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|  |  | **Organizational Identifiers** |  |  |
|  | VAMCCONTROLQICBEGDTEREVDTE | Facility IDControl NumberAbstractor IDAbstraction Begin DateAbstraction End Date | Pre-fillQI pre-fillAuto-fillAuto-fillAuto-fill |  |
|  |  | **Patient Identifiers** |  |  |
|  | SSNFINPTNAMEFPTNAMELBIRTHDTSEXRACEETHNICITYCOHORTAGE | Patient SSNFINFirst NameLast NameBirth DateSexRaceEthnicityCohortAge | Pre-fill: no changePre-fill: no changePre-fill: no changePre-fill: no changePre-fill: no changePre-fill: can changePre-fill: no changePre-fill: no changePre-fill: no changeCalculate age at COLONDT |  |
|  |  | **Colonoscopy** |  |  |
| 1 | colondt | Enter the date of the colonoscopy completed during the timeframe from (computer display stdybeg to stdyend). | mm/dd/yyyy**Computer will** **pre-fill from pull list**

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| >= stdybeg and <= stdyend |

 | Computer will pre-fill the date of the colonoscopy completed during the specified timeframe.Suggested data sources: Procedure note, procedure report, VistA imaging, Joint Longitudinal Viewer |
| 2 | colodone | On (computer to display colondt), is there documentation of the colonoscopy in the medical record?1. Yes2. No  | 1,2If 1, auto-fill othcolon as 95, othcoldt as 99/99/9999, and go to colonrpt | Search procedure reports, surgical reports, and progress notes for documentation that a colonoscopy was performed on the date entered in COLONDT. If a colonoscopy was not performed on COLONDT, enter 2.  |
| 3 | othcolon | During the timeframe from (computer to display to stdybeg to stdyend), is there documentation a colonoscopy was performed?1. Yes2. No95. Not applicable | 1,2,95Will be auto-filled as 95 if colodone = 1**If 2, the case is excluded** | Search procedure reports, surgical reports, and progress notes for documentation that a colonoscopy was performed during the timeframe displayed in the question.**Exclusion Statement: Lack of medical record documentation that a colonoscopy was performed during the study month excludes the case from review.** |
| 4 | othcoldt | Enter the date of the most recent colonoscopy completed during the timeframe from (computer to display stdybeg to stdyend).  | mm/dd/yyyyWill be auto-filled as 99/99/9999 if colodone = 1

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| >=stdybeg and <=stdyend  |

 | If more than one colonoscopy was performed during the timeframe, enter the date of the most recent colonoscopy. |
| 5 | colonrpt | Was the colonoscopy procedure report/note found in the medical record?3. Procedure report/note found in CPRS or Cerner Electronic Health Record (EHR)4. Procedure report/note found in VistA imaging or Joint Longitudinal Viewer (JLV)99. Procedure report/note not found in medical record | 3,4,99**If 99, go to end**

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| **Warning if 99** |

 | If the procedure report/note is found in CPRS or Cerner EHR, enter value 3. If the procedure report/note is found in CPRS (or Cerner EHR) AND VistA imaging or JLV, enter value 3. If the procedure report/note is only found in VistA imaging or JLV, enter value 4.If the actual colonoscopy report/note is not found in CPRS, Cerner EHR, VistA imaging or JLV, enter “99”. Suggested data sources: Procedure note, gastroenterology consult, procedure report, VistA imaging, JLV |
| 6 | biopsy | During the colonoscopy performed on (if colodone = 1, computer display colondt or if colodone = 2, display othcoldt), was a biopsy or other tissue removal (e.g., polypectomy) performed during the colonoscopy? 1. Yes2. No | 1,2**If 1, go to end** | **Review the colonoscopy procedure note/report to determine if a biopsy or other tissue removal (polypectomy) was performed during the procedure.**If the colonoscopy report/procedure note contains documentation that a biopsy or other tissue removal (polypectomy) was performed, enter “1”. If there is no documentation in the colonoscopy report/procedure note indicating a biopsy or other tissue removal (polypectomy) was performed, enter “2”. Suggested data sources: Procedure note, gastroenterology consult, procedure report, VistA imaging, JLV |
| 7 | foloint | Does the colonoscopy report contain documentation of a recommended follow-up interval of at **least 10 years** for a repeat colonoscopy?1. Yes2. No | 1,2**If 1, go to end** | * **Use the final colonoscopy report to abstract the recommended follow-up interval.**
* **If a recommended follow-up interval of at least 10 years is documented, enter “1”.** For example, “Normal screening colonoscopy; repeat in 10 years.”
* Do not accept timeframes such as “5 – 10 years”, “prn”, “when symptoms return,” or “routine screening per recommended guidelines.”
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| 8 | fololess | Does the colonoscopy report document a recommended follow-up interval of **less than 10 years** for a repeat colonoscopy?1. Yes2. No | 1,2If 2, go to nfolo as applicable

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| **Warning if 2** |

 | **Use the colonoscopy report to abstract the recommended follow-up interval.** **Examples include but are not limited to:**“Recommend repeat colonoscopy in 5 years;” “History of polyps and family history of colon cancer. Repeat colonoscopy in 3 years.” |
| 9 | reasless | Is there physician/APN/PA documentation of a medical reason for a recommended follow-up interval of less than 10 years for a repeat colonoscopy?1. Yes2. No | 1,2**If 1, go to end** | * **Documentation in the colonoscopy report or other physician/APN/PA documentation of a medical reason for a follow-up interval of less than 10 years is acceptable.**
* **Medical reasons may include a diagnosis, symptom or condition.**

**Examples of medical reasons for follow-up interval of less than 10 years include but are not limited to:*** + Above average risk patient
	+ Diverticulitis
	+ Inadequate bowel prep
	+ Family history of colon cancer (e.g., colonoscopy report states “Indication: immediate family history of colon cancer” and “Impression: Normal colonoscopy, Recall: 5 years”)
	+ Family history of colorectal adenomas or polyps
	+ Personal history of colorectal cancer
	+ Personal history of polyps
	+ Inflammatory bowel disease, Crohn’s disease or ulcerative colitis
* **Documentation of a follow-up interval of less than 10 years for surveillance must reference a medical reason.** For example, “Indication for scope: high risk colon cancer surveillance. Personal history of colon polyps. Recommendation: Repeat colonoscopy in 5 years for surveillance.” Select value “1” as history of polyps is a medical reason for follow-up interval of less than 10 years.
* Documentation of only *diverticulosis* and/or hemorrhoids are not acceptable indications for recommended follow-up interval of less than 10 years for repeat colonoscopy. For example, findings in the colonoscopy report indicates: “Few diverticula seen in sigmoid colon; no polyps or lesions seen; mild-moderate internal hemorrhoids” Recommendations: “Repeat colonoscopy in 3-5 years based on age/findings.” Select value “2” since these are not medical reasons to repeat the colonoscopy in less than 10 years.
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| **If patient’s age is >= 66 years old, go to nofolo; else go to lifexpec** |
| 10 | nofolo | Did the physician/APN/PA document in the colonoscopy report that a follow-up colonoscopy is NOT needed or recommended?1. Yes2. No | 1,2**If 1, go to end** | **Review the final colonoscopy report to determine if physician/APN/PA documented a follow-up colonoscopy is not needed.** For example, physician noted, “Follow-up colonoscopy is not indicated. No finding of adenoma and patient is 70 years old.”  |
| 11 | lifexpec | At any time prior to and including (if colodone = 1, computer display colondt or if colodone = 2, display othcoldt), did a physician/APN/PA document that patient’s life expectancy is less than 10 years?1. Yes2. No | 1,2 | Patient’s life expectancy of less than 10 years must be documented by a physician/APN/PA in the medical record (e.g., progress note, procedure report, consultation), on the problem list or in the computer field “health factors.”  |