap = 6,98,or 99  If testpap = 1, go to hpvtest2  If testpap = 3, go to pvtpaprpt | | | **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.** | |

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| 50 | pvtpaprpt | Is the actual report of the pap test done by the private sector provider/outside the VHA found in the medical record?  1. Yes  2. No | 1,2  If 1, go to hpvtest2 | The intent of this question is to determine if the report of the pap test performed by a private sector provider/outside the VHA is in the medical record. Reports from private sector providers may be scanned in to the electronic medical record.  **Suggested data sources**: VistA Imaging |
| 51 | papslfrpt | Does the documentation in the medical record indicate the result of the pap test done by a private sector provider/outside the VHA was a self-report by the patient?  1. Yes  2. No  99. Unable to determine from documentation in the medical record | 1,2,99 | The intent of this question is to determine if the source of the information about the pap test report (e.g., where performed, date, result) was by patient self-report.   * If the documentation clearly indicates the report was a self-report by the patient, select “yes”. For example, in a clinic note: “Patient states she had a pap test 3 years ago at XYZ Gynecology Center and it was normal.” * If the documentation clearly indicates the report was obtained and noted in the record by a licensed member of the health care team, select “no”. For example, VHA provider notes, “Spoke with Dr. Jones at ABC Gynecology. Indicated pap test was completed on 2/05/16 with normal findings.”   **If the abstractor is unable to determine if the documentation of the pap test and result is a self-report, select “99”.** |

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| 52 | hpvtest2 | Within the past 5 years, was a cervical hrHPV/HPV test performed?  1. hrHPV/HPV test was performed by the VHA  3. hrHPV/HPV test was performed by the private sector  99. No documentation hrHPV/HPV test performed | 1,3, 99  If 99, and age <= 24, go to sxactv1; else if 99, go to mamgram3 as applicable | **A cervical high-risk human papillomavirus test (hrHPV) is a test for a specific type of HPV, which is the likely cause of abnormal cell growth. Generic documentation of “HPV test” can be counted as evidence of hrHPV test.**   * A hrHPV/HPV test may be performed in conjunction with a pap test or as a stand-alone test. * A hrHPV/HPV test may be performed by the VHA or sent to non-VHA lab. Look at cervical cytology reports first because even if hrHPV/HPV is noted as a chemistry test, the report may be added to the cytology report.  Then, if hrHPV/HPV test not found, do a search on the lab tab under selected lab tests and see if hrHPV/HPV or Human Papillomavirus is listed. * **Results of hrHPV/HPV test must be in the medical record for tests done by any VAMC.**   **For hrHPV/HPV tests performed by a community provider PRIOR to 10/01/2018:**   * Patient self-report of a hrHPV/HPV test done outside the VHA is acceptable. * The medical record documentation must include the year the hrHPV/HPV test was performed and the results.   **For hrHPV/HPV test performed by community provider ON or AFTER 10/01/2018:**   * **Patient self-report of a hrHPV/HPV test done outside the VHA is acceptable if the Primary Care Practitioner documentation clearly indicates that the hrHPV/HPV test was performed, the year and results.** * Primary care practitioner (PCP): A physician or non-physician (e.g., nurse practitioner, physician assistant) who offers primary care medical services. Licensed practical nurses and registered nurses are not considered PCPs. * Nurse documentation of patient self-report is **NOT** acceptable.   **Suggested data sources:** Consult notes,Cytology reports, Lab reports,History and Physical, Progress notes |
| 53 | hpvtstdt2 | Enter the date of the most recent cervical hrHPV/HPV test performed. | mm/dd/yyyy   |  | | --- | | <= 5 years prior to or = stdybeg and <= stdyend | | Enter the date the most recent cervical hrHPV/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. |
| 54 | hpvrptdt2 | Enter the date the hrHPV/HPV test result was reported. | mm/dd/yyyy  Abstractor can enter 99/99/9999  If hpvtest2 = 1, go to sxactv1 as applicable; else go to pvthpvrpt   |  | | --- | | >= hpvtstdt2 and <= 45 days after hpvtstdt2 and <= pulldt or (<= stdyend if stdyend > pulldt) | | The hrHPV/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 hrHPV/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. |
| 55 | pvthpvrpt | Is the actual report of the hrHPV/HPV test done by the private sector provider/outside the VHA found in the medical record?  1. Yes  2. No | 1,2  If 1, go to sxactv1 as applicable | The intent of this question is to determine if the report of the hrHPV/HPV test performed by a private sector provider/outside the VHA is in the medical record. Reports from private sector providers may be scanned in to the electronic medical record.  **Suggested data sources:** VistA Imaging |
| 56 | hpvslfrpt | Does the documentation in the medical record indicate the result of the hrHPV/HPV test done by a private sector provider/outside the VHA was a self-report by the patient?  1. Yes  2. No  99. Unable to determine from documentation in the medical record | 1,2,99 | The intent of this question is to determine if the source of the information about the hpv test report (e.g., where performed, date, result) was by patient self-report.   * If the documentation clearly indicates the report was a self-report by the patient, select “yes”. For example, in a clinic note: “Patient states she had a hrHPV/HPV test 3 years ago at XYZ Gynecology Center and it was negative.” * If the documentation clearly indicates the report was obtained and noted in the record by a licensed member of the health care team, select “no”. For example, VHA provider notes, “Spoke with Dr. Smith at ABC Gynecology Center. Indicated hrHPV/HPV test was completed on 2/05/16 with negative findings.”   **If the abstractor is unable to determine if the documentation of the hrHPV/HPV test and result is a self-report, select “99”.** |
| **If female patient age >= 18 and <= 24, go to sxactv1; else go to mamgram3 as applicable.** | | | | |
| 57 | sxactv1  sxactv2  sxactv3  sxactv4  sxactv99 | Is there documentation in the medical record of any of the following during the past year?  **Indicate all that apply:**  1. Prescription for contraceptives  2. Pregnancy  3. Documentation the patient is sexually active  4. Pregnancy test performed  99. None of the above documented during the past year | 1,2,3,4,99  If 1,2, 3 or 4 = -1 go to chlamtst  If 99, go to mamgram3 as applicable | The intent of this question is to determine if the patient is sexually active. Documentation of any of the following is considered acceptable:   * prescription for contraceptives, * pregnancy * documentation the patient is sexually active   Prescription contraceptives may include but are not limited to:   * Oral contraceptives (desogestrel-ethinyl estradiol, ethinyl estradiol-ethynodiol, levonorgestrel, medroxyprogesterone, etc.) * Contraceptive devices (diaphragm) * Topical contraceptives (spermicide e.g., nonxynol 9)   Pregnancy: Documentation in a clinical note that the patient is pregnant is acceptable to select value 2.  Sexually Active: Documentation in a clinical note that the patient is sexually active is acceptable to select value 3.  Tests for pregnancy may include but are not limited to:   * Gonadotropin, chorionic (hCG); qualitative * hcg, Pregnancy Screen * hcg, Beta, Quant * hcg, Total Beta * hCG, Total, Qualitative * hCG, Urine * Human Chorionic Gonadotropin (hCG), Qualitative, Urine   Pregnancy test may be performed by the VHA or by private sector provider. The date of the pregnancy test must be in the medical record. Patient self-report of the date of a pregnancy test is NOT acceptable. |
| 58 | chlamtst | Does the medical record contain the report of a chlamydia test performed for this patient within the past year?  1. Chlamydia test performed by VHA  3. Chlamydia test performed by private sector provider  98. Patient refused all chlamydia tests  99. No documentation a chlamydia test was performed | 1,3,98,99  If 98 or 99 AND ONLY sxactv4 = -1, go to prgtstdt  Else go to mamgram3 as applicable | * Chlamydia is a common sexually transmitted disease (STD) caused by bacteria called Chlamydia trachomatis. Women can get chlamydia in the cervix, rectum or throat. * A chlamydia test is used to determine the presence of chlamydia infection. Examples of tests used to detect chlamydia include, but are not limited to: * Chlamydia Ab, Igg * Chlamydia Antibodies, Igg * Chlamydia Dna Probe * Chlamydia NAAT/NAT * Chlamydia/GC STD Panel * Chlamydia trachomatis cervical/vaginal/urine culture   Refer to Table 3 - CHLAMYDIA TESTS for other examples of tests for chlamydia.  Chlamydia test may be performed by the VHA or by private sector provider. The chlamydia test report must be in the medical record.  Patient self-report of the result of a Chlamydia test is not acceptable. |
| 59 | prgtstdt | Enter the date of the pregnancy test performed during the past year. | mm/dd/yyyy   |  | | --- | | <= 1 year prior to stdybeg and <= stdyend | | Enter the date of the pregnancy test performed during the past year. |
| 60 | retmed | During the time frame from (computer to enter prgtstdt to prgtstdt + 6 days) is there documentation of a prescription for a retinoid medication?  1. Yes  2. No | 1,2  If 1, go to mamgram3 as applicable | A retinoid medication may be prescribed for treatment of acne. The most common generic retinoid medication is isotretinoin.  Suggested Data Sources: Lab reports, physician orders, medication administration record |
| 61 | dxray | During the time frame from (computer to enter prgtstdt to prgtstdt + 6 days) is there documentation of a diagnostic x-ray performed?  1. Yes  2. No | 1,2 | A diagnostic x-ray may include any x-ray done for diagnostic purposes. Examples may include but are not limited to:   * Diagnostic X-ray of the Head and Neck * Diagnostic X-ray of the Chest * Diagnostic X-ray of any extremity   Exclude: Ultrasound procedures, Computed Tomography (CT), Magnetic Resonance Imagery (MRI), other radiologic procedures not considered diagnostic  Refer to Table 4 - DIAGNOSTIC RADIOLOGY for other CPT Codes indicating diagnostic X-ray procedures. |
| **If female patient age > = 40, go to mamgram3; if [female patient age < 40 and (testpap = 99 or** **hpvtest2 = 99)] OR [female patient age >=21 and <=29 and (testpap = 1 or 3) and (stdybeg - papdt > 36 mos)], go to nocascrn; = 99 = 99, go to nocascrn;ap = else go to end** | | | | |
|  |  | Screening for Breast Cancer |  |  |
| 62 | mamgram3 | Does the medical record contain the report of a mammogram [screening, digital or tomosynthesis (3D mammogram)] performed for this patient during the timeframe from (computer to display stdybeg – 27 months to stdyend)?  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 mamperva2 as 95, mammdt as 99/99/9999, mamrptdt as 99/99/9999, mamrad as 95, biradcod as 95, and go to nomammo | * **This measure evaluates primary screening. Do not count breast biopsies, breast ultrasounds, or Magnetic Resonance Imaging (MRI), because they are not appropriate methods for primary breast cancer screening.** * **Screening, digital or tomosynthesis (3D) mammogram 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.   **Results of the mammogram must be in the medical record for tests done by any VAMC**. .  **For mammograms performed by a community provider PRIOR to 10/01/2018:**   * Patient self-report of a mammogram done outside the VHA is acceptable * The medical record documentation must include the date the mammogram was performed and the results.   **For mammograms performed by a community provider ON or AFTER 10/01/2018:**   * **Patient self-report of a mammogram done outside the VHA is acceptable if the Primary Care Practitioner documentation clearly indicates that the mammogram was performed, the date and results.**    + Primary care practitioner (PCP): A physician or non-physician (e.g., nurse practitioner, physician assistant) who offers primary care medical services. Licensed practical nurses and registered nurses are not considered PCPs.   + Nurse documentation of patient self-report is **NOT** acceptable * 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 “2.” * Patient refusal must be clearly documented in record.   **Suggested Data Sources:** Consult notes, History and Physical, Progress notes, Procedure notes, Radiology notes |
| 63 | mamperva2 | Was the mammogram performed by the VHA?  3. Mammogram performed at a VAMC  4. Mammogram performed outside VHA, fee basis  5. Mammogram performed private sector, not fee basis  95. Not applicable | 3,4,5,95  Will be auto-filled as 95 if mamgram3 = 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 PCP or outside mammogram report without evidence it was ordered by VHA. |
| 64 | mammdt | Enter the date of the most recent mammogram [screening, digital or tomosynthesis (3D mammogram)] performed during the past 27 months. | mm/dd/yyyy  If mamgram3 = 2 or 98 will be auto-filled as 99/99/9999   |  | | --- | | < = 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. |
| 65 | mamrptdt | Enter the report date of the most recent mammogram performed during the past 27 months. | mm/dd/yyyy  Will be auto-filled as 99/99/9999 if mamgram3 = 2 or 98  Abstractor can enter 99/99/9999   |  | | --- | | >= 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. |
| 66 | 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 mamgram3 = 2 or 98 If 2, auto-fill biradcod as 95 AND if (mamperva2 = 3, go to nocascrn as applicable) OR if (mamperva2 = 4 or 5, go to pvtmamrpt) | **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. |
| 67 | 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 mamgram3 = 2 or 98, or mamrad = 2  If mamperva2 = 4 or 5, go to pvtmamrpt; else go to nomammo 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. |
| 68 | pvtmamrpt | Is the actual report of the mammogram done by the private sector provider/outside the VHA found in the medical record?  1. Yes  2. No | 1,2  If 1, go to nomammo as applicable | The intent of this question is to determine if the report of the mammogram performed by a private sector provider/outside the VHA is in the medical record. Reports from private sector providers may be scanned in to the electronic medical record.  **Suggested data sources:** VistA Imaging |
| 69 | mamslfrpt | Does the documentation in the medical record indicate the result of the mammogram done by a private sector provider/outside the VHA was a self-report by the patient?  1. Yes  2. No  99. Unable to determine from documentation in the medical record | 1,2,99 | The intent of this question is to determine if the source of the information about the mammogram report (e.g., where performed, date, result) was by patient self-report.   * If the documentation clearly indicates the report was a self-report by the patient, select “yes”. For example, in a clinic note: “Patient states she had a mammogram last year at XYZ Radiology Center and it was normal.” * If the documentation clearly indicates the report was obtained and noted in the record by a licensed member of the health care team, select “no”. For example, VHA provider notes, “Spoke with Dr. Jones at ABC Radiology Center. Indicated mammogram was completed on 2/05/17 with normal findings.”   **If the abstractor is unable to determine if the documentation of the mammogram and result is a self-report, select “99”.** |
| **If mamgram3 = 1, go to nocascrn as applicable; else go to nomammo** | | | | |
| 70 | 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 mamgram3 = 1  If 2, go to nocascrn  If 1 and if (testpap = 99 or hpvtest2 = 99), go to nocascrn; else if 1, to osteotx as applicable | Acceptable documentation:   * Documented evidence of bilateral mastectomy * Documented evidence the patient had two unilateral mastectomies on the same date or different dates of service.   Patients are considered to be the gender documented in the record **unless** there is evidence of a gender change procedure in the record. |
| **If (testpap = 99 or hpvtest2 = 99), go to nocascrn; else go to osteotx, as applicable** | | | | |
| 71 | nocascrn | 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. Yes  2. 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 > 65 and <= 75 years, go to osteotx; else go out of module** | | | | |
| 72 | osteotx | At any time prior to (computer to display stdyend - 1 year) is there documentation in the medical record the patient received any of the following medications for treatment of osteoporosis?   * denosumab, 1mg injection * ivandronate sodium, 1 mg injection * teriparatide, 10 mcg injection * zoledronic acid, 1 mg   1. Yes  2. No | 1,2  If 2, autofill osteotxdt as 99/99/9999 and go to ostmed | Look back in the patient’s record to determine if the patient received any of the osteoporosis therapy medications during the timeframe displayed in the question.  **Suggested data sources**: BCMA, progress notes |
| 73 | osteotxdt | Enter the date of the most recent encounter for administration of the osteoporosis treatment medication. | mm/dd/yyyy  Will be auto-filled as 99/99/9999 if  osteotx = 2   |  | | --- | | > patient’s DOB and <= 1 year prior to stdyend |   **If osteotx = 1, go out of module** | Look back in the patient’s record to determine the date of the most recent encounter in the specified time frame when the patient received any of the osteoporosis therapy medications at any time in her history. |
| 74 | ostmed | During the timeframe from (computer to display < = 3 years to stdybeg date and > 1 year prior to the stdyend) is there documentation in the medical record the patient had a dispensed prescription for any of the following medications for treatment of osteoporosis?   |  |  | | --- | --- | | **Description** | **Prescription** | | Bisphosphates | * Alendronate * Alendronate-cholecalciferol * Ibandronate * Risedronate * Zoledronic acid | | Other agents | * Abaloparatide * Denosumab * Raloxifene * Romosozumab * Teriparatide |   1. Yes  2. No | 1,2  If 2, auto-fill ostmedt as 99/99/9999 and go to ostscrn | Look back during the specified timeframe to determine if there was a dispensed prescription for any of the specified medications used for the treatment of osteoporosis.  Generic or brand medication names should be included. For example, Fosamax (Alendronate) Vitamin D3 alone would not be acceptable, however, the combination of alendronate and cholecalciferol (vitamin D3) are listed in the table and would be acceptable.    **Suggested data sources**: BCMA, Meds tab, Order Summary, Progress Notes |
| 75 | ostmedt | Enter the most recent date there was a dispensed prescription for any of the specified medications used for the treatment of osteoporosis. | mm/dd/yyyy  Will be auto-filled as 99/99/9999 if  ostmed = 2   |  | | --- | | <=3 years prior to stdybeg and > 1 year prior to stdyend |   **If ostmed = 1, go out of module** | Look back during the specified timeframe, determine the **most recent** date that there was a dispensed prescription for any of the specified medications used for the treatment of osteoporosis. |
| 76 | ostscrn | During the timeframe from (computer to display patient’s 65th birthday to stdyend), is there documentation in the medical record of any of the following screening tests for osteoporosis?   * Ultrasound bone density (radial, wrist and/or heel) * Computed Tomography (hips, pelvis, and/or spine) * DEXA scan (hips, pelvis, and/or spine) * DEXA scan (peripheral - radius, wrist and/or heel) * Dual energy X-ray absorptiometry (DXA), (hips, pelvis, and/or spine)   1. Yes  2. No  98. Patient refused osteoporosis screening | 1, 2, 98  **If 2 or 98, go out of module** | Osteoporosis involves a gradual loss of calcium, causing bones to become thinner, more fragile, and more likely to break. Look back in the patient’s record to age 65 to determine whether a screening test for osteoporosis was done.  **Screening tests acceptable to answer “Yes” include:**   * Ultrasound bone density (peripheral sites i.e. radial, wrist and/or heel) * Computed Tomography (CT) (hips, pelvis, and/or spine) * DEXA scan (hips, pelvis, and/or spine) * DEXA scan (peripheral - radius, wrist and/or heel) * Dual energy X-ray absorptiometry (DXA), (hips, pelvis, and/or spine)   Note: If using a CT, an indication it was for osteoporosis screening should be documented.  If there is no documentation of any of the osteoporosis screening tests during the specified timeframe, select value “2”.  **Suggested data source**: Imaging tab |
| 77 | ostscrndt | Enter the date of the patient’s most recent osteoporosis screening test. | mm/dd/yyyy   |  | | --- | | >= patient’s 65th birthday and < = study end | | Look back in the patient’s record to age 65 to determine the date of the screening test  Enter the exact date if possible. If exact date cannot be determined, enter month and year at a minimum. If the day cannot be determined, enter 01 for day. |
| 78 | vaostscrn | Was the osteoporosis screening test performed by the VHA?  3. Screening performed at a VAMC  4. Screening performed outside VHA, fee basis  5. Screening performed private sector, not fee basis | 3,4,5 | * Value 3 = osteoporosis screening was performed at a VAMC. * Value 4 = osteoporosis screening performed outside VHA, **fee basis**, may be determined by checking to see if screening was ordered by and consult placed by VHA. If the screening was ordered by VHA and performed outside VHA, enter 4. * Value 5 = screening performed private sector, **not fee basis**, includes documentation the osteoporosis screening was performed outside VHA such as patient self-report documented by VHA PCP or outside screening report without evidence it was ordered by VHA. |