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|  |  | **Organizational Identifiers** |  |  |
|  | VAMC  CONTROL  QIC  BEGDTE  REVDTE | Facility ID  Control Number  Abstractor ID  Abstraction Begin Date  Abstraction End Date | Pre-fill  QI pre-fill  Auto-fill  Auto-fill  Auto-fill |  |
|  |  | **Patient Identifiers** |  |  |
|  | SSN  FIN  PTNAMEF  PTNAMEL  BIRTHDT  SEX  RACE  ETHNICITY  COHORT  AGE | Patient SSN  FIN  First Name  Last Name  Birth Date  Sex  Race  Ethnicity  Cohort  Age | Pre-fill: no change  Pre-fill: no change  Pre-fill: no change  Pre-fill: no change  Pre-fill: no change  Pre-fill: can change  Pre-fill: no change  Pre-fill: no change  Pre-fill: no change  Calculate 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**   |  | | --- | | >= 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. Yes  2. No | 1,2  If 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. Yes  2. No  95. Not applicable | 1,2,95  Will 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/yyyy  Will be auto-filled as 99/99/9999 if  colodone = 1   |  | | --- | | >=stdybeg and <=stdyend | | If more than one colonoscopy was performed during the timeframe, enter the date of the most recent colonoscopy. |

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| 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**   |  | | --- | | **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. Yes  2. 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. Yes  2. 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. Yes  2. No | 1,2  If 2, go to nfolo as applicable   |  | | --- | | **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.” |

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| 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. Yes  2. 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. |
| **If patient’s age is >= 66 years old, go to nofolo; else go to lifexpec** | | | | |

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| 10 | nofolo | Did the physician/APN/PA document in the colonoscopy report that a follow-up colonoscopy is NOT needed or recommended?  1. Yes  2. 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. Yes  2. 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.” |