#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
		Immunization		
1	dochospce	Is <u>one</u> of the following documented in the medical record: • the patient is enrolled in a VHA or community-based Hospice program • the patient has a diagnosis of cancer of the liver, pancreas, or esophagus • <u>on the problem list</u> it is documented the patient's life expectancy is less than 6 months?	1*, 2 *If 1, go to modsevci If 2, go to fluhirsk	A "yes" answer to this question will exclude the case from the PI module. Although all noted conditions may be applicable to the case, only one is necessary for exclusion from the PI Module. The stage of cancer of the liver, esophagus, or pancreas is not applicable. Even if the patient is newly diagnosed, the case is excluded. Patient's life expectancy of less than six months must be documented on the problem list or in the computer field "health factors," without exception. **Acceptable:** Enrollment in a VHA or community-based Hospice **Unacceptable:** Enrollment in a VHA Palliative Care program or HBPC.
2	fluhirsk1 fluhirsk2 fluhirsk3 fluhirsk4 fluhirsk5 fluhirsk6 fluhirsk9 fluhirsk10 fluhirsk99	Was the patient in one or more of the following influenza high-risk categories? **Indicate all that apply:** 1. resident of chronic care facility, to include a Domiciliary 2. chronic cardiopulmonary disorder 3. metabolic disease (<u>including diabetes mellitus</u>) 4. hemoglobinopathy 5. immunosuppression 6. renal dysfunction 9. pregnancy during immunization period 10. neurological or neuromuscular condition that could compromise respiratory function, handling of respiratory secretions, or increase risk of aspiration 99. none of the above	1, 2, 3, 4, 5, 6, 9, 10, 99 Warning if fluhirsk = 2 and selcopd = F or selchf = F. Warning if fluhirsk = 3 and seldm = F Warning if fluhirsk = 6 and selckd = F Cannot enter 9 if sex = 1 or 3 99 cannot be entered with any other number	**Groups at Increased Risk for Complications from Influenza:** 1. Residents of nursing homes and other chronic-care facilities that house persons who have chronic medical conditions 2. Chronic disorders of the pulmonary or cardiovascular system, i.e., COPD, CHF, cor pulmonale, and including asthma, aortic stenosis, mitral valve regurgitation 3. Diabetes Mellitus, Metabolic disease: Cushing's Syndrome, Graves disease, myxedema, Addison's disease 4. Hemoglobinopathy: Sickle cell anemia, polycythemia, thalassemia 5. Immunosuppression: AIDS, chemotherapy, organ transplant 6. Renal dysfunction: chronic renal failure, nephrotic syndrome 9. Pregnancy during immunization period = July 1, 2013 - March 31, 2014. 10.Neurological or neuromuscular condition (e.g., cognitive dysfunction, spinal cord injuries, seizure disorders, or other neuromuscular disorders) that can compromise respiratory function or the handling of respiratory secretions or that can increase the risk for aspiration 99.Patient has none of these conditions documented in record

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
3	allerflu	Does the patient have known allergy to eggs or other flu vaccine components, a history of Guillain-Barre Syndrome, a bone marrow transplant within the past 12 months?	1, 2	"Inactivated influenza vaccine should not be administered to persons known to have anaphylactic hypersensitivity to eggs or other components of the influenza vaccine." **Allergy to eggs or other flu vaccine component must be documented in the paper or electronic record. Notation does not have to state "anaphylactic."** **If the facility is using single dose syringes and the veteran has a documented latex allergy, answer "yes."**

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
4	fluvac13	During the period 7/01/2013 to 3/31/2014, did the patient receive influenza vaccination? 1. received vaccination from VHA 3. received vaccination from private sector provider 4. patient's only visit during immunization period preceded availability of vaccine 98. patient refused vaccination 99. no documentation patient received vaccination	1, 3, 4, 98, 99 **If 4, 98 or 99, auto-fill fluvacdt as 99/99/9999**	**To enter response #4, the abstractor must see the pharmacy record stating the date the vaccine arrived on station (shipping slip, inventory record, etc.) The patient's only visit during the immunization period must have occurred prior to receipt of the facility's flu vaccine. (Example: patient's only visit during immunization season of 7/01/13 - 3/31/14 was on 8/26/13. Facility did not receive vaccine until 9/05/13. Enter response #4.)** **For patients who had no visits at all during immunization season and did not receive vaccine at this VAMC or elsewhere, answer "99."** **Acceptable as documentation of influenza immunization:** 1. Notation of "flu shot given" entered in paper or electronic record. The month and year (or the fact it was flu vaccination season) when the patient received the vaccine must be known. 2. Influenza vaccine given in another setting, i.e., acute care, NHCU, etc., and the month and year are known 3. Patient self-report of flu shot at community facility if month and year are known and documented. 4. Checkmark on a checklist, if there is a month and year, and the checkmark is accompanied by the clinician's signature or initials. The patient must have had a clinic visit or visit to a vaccination clinic on the date indicated on the checklist. **5. Historical information obtained by telephone by a licensed member of the healthcare team and entered in a CPRS progress note is acceptable.** **Unacceptable documentation:** 1. Patient is told to return later for flu vaccine. 2. "Shortfall" of flu vaccine, unless nationally publicized shortage 3. Documented assumption "patient gets annual flu shot or vaccination" **Patient refusal = during the vaccination season, when flu shot was offered, patient stated he did not wish to receive flu vaccination**
5	fluvacdt	Enter the date influenza vaccination was given.	mm/dd/yyyy > = 7/01/2013 and < = 3/31/2014 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.**

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
6	pnuhirsk1 pnuhirsk2 pnuhirsk3 pnuhirsk4 pnuhirsk5 pnuhirsk7 pnuhirsk8 pnuhirsk99	Was the patient in one or more of the following pneumococcal pneumonia high-risk categories? **Indicate all that apply:** 1. institutional resident age 50 or older, including Domiciliary 2. diabetes mellitus 3. chronic cardiac disease (past MI, CHF, or cardiomyopathy) 4. chronic pulmonary disease (COPD or emphysema) 5. anatomic asplenia (includes sickle cell disease or splenectomy) 7. HIV positive 8. Immunocompromised patients 99. none of the above	1, 2, 3, 4, 5, 7, 8, 99 Disable pnuhirsk1 if pt age < 50 Hard edit on pnuhirsk2: seldm = T must =T Warning on pnuhirsk3 if selmi or selchf=F Warning on pnuhirsk4 if selcopd=F Cannot enter 99 with any other number **Enable seldm in Validation Module if pnuhirsk2 = T.** **Enable selcopd in Validation Module if pnuhirsk = 4.**	**High Risk Groups for Which Vaccination is Recommended** 1 = resident of long-term care facility, Domiciliary, etc. 3= includes past MI, congestive heart failure and cardiomyopathies 4 = includes COPD and emphysema 5 = includes sickle cell disease and splenectomy 8 = immunocompromised patients with chronic illnesses specifically associated with increased risk from pneumococcal infection (e.g., persons with Hodgkin's disease, lymphoma, multiple myeloma, chronic renal failure, nephrotic syndrome, or conditions such as organ transplantation associated with immunosuppression)
7	pnumovac	At any time, not later than the study end date, did the veteran receive pneumococcal vaccination, either as an inpatient or outpatient? 1. received vaccination from VHA 3. received vaccine from private sector provider 98. patient refused vaccination 99. no documentation patient received vaccine	1, 3, 98, 99 **If 98 or 99, auto-fill pnuvacdt as 99/99/9999**	**Acceptable: Documentation that patient had pneumovax if year is known.** It is preferable to know the month and year of pneumococcal vaccination: however, this data is not always available. **Historical information obtained by telephone by a licensed member of the healthcare team and entered in a CPRS progress note is acceptable.** **Unacceptable**: Notation in the record that patient has had pneumococcal vaccination if year of administration is not documented. Patient refusal = each time it was offered, patient stated he/she states he does not want pneumococcal vaccination

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
8	pnuvacdt	Enter the date of the most recent pneumococcal vaccination.	mm/dd/yyyy If pnumovac = 98 or 99, will be auto-filled as 99/99/9999 Warning if > 15 years prior to stdybeg and < = stdyend	Notation in the record that patient has had pneumococcal vaccination is not acceptable unless, at a minimum, year is documented. If more than one pneumococcal vaccination, use the most recent date. Enter the year if that is the only information known, with 01 for month and day.
		Hepatitis C		
9	testhcv	Within the past two years, was the veteran tested for HCV antibodies? 1. Yes 2. No 3. Vet diagnosed with Hep-C prior to past two years 98. Patient refused to be tested	1, 2, 3, 98 **If 2, 3, or 98, auto-fill the following: hcvtstdt as 99/99/9999, poshcv as 95, tstposdt as 99/99/9999, hcvconf as 95, hcvcondt as 99/99/9999, informpt as 95, informdt as 99/99/9999, hcvtxref as 95, disrefdt as 99/99/9999, and go to notobuse as applicable**	**Tests for HCV Antibodies: Anti-Hep C Virus Ab (EIA or ELISA)** **Anti-Hep C Virus Ab tests (EIA or ELISA) are used to detect the presence of antibody to hepatitis C virus (anti-HCV). These tests do not confirm active HepC.** The question applies to testing at this or another VAMC or in the private sector. If patient was tested at another VAMC or in the private sector, the date and the test results must be known to answer yes. Patient refusal documented in record = during a patient encounter, when testing for Hepatitis-C offered or recommended, the patient stated he/she does not wish to be tested.
10	hcvtstdt	Enter the date of the most recent HCV antibody test reported within the past two years.	mm/dd/yyyy Will be auto-filled as 99/99/9999 if testhcv = 2, 3, or 98 < = 2 years prior to or = stdybeg and < = stdyend	**If the laboratory date is not available, use the date of documentation in the record that the test was done.** At a minimum the month and year should be documented and entered accurately. If the day is unknown, enter 01 as the default.

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
11	poshcv	Within the two-year period, was <u>any</u> of the Anti-Hep C Virus Ab (EIA or ELISA) test positive? 1. Yes 2. No 95. Not applicable	1, 2, 95 Will be auto-filled as 95 if testhcv = 2, 3, or 98 **If 2, auto-fill tstposdt as 99/99/9999, hcvconf as 95, hcvcondt as 99/99/9999, informpt as 95, informdt as 99/99/9999, hcvtxref as 95, disrefdt as 99/99/9999, and if hcvtstdt <= 90 days prior to or = stdyend, go to enchcv; else go to notobuse as applicable**	If more than one Anti-Hep C Virus Ab (EIA or ELISA) test was performed during the two-year period, the results may differ. If <u>any</u> HCV antibody test result was positive within the past two years, answer "1." **Patient self-report is not acceptable.**
12	tstposdt	Enter the date of the first <u>positive</u> test for Anti-Hep C Virus Ab (EIA or ELISA).	mm/dd/yyyy Will be auto-filled as 9/99/9999 if testhcv = 2, 3, or 98, or poshcv = 2 < = 2 years prior to or = stdybeg and < = stdyend	**If more than one** Anti-Hep C Virus Ab (EIA or ELISA) **test was performed, enter the date of the <u>first</u> Anti-Hep C Virus Ab test with a <u>positive</u> result. Use the laboratory report date. If the lab report date is not available, use the date the clinician documented that results were positive.** At a minimum the month and year should be documented and entered accurately. If the day is unknown, enter 01 as the default.

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
13	hcvconf	Following the positive test for HCV antibodies, was further testing for active HCV performed? 1. HCV RNA test done, results positive 2. HCV RNA test done, results negative 3. RIBA test done, results negative 95. Not applicable 98. Patient refused further testing for HCV 99. Further testing for HCV not documented	1, 2, 3, 95, 98, 99 Will be auto-filled as 95 if testhcv = 2, 3, or 98, or poshcv = 2 **If 98 or 99, auto-fill hcvcondt as 99/99/9999, informpt as 95, informdt as 99/99/9999, hcvtxref as 95, disrefdt as 99/99/9999, and if hcvtstdt <= 90 days prior to or = stdyend, go to enchcv; else go to notobuse as applicable**	**Tests for assessment of active HCV:** HCV RNA Qualitative (RT-PCR) HCV RNA Qualitative (bDNA) HCV RNA Quantitative (RT-PCR) HCV RNA Quantitative (bDNA) HCV genotype result (expressed as 1, 1a, 1b, 2, 3, or other number) **Exclusion test for active HCV:** Option #3 = Recombinant immunoblot assay (RIBA) - **only enter "3" if RIBA test was performed and the RIBA results were negative.** If RIBA test was positive, a RNA test must be done to confirm (or exclude) active HCV infection. **If RIBA test was positive but HCV RNA test was not done, enter "99."** This question applies to testing at this or another VAMC or in the private sector. If patient was tested at another VAMC or in the private sector, the date and the outcome must be known to answer yes. **Patient refusal documented in record =** during a patient encounter, when further testing for active Hepatitis-C offered or recommended, the patient stated he/she does not wish to be tested.

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
14	hcvcondt	Enter the date the test for assessment of active HCV was performed.	mm/dd/yyyy Will be auto-filled as 99/99/9999 if testhcv = 2, 3, or 98, or poshcv = 2, or hcvconf = 98 or 99 **If hcvconf = 2 or 3, auto-fill informpt as 95, informdt as 99/99/9999, hcvtxref as 95, disrefdt as 99/99/9999, and if hcvtstdt <= 90 days prior to or = stdyend, go to enchcv; else go to notobuse as applicable** > = tstposdt and < = stdyend	Use the laboratory report date. If the lab report date is not available, use the date the clinician documented the test results. **Tests for assessment of active HCV:** HCV RNA Qualitative (RT-PCR) HCV RNA Qualitative (bDNA) HCV RNA Quantitative (RT-PCR) HCV RNA Quantitative (bDNA) HCV genotype result (expressed as 1, 1a, 1b, 2, 3, or other number) RIBA (if negative) Enter the exact date. The use of 01 to indicate missing month or day is not acceptable.

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
15	informpt	Was the patient notified of the positive HCV confirmatory test result? 1. Yes 2. No 3. No, positive test result was reported less than 60 days prior to the study end date 95. Not applicable	1, 2, 3, 95 Will be auto-filled as 95 if testhcv = 2, 3, or 98, or poshcv = 2 or hcvconf = 2, 3, 98 or 99 **Cannot enter 3 if hcvcondt > = 60 days prior to stdyend** **If 2 or 3, auto-fill informdt as 99/99/9999, hcvtxref as 95, disrefdt as 99/99/9999, and if hcvtstdt <= 90 days prior to or = stdyend, go to enchcv; else go to notobuse as applicable**	**Confirmatory HCV test = definitive test performed to confirm active HCV infection** **This question refers to the HCV RNA test date entered in HCVCONDT. Examples of notification of the patient of the positive HCV confirmatory test result include, but are not limited to:** • Hepatitis C mentioned in progress note (lab result or other note) indicating the information was shared with the patient. • The patient was informed of the reason (positive test result) for referral to a liver specialist, GI specialist, or Hepatitis C service. • Documentation in a clinic note that a letter was sent to the patient regarding the test results. • Physician or other provider states in a clinic note, "Talked to patient by phone and discussed HCV test results" or other similar statement. **Only answer "3" if the patient was not notified of the HCV test results AND the positive confirmatory test result was reported from the lab less than 60 days prior to the study end date.**
16	informdt	Enter the date the patient was notified of positive HCV confirmatory test result.	mm/dd/yyyy Will be auto-filled as 99/99/9999 if testhcv = 2, 3, or 98, or poshcv = 2, or hcvconf =2, 3, 98, or 99, or informpt = 2 or 3 > = hcvcondt and < = stdyend	If more than one form of notification is applicable, use the date of the event occurring earliest in time. (Example: clinician writes in progress note of 11/10/08 that patient was notified of test result. On 11/21/08, the clinician discusses referral to a liver specialist with the patient. Use the 11/10/08 date.) Enter the exact date. The use of 01 to indicate unknown month or day is not acceptable

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
17	hcvtxref	Within 3 months of the positive HCV RNA confirmatory test result, does the record document discussion of HCV treatment options with the patient or referral to a specialty clinic? 1. Discussion of HCV treatment options by primary care or mental health provider 2. Referral to a specialty clinic by primary care or mental health provider 3. Both 1 and 2 4. Positive HCV RNA confirmatory test result was reported less than 3 months prior to the study end date 95. Not applicable 98. Patient refused referral to specialty clinic 99. None of the above	1, 2, 3, 4, 95, 98, 99 Will be auto-filled as 95 if testhcv = 2, 3, or 98, or poshcv = 2, or hcvconf =2, 98, or 99, or informpt = 2 or 3 **Cannot enter 4 if hcvcondt > = 3 months prior to stdyend** If 4, 98, or 99, auto-fill disrefdt as 99/99/9999, **and if hcvtstdt <= 90 days prior to or = stdyend, go to enchcv; else go to notobuse as applicable**	**This question refers to the HCV RNA test date entered in HCVCONDT. Discussion of HCV treatment options with the patient by the primary care or mental health provider:** • **Decreasing (or stopping) alcohol use may be the most important initial treatment for Hepatitis C; thus, discussion of referral to substance abuse or Mental Health is a treatment option.** • Other treatment options may include discussion of: anti-viral therapy (alpha interferon, Peginterferon, with or without Ribavirin) **Specialty clinic = Hepatitis C service, Gastroenterologist, (GI service), Liver specialist, Infectious disease, Hepatitis C nurse coordinator, HCV education coordinator** • Documentation that a referral was placed to a specialty clinic for management of the positive HCV test results is sufficient to answer "2" (or "3" as applicable). There does not need to be documentation that the patient was seen by the specialty clinic. • **If referral to a specialty clinic was discussed and the patient refused referral, answer "98."** **Only answer "4" if HCV treatment options were not discussed or the patient was not referred to a specialty clinic** within 3 months of the positive HCV RNA test **AND the positive HCV RNA confirmatory test result was reported from the lab less than 3 months prior to the study end date.**

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
18	disrefdt	Enter the date of the first discussion of treatment options with the patient or of referral to a specialty clinic.	mm/dd/yyyy Will be auto-filled as 99/99/9999 if testhcv = 2, 3, or 98, or poshcv = 2, or hcvconf =2, 3, 98, or 99, or informpt = 2 or 3, or if hcvtxref= 4, 98, or 99 >= hcvcondt and <= 3 months after hcvcondt and < = stdyend **If hcvtstdt <= 90 days prior to or = stdyend, go to enchcv; else go to notobuse as applicable**	Discussion may include the benefits and risks of anti-viral therapy, or referral to a specialist or Hepatitis C service. **Discussion of referral to substance abuse or Mental Health is a treatment option.** If both treatment options were discussed and referral was made, enter the earliest date of the interventions. Enter the exact date. The use of 01 to indicate unknown month or day is not acceptable

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
19	enchcv	During the timeframe from [computer display hcvtstdt to hcvtstdt + 14 days and <=pulldt or (<=stdyend if stdyend > pulldt)], did the patient have a face-to-face encounter with the VHA provider who ordered the HCV antibody test? 1. Yes 2. No 3. No, 14 day timeframe has not elapsed 4. No, HCV antibody test was ordered by non-VHA provider, provider at other VAMC, during ED/urgent care encounter, or during inpatient hospitalization	1, 2, 3, 4 If 2 or 3, go to comhcv If 4, go to notobuse as applicable **Cannot enter 3 if hcvtstdt > = 14 days prior to pulldt or (prior to stdyend if stdyend > pulldt)**	**Tests for HCV Antibodies: Anti-Hep C Virus Ab (EIA or ELISA)** In order to answer this question, it is necessary to determine the VHA provider that ordered the most recent HCV antibody test. **Ordering provider** = physician/APN/PA that ordered the test or a physician/APN/PA that is part of the same service/clinic (e.g,, primary care physician orders the test and patient sees the primary care clinic PA). Per local VAMC policy, a registered nurse (RN) may be authorized to order certain lab tests. If a RN ordered the test and the patient had an encounter with the same RN within 14 days of the test, answer "1". If there is documentation that the patient had a face-to-face encounter during the specified timeframe with the provider that ordered the most recent HCV antibody test, answer "1". If the lab test is ordered or obtained on the same date as the face-to-face encounter and it is not evident that the lab results were available to the provider by the time of the encounter, answer "2". **Only answer "3" if the patient did not have an encounter with the ordering VHA provider of the HCV antibody test AND the HCV test result was reported from the lab less than 14 days prior to the pull list date.** **Answer "4" if the HCV antibody test was ordered by a non-VHA provider, provider at other VAMC, during an ED/urgent care encounter, or during inpatient hospitalization.**

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
20	enchcvdt	Enter the date of the earliest face-to-face encounter with the ordering VHA provider of the HCV antibody test within 14 days of the most recent HCV antibody test.	mm/dd/yyyy If enchcv = 1, go to notobuse as applicable >= hcvtstdt and <= 14 days after hcvtstdt and <=pulldt or (<=stdyend if stdyend > pulldt)	If the patient had multiple face-to-face encounters with the ordering VHA provider of the most recent HCV antibody test, enter the date of the earliest encounter during the specified timeframe. Enter the exact date.

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
21	comhcv	During the timeframe from [computer display hcvtstdt to hcvtstdt + 30 days and <= pulldt or (<=stdyend if stdyend > pulldt)], was the HCV antibody result communicated to the patient by licensed health care staff? 1. Yes 2. No 3. No, 30 day timeframe has not elapsed	1, 2, 3 If 2 or 3, go to notobuse as applicable **Cannot enter 3 if hcvtstdt > = 30 days prior to pulldt or (prior to stdyend if stdyend > pulldt)**	**Communication of HCV antibody result to the patient must be documented in the record and any of the following communication methods may be used: telephone, mailed letter, secure message, Telehealth, or face-to-face encounter.** **The documentation must indicate an attempt was made to communicate the test results to the patient; the attempt does not have to be successful.** • Letter does not have to be sent by certified mail. • Telehealth refers to real time clinic based video encounter between the patient and provider. • Secure messaging is a confidential message functionality of My HealtheVet similar to email between patient and provider for non-urgent matters. • Face-to-face encounter **Examples of acceptable documentation include:** attempted to contact patient by phone and left voice message to return call; statements indicating test results were reviewed with the patient; notations in the care plan that medications/treatments/interventions/consults were initiated/changed based on test results; or statements indicating the treatment plan was not altered or patient should continue with the current regimen based on test results. **Licensed health care staff may include, but is not limited to: Physician, APN (NP or CNS), physician assistant (PA), registered nurse, licensed practical/vocational nurse (LPN/LVN), pharmacist, psychologist, social worker** **If the HCV test result was reported from the lab at least 30 days prior to pull list date AND the HCV test result was not communicated to the patient by licensed health care staff during the specified timeframe, answer "2".** **If the HCV test result was reported from the lab less than 30 days prior to pull list date AND the HCV test result was not communicated to the patient, answer "3".**

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
22	comhcvdt	Enter the earliest date the HCV antibody test result was communicated to the patient.	mm/dd/yyyy >= hcvtstdt and <= 30 days after hcvtstdt and <=pulldt or (<=stdyend if stdyend > pulldt)	If there is more than one attempt to communicate the HCV antibody test result to the patient, enter the date of the earliest attempt. Exact date must be entered.
23	comhcvpro	Which licensed health care staff communicated the HCV antibody test result to the patient? 1. Physician 2. Advanced Practice Nurse (NP or CNS) 3. Registered Nurse 4. Licensed Practical (Vocational) Nurse (LPN/LVN) 5. Physician Assistant (PA) 6. Other licensed health care staff	1, 2, 3, 4, 5, 6	**Licensed health care staff may include, but is not limited to:Physician, APN (NP or CNS), physician assistant (PA), registered nurse, licensed practical/vocational nurse (LPN/LVN), pharmacist, psychologist, social worker**
24	comhcvmet	What method was used to notify the patient of the HCV antibody test result? 1. Telephone 2. Mailed letter 3. Secure Message 4. Clinic Based Video Telehealth 5. Face-to-face encounter	1, 2, 3, 4, 5	• Letter does not have to be sent by certified mail. • Telehealth refers to real time clinic based video encounter between the patient and provider. • Secure messaging is a confidential message functionality of My HealtheVet similar to email between patient and provider for non-urgent matters.
		If catnum = 61 AND (seenyr = 2 or specvst = 1), go to vascdis; else go to notobuse		
		Screening for Tobacco Use		

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
25	notobuse	Is there evidence in the record the patient is a lifetime non-user of tobacco, or has not used tobacco for the past 7 years?	1, 2 If 1, auto-fill tobscrdt as 99/99/9999, erenotob as 95, tobnow as 95, tobuseyr as 95, tuconsel as 95, tucnsldt as 99/99/9999, tucrefer as 95, tucrefdt as 99/99/9999, offtucrx as 95, tucmedt as 99/99/9999, ptreqrx as 95, offmedrx as 95, tucrxdt as 99/99/9999, tucmedrx as 95, and clinone as 95, and go to vascdis1	Tobacco use: cigarettes, cigars, pipe smoking, snuff, and chewing tobacco. Information may be taken from inpatient or outpatient record. Patient need not report specifically that he/she has not used tobacco for 7 or more years. **Acceptable documentation** = denies history of tobacco use, lifetime non-tobacco user; never used tobacco; no history of tobacco use; tobacco use history negative, has not used tobacco for 20+ years, quit tobacco in 1985, etc. Documentation that the patient is a lifetime non-user or quit > 7 years ago may be obtained from information entered in the record prior to the past year, if the information does not conflict with more recent data.

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
26	tobscrdt	Enter the most recent date within the past year that the patient was screened for tobacco use.	mm/dd/yyyy < = 1 year prior to or = stdybeg and < = stdyend If notobuse = 1, will be auto-filled as 99/99/999 **Abstractor may enter 99/99/9999 if the patient was not screened within the past year** **If <> 99/99/9999, auto-fill erenotob as 95** **If 99/99/9999, auto-fill tobnow as 95, tobuseyr as 95 tuconsel as 95, tucnsldt as 99/99/9999, tucrefer as 95, tucrefdt as 99/99/9999, offtucrx as 95, tucmedt as 99/99/9999, ptreqrx as 95, offmedrx as 95, tucrxdt as 99/99/9999, tucmedrx as 95, clinone as 95, and go to erenotob**	**Most recent date: the date most immediately prior to or during the study interval when the patient was asked whether he/she was a current tobacco user. May be by direct question to the patient or completion of a patient questionnaire form.** **If the patient was not screened for tobacco use within the past year, enter default date 99/99/9999.** Most recent date may be taken from either the inpatient or outpatient record. Date must be specific. Use of default 01 is not acceptable**.**

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
27	erenotob	During the past year, did a physician/APN/PA document a reason why the patient was not screened for tobacco use? 1. Yes 2. No 95. Not applicable	1, 2, 95 Will be auto-filled as 95 if notobuse = 1 or tobscrdt <> 99/99/9999 If 1 or 2, go to vascdis1	This question is informational only and does not impact current tobacco screening measures. In order to answer "1", a physician/APN/PA must document a medical reason he/she does not believe that this patient will experience a net-benefit from tobacco screening, i.e. no benefit is expected or benefits are not expected to outweigh harms. **Examples of medical reasons for not screening for tobacco use include, but are not limited to:** Terminal illness, tobacco cessation treatment not indicated due to poor prognosis
28	tobnow	At the most recent screening for tobacco use, did the patient report he/she is a current tobacco user? 1. Reported he/she is a current tobacco user 2. Reported he/she is not a current tobacco user 95. Not applicable	1, 2, 95 If notobuse = 1 or tobscrdt = 99/99/9999, will be auto-filled as 95	• **This question refers to the most recent screening for tobacco use that occurred on the date entered in TOBSCRDT. There must be documentation in the record of the patient's response to the question of whether he/she is a current tobacco user at the most recent screening for tobacco use.** • If the patient's response is ambiguous, or documentation is conflicting (patient states to clinic intake clerk that he "has an occasional cigarette," but states to MD that he does not use tobacco), consider that the patient uses tobacco and answer "1." **Exclude:** Documentation of electronic cigarette (e-cigarette) use only

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
29	tobuseyr	Did the patient use tobacco any time during the year prior to the most recent Nexus clinic visit? 1. Yes 2. No 95. No applicable	1, 2, 95 If notobuse = 1, or tobscrdt = 99/99/9999, will be auto-filled as 95 **If 2, <u>and</u> tobnow = 2, auto-fill tuconsel as 95, tucnsldt as 99/99/9999, tucrefer as 95, tucrefdt as 99/99/9999, offtucrx as 95, tucmedt as 99/99/9999, ptreqrx as 95, offmedrx as 95, tucrxdt as 99/99/9999, tucmedrx as 95, clinone as 95, and go to vascdis1** If tobnow = 1, cannot enter 2	**"During the year prior to the most recent Nexus clinic visit" = from the visit or encounter date to the same date exactly one year previously.** If documentation in the record is non-specific as to the time period the patient has not used tobacco (example: "patient doesn't smoke"), consider the veteran a tobacco user and answer "1." If there is conflicting information in the record regarding the patient's tobacco use, consider the patient uses tobacco (e.g., inpatient H&P states "current smoker" but clinic note states "quit 2 years ago.") Answer that the patient used tobacco. There must be a documented 12-month history of non-use of tobacco to answer "no." (Example: if there is an entry in the record six months ago that the patient quit smoking five months previously, but there is no further entry, the abstractor cannot know the patient has not used tobacco within the past year - he may have resumed smoking in the interim.) If there is a subsequent entry that indicates the patient is still not smoking, and a total of 12 months without tobacco use can be determined, answer "2" to the question. To answer "no," medical record documentation must convey to the abstractor the certainty that the veteran has not used tobacco within the past 12 months. **Exclude:** Documentation of electronic cigarette (e-cigarette) use only

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
30	tuconsel	Within the past year, was the patient provided with direct brief counseling to quit using tobacco? 1. Yes 2. No 95. Not applicable	1, 2, 95 Will be auto-filled as 95 if notobuse = 1, or tobscrdt = 99/99/9999, or tobnow = 2 and tobuseyr = 2 **If 2, autofill tucnsldt as 99/99/9999**	Within the past year: from the first day of the study interval to the first day of the same month one year previously. Counseling done from the first day of the study interval to the study end date is also acceptable. **In order to answer "1," the direct brief counseling must include at least three points on how to quit tobacco.** Documentation of direct brief counseling should indicate general guidance on elements such as: • advising the patient to set a quit date when ready to quit • identify reasons for and benefits of quitting • remove all tobacco products from home and work settings • identify and plan ahead for challenges to quitting • get support from family, friends, and co-workers • communicate support and encouragement The provider should communicate support and encouragement to the patient. The provider should advise total abstinence from tobacco use, should encourage use of pharmacotherapy, and help provide information about potential resources such as the national number linking to any state telephone counseling quitline, 1-800-QUIT-NOW. (1-800-Quit Now is a program outside VHA, and while it may be used as a patient resource, it does not replace the responsibility to provide counseling.) Provision of brief counseling must be documented. • **Any provider who is able to refer is able to provide brief counseling and/or refer for individual intervention or specialty smoking cessation clinic, including physicians, APN, PA, RN, LPN, pharmacists, social workers, psychologists, dentists, and substance abuse counselors.** • **Provider documentation of direct brief counseling to quit using tobacco via telephone is acceptable.** • **Provision of a brochure or pamphlet to the patient without documented direct discussion of how to quit is NOT acceptable.**

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
31	tucnsldt	Enter the date brief direct tobacco use counseling was provided.	mm/dd/yyyy Will be auto-filled as 99/99/9999 if tuconsel = 2 < = 1 year prior to or = stdybeg and < = stdyend	Exact date must be entered. The use of 01 to indicate missing day or month is not acceptable.
32	tucrefer	Within the past year, was the patient offered referral for individual intervention or to a tobacco use cessation program? 1. Yes 2. No 95. Not applicable	1, 2, 95 Will be auto-filled as 95 if notobuse = 1, or tobscrdt = 99/99/9999, or tobnow = 2 and tobuseyr = 2 **If 2, auto-fill tucrefdt as 99/99/9999**	**Any provider who is able to refer is able to provide brief counseling and/or refer for individual intervention or to a specialty smoking cessation clinic, including physicians, APN, PA, RN, LPN, pharmacists, social workers, psychologists, dentists, and substance abuse counselors. The referral should inform the patient of services available through a VA smoking or Tobacco Use Cessation Specialty Clinic or VA providers who are local specialists in evidence-based smoking cessation care. If the patient cannot or will not attend a VA clinic, the provider can also offer to refer the patient to a local smoking cessation program in the community, such as the American Lung Association, the American Cancer Society, or a state telephone counseling quitline, through the national portal number, 1-800-QUIT-NOW, as appropriate.** **If documentation indicates the program was offered, answer "1" even if the patient refused to enroll or participate.**
33	tucrefdt	Enter the date the patient was offered referral for individual intervention or to a tobacco use cessation program.	mm/dd/yyyy Will be auto-filled as 99/99/9999 if tucrefer = 2 < = 1 year prior to or = stdybeg and < = stdyend	Exact date must be entered. The use of 01 to indicate missing day or month is not acceptable.

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
34	offtucrx	Within the past year, was the patient <u>offered</u> medication to assist in tobacco use cessation by a provider? 2. Yes, medication offered by a prescribing provider 3. Yes, medication offered by non-prescribing provider 4. No offer of medication documented 95. Not applicable	2, 3, 4, 95 Will be auto-filled as 95 if notobuse = 1, or tobscrdt = 99/99/9999, or tobnow = 2 and tobuseyr = 2 If 4, auto-fill tucmedt as 99/99/9999, ptreqrx as 95, **offmedrx as 95, tucrxdt as 99/99/9999,** tucmedrx as 95, and go to clinone, else go to tucmedt	**Prescribing provider** = includes, but may not be limited to, MD/DOs, dentists, APNs, PAs, and PharmDs. Facilities may have local policies in place allowing other providers to prescribe over-the-counter nicotine replacement therapy. **Non-prescribing provider** = This includes, but may not be limited to, pharmacists, psychologists, RNs, LPNs, social workers, and substance abuse counselors**.** **If there is documentation the patient was currently on a tobacco cessation medication <u>at the time of the most recent tobacco screening</u>, answer "2."** Referral to a smoking cessation program does not meet the measure for offering medications. If a non-prescribing provider has been authorized by the facility to prescribe OTC nicotine replacement therapy (e.g. RN) and there is documentation the non-prescribing provider offered and prescribed the OTC nicotine replacement product, select "2." **Examples of tobacco cessation products and medications such as:** **Nicotine replacement products (OTC)** Nicotine patch (Nicoderm CQ, Habitrol) Nicotine gum (Nicorette) Nicotine lozenges (Commit) **Nicotine replacement products prescription** Nicotine inhaler (Nicotrol inhaler) - prescription only Nicotine nasal spray (Nicotrol) - prescription only **Oral medications: Bupropion (Zyban, Wellbutrin), varenicline (Chantix) - Rx only**

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
35	tucmedt	Enter the date the patient was offered medication to assist in tobacco use cessation.	mm/dd/yyyy Will be auto-filled as 99/99/9999 if offtucrx = 4 If offtucrx = 2, auto-fill ptreqrx as 95, **offmedrx as 95, tucrxdt as 99/99/9999,** and go to tucmedrx If offtucrx = 3, go to ptreqrx < = 1 year prior to or = stdybeg and < = stdyend	Exact date must be entered. The use of 01 to indicate missing day or month is not acceptable.
36	ptreqrx	Did the non-prescribing provider who offered tobacco cessation medication document that the patient requested tobacco cessation medication? 1. Yes 2. No 95. Not applicable 98. Patient refused tobacco cessation medication	1, 2, 95, 98 Will be auto-filled as 95 if offtucrx = 2 or 4 If 2, auto-fill offmedrx as 95 and tucrxdt as 99/99/9999, and go to tucmedrx If 98, auto-fill offmedrx as 95, tucrxdt as 99/99/9999, tucmedrx as 95, and go to clinone	If a non-prescribing provider offers the tobacco cessation medication as part of counseling and the patient reports that he or she would like to receive such assistance, the non-prescribing provider is responsible for documenting this in the chart and communicating the patient request to a provider who can prescribe medications. For example, social worker notes, "talked to patient about tobacco cessation medication. Patient interested in bupropion." Enter "1." If the non-prescribing provider who offered tobacco cessation medication does not document whether the patient is interested in receiving tobacco cessation medication, enter "2." For example, LPN notes, "discussed/offered tobacco cessation medications." If the non-prescribing provider who offered tobacco cessation medication documented that the patient declined or refused tobacco cessation medication, enter "98." **Non-prescribing provider** = This includes, but may not be limited to, pharmacists, psychologists, RNs, LPNs, social workers, and substance abuse counselors**.**

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
37	offmedrx	On or after the date when the patient was offered tobacco cessation medication, was tobacco cessation medication prescribed by the provider? 1. Yes 2. No 95. Not applicable	1, 2, 95 Will be auto-filled as 95 if ptreqrx = 2 or 98 If 1, auto-fill ealltob as 95 If 2, auto-fill tucrxdt as 99/99/9999 and go to tucmedrx	**Provider = includes, but may not be limited to, MD/DOs, APNs, PAs, and PharmDs.** **Tobacco cessation medication prescribed =** Prescribing clinician entered an order or wrote a prescription for tobacco cessation medication. **Examples of tobacco cessation medications such as:** **Nicotine replacement products prescription** Nicotine inhaler (Nicotrol inhaler) - prescription only Nicotine nasal spray (Nicotrol) - prescription only **Oral medications: Bupropion (Zyban, Wellbutrin), varenicline (Chantix) - Rx only**
38	tucrxdt	Enter the date the tobacco cessation medication was prescribed.	mm/dd/yyyy Will be auto-filled as 99/99/9999 if ptreqrx = 2 or 98 or offmedrx = 2 If offmedrx = 1, auto-fill tucmedrx as 95, and go to clinone > = tucmedt or = tucmedt and <= stdyend	Enter the exact date. The use of 01 to indicate missing month or day is not acceptable.
39	tucmedrx	Within the past year, was the patient prescribed medication to assist in tobacco use cessation by a provider? 1. Yes 2. No 95. Not applicable 98. Patient refused tobacco cessation medication	1, 2, 95, 98 Will be auto-filled as 95 if notobuse = 1, or tobscrdt = 99/99/9999, or tobnow = 2 and tobuseyr = 2, offtucrx = 4, ptreqrx = 98, or offmedrx = 1 If 1 or 98, auto-fill ealltob as 95, and go to clinone	**Provider = includes, but may not be limited to, MD/DOs, APNs, PAs, and PharmDs.** **Tobacco cessation medication prescribed =** Prescribing clinician entered an order or wrote a prescription for tobacco cessation medication. **Examples of tobacco cessation medications such as:** **Nicotine replacement products prescription** Nicotine inhaler (Nicotrol inhaler) - prescription only Nicotine nasal spray (Nicotrol) - prescription only **Oral medications: Bupropion (Zyban, Wellbutrin), varenicline (Chantix) - Rx only**

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
40	ealltob	During the past year, is there documentation of an allergy/adverse reaction to tobacco cessation medication? 1. Yes 2. No 95. Not applicable	1, 2, 95 Will be auto-filled as 95 if offmedrx = 1 or tucmedrx = 1 or 98	This question is informational only and does not impact current tobacco screening measures. Documentation of an allergy, adverse reaction, intolerance, or sensitivity to any tobacco cessation medication is sufficient to answer "1." **Examples of tobacco cessation medications such as:** • Nicotine replacement products (OTC) • Nicotine inhaler (Nicotrol inhaler) - prescription only • Nicotine nasal spray (Nicotrol) - prescription only • **Oral medications:** Bupropion (Zyban, Wellbutrin), varenicline (Chantix) - prescription only
41	clinone	During at least one outpatient encounter in the past year, did a clinician provide direct counsel to the patient regarding tobacco use cessation? 1. Yes 2. No 95. Not applicable	1, 2, 95 Will be auto-filled as 95 if notobuse = 1, or tobscrdt = 99/99/9999, or tobnow = 2 and tobuseyr = 2	Clinician = MD, APN, PA, or Psychologist Clinician counseling: direct discussion between clinician and patient, or direct advice provided to patient to stop using tobacco, or direct warning to patient of the risks associated with tobacco use. Referral by the clinician to a tobacco use cessation program is acceptable. Counseling provided by telephone is acceptable.

<table>
<tr><th>#</th><th>Name</th><th>QUESTION</th><th>Field Format</th><th>DEFINITION/DECISION RULES</th></tr>
<tr><td>42</td><td>vascdis1
vascdis2
vascdis3
vascdis4
vascdis5
vascdis6
vascdis7
vascdis8
vascdis99</td><td>Within the past two years, at any inpatient or outpatient encounter, did the patient have an active diagnosis of any of the following?
Indicate all that apply:
<table><tr><td>1. Coronary artery disease</td><td>414.0x, 414.2, 414.8, 414.9, 429.2</td></tr><tr><td>2. Angina</td><td>411.xx, 413.xx</td></tr><tr><td>3. Lower extremity arterial disease/peripheral artery disease</td><td>440.2, 440.4</td></tr><tr><td>4. Transient cerebral ischemia</td><td>435.xx</td></tr><tr><td>5. Stroke</td><td>433.xx, 434.xx</td></tr><tr><td>6. Atheroembolism</td><td>444.xx, 445.xx</td></tr><tr><td>7. Abdominal aortic aneurysm</td><td>441.xx</td></tr><tr><td>8. Renal artery atherosclerosis</td><td>440.1</td></tr><tr><td>99. No ischemic vascular disease diagnosis</td><td></td></tr></table></td><td>1, 2, 3, 4, 5, 6, 7, 8, 99

If 1 or 2 warning if selmi = F and selpci = F, and selcabg = F
Auto-fill 1 if selpci, selcabg or selmi = T</td><td>Within the past two years: from the first day of the study interval to the first day of the same month two years previously
'Active' diagnosis = the condition was ever diagnosed and there is no subsequent statement, prior to the most recent outpatient visit, indicating the condition was resolved or is inactive.
Include diagnoses noted in clinic notes or progress notes. Diagnoses documented on a problem list must be validated by a clinician diagnosis within the past 2 years.
Diagnoses may be taken from the inpatient or outpatient setting. The abstractor is not limited to the codes provided and may take diagnoses from clinician documentation even though an applicable code is not present.
Do not include diagnoses that occurred greater than two years in the past or are not active diagnoses.</td></tr>
<tr><td>43</td><td>famhx</td><td>Does the record document any one of the following:
1. patient has a family history of coronary events occurring prior to age 45
2. patient's father or other male first-degree relative had a definite MI or sudden death before age 55
3. patient's mother or other female first-degree relative had a definite MI or sudden death before age 65
99. none of these factors documented</td><td>1, 2, 3, 99</td><td>Definition of "family history" is the same as that for "first-degree relative," i.e., father, mother, brother, or sister.
First-degree relative = a natural (not adoptive) parent or sibling with whom an individual shares one-half of his/her genetic material, i.e., father, mother, brother, or sister
Coronary events occurring before age 45 = acute myocardial infarction and unstable angina, conditions associated with stenosis within the coronary artery
Sudden death before age 55 = death from cardiovascular disease, not as the result of an accident or other disease</td></tr>
<tr><td></td><td></td><td>If the patient is male and <= age 50, the module will end.
If the patient is female and < age 51, the computer will go to question testpap.</td><td></td><td></td></tr>
<tr><td></td><td></td><td>Colorectal Cancer Screening</td><td></td><td></td></tr>
</table>

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
44	colondx	Does the patient have a diagnosis of one of the following: 1. Colon cancer 2. Total colectomy 99. 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**
45	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 those procedures performed by this VAMC. Entry in the computer package is acceptable, as long as the interpretation is present. Sources: Progress notes, operative report, or electronic database If the colonoscopy was performed by another VAMC or private sector provider, the abstractor must be certain the colonoscopy was accomplished. The year must be documented in order to be able to compute if the test was accomplished within the accepted time window. Patient refused colonoscopy = during the visit when the colonoscopy was recommended, the patient stated he/she does not wish to perform this procedure. If the record states only "refuses colon cancer screening," with no other documentation, answer "98." Note: spiral CT scan is not a substitute for colonoscopy and is not acceptable for colorectal cancer screening. Patient self-report of result of colonoscopy done outside VHA is acceptable.
46	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 or 2, go to testpap as applicable** <= 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.

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
47	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 4, auto-fill gfobths as 95, and go to occbldt If 99, auto-fill gfobths as 95, occbldt as 99/99/9999, and go to ifobtst	• **Only screening by serial (three-card) stool sampling is acceptable as screening for colorectal cancer by guaiac fecal occult blood testing (gFOBT).** • If unable to determine whether the fecal occult blood testing was a gFOBT or immunochemical (iFOBT), consider as gFOBT. • Adequate screening requires three stool samples returned to the VAMC for gFOBT. Testing of the stool for occult blood may be done by the laboratory. The results of all three cards (three-card serial screening) should be reported within a 6 month timeframe. • Results of gFOBT must be in the medical record for those tests done by this VAMC. Entry in the computer package is acceptable, as long as the interpretation is present. • If gFOBT was done by another VAMC or private sector provider, documentation must indicate the result of the three-card serial test. Either the three-care serial gFOBT lab report or a report from the private sector provider containing the result of the three-card gFOBT must be documented in the record. The date must also be documented in sufficient detail to be able to compute if the test was accomplished within the accepted time window. • **Patient self-report of gFOBT result is NOT acceptable.** A digital rectal exam is not screening for colon cancer. Digital rectal examination with hemetest of fecal matter is not acceptable as colorectal cancer screening by fecal occult blood testing.
48	gfobths	Is the gFOBT reported as a high sensitivity product? 1. Yes 2. No 95. Not applicable	1, 2, 95 Will be auto-filled as 95 if gfecalbld = 4 or 99	**If the gFOBT results are not reported as High Sensitivity (HS) as described below, assume the gFOBT is NOT a HS product and select "2."** The letters HS must be included as part of the name of the panel name: (OCCULT BLOOD GUAIAC-HS X3 SCREEN), test name (OCCULT BLOOD-HS#1 OCCULT BLOOD-HS#2 OCCULT BLOOD-HS#3), print name FOBHS#1 FOBHS#2 FOBHS#3) and test header (FOB-HS #1 FOB-HS #2 FOB-HS#3)

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
49	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 prefobt4 < = 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.
50	ifobtst	Does the medical record contain the results of immunochemical fecal occult blood testing (iFOBT or FIT) done within the past year? 3. iFOBT/FIT performed by VHA 4. iFOBT/FIT performed by private sector provider 99. No result of iFOBT/FIT done within past year	3, 4, 99 If 4, auto-fill fitman as 95, fitmanum as z, fitrslt as z, fobtordr as 95, givcardt as 99/99/9999, and go to ifobtdt If 99, auto-fill ifobtdt as 99/99/9999, fitman as 95, fitmanum as z, fitrslt as z, and go to fobtordr	• 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.**

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
51	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 = 4, go to prefobt4; else go to fitman < = 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.
52	fitman	Does the lab report document the number of immunochemical fecal occult blood tests/vials required by the manufacturer? 1. Yes 2. No 95. Not applicable	1, 2, 95 Will be auto-filled as 95 if ifobtst = 4 or 99 If 2, auto-fill fitmanum as z, and go to fitreslt	**For immunochemical fecal occult blood tests performed within VHA, the lab report must indicate the number of tests that are required by the manufacturer along with the results of each of the required tests. Specifically, results reporting for a FIT product that requires only 1 test should include the following information:** • panel name: OCCULT BLOOD FIT X1 SCREEN • test name: OCCULT BLOOD (FIT) #1 OF 1 • print name: FIT1/1 • test header: FIT1/1 **Results reporting for a FIT product that requires two tests should include the following information:** • panel name: OCCULT BLOOD FIT X2 SCREEN • test names: OCCULT BLOOD (FIT) #1 OF 2 OCCULT BLOOD (FIT) #2 OF 2 • print names: FIT1/2 FIT2/2 • test headers: FIT1/2 FIT2/2 Instructions for naming conventions which include the number of tests that are required is provided in the Laboratory Reporting of FOBT document available as part of the VHA Colorectal Cancer Screening Guidance Statement.

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
53	fitmanum	Enter the number of iFOBT/FIT tests/vials required by the manufacturer.	__ Will be auto-filled as z if ifobtst = 4 or 99 or if fitman = 2 Whole numbers only 1 to 5	**For immunochemical fecal occult blood tests performed within VHA, the lab report must indicate the number of tests that are required by the manufacturer.**
54	fitreslt	Enter the number of iFOBT/FIT results reported in the record.	__ **If fitreslt = fitmanum, go to prefobt4, else go to cfobtpos as applicable** Whole numbers only 1 to 5	**For immunochemical fecal occult blood tests performed within VHA, the panel name, test name, print name and test header should be used. Specifically, results reporting for a FIT product that requires only 1 test should include the following information:** • panel name: OCCULT BLOOD FIT X1 SCREEN • test name: OCCULT BLOOD (FIT) #1 OF 1 • print name: FIT1/1 • test header: FIT1/1 **Results reporting for a FIT product that requires two tests should include the following information:** • panel name: OCCULT BLOOD FIT X2 SCREEN • test names: OCCULT BLOOD (FIT) #1 OF 2 OCCULT BLOOD (FIT) #2 OF 2 • print names: FIT1/2 FIT2/2 • test headers: FIT1/2 FIT2/2 For example, the lab report notes FIT X2 screen, but contains results for FIT1/2 only; enter "1."

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
55	fobtordr	Within the past year, did the record document that guaiac or immunochemical fecal occult blood testing for colorectal cancer screening was ordered for or provided to the patient by the VA? 3. gFOBT or iFOBT ordered, but no tests returned 4. gFOBT or iFOBT ordered, but less than required number of tests returned 5. No documentation gFOBT or iFOBT was ordered or provided to the patient 95. Not applicable 98. Patient refused FOBT	3, 4, 5, 95, 98 Will be auto-filled as 95 if ifobtst = 3 or 4 If 5 or 98, auto-fill givcardt as 99/99/9999 and go to sigmoid5	Review the orders and/or clinic notes for the past year to determine if gFOBT or iFOBT was ordered for colorectal cancer (CRC) screening or a FOBT CRC screening kit was given to the patient. **Patient refused FOBT = during the visit when the test, using hemoccult cards, 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."**
56	givcardt	Enter the date the most recent gFOBT or iFOBT for CRC screening was ordered for or provided to the patient.	mm/dd/yyyy Will be auto-filled as 99/99/9999 if ifobtst = 3 or 4 OR if fobtordr = 5 or 98 ***Go to sigmoid5** <= 1 year prior to or = stdybeg and < = stdyend	Enter the exact date. The use of 01 to indicate missing month or day is not acceptable.

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
57	prefobt4	During the **4 years prior to the study year**, does the medical record contain the results of a three-card gFOBT or at least one iFOBT/FIT? 1. Yes 2. No	1, *2 ***If 2, go to cfobtpos as applicable**	**4 years prior to study year** = Count back 1 year prior to study begin date and from that date, subtract 4 years (e.g. If study begin date is 12/01/13, 1 year prior is 12/01/12 - timeframe would be 12/01/08 to 11/30/12). • **Only screening by serial (three-card) stool sampling is acceptable as screening for colorectal cancer by guaiac fecal occult blood testing (gFOBT).** • **For purposes of this question only, if there is documentation of at least one iFOBT/FIT result, answer "yes."** • 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 FOBT 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 FOBT was done by another VAMC or private sector provider, documentation must indicate the result of the three-card serial test. Either the three-care serial FOBT lab report or a report from the private sector provider containing the result of the three-card FOBT 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 FOBT result is NOT acceptable.** A digital rectal exam is not screening for colon cancer. Digital rectal examination with hemetest of fecal matter is not acceptable as colorectal cancer screening by fecal occult blood testing.

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
58	fobtdt1 fobtdt4 fobtdt3 fobtdt2	Starting with the most recent gFOBT or iFOBT, enter the date of the laboratory report for each three-card serial screening or at least one iFOBT performed **annually** during the 4 years prior to the study year. **May enter up to 4 dates.**	mm/dd/yyyy **May enter up to 4 dates** ***If (gfecalbld = 3 and occblddt <= 90 days prior to or = stdyend) OR (ifobtst = 3 and ifobtdt <= 90 days prior to or = stdyend), go to cfobtpos; else if fitreslt <> fitmanum), go to sigmoid5) OR (fitreslt = fitmanum), go to testpap as applicable** > 1 year prior to stdybeg and < = 5 years prior to stdybeg	If serial FOBT 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. If more than one serial FOBT is performed during a year, enter the date of the most recent. . 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.
59	cfobtpos	On (computer display valid occblddt or ifobtdt), was any fecal occult blood test (FOBT) result positive? 1. Yes 2. No	1, 2	If any FOBT result is positive for the most recent FOBT completed on OCCBLDDT or IFOBTDT, select "1".

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
60	encfobt	During the timeframe from [if gfecalbld = 3, occblddt to occblddt + 14 days and <= pulldt or (<=stdyend if stdyend > pulldt)] OR [if ifobtst = 3, ifobtdt to ifobtdt + 14 days and <= pulldt or (<=stdyend if stdyend > pulldt)], did the patient have a face-to-face encounter with the provider who ordered the fecal occult blood test (FOBT)? 1. Yes 2. No 3. No, 14 day timeframe has not elapsed 4. No, FOBT was ordered by non-VHA provider, provider at other VAMC, during ED/urgent care encounter, or during inpatient hospitalization	1, 2, 3, 4 If 2 or 3, go to commfobt If 4 and fitreslt <> fitmanum, go to sigmoid5; else if 4 go to testpap as applicable Cannot enter 3 if occblddt or ifobtdt >= 14 days prior to pulldt or (prior to stdyend if stdyend > pulldt)	In order to answer this question, it is necessary to determine the VHA provider that ordered the most recent FOBT entered for OCCBLDDT or IFOBTDT. **Ordering provider** = physician/APN/PA that ordered the test or a physician/APN/PA that is part of the same service/clinic (e.g,, primary care physician orders the test and patient sees the primary care clinic PA). Per local VAMC policy, a registered nurse (RN) may be authorized to order certain lab tests. If a RN ordered the test and the patient had an encounter with the same RN within 14 days of the test, answer "1". If there is documentation that the patient had a face-to-face encounter during the specified timeframe with the provider that ordered the most recent FOBT, answer "1". If the lab test is ordered or obtained on the same date as the face-to-face encounter and it is not evident that the lab results were available to the provider by the time of the encounter, answer "2". **Only answer "3" if the patient did not have an encounter with the ordering VHA provider of the FOBT AND the FOBT result was reported from the lab less than 14 days prior to the pull list date.** **Answer "4" if the FOBT was ordered by non-VHA provider, provider at other VAMC, during ED/urgent care encounter, or during inpatient hospitalization.**

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
61	encfobtdt	Enter the date of the earliest face-to-face encounter with the ordering VHA provider of the fecal occult blood test within 14 days of the most recent fecal occult blood test.	mm/dd/yyyy ***If encfobt = 1 and (fitreslt <> fitmanum), go to sigmoid5; else, go to testpap as applicable** [If gfecalbld = 3, <= 14 days after or = occbldt and <= pulldt or (<= stdyend if stdyend > pulldt)]OR [if ifobtst = 3, <= 14 days after or = ifobtdt and <= pulldt or (<= stdyend if stdyend > pulldt)]	If the patient had multiple face-to-face encounters with the ordering VHA provider of the most recent fecal occult blood test, enter the date of the earliest encounter. Enter the exact date.

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
62	commfobt	During the timeframe from [if gfecalbld = 3, occblddt to occblddt + 30 days and <= pulldt or (<=stdyend if stdyend > pulldt)] OR (if ifobtst = 3, ifobtdt to ifobtdt + 30 days and <= pulldt or (<=stdyend if stdyend > pulldt)], was the fecal occult blood test result communicated to the patient by licensed health care staff? 1. Yes 2. No 3. No, 30 day timeframe has not elapsed	1, 2, 3 ***If 2 or 3 AND (fitreslt <> fitmanum), go to sigmoid5; else, if 2 or 3, go to testpap as applicable** Cannot enter 3 [if gfecalbld = 3 and occblddt > = 30 days prior to pulldt or (prior to stdyend if stdyend > pulldt)] OR [ifobtst = 3 and ifobtdt >= 30 days prior to pulldt or (prior to stdyend if stdyend > pulldt)]	**Communication of fecal occult blood test result to the patient must be documented in the record and any of the following communication methods may be used: telephone, mailed letter, secure message, Telehealth, or face-to-face encounter.** **The documentation must indicate an attempt was made to communicate the test results to the patient; the attempt does not have to be successful .** • Letter does not have to be sent by certified mail. • Telehealth refers to real time clinic based video encounter between the patient and provider. • Secure messaging is a confidential message functionality of My HealtheVet similar to email between patient and provider for non-urgent matters. • Face-to-face encounter **Examples of acceptable documentation include:** attempted to contact patient by phone and left voice message to return call; statements indicating test results were reviewed with the patient; notations in the care plan that medications/treatments/interventions/consults were initiated/changed based on test results; or statements indicating the treatment plan was not altered or patient should continue with the current regimen based on test results. **Licensed health care staff may include, but is not limited to: Physician, APN (NP or CNS), physician assistant (PA), registered nurse, licensed practical/vocational nurse (LPN/LVN), pharmacist, psychologist, social worker** **If the fecal occult blood test result was reported from the lab at least 30 days prior to pull list date AND the fecal occult blood test result was not communicated to the patient by licensed health care staff during the specified timeframe, answer "2".** **If the fecal occult blood test result was reported from the lab <u>less</u> than 30 days prior to pull list date AND the fecal occult blood test result was not communicated to the patient, answer "3".**

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
63	comfobtdt	Enter the earliest date the fecal occult blood test result was communicated to the patient.	mm/dd/yyyy [If gfecalbld = 3, <= 30 days after or = occbldt and <=pulldt or (<= stdyend if stdyend > pulldt)] OR [if ifobtst = 3, <= 30 days after or = ifobtdt and <=pulldt or (<= stdyend if stdyend > pulldt)]	If there is more than one attempt to communicate the fecal occult blood test result to the patient, enter the date of the earliest attempt. Exact date must be entered.
64	comfobtpro	Which licensed health care staff communicated the fecal occult blood test result to the patient?1. Physician 2. Advanced Practice Nurse (NP or CNS) 3. Registered Nurse 4. Licensed Practical (Vocational) Nurse (LPN/LVN) 5. Physician Assistant (PA) 6. Other licensed health care staff	1, 2, 3, 4, 5, 6	**Licensed health care staff may include, but is not limited to: Physician, APN (NP or CNS), physician assistant (PA), registered nurse, licensed practical/vocational nurse (LPN/LVN), pharmacist, psychologist, social worker**
65	comfobtmet	What method was used to notify the patient of the fecal occult blood test result? 1. Telephone 2. Mailed letter 3. Secure Message 4. Clinic Based Video Telehealth 5. Face-to-face encounter	1, 2, 3, 4, 5 ***If fitreslt <> fitmanum, go to sigmoid5; else, go to testpap as applicable**	• Letter does not have to be sent by certified mail. • Telehealth refers to real time clinic based video encounter between the patient and provider. • Secure messaging is a confidential message functionality of My HealtheVet similar to email between patient and provider for non-urgent matters.

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
66	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 dcbe**	**Results of the flexible sigmoidoscopy must be in the medical record for those procedures performed by this VAMC. Entry in the computer package is acceptable, as long as the interpretation is present.** **If unable to determine whether the sigmoidoscopy was flexible or rigid, accept as flexible sigmoidoscopy.** If the flexible sigmoidoscopy was performed by another VAMC or private sector provider, the abstractor must be certain the flexible sigmoidoscopy was accomplished. The year must be documented in order to be able to compute if the test was accomplished within the accepted time window. **Patient refused sigmoidoscopy = during the visit when the sigmoidoscopy was recommended, the patient stated he/she does not wish to perform this procedure.** **If the record states only "refuses colon cancer screening," with no other documentation, answer "98."** **Note: spiral CT scan is not a substitute for flexible sigmoidoscopy and is not acceptable for colorectal cancer screening.** **Patient self-report of result of sigmoidoscopy done outside VHA is acceptable.**
67	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 or 2, go to testpap as applicable** < = 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.

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
68	dcbe	Does the medical record contain the report of a double-contrast barium enema performed within the past five years and prior to 10/01/10? 1. DCBE performed by VHA 2. DCBE performed by a private sector provider 98. Patient refused DCBE 99. No documentation of DCBE performed within last five years	1, 2, 98, 99 **If 98 or 99, auto-fill dcbedt as 99/9999, and if [(prevcoln, gfecalbld, AND sigmoid5 = 98 OR 99) AND (ifobtst = 99 or (fitman = 1 and fitreslt <> fitmanum) or fitman - 2)], go to ctcolon; else go to testpap as applicable**	**Record must document that a double-contrast barium enema was performed. A barium enema alone without double-contrast is not acceptable.** Double-contrast barium enema: imaging technique in which the bowel is filled with air or gas between the introduction of barium and radiographic imaging. This allows accurate visualization of the inner surface of the bowel. If DCBE was done by another VAMC or private sector provider, documentation must indicate the test was accomplished. The year must be documented in order to be able to compute if the test was accomplished within the accepted time window. **Patient refusal = at all encounters when DCBE recommended, he/she states he does not wish to undergo this test. If the record states only "refuses colon cancer screening," with no other documentation, answer "98."** **Patient self-report of result of DCBE done outside VHA is acceptable.**
69	dcbedt	Enter the date of the most recent double-contrast barium enema performed within the past five years.	mm/yyyy If dcbe = 98 or 99, will be auto-filled as 99/9999 < = 5 years prior to stdybeg and < = 9/30/10	The year must be documented and entered accurately. If the month is not documented, enter the study month as the default. DCBEDT will be auto-filled as 99/9999 if DCBE = 98 or 99.
		If [(prevcoln, gfecalbld, sigmoid5, AND dcbe = 98 or 99) AND (ifobtst = 99 or (fitman = 1 and fitreslt <> fitmanum) or fitman = 2)], go to ctcolon; else go to testpap as applicable		

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
70	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 those procedures performed by this VAMC. Entry in the computer package is acceptable, as long as the interpretation is present.** **Sources:** Progress notes, operative report, or electronic database If the CT colonography was performed by another VAMC or private sector provider, the abstractor must be certain the CT colonography was accomplished**.** The year must be documented in order to be able to compute if the test was accomplished within the accepted time window. **Patient self-report of result of CT colonography done outside VHA is acceptable.** **This question is not enabled if the patient was screened for colorectal cancer by another accepted modality within the appropriate timeframe.**
71	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 < = 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.
72	sdnatest	Does the medical record contain the report of a stool- based DNA test performed within the past year? 1. Stool-based DNA test performed by VHA 2. Stool-based DNA test performed by a private sector provider 99. No documentation of stool-based DNA test performed in the past year	1, 2, 99 If 2 or 99, auto-fill sdnadt as 99/99/9999 If ctcolon = 99 AND sdnatest = 99, go to nocrcscr; else if sdnatest = 2 or 99, go to testpap	Stool-based deoxyribonucleic acid (DNA) testing (e.g. Pre-Gen Plus) is a noninvasive test that is intended to identify the presence of genetic mutations known to be associated with colorectal cancer (CRC). ***Patient self-report of result of stool based DNA test is NOT acceptable.** **This question is not enabled if the patient was screened for colorectal cancer by another accepted modality within the appropriate timeframe.**

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
73	sdnadt	Enter the date of the most recent stool-based DNA test performed within the past year.	mm/dd/yyyy Will be auto-filled as 99/99/9999 if sdnatest = 2 or 99 < = 1 year prior or = stdybeg and < = stdyend	Enter the exact date. The use of 01 to indicate missing month or day is not acceptable.
		If ctcolon and sdnatest = 99, go to nocrcscr; else go to testpap as applicable		
74	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 mamord; else go to testpap.**		

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
75	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 3. Pap test performed by private sector provider 6. Hysterectomy or congenital absence of a cervix 7. **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 3, auto-fill paplab as 95** **If 6, 98, or 99, auto-fill papdt as 99/99/9999, paplab as 95, hpvtest as 95, hpvtstdt as 99/99/9999, hpvrslt as 95, and if age > = 40, go to mamord** **If 99 and age < 40, go to nocascrn** **If 6 or 98, and age < 40, go to end**	**Historical information obtained by telephone by a licensed member of the healthcare team and entered in a CPRS progress note is acceptable, as long as the outcome of the test is known.** Patient self-report of the result of a Pap test done outside the VHA is acceptable. **Results of Pap smear must be in the medical record for those tests done by this VAMC. Entry in the computer package is acceptable, as long as the interpretation is present.** If Pap test was done by another VAMC or private sector provider, the abstractor must be certain the Pap test was accomplished. The date is documented closely enough to be able to compute if the test was accomplished within the accepted time window. Clinically relevant documentation must also include findings, e.g., "normal." **If all pap test reports within the past five years note the sample was inadequate for evaluation, consists only of vaginal cells or that NO cervical cells (ectocervical or endocervical) were present, select "7."** **Note:** Lab results that indicate that the sample was adequate for evaluation but did not contain endocervical cells (e.g. "no endocervical cells") may be used, provided a valid result was reported for the pap test. (e.g., pap test pathology report noted, "Negative for intraepithelial lesion and malignancy, Specimen satisfactory for evaluation. No endocervical component is identified" is acceptable.) Do not count biopsies because they are diagnostic and therapeutic only and are not valid for primary cervical cancer screening. Report of the hysterectomy does not have to be present in the medical record. Notation of past hysterectomy in clinic notes, progress notes, or other source is sufficient. Notation of whether cervix is or is not still present is not applicable. Documentation of hysterectomy is sufficient. **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.**

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
76	papdt	Enter 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	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 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 TESTPAP = 6, 98, or 99, PAPDT will be auto-filled as 99/99/9999.
77	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 = 3, 6, 98, or 99 If papdt > 3 years prior to stdybeg, go to hpvtest; else go to mamord as applicable	**Only answer "1" if the pap test results are documented in the laboratory package. Do not include scanned reports located in VISTA imaging.**

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
78	hpvtest	During the timeframe from (computer to display papdt - 4 days to papdt + 4 days), does the medical record document a cervical human papillomavirus (HPV) test was performed for this patient? 1. HPV test performed by VHA 3. HPV test performed by private sector provider 99. No documentation HPV test performed	1, 3, 99 If 99, auto-fill hpvtstdt as 99/99/9999, hpvrslt as 95, and go to mamord as applicable	A HPV test is usually performed in conjunction with a pap test. For the purpose of this question, an HPV test may be obtained during the timeframe of 4 days prior and up to 4 days after the pap test date. HPV tests may be performed by the VHA or sent to non-VHA lab. Look at cervical cytology reports first because even if HPV is noted as a chemistry test, the report may be added to the cytology report. Then, if HPV test not found, do a search on the lab tab under selected lab tests and see if HPV or Human Papillomavirus is listed. **Historical information obtained by telephone by a licensed member of the healthcare team and entered in a CPRS progress note is acceptable, as long as the outcome of the HPV test is known.** Patient self-report of the result of a HPV test done outside the VHA is not acceptable. **Results of HPV test must be in the medical record for those tests done by this VAMC. Entry in the computer package is acceptable, as long as the interpretation is present.** If HPV test was done by another VAMC or private sector provider, the abstractor must be certain the HPV test was accomplished. The date is documented closely enough to be able to compute if the HPV test were accomplished within the accepted time window. Clinically relevant documentation must also include findings, e.g., "positive". **Suggested data sources: cytology reports, lab reports**
79	hpvtstdt	Enter the date of the most recent cervical HPV test performed.	mm/dd/yyyy Will be auto-filled as 99/99/9999 if testpap = 6, 98, or 99 or hpvtest = 99 < = 4 days prior to or = papdt and <= 4 days after papdt	Although the day may be entered as day = 01 if the specific date is unknown, the exact month and year must be entered accurately.

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
80	hpvrslt	What result was reported for the most recent HPV test? 1. Positive 2. Negative 95. Not applicable 99. Unable to determine	1, 2, 95, 99 Will be auto-filled as 95 if testpap = 6, 98, or 99 or hpvtest = 99	HPV test results may be reported in pap cervical cytology report or chemistry report. Example: TEST FOR HIGH RISK HPV (13 TYPES TESTED): NEGATIVE
		If female patient age > = 40, go to mamord; if female patient age < 40 and (testpap = 99 or hpvtest = 99), go to nocascrn; if female patient age < 40 and (testpap <> 99), go to end		
		Screening for Breast Cancer		
81	mamord	Did the record document a mammogram was ordered by VHA within the past 27 months? 1. Yes 2. No	1, 2 If 2, auto-fill mamordt as 99/99/9999, and go to mamgram2	Mammogram ordered = Clinician order for mammogram entered in CPRS
82	mamordt	Enter the most recent date a mammogram was ordered by VHA within the past 27 months.	mm/dd/yyyy Will be auto-filled as 99/99/9999 if mamord = 2 <= 27 months prior to or = stdybeg and <= stdyend	Enter the exact date. The use of 01 to indicate missing month or day is not acceptable.

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
83	mamgram2	Does the medical record contain the report of a mammogram performed for this patient during the timeframe from (computer to display stdybeg - 27 months to stdyend)? 1. 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 mammdt as 99/99/9999, mamperva as 95, mamrad as 95, biradcod as 95, and go to nomammo	• Historical information obtained by telephone by a licensed member of the healthcare team and entered in a CPRS progress note is acceptable, as long as the outcome of the test is known. • Results of mammogram must be in the medical record for those tests done by this VAMC. Entry in the computer package is acceptable, as long as the interpretation is present. • If mammogram was done by another VAMC or private sector provider, the abstractor must be certain the mammogram was accomplished. The date must be documented closely enough to be able to compute if the test was accomplished within the accepted time window. Clinically relevant documentation must also include the findings, e.g., "normal." • Patient self-report of the result of a mammogram done outside the VHA is acceptable. • A diagnostic mammogram is used to evaluate signs or symptoms of breast cancer and is acceptable for breast cancer screening ONLY if the diagnostic mammogram evaluates both breasts or one breast if the patient has had a unilateral mastectomy. • If the appointment for a mammogram is scheduled for a later date, and the patient has not had a mammogram within the past 27 months, answer '99.' • Patient refusal must be clearly documented in record. **Sources:** Progress notes from General Medicine, Primary Care, or Women's Health in paper record. Access VISTA Radiology or Selected Radiology or Procedures in CPRS.
84	mamperva	Was the mammogram performed by the VHA? 1. Yes 2. No	1, 2, 95 Will be auto-filled as 95 if mamgram2 = 2 or 98	Mammogram performed by VHA includes fee based mammogram ordered by VHA.

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
85	mammdt	Enter the date of the most recent mammogram reported during the past 27 months.	mm/dd/yyyy If mamgram2 = 2 or 98, will be auto-filled as 99/99/9999 If mamperva = 2 and (testpap = 99 or hpvtest = 99), go to nocascrn; else if mamperva = 2, go to bonefx as applicable < = 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.
86	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 mamgram2 = 2 or 98 If 1, go to biradcod If 2, auto-fill biradcod as 95 AND (if testpap = 99 or hpvtest = 99, go to nocascrn); (if testpap <> 99 and mammdt <= 90 days prior to or = stdyend, go to encmamm); (if testpap <> 99 and mammdt > 90 days prior to stdyend, go to bonefx as applicable)	**Do not include scanned reports located in VISTA imaging.** **Only answer "1" if the mammogram results are documented in the radiology package.** Documentation of the date of the mammogram with the BI-RAD results (e.g., Primary Diagnostic Code: BI-RAD #2 - Benign Finding) in the radiology package is acceptable. The BI-RAD categories are 0, 1, 2, 3, 4, 5, and 6.

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
87	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 mamgram2 = 2 or 98, or mamrad = 2 If testpap = 99 or hpvtest = 99, go to nocascrn If testpap <> 99 and mammdt <= 90 days prior to or = stdyend, go to encmamm; else if testpap <> 99, go to bonefx 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.
88	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 mamgram2 = 1 If 2, go to nocascrn If 1 and (testpap = 99 or hpvtest = 99), go to nocascrn; else if 1, to bonefx as applicable	Documentation the patient had two unilateral mastectomies on different dates of service is acceptable to answer "1". Patients are considered to be the gender documented in the record **unless** there is evidence of a gender change procedure in the record.

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
89	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 If mamperva = 1 and mammdt <= 90 days prior to or = stdyend, go to encmamm; else go to bonefx as applicable	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.

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
90	encmamm	During the timeframe from [computer display mammdt to mammdt + 14 days and <=pulldt or (<=stdyend if stdyend > pulldt)], did the patient have a face-to-face encounter with the VHA provider who ordered the mammogram? 1. Yes 2. No 3. No, 14 day timeframe has not elapsed 4. No, mammogram was ordered by provider at other VAMC, during ED/urgent care encounter, or during inpatient hospitalization	1, 2, 3, 4 If 2 or 3, go to comamm If 4, go to bonefx as applicable **Cannot enter 3 if mammdt > = 14 days prior to pulldt or (prior to stdyend if stdyend > pulldt)**	In order to answer this question, it is necessary to determine the VHA provider that ordered the most recent mammogram. **Ordering provider** = physician/APN/PA that ordered the test or a physician/APN/PA that is part of the same service/clinic (e.g., primary care physician orders the test and patient sees the primary care clinic PA). Per local VAMC policy, a registered nurse (RN) may be authorized to order certain lab tests. If a RN ordered the test and the patient had an encounter with the same RN within 14 days of the test, answer "1". If there is documentation that the patient had a face-to-face encounter during the specified timeframe with the provider that ordered the most recent mammogram, answer "1". If the test is ordered or obtained on the same date as the face-to-face encounter and it is not evident that the results were available to the provider by the time of the encounter, answer "2". **Only answer "3" if the patient did not have an encounter with the ordering provider of the mammogram AND the mammogram was completed less than 14 days prior to the pull list date.** Only answer "4" if the mammogram was ordered by provider at other VAMC, during an ED/urgent care encounter, or during an inpatient hospitalization.
91	encmamdt	Enter the date of the earliest face-to-face encounter with the ordering VHA provider of the mammogram within 14 days of the most recent mammogram.	mm/dd/yyyy If encmamm = 1, go to bonefx as applicable >= mammdt and <= 14 days after mammdt and <=pulldt or (<= stdyend if stdyend > pulldt)	If the patient had multiple face-to-face encounters with the ordering VHA provider of the most recent mammogram, enter the date of the earliest encounter. Enter the exact date.

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
92	comamm	During the timeframe from [computer display mammdt to mammdt + 30 days and <=pulldt or (<=stdyend if stdyend > pulldt)], was the mammogram result communicated to the patient by licensed health care staff? 1. Yes 2. No 3. No, 30 day timeframe has not elapsed	1, 2, 3 If 2 or 3, go to bonefx as applicable **Cannot enter 3 if mammdt > = 30 days prior to pulldt or (prior to stdyend if stdyend > pulldt)**	**Communication of mammogram result to the patient must be documented in the record and any of the following communication methods may be used: telephone, mailed letter, secure message, Telehealth, or face-to-face encounter.** **The documentation must indicate an attempt was made to communicate the test results to the patient; the attempt does not have to be successful.** • Letter does not have to be sent by certified mail. • Telehealth refers to real time clinic based video encounter between the patient and provider. • Secure messaging is a confidential message functionality of My HealtheVet similar to email between patient and provider for non-urgent matters. • Face-to-face encounter **Examples of acceptable documentation include:** attempted to contact patient by phone and left voice message to return call; statements indicating test results were reviewed with the patient; notations in the care plan that medications/treatments/interventions/consults were initiated/changed based on test results; or statements indicating the treatment plan was not altered or patient should continue with the current regimen based on test results. **Licensed health care staff may include, but is not limited to:Physician, APN (NP or CNS), physician assistant (PA), registered nurse, licensed practical/vocational nurse (LPN/LVN), pharmacist, psychologist, social worker** **If the mammogram result was reported from the lab at least 30 days prior to pull list date AND the mammogram result was not communicated to the patient by licensed health care staff during the specified timeframe, answer "2".** **If the mammogram result was reported from the lab <u>less</u> than 30 days prior to pull list date AND the mammogram result was not communicated to the patient, answer "3".**

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
93	comammdt	Enter the earliest date the mammogram result was communicated to the patient.	mm/dd/yyyy >= mammdt and <= 30 days after mammdt and <=pulldt or (<= stdyend if stdyend > pulldt)	If there is more than one attempt to communicate the mammogram result to the patient, enter the date of the earliest attempt. Exact date must be entered.
94	comampro	Which licensed health care staff communicated the mammogram result to the patient? 1. Physician 2. Advanced Practice Nurse (NP or CNS) 3. Registered Nurse 4. Licensed Practical (Vocational) Nurse (LPN/LVN) 5. Physician Assistant (PA) 6. Other licensed health care staff	1, 2, 3, 4, 5, 6	**Licensed health care staff may include, but is not limited to:Physician, APN (NP or CNS), physician assistant (PA), registered nurse, licensed practical/vocational nurse (LPN/LVN), pharmacist, psychologist, social worker**
95	comamet	What method was used to notify the patient of the mammogram result? 1. Telephone 2. Mailed letter 3. Secure Message 4. Clinic Based Video Telehealth 5. Face-to-face encounter	1, 2, 3, 4, 5	• Letter does not have to be sent by certified mail. • Telehealth refers to real time clinic based video encounter between the patient and provider. • Secure messaging is a confidential message functionality of My HealtheVet similar to email between patient and provider for non-urgent matters.
		If female patient age is < = 64, go out of module. If age > 64, go to bonefx.		

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
96	bonefx	Did the patient have a history of bone fracture within the past eighteen months?	1, 2 **If 2, auto-fill whenfrac as 99/99/9999, prevfx as 95, prevfxdt as 99/99/9999, prefxtst as 95, fxbmdt as 99/99/9999, and prefxmed as 95**	Past 18 months = from the first day of the study interval to the first day of the month 18 months previously **Do not include fractures of the finger, toe, face, or skull**. **If fracture occurred in any other bone, answer "yes."**
97	whenfrac	Enter the date the fracture occurred. (If more than one fracture, enter the date of the first fracture.)	mm/dd/yyyy If bonefx = 2, will be auto-filled as 99/99/9999 < = 18 mos prior to or = stdybeg and < = stdybeg	At a minimum, enter the month and year the fracture occurred. 01 may be used as default for day. If more than one fracture occurred during the period, enter the date of the first fracture.
98	prevfx	Within 60 days prior to the date of the first fracture, did the record document a previous bone fracture? 1. Yes 2. No 95. Not applicable	1, 2, 95 Will be auto-filled as 95 if bonefx = 2 If 2, auto-fill prevfxdt as 99/99/9999	**Do not include fractures of the finger, toe, face, or skull**. **If fracture occurred in any other bone, answer "yes."**
99	prevfxdt	Enter the date the previous fracture occurred.	mm/dd/yyyy Will be auto-filled as 99/99/9999 if bonefx = 2 or prevfx = 2 < = 60 days prior to whenfrac and < whenfrac	Enter the exact date. The use of 01 to indicate missing month and day is not acceptable.

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
100	prefxtst	Within 365 days prior to the first fracture, did the patient have a bone mineral density test to screen for osteopenia or osteoporosis? 1. Yes 2. No 95. Not applicable 98. Patient refused bone mineral density test	1, 2, 95, 98 If 2 or 98, auto-fill fxbmdt as 99/99/9999 If bonefx = 2, will be auto-filled as 95	Osteopenia = term is used to refer to any decrease in bone mass below the normal. Osteoporosis = a disease characterized by low bone mass and microarchitectural deterioration of bone tissue, leading to enhanced bone fragility and a consequent increase in fracture risk. Bone mineral density test: DEXA is preferred test; other tests include Quantitative computed tomography (QCT), and calcaneal ultrasonography. In order to answer "98," there must be documentation by the provider that the patient refused to have a bone mineral density test performed.
101	fxbmdt	Enter the date of the bone mineral density test done within 365 days prior to the first fracture.	mm/dd/yyyy If bonefx = 2 or prefxtst = 2 or 98, will be auto-filled as 99/99/9999 < = 365 days prior to whenfrac and < whenfrac	If exact date is unknown, 01 may be used as the default day; however, month and year must be known and entered accurately.
102	prefxmed	Within 365 days prior to the first fracture, did the patient receive medication to treat or prevent osteopenia or osteoporosis? 1. yes 2. no 95. not applicable 98. Patient refused ALL medications to treat/prevent osteoporosis	1, 2, 95, 98 If bonefx = 2, will be auto-filled as 95	Answer "1" if the patient received any of the following medications within 365 days prior to the first fracture: alendronate, risedronate, calcitonin, raloxifene, estrogen, teriparatide In order to answer "98," there must be documentation by the provider that the patient refused ALL medications used to prevent or treat osteopenia or osteoporosis.

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
103	bmdtdt	Enter the date of the patient's most recent bone mineral density test.	mm/dd/yyyy Abstractor can enter 99/99/9999 if no BMDT done If 99/99/9999, auto-fill skelsite as 95, and bonefind as 95 Warn if < age 60 and < = study end date	Bone mineral density test: DEXA (Dual-energy X-ray absorptiometry) is preferred test; other tests include Quantitative computed tomography (QCT), and calcaneal untrasonography. Look back in the patient's record to age 60 to determine whether BMDT was done and the date of screening is documented Enter the exact date if possible. If exact date cannot be determined, enter month and year at a minimum. Enter default date 99/99/9999 if no bone mineral density test can be found in the record.
104	bonescrn	Was the patient screened by one of the following bone mineral density tests: 1. Dual-energy X-ray absorptiometry (DEXA) 2. Quantitative computed tomography (QCT) 3. Calcaneal ultrasonography 4. Other 98. Patient refused bone mineral density screening 99. No documentation of bone mineral density screening	1, 2, 3, 4, 98, 99 If bmdtdt = 99/99/9999, bonescrn can only = 98 or 99	Look back in the patient's record to age 60 for BMDT. Osteoporosis involves a gradual loss of calcium, causing bones to become thinner, more fragile, and more likely to break. Dual-energy X-ray absorptiometry (DEXA) = DXA or DEXA is the established standard for measuring bone mineral density. The DEXA machine sends a thin, invisible beam of low-dose X-rays through the bones via two energy streams Quantitative computed tomography = QCT of the spine utilizes a conventional CT scanner with a calibration phantom and special software to measure vertebral bone mass. Calcaneal ultrasonography = less precise that DEXA scan but is portable and less expensive. Measurement based on two factors. i.e., broadband ultrasonic attenuation and speed of sound.
105	skelsite1 skelsite2 skelsite3 skelsite4 skelsite95 skelsite99	What was the skeletal site of testing? **Indicate all that apply:** 1. Hip 2. Forearm 3. Lumbar spine 4. Calcaneus 95. Not applicable 99. Site not documented	1, 2, 3, 4, 95, 99 If bmdtdt = 99/99/9999 or bonescrn = 98 or 99, will be auto-filled as 95	Central DEXA devices measure bone density in the hip and spine. The term "hip" also includes the femoral neck. The term "proximal femur" is also acceptable. Documentation of "femur" alone is not sufficient to indicate hip was the site. Peripheral DEXA devices measure bone density in the wrist, heel, or finger. QCT measures vertebral mass of the spine and also peripheral sites. Calcaneal ultrasonography measures only calcaneus bone mineral density Hip is the preferred skeletal site for testing. Always indicate this site if several body areas, including hip, have been tested. Do not attempt to guess site from the test administered. If site is not documented, enter "99."

<table>
<tr><th>#</th><th>Name</th><th>QUESTION</th><th>Field Format</th><th>DEFINITION/DECISION RULES</th></tr>
<tr><td>106</td><td>bonefind</td><td>What was the outcome of the bone mineral density screening?
1. Result normal
2. Result indicative of Osteopenia
3. Result indicative of Osteoporosis
95. Not applicable
99. No outcome documented</td><td>1, 2, 3, 95, 99
If bmdtdt = 99/99/9999 or bonescrn = 98 or 99, will be auto-filled as 95</td><td>T-Score WHO Criteria for Osteoporosis in Women
<table><tr><td>Normal</td><td>BMD > -1.0 below young adult reference range</td></tr><tr><td>Osteopenia</td><td>BMD is -1.0 - -2.5 SD below young adult reference range</td></tr><tr><td>Osteoporosis</td><td>BMD < -2.5 SD below young adult reference range</td></tr><tr><td>Severe Osteoporosis</td><td>BMD < -2.5 SD below young adult reference range and the patient has one or more fractures</td></tr><tr><td colspan="2">Patient self-report of BMDT done outside VHA is not acceptable.</td></tr></table></td></tr>
<tr><td>107</td><td>osteotx</td><td>Was the patient on medication to prevent or treat osteopenia or osteoporosis?
1. Bisphosphonate (Alendronate) (Risedronate)
2. Serum estrogen receptor modulator (SERM) (Raloxifene)
3. Parathyroid hormone (Calcitonin, Teriparatide)
4. Hormone therapy (estrogen)
5. Other agents (denosumab)
98. Patient refused ALL of the above medications
99. No documented medication for prevention or treatment of osteopenia/osteoporosis</td><td>1, 2, 3, 4, 5, 98, 99

If 98 or 99, auto-fill ostxdt as 99/99/9999</td><td>FDA-Approved Osteoporosis Therapies
Bisphosphonates: alendronate (Fosamax), risedronate (Actonel), ibandronate (Boniva), zoledronic acid (Zometa)
Serum estrogen receptor modulator (SERM): raloxifene (Evista)
Parathyroid hormone: Calcitonin, teriparatide (Forteo)
Hormone therapy: estrogen, estradiol, estropipate
Other agents = denosumab (Prolia)
In order to answer "98," there must be documentation by the provider that the patient refused ALL medications used to prevent or treat osteopenia or osteoporosis.</td></tr>
<tr><td>108</td><td>ostxdt</td><td>Enter the treatment start date.</td><td>mm/dd/yyyy
Abstractor can enter 99/99/9999 if treatment start date not available.
If osteotx = 98 or 99, auto-fill as 99/99/9999
> = age 60 and < = stdyend
Warning if age < 60 at start date</td><td>Check pharmacy records for start date of osteoporosis medication. If medication was prescribed by a private sector physician, look for approximate start date. Enter a date as specific as possible. If exact day is unavailable, enter exact month and year at a minimum.
If treatment start date not available, enter 99/99/9999</td></tr>
</table>