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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 | sexbirth | What is the patient’s reported sex assigned at birth?  1. Female 2. Male 3. Intersex 4. None of the Above, Other, or Unable to Determine 5. Preferred Not to Answer | 1,2,3,4,5 | **Enter the patient’s reported sex assigned at birth. Do not answer according to gender identity.**  **Please note that the response values for this question differ from response values used in other instrument questions. For example, this question uses value 4 for none of the above, other, or unable to determine; other instrument questions may use value 99.**  **Selecting value “3”:**   * Intersex is a general term used to refer to individuals born with, or who develop naturally in puberty, biological sex characteristics that are typically male or female.   **Selecting value “4”:**   * If the patient does not describe themselves as female, male, intersex, describes themselves in other terms, or if the medical record does not include information about the patient’s biological sex assigned at birth, select value 4. * Consider the sex to be unable to be determined and select value 4 if there is contradictory documentation, or if the sex assigned at birth is not documented or not available.   **Suggested Data Sources:** Consultation Notes, Emergency Department Record, Face Sheet, History and Physical, Nursing Admission Notes, Progress Notes. |
| 2 | 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 |
| 3 | 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. |

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| 4 | 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.** |
| 5 | 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. |
| 6 | colonrpt | Was the colonoscopy procedure report/note found in the medical record?  3. Procedure report/note found in CPRS or Oracle Health 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 Oracle Health EHR, enter value 3.  If the procedure report/note is found in CPRS (or Oracle Health 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, Oracle Health EHR, VistA imaging or JLV, enter “99”.  Suggested data sources: Procedure note, gastroenterology consult, procedure report, VistA imaging, JLV |
| 7 | 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 |
| 8 | 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.” |
| 9 | 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.” |
| 10 | 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   **Cont’d next page**   * **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** | | | | |
| 11 | 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.” |
| 12 | 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.” |