Kentucky Women's Cancer Screening Program (KWCSP)
Minimum Data Elements (MDEs) Descriptions
For the WH-58 Data Collection Form

Minimum Data Elements (MDEs)
KWCSP Data Collection Manual

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Acknowledgements

We thank Kentucky's Local Health Department staff, Custom Data Processing Inc, Information Management Services, and Centers for Disease Control and Prevention (CDC) for their immensely helpful comments and suggestions in developing this MDE Data Manual. This manual was written based on the National Breast and Cervical Cancer Early Detection Program's Data User's Manual.

We thank LHD staff for all their efforts in collecting and entering all the MDE data.

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Table of Contents

Abbreviations:

1. KWCSP: Kentucky Women's Cancer Screening Program
2. CDC: Centers for Disease Control and Prevention
3. LHD: Local Health Departments (KY Only)
4. CDP: Custom Data Processing, Inc. (KDPH Data Management Vendor)

Kentucky Women's Cancer Screening Program (KWCSP)
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A. Introduction and purpose of MDEs

This is the third release of the Minimum Data Elements (MDE) data manual by the KWCSP. The purpose of this data manual is to describe the information needed to collect MDE data for the KWCSP. The intended audience for this MDE data manual is the LHD and health system's program staff responsible for the collection and aggregation of the MDEs. This data manual provides a detailed description of thirty eight (38) data elements collected through KWCSP's data collection form, newly entitled "WH-58 form and formerly known as the "ACH-58" form. The computer screen title remains the same for the KWCSP data collection, commonly referred to as the "'cancer screen'" or "BC screen". This manual does not replace the Program's Administrative Reference (AR) and Core Clinical Service Guide (CCSG) sections, but supplements them. This manual is a work in progress. We will continue to update this manual based on recommendations from our stakeholders, Centers for Disease Control and Prevention (CDC) and from our data analysis. All drafts will be forwarded to our providers before updating this manual. We welcome your suggestions and comments about its contents.

Minimum Data Elements (MDEs)

The KWCSP collects MDE data from all providers participating in the program. The data is transmitted through the "'cancer screen'" to the Kentucky Department for Public Health data management vendor, Custom Data Processing Inc. (CDP) to the KWCSP along with patient demographic information in a standardized format. The Program receives MDE data file from CDP every month. Based on this data, the Program develops key reports and shares them with the CDP, CDC and other stakeholders. LHDs are contacted for any outstanding and pending records or to address any inconsistencies in the MDE data.

MDE's data should be collected only on women who are 21 to 64 years of age, whose income level is below 250% of the annual federal poverty guidelines and who have no Medicare, Medicaid or any private health insurance. MDE's are also collected on the Family Planning program patients who had a Pap test and qualify for KWCSP. The Program collects the MDE data electronically from LHDs in Kentucky through the "'cancer screen'". This information should be entered into the Patient Services Reporting System (PSRS) from the WH-58 form by the support staff, after a nurse completes the data form.

Core Program Performance Indicators

There are eleven core program performance indicators for the Program. These indicators were established by the CDC. The Program's goal is to meet all the indicators to justify funding from the CDC. These indicators not only provide a systematic approach for a rapid assessment but also a snapshot of the program's overall performance regarding the quality of care and efficient use of program funds. It is important that the KWCSP meets all the indicators as future funding from CDC is based on the Program's compliance in meeting or exceeding the indicators. The Program will continue to share the indicator report with our stakeholders. The incidence report data comes from the MDE data submitted to the Program.

Kentucky Women's Cancer Screening Program (KWCSP)
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The purpose of collection of MDE data is to:

1. Assure high quality services for women screened by the Program;
2. Manage the Program efficiently and effectively;
3. Prepare reports to the Kentucky State Legislatures and other Program stakeholders; and
4. Secure necessary funding from the CDC for implementing the Program.

Structure of MDE data manual

This data manual is divided into the following three chapters:

Chapter 1 General Information Data

This chapter contains five (5) data elements. The computer system automatically enters this MDE data onto the 'cancer screen' after the KWCSP data collection screen opens up on the computer system. The LHDs staff cannot modify these data elements on the 'cancer screen'. Place the label "C" on the WH-58 form containing these data elements generated by the computer system.

Chapter 2 Breast Cancer Data

This chapter contains a detailed description of each MDE data item related to the breast cancer screening, diagnostic and treatment services. This chapter is divided into the following three sections:

Section A: Breast Screening Data
Section B: Mammogram / MRI Results Data
Section C: Breast Diagnostic/Follow-up Data

Chapter 3 Cervical Cancer Data

This chapter contains a detailed description of each MDE data item related to the cervical cancer screening, diagnostic and treatment services. This chapter is divided into the following three sections:

Section A: Cervical Screening Data
Section B: Pap / HPV Test Results Data
Section C: Cervical Diagnostic/Follow-up Data

B. KWCSP Staff Contact Information

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KWCSP staff can also be reached by mail:

KY Department for Public Health
Division of Women's Health
KWCSP
275 E Main St., HS1WF
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Kentucky Women's Cancer Screening Program (KWCSP)
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C. The WH-58 Form (front)

WH-58 (a.k.a. ACH-58)

Kentucky Women's Cancer Screening Program (KWCSP) data collection form

Use this form for KWCSP-eligibles: uninsured/underinsured women, age 21- 64, at or below 250% poverty level

REQUIRED data collection that must be entered electronically for ALL KWCSP-eligible women.

Patient Name_____
First M.I. Last

PASTE "C Label" HERE

SSN: _____ Health Dept._____

Visit Date: ____/____/____
MM DD YYYY

Provider ID# _____

Prior Pap test? ( ) 1. Yes ( ) 2. No **If yes, date:** ___/____
MM YYYY

Breast Services Provided?	*Cervical Services Provided?*
( ) 1. Yes ( ) 2. No	**( ) 1. Yes ( ) 2. No**
If no, proceed to cervical section	If no, proceed to breast section

Section A. Breast Screening Data

Clinical Breast Exam (CBE):
( ) 1. Normal ( ) 2. Abnormal ( ) 3. Not Performed
CBE date: ____/____/____
MM DD YYYY

Mammogram:
( ) 1. Yes, mammogram ordered as part of routine screening
( ) 2. Yes, mammogram ordered as part of diagnostics
( ) 3. Yes, mammogram performed elsewhere, LHD now referring for diagnostics
Date referred to LHD: ____/____/____
MM DD YYYY
( ) 4. No, mammogram not performed

MRI:
( ) 1. Yes, MRI performed as primary screening
( ) 2. No, MRI not performed as primary screening

***Is client at HIGH risk for breast cancer?**
( ) 1. Yes ( ) 2. No ( ) 3. Unknown

Section A. Cervical Screening Data

Pap test:
( ) 1. Yes, Pap performed as part of routine screening
( ) 2. Yes, Pap performed as short-term follow-up
( ) 3. Yes, Pap performed elsewhere, LHD now referring for diagnostics
Date referred to LHD: ____/____/____
MM DD YYYY
( ) 4. Yes, Pap performed after primary HPV+
[This option will be available 07.2019]
( ) 5. No, Pap not performed

HPV test: ( ) 1. Co-Testing ( ) 2. Reflex ( ) 3. Test not done

***Is client at HIGH risk for cervical cancer?**
( ) 1. Yes ( ) 2. No ( ) 3. Unknown

Section B. Mammogram / MRI Results Data

***Mammogram results** (BI-RADS): ____ **Mamm date:** ___/___/____
MM DD YYYY

***MRI results** (BI-RADS): _____ **MRI date:** ___/___/____
MM DD YYYY

Diagnostic procedures (work-up) planned: ( ) 1. Yes ( ) 2. No

Section B. Pap / HPV Test Results Data

***Pap test results**: _____ **Pap date:** ____/____/____
MM DD YYYY

***HPV test results**: _____ **HPV date:** ____/____/____
MM DD YYYY

Diagnostic procedures (work-up) planned: ( ) 1. Yes ( ) 2. No

Section C. Breast Diagnostic/Follow-up Data

1. Status of Breast Diagnosis:
( ) 1. Work-up complete
( ) 2. Lost to follow-up
( ) 3. Work-up refused

4. Treatment Status:
( ) 1. Treatment started
( ) 2. Lost to follow-up
( ) 3. Treatment refused
( ) 4. Treatment not needed

2. Date of Final Diagnosis:
____/____/____
MM DD YYYY

5. Date of Treatment Status:
____/____/____
MM DD YYYY

3. Final Breast Diagnosis:
( ) 1. Ductal Carcinoma in Situ (Stage 0)
( ) 2. Invasive Breast Cancer
( ) 3. Breast Cancer not diagnosed
( ) 4. Lobular Carcinoma in Situ (Stage 0)

Section C. Cervical Diagnostic/Follow-up Data

1. Status of Cervical Diagnosis:
( ) 1. Work-up complete
( ) 2. Lost to follow-up
( ) 3. Work-up refused

4. Treatment Status:
( ) 1. Treatment started
( ) 2. Lost to follow-up
( ) 3. Treatment refused
( ) 4. Treatment not needed

2. Date of Final Diagnosis:
____/____/____
MM DD YYYY

5. Date of Treatment Status:
____/____/____
MM DD YYYY

3. Final Cervical Diagnosis:
( ) 1. Normal / Benign Reaction/Inflammation
( ) 2. HPV / Condylomata/Atypia
( ) 3. CIN1 / Mild dysplasia (biopsy diagnosis)
( ) 4. CIN2 / Moderate dysplasia (biopsy diagnosis)
( ) 5. CIN3 / Severe dysplasia/Carcinoma in Situ (stage 0)
( ) 6. Invasive Cervical Carcinoma (biopsy diagnosis)

***Denotes quick reference sections on following page**

Nurse Case Manager: _____ Date Case Closed: _____ **WH-58 (Effective 01.01.19)**

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C. The WH-58 Form (back)

WH-58 (a.k.a. ACH-58)

Kentucky Women's Cancer Screening Program (KWCSP) data collection form

Use this form for KWCSP-eligibles: uninsured/underinsured women, age 21- 64, at or below 250% poverty level

Patient Name _____
First M.I. Last

PASTE "C Label" HERE

SSN: _____ Health Dept. _____

POWERED BY CDC SCREENOUTCANCER National Breast & Cervical Cancer Early Detection Program

QUICK REFERENCE – For WH-58 front page

***BREAST Cancer Risk Assessment**

1 = YES, client is high risk because ONE of the following is true:
- Woman with BRCA mutation
- Has a first-degree relative with a history of premenopausal breast cancer or known BRCA mutation
- Has a lifetime risk of 20-25% or greater as defined by a risk assessment model
- A history of radiation treatment to the chest wall
- Personal or family history of genetic syndromes such as Li-Fraumeni syndrome

2 = NO, client is not high risk

3 = UNKNOWN, risk is unknown

***CERVICAL Cancer Risk Assessment**

1 = YES, client is high risk because ONE of the following is true:
- Woman with a history of CIN2 or CIN3 or cervical cancer
- Intrauterine exposure to DES
- Immunocompromised

2 = NO, client is not high risk

3 = UNKNOWN, risk is unknown

***MAMM / MRI (BI-RADS) results**

0 = Assessment is Incomplete

1 = Negative

2 = Benign Finding

3 = Probably Benign

4 = Suspicious Abnormality

5 = Highly Suggestive of Malignancy

6 = Known Biopsy-Proven Malignancy

U = Technically Unsatisfactory (not a BI-RADS)
Image could not be read by radiologist

***PAP TEST results**

1 = Negative for Intraepithelial Lesion or Malignance

2 = Atypical Squamous Cells of Undetermined Significance (ASC-US)

3 = Atypical Squamous Cells Cannot Exclude High Grade Lesions (ASC-H)

4 = Low Grade SIL (CIN I, Mild Dysplasia including HPV changes)

5 = High Grade SIL (CIN II, CIN III, Moderate-Severe Dysplasia, CIS)

6 = Squamous Cell Carcinoma

7 = Adenocarcinoma or Adenocarcinoma-in-Situ

8 = Unsatisfactory

9 = Atypical Glandular Cell of Undetermined Significance (AGC)

***HPV TEST results**

1 = Positive with positive genotyping (types 16 or 18)

2 = Positive with negative genotyping (positive HPV, but not types 16 or 18)

3 = Positive with genotyping not done

4 = Negative

9 = Unknown

RECOMMENDED Patient Education and Counseling – on ALL women with an abnormal test result

BREAST Cancer Risk Factors

____ Female age 40 or older
____ 1st degree relative (mother, sister, daughter) with history of breast cancer prior to age 50
____ Close relative with a male breast cancer or a known BRCA mutation
____ Personal history of benign breast condition
____ Early menarche (prior to age 12)
____ Late menopause (after age 52)
____ No pregnancies or 1st pregnancy after age 30
____ Hormone use: some oral contraceptives and/or combination hormone replacement therapy
____ Use of the drug diethylstilbestrol (DES) or intrauterine exposure to DES
____ Overweight/Obese (especially after menopause)
____ Lack of physical activity
____ Alcohol consumption – risk increases with amount consumed

Date assessed/counseled on breast cancer risks_____/_____/_____

CERVICAL Cancer Risk Factors

____ History of HPV and/or dysplasia
____ Multiple (3+) sexual partners in lifetime
____ A sex partner with multiple sex partners
____ A sex partner who has had a partner with HPV/dysplasia/cervical cancer
____ Cigarette smoking
____ Beginning sexual intercourse at a young age (18 or younger)
____ Intrauterine exposure to DES
____ Infrequent screening (≥5 years since last Pap)
____ Immunosuppressed-HIV/AIDS, diabetes, transplant recipient, chronic steroid use
____ Other auto-immune disorders_____

Date assessed/counseled on cervical cancer risks_____/_____/_____

PATIENT NOTIFICATION of abnormal results

____ Telephone Call Date & Response _____
____ Letter #1 Date & Response _____
____ Certified Letter Date & Response _____
____ Home Visit Date & Response _____
____ Face to Face Date & Response _____

PATIENT Cancer Screening Cycle SUMMARY

Procedure	Date	Results & Follow-up
Annual/Initial Exam		
CBE		
Screening mammogram		
FINAL breast diagnosis		
Pap test		
HPV test and/or vaccine		
FINAL cervical diagnosis		
Initiation of Treatment		
NEXT Breast Screening due:		
NEXT Cervical Screening due:		

BREAST and CERVICAL diagnostic / treatment procedures

Procedure	Date	Findings & Follow-up
Diagnostic mammogram		
Ultrasound		
MRI		
Surgical or GYN Consult		
Breast Biopsy/Aspiration		
Colposcopy & Biopsy		
Endometrial Biopsy		
Cryotherapy or LEEP		
Cold knife cone		

WH-58 (Effective 01.01.19)

D. KWCSP Audit Reports (E-reports):

A. Provided by CDP to all Local Health Departments and/or health systems each month.
B. Download E-reports from the CDP website on a monthly basis – please check with the CDP regarding access to E-reports.
C. E-reports run on different scheduled dates in a month.
D. Send questions or suggestion to Sivaram "Ram" Maratha to improve the timeliness completeness and accuracy of the reporting.

E-reports for KWCSP:

323 (Cervical Cancer Screening Report): This report provides a list of Pap and HPV tests performed through the Local Health Departments (LHDs) and reported through the Patient Encounter Reporting System (PERS) or Supplemental Reporting System (SRS). This report is also called the Pap log report. This report is scheduled to run on 25th or next business day of each month.

676 (Breast Cancer Screening and Diagnostic Report): This report provides a list of screening, diagnostic mammograms and ultrasounds reported through the PERS or SRS. This report is also called the Mam log report. This report is scheduled to run on 25th or next business day of each month.

1709 (BC Screen Missing Data Report): This report provides a list of all breast and cervical cancer records that have incomplete MDE data or records that need to have MDE data collection screens. This report is scheduled to run on 25th or next business day of each month.

1706 (Breast Cancer Final Diagnostic Pending Report): This report provides a list of all diagnostic pending records for breast cancer. To complete these records, data from the WH-58 form must be entered on to the BC screen. The records from this report will be removed only after the required data is entered on the BC screen. This report is scheduled to run on 25th or next business day of each month.

1707 (Cervical Cancer Final Diagnostic Pending Report): This report will list all diagnostic pending records for cervical cancer. To complete these records, data from the WH-58 form must be entered on the BC screen. The records from this report will be removed only after the required data is entered on the BC screen. This report is scheduled to run on 25th or next business day of each month. This report is scheduled to run on 25th or next business day of each month.

2646 (Cervical Cancer Lost to Follow-up or Work-up Refused): This report provides a list all cervical cancer BC records that have been reported to the KWCSP either as Lost to Follow-up or Work- up Refused. This report will help LHDs track women who had an abnormal Pap test but did not receive the required follow-up. These women are at high risk of developing cervical cancer. This report is scheduled to run on 25th or next business day of each month.

2647 (Breast Cancer lost to Follow-up or Work-up Refused): This report provides a list all breast cancer BC records that have been reported to the KWCSP either as Lost to Follow-up or Work- up Refused. This report will help LHDs track women who had an abnormal clinical breast exam or mammogram, but did not receive the required follow-up. These women are at high risk of developing breast cancer. This report is scheduled to run on 25th or next business day of each month.

2649 (Duplicate MDE records Report): This report provides a list of all duplicate MDE records that need to be corrected. This report is scheduled to run on 25th or next business day of each month.

2653 (KWCSP Clinical Services Reimbursement Report): This is an explanation of benefits report for clinical services provided by or through the LHDs. Amounts calculated on this report is a potential reimbursement amounts. The actual amount will be determined once the amounts are compared to the allocations by the Department for Public Health. This report is scheduled to run on 25th or next business day of each month.

2654 (Duplicate Cancer CPT Codes): This report provides a list of all the KWCSP approved CPT codes that have been entered twice in the PERS. Payments to the LHDs will not be made for these clinical services until they are all corrected. This report is scheduled to run on 25th or next business day of each month.

E-reports for Family Planning

2663 (Family Planning Clinical Services Reimbursement Report): This is an explanation of benefits report for Family Planning program clinical services provided by or through the LHDs. Amounts calculated on this report is a potential reimbursement amounts. The actual amount will be determined once the amounts are compared to the allocations by the Department for Public Health. This report is scheduled to run on 25th or next business day of each month.

These reports can be downloaded on 25th each month, (or the next business day if the 25th falls on a weekend). Download these reports monthly to identify records with missing MDE data. Enter the missing information for each record on the 'cancer screen' and hit '**re-transmit'**. Completing these records will assist the KWCSP to meet the CDC's core program performance indicators, provide timely and complete MDE data to CDC and also secure federal funding for the program.

Please contact CDP (Gary Causey: gcausey@customdatainc.com or by phone: 502-695-1999) or Sivaram "Ram" Maratha: sivaramr.maratha@ky.gov or by phone: 502-564-3236 ext. 4161), if you are unable to download these reports or have any questions.

Kentucky Women's Cancer Screening Program (KWCSP)
Minimum Data Elements (MDEs) Descriptions
For the WH-58 Data Collection Form

Chapter 1: General Information Data

Item No: 1
Item Name: **Client**
Will always be 30 for Kentucky.
Automatically entered by the system and cannot be modified.

Item No: 2
Item Name: **Hid/Loc/S**
Valid Health Department ID.
3-digit district number/ 3-digit county number/ alphabetic site.
Automatically entered by the system and cannot be modified.

Item No: 3
Item Name: **Patient ID**
Valid patient ID in the patient master file.
Automatically entered by the system and cannot be modified.

Item No: 4
Item Name: **Visit Date**
The date the record was created in the system.
Automatically entered by the system and cannot be modified.
Form = MMDDYYYY

Item No: 5
Item Name: **Provider ID**
Provider ID for CBE, Pap or mammogram.
Must be a valid provider on file.
Automatically entered by the system and cannot be modified.

Note:

Valid Codes:
C = Change Record
D = Delete Record

Chapter 2: Breast Cancer Data

Item No: 6

Item Name: **Breast Services Provided?**

Purpose: To determine if clinical breast exam (CBE)/mammogram/breast diagnostic services were performed.

Type: Numeric

Skip Pattern: This data item should always be completed.

Cancer Screen: Breast Services Provided

Contents: 1 = Yes
2 = No

Explanation: Report 1, if patient had a CBE, mammogram or breast diagnostic service.

Report 2, if the patient had cervical cancer services only.

Example: A CBE was performed: 1.

Notes: Do **NOT** complete Breast Cancer Sections if you mark Breast Services Provided as "No".

Item No: 7

Item Name: **Clinical Breast Exam (CBE)**

Purpose: The provider's assessment of the CBE.

Type: Numeric

Skip Pattern: This data item should always be completed.

Cancer Screen: CBE

Contents:

If Yes,
1 = Normal
2 = Abnormal

If No,
3 = Not performed

Explanation: This data item notes whether the nurse reported breast symptoms or not.

If CBE result is a 2, the abnormal follow-up section of the MDEs should be completed, regardless of the initial mammogram findings.

If CBE result is a 1, or 3, no further follow up information regarding CBE is required for this screening cycle.

Example: A CBE was performed with normal findings: 1.

Notes:

Item No: 8

Item No: **Date of Clinical Breast Exam (CBE)**

Purpose: To specify date of the CBE.

Type: Numeric

Skip Pattern: If data item 7 (CBE was performed?) is 1, this data item should be completed; otherwise it should be left blank.

Cancer Screen: Dt

Contents: An 8-digit numeric data item of the form MMDDYYYY, where MM is a number from 1 to 12, DD is a number from 1 to 31, and YYYY is the year of the CBE.

Explanation: Self-explanatory

Example: CBE was performed on January 14, 2019: 01142019.

Notes:

Chapter 2: Breast Cancer Data **Section A: Breast Screening Data**

Item No: 9

Item Name: **Mammogram**

Purpose: To determine if a mammogram was ordered.

Type: Numeric

Skip Pattern: This data item **should always** be completed, if the data item "breast services provided" was marked as YES.

Cancer Screen: MAM

Contents:
1 = Yes, mammogram ordered as part of routine screening
2 = Yes, mammogram ordered as part of diagnostics
3 = No, mammogram performed elsewhere and LHD referred this patient for diagnostic services*
4 = No, mammogram not performed

Explanation: Report "1" if a routine screening mammogram was ordered.
Report "2" if a diagnostic mammogram was performed as additional evaluation of a recent mammogram prior to this screening cycle. An example can be a short term follow-up.
Report "3" if neither CBE nor a mammogram were performed. The patient visited the LHD for cervical cancer services only.
Report "4" if a woman goes directly to the diagnostic work-up without having a screening mammogram/CBE performed. The women had these services done elsewhere before arriving at the LHD.
Report "5" if only CBE was performed and a mammogram was not performed. For example, the woman moved, refused, did not keep appointment, the test was not appropriate for this woman at this time or recently had a mammogram.

Example: Woman did not keep an appointment for the screening mammogram: 4.

Notes:

Item No: 10

Item No: **Date referred to LHD**
(No, Mammogram not performed, referred in for diagnostic services)

Purpose: To specify a diagnostic referral date.

Type: Numeric

Skip Pattern: If data item 9 (Mammogram) was reported as 4, this data item should be completed; otherwise it should be left blank.

Cancer Screen: Ref Dt

Contents: An 8-digit numeric data item on the form MMDDYYYY, where MM is a number from 1 to 12, DD is a number from 1 to 31, and YYYY is the year of breast diagnostic referral date.

Explanation: The date the nurse case manager called provider's office to schedule an appointment for the patient for other diagnostic services.

Example: A woman was referred for an ultrasound service on January 10, 2019 following an abnormal CBE provided on January 10, 2019: 01102019.

Notes:

Chapter 2: Breast Cancer Data **Section A: Breast Screening Data**

Item No: 11

Item Name: **MRI**

Purpose: To determine if an MRI was performed as a screening procedure.

Type: Numeric

Skip Pattern: This data item **should always** be completed.

Cancer Screen: MRI

Contents: 1 = Yes, MRI performed as primary screening.
2 = No, MRI not performed as primary screening.

Explanation: Self-explanatory

Example: MRI was performed as screening procedure: 1.

Notes:

Chapter 2: Breast Cancer Data **Section A: Breast Screening Data**

Item No: 12

Item Name: ***Is client at HIGH risk for breast cancer?**

Purpose: To determine the women's breast cancer risk.

Type: Numeric

Skip Pattern: This data item **should always** be completed.

Cancer Screen: Client High Risk for Cancer

Contents:
1 = Yes
2 = No
3 = Unknown

Explanation: Report "1" if one of the following is true:

- Woman with BRCA mutation
- Has a first-degree relative with a history of premenopausal breast cancer or known BRCA mutation
- Has a lifetime risk of 20-25% or greater as defined by a risk assessment model
- A history of radiation treatment to the chest wall
- Personal or family history of genetic syndromes such as Li-Fraumeni syndrome

Report "2" if the client is not at risk

Report "3" if the risk is unknown

Example: Breast cancer risk assessment of the patient was high: 1.

Notes: *Denotes quick reference on back of form

Chapter 2: Breast Cancer Data **Section B: Mammogram / MRI Results Data**

Item Number: 13

Item Name: ***Mammogram Results (BIRADS)**

Purpose: To report results of mammography using the American College of Radiology lexicon.

Type: Alpha-Numeric

Skip Pattern: This data item **should always** be completed if woman had a mammogram.

Cancer Screen: Mam Results

Contents:
0 = Assessment is Incomplete
1 = Negative
2 = Benign Finding
3 = Probably Benign
4 = Suspicious Abnormality
5 = Highly Suggestive of Malignancy
6 = Known Biopsy-Proven Malignancy
U = Unsatisfactory

Explanation: The intent for the response category 0 (Assessment is incomplete) is to represent those instances where radiologic assessment is incomplete. For example, additional views are needed to arrive at a final interpretation of the mammogram films. This data item should always be completed even if the initial mammogram is a diagnostic mammogram and not a screening mammogram.

"U" (unsatisfactory) applies if the mammogram was technically unsatisfactory and could not be interpreted by the radiologist. Mammograms with unsatisfactory results must be repeated. The Program will not reimburse for mammograms that have unsatisfactory results.

Example: Screening mammogram result is Negative: 1.

Notes: *Denotes quick reference on back of form

Chapter 2: Breast Cancer Data **Section B: Mammogram / MRI Results Data**

Item No: 14

Item Name: **Date of Mammogram**

Purpose: To specify date of the initial mammogram.

Type: Numeric

Skip Pattern: If data item 13 (Mammogram Results, BIRADS) is reported, this data item must be completed; otherwise should be left blank.

Cancer Screen: Mam Dt

Contents: An 8-digit numeric data item of the form MMDDYYYY, where MM is a number from 1 to 12, DD is a number from 1 to 31, and YYYY is the year of the mammogram.

Explanation: Self-explanatory

Example: Mammogram was performed on January 5, 2019: 01052019.

Notes:

Chapter 2: Breast Cancer Data **Section B: Mammogram / MRI Results Data**

Item Number: 15

Item Name: ***MRI Results (BIRADS)**

Purpose: To report results of MRI using the American College of Radiology lexicon.

Type: Alpha-Numeric

Skip Pattern: This data item **should always** be completed if woman had a MRI.

Cancer Screen: MRI Results

Contents:
0 = Assessment is Incomplete
1 = Negative
2 = Benign Finding
3 = Probably Benign
4 = Suspicious Abnormality
5 = Highly Suggestive of Malignancy
6 = Known Biopsy-Proven Malignancy
U = Unsatisfactory

Explanation: The intent for the response category 0 (Assessment is incomplete) is to represent those instances where radiologic assessment is incomplete. For example, additional views are needed to arrive at a final interpretation of the MRI films.

This should be distinguished from when a clinical assessment is incomplete. For example there is a final interpretation of the mammogram with a reported response category 1-5, but diagnostic work-up, such as a biopsy, is necessary to arrive at a more definitive diagnosis.

Example: MRI result is Negative: 1.

Notes: *Denotes quick reference on back of form

Chapter 2: Breast Cancer Data **Section B: Mammogram / MRI Results Data**

Item No: 16

Item Name: **Date of MRI**

Purpose: To specify date of the initial MRI.

Type: Numeric

Skip Pattern: If data item 13 (MRI Results, BIRADS) is reported, this data item must be completed; otherwise should be left blank.

Cancer Screen: MRI Dt

Contents: An 8-digit numeric data item of the form MMDDYYYY, where MM is a number from 1 to 12, DD is a number from 1 to 31, and YYYY is the year of the MRI.

Explanation: Self-explanatory

Example: MRI was performed on January 5, 2019: 01052019.

Notes:

Chapter 2: Breast Cancer Data **Section B: Mammogram / MRI Results Data**

Item No: 17

Item Name: **Diagnostic procedures (work-up) planned for Breast Cancer**

Purpose: To indicate the clinical recommendation for immediate diagnostic work-up.

Type: Numeric

Skip Pattern: This data item **should always** be completed.
Automatically filled by the system and can be modified.
If reported as 1, then Section C. Breast Diagnostic/Follow-up Data must be completed.

Cancer Screen: Diagnostic Work-up Planned

Contents: 1 = Yes
2 = No

Explanation: This data item was created to eliminate confusion about which women are to have diagnostic procedures (work-up). This item should reflect the clinical recommendation for diagnostic procedures (work-up).

If data item 13 (Mammogram / MRI Results, BIRADS) is 4, 5 or 6 or if data item 6 (CBE performed?) is 2, this item must be reported as "1" and the Breast Diagnostic/Follow-up Data section must be completed.

All women who have a diagnostic work-up should have a response for the diagnostic procedures, final diagnosis, status of final diagnosis, and date of final diagnosis data items. Additionally, for those women who received any type of breast imaging procedure including film comparison, a final imaging outcome result must be reported. Furthermore, for some women it may be necessary to complete the Treatment Status and Date of Treatment Status.

Example: Diagnostic work-up is planned: 1.

Notes:

Chapter 2: Breast Cancer Data **Section C: Breast Diagnostic/Follow-up Data**

Item No: 18

Item Name: **Status of Final Breast Diagnosis**

Purpose: To specify status of final breast diagnosis.

Type: Numeric

Skip Pattern: This data item should always be completed if data item 17 (Diagnostic Procedures (work-up) Planned) for breast cancer is reported as 1.

Cancer Screen: Status of Dx

Contents:
1 = Work-up complete
2 = Lost to follow-up
3 = Work-up refused

Explanation: A status of Work-up complete means that the diagnostic testing is complete, and that final diagnosis and date of final diagnosis are known.

Lost to Follow-up should only be reported when efforts to track the woman have been attempted, but have failed regardless of whether the reason is known (i.e., death, moved). If a woman does not keep an appointment to have the diagnostic procedure, then this data item should be reported as 4.

LHDs should document more detailed information in the medical record about each case reported to the Program as Lost to follow-up/Work-up refused. This documentation should include all tracking efforts.

Notes:

Chapter 2: Breast Cancer Data **Section C: Breast Diagnostic/Follow-up Data**

Item No: 19

Item Name: **Date of Final Diagnosis**

Purpose: To specify date of final diagnosis.

Type: Numeric

Skip Pattern: If data item 17 (Status of Breast Diagnosis) is reported as 1, 2 or 3, this item should be completed; otherwise it should be left blank.

Cancer Screen: Final Dt

Contents: An 8-digit numeric data item of the form MMDDYYYY, where MM is a number from 1 to 12, DD is a number from 1 to 31, and YYYY is the year of final diagnosis.

Explanation: This data item should be used for reporting the date the clinical diagnosis is made, or the date on which the clinical decision is made that no cancer or cancer is present. **If more than one diagnostic procedure was performed, then use the date of the procedure that provided the definitive diagnosis.**

The date of final diagnosis is an important outcome measure for the Program.

Measures such as time from screening to diagnosis and time from diagnosis to treatment are calculated using this date.

If a woman dies before the diagnostic work-up is started, enter the date of death as the date of medical record closeout date.

Notes:

Chapter 2: Breast Cancer Data **Section C: Breast Diagnostic/ Follow-up Data**

Item No: 20

Item Name: **Final Breast Diagnosis**

Purpose: To specify final breast diagnosis.

Type: Numeric

Skip Pattern: This data item should always be completed if data item 17 (Diagnostic Procedures (work-up) Planned) for breast cancer is reported as 1 and also if data item 18 (Status of Breast diagnosis) is reported as 1, this item should be completed; otherwise it should be left blank.

Cancer Screen: Final Dx

Contents:
1 = Ductal Carcinoma in Situ (Stage 0)
2 = Invasive Breast Cancer
3 = Breast Cancer not Diagnosed
4 = Lobular Carcinoma in Situ (Stage 0)

Explanation: Final diagnosis is an important outcome measure for the Program. Thus it is especially important this data item be complete, timely, and of high quality.

Notes:

Chapter 2: Breast Cancer Data **Section C: Breast Diagnostic/Follow-up Data**

Item No: 21

Item Name: **Treatment Status**

Purpose: To specify status of standard treatment for breast cancer.

Type: Numeric

Skip Pattern: If data item 20 (Final Breast Diagnosis) is 1 (Ductal Carcinoma In Situ (Stage 0)), or 2 (Invasive Breast Cancer), this item must be completed; otherwise it should be left blank.

If data item 20 (Final Breast Diagnosis) is 3 (Breast Cancer not diagnosed), this item should be left blank.

If data item 20 (Final Breast Diagnosis) is 4 (Lobular Carcinoma in Situ), this item may be completed.

Cancer Screen: Treatment Status

Contents:
1 = Treatment started
2 = Lost to follow-up
3 = Treatment refused
4 = Treatment not needed

Explanation: The Program requires the reporting of standard or conventional treatments.

Non-standard or alternative treatments should not be reported as "1" (Treatment Started).

Report "1" for experimental drugs, such as those used in clinical trials.

The fact that a woman is referred for standard treatment is NOT a sufficient confirmation that treatment has been started. A woman should be classified as having started treatment when the nurse has confirmed that a plan for standard treatment of the cancer or pre-cancerous lesion has been developed and started.

(Explanation continued)

Report "3" in the event the woman chooses a form of non-standard or alternative treatment.

A response of "4' (Treatment not needed) should be used in instances where the doctor and the woman jointly agree treatment would adversely affect the woman's quality of life. This often occurs with late or end stage cancers.

In some instances, a diagnostic procedure may also constitute treatment. In these cases, the procedure should be reported in the diagnostic procedures section, Date of Final Diagnosis and a Final Diagnosis should be reported.

In few instances, the Date of Final Diagnosis and Date of Treatment may be the same.

A list of standard treatment options for in situ and invasive breast cancer:

Mastectomy
Lumpectomy; Excisional Biopsy; Tylectomy
Re-excision of the Biopsy site
Wedge Resection
Quadrantectomy
Radiation Therapy
Chemotherapy
Hormonal Therapy
Bone Marrow Transplant

Notes:

Chapter 2: Breast Cancer Data **Section C: Breast Diagnostic/Follow-up Data**

Item No: 22

Item Name: **Date of Treatment Status**

Purpose: To specify date of treatment status.

Type: Numeric

Skip Pattern: If data item 21 (Treatment Status) is 1, 2, 3 or 4, this data item should be completed; otherwise it should be left blank.

Cancer Screen: Treatment Status Date

Contents: An 8-digit numeric data item of the form MMDDYYYY, where MM is a number from 1 to 12, DD is a number from 1 to 31, and YYYY is the year of treatment status.

Explanation: Refer to explanation in data item 21 (Treatment Status).

Notes:

Chapter 3: Cervical Cancer Data

Item No: 23

Item Name: **Prior Pap test?**

Purpose: To determine if a woman has had a prior Pap test.

Type: Numeric

Skip Pattern: This data item **should always** be completed.

Cancer Screen: Prior Pap

Contents:
1 = Yes
2 = No

Explanation: For the first Pap test record for a woman, this data item should be reported either as 1 or 2. For subsequent records, this data item should be reported as 1.

Notes:

Chapter 3: Cervical Cancer Data

Item No: 24

Item Name: **Date of Prior Pap test**

Purpose: To specify date of prior Pap Test.

Type: Numeric

Skip Pattern: If data item 23 (Prior Pap Test) is 1, this data item should be completed; otherwise it should be blank.

Cancer Screen: Prior Pap Dt

Contents: A 6-digit numeric data item of the form MMYYYY, where MM is a number from 1 to 12 and YYYY is the year of the Prior Pap Test.

If the year of Prior Pap test is known, but not the month, enter 99 for the month with "99" (e.g., 992001).

For the first Pap test record for a woman, a date should be provided if data item 23 (Prior Pap Test) is 1; otherwise it should be left blank.

Explanation: Self-explanatory

Example: If a Pap test was performed in December 2001: 122001.

Notes:

Chapter 3: Cervical Cancer Data

Item No: 25

Item Name: **Cervical Services Provided?**

Purpose: To determine if Pap test/HPV/cervical diagnostic services were performed.

Type: Numeric

Skip Pattern: This data item should always be completed.

Cancer Screen: Cervical Services Provided

Contents:
1 = Yes
2 = No

Explanation: Report 1, if patient had a Pap/HPV/cervical diagnostic services completed.
Report 2, if the patient had breast cancer services only.

Example: A Pap test was performed: 1.

Notes: Do **NOT** complete Cervical Cancer Sections if you mark Cervical Services Provided as "no".

Item No: 26

Item Name: **Pap test**

Purpose: To determine if a Pap test was performed.

Type: Numeric

Skip Pattern: This data item **should always** be completed.

Cancer Screen: Pap

Contents:

1. Yes, Pap performed as part of routine screening
2. Yes, Pap performed as short-term follow-up
3. Yes, Pap performed elsewhere, LHD now referring for diagnostics
4. Yes, Pap performed after primary HPV+
   [*This option will be available 07.2019*]
5. No, Pap not performed

Explanation: Report "1" if the Pap test was performed as part of a routine screening schedule.

Report "2" if the Pap test was performed as part of a repeat Pap test for a short term follow-up.

Report "3" if the patient had a Pap test elsewhere and came to the LHD for cervical diagnostic testing because of an abnormal Pap test result testing or diagnostic work-up.

Report "5" if a Pap test was not performed. For example, the woman moved, refused, did not keep appointment, the test was not appropriate for this woman at this time, recently had a hysterectomy or she had a recent Pap test.

Example: The patient had a routine Pap test: 1.

Notes:

Definition:

Short Term Follow-up: Short term follow-up is defined as cases in which the provider decides that further diagnostic work-up is not needed at this time, and there is a **planned delay** between the current and the subsequent visit for the woman. Short term follow-up begins a new cycle in the MDEs, as opposed to immediate diagnostic follow-up which is reported in the same MDE cycle with the screening test that indicated the need for immediate diagnostic evaluation. Short term follow-up is defined by the provider's intent.

It is not the amount of time that passes between tests, but rather the reason the amount of time passed: was it on purpose or could the test have been done earlier? A planned delay, such as a clinician wanting some time to pass before re-evaluating would begin a new cycle. If the clinician wanted immediate diagnostic tests, but the tests were delayed by the woman or a scheduling problem, then the tests are a continuation of the abnormal screening cycle.

For example, often a physician will recommend a repeat Pap test in six (6) months based on a previous diagnostic test results. In the MDEs, the short term repeat Pap test begins a new MDE record.

Notes:

Chapter 3: Cervical Cancer Data **Section A: Cervical Screening Data**

Item No: 27

Item No: **Date referred into LHD/KWCSP**

Purpose: To specify a diagnostic referral date.

Type: Numeric

Skip Pattern: If data item 26 (**Pap test**) was reported as 3, this data item should be completed; otherwise it should be left blank.

Cancer Screen: Ref Dt

Contents: An 8-digit numeric data item of the form MMDDYYYY, where MM is a number from 1 to 12, DD is a number from 1 to 31, and YYYY is the year of cervical diagnostic referral date.

Explanation: The date that outside provider contacted the LHD to refer the patient to the KWCSP for program services.

Notes:

Chapter 3: Cervical Cancer Data **Section A: Cervical Screening Data**

Item No: 28

Item Name: **HPV test**

Purpose: To indicate if HPV test was performed.

Type: Numeric

Skip Pattern: This data item **should always** be completed.

Cancer Screen: HPV

Contents: 1 = Co-testing
2 = Reflex
3 = Test not done

Explanation: The contents will allow LHDs to report on HPV testing.

Example: HPV test was performed: 1.

Notes:

Chapter 3: Cervical Cancer Data **Section A: Cervical Screening Data**

Item No: 29

Item Name: ***Is client at HIGH risk for cervical cancer?**

Purpose: To determine the women's cervical cancer risk.

Type: Numeric

Skip Pattern: This data item **should always** be completed.

Cancer Screen: Client High Risk for Cancer

Contents:
1 = Yes
2 = No
3 = Unknown

Explanation: Report "1" if one of the following is true:
- Woman with a history of CIN2/CIN3/cervical cancer
- Has Intrauterine exposure to DES
- Immunocompromised

Report "2" if the client is not at risk

Report "3" if the risk is unknown

Example: Cervical cancer risk assessment of the patient was high: 1.

Notes: *Denotes quick reference on back of form

Chapter 3: Cervical Cancer Data **Section B: Pap / HPV Test Results Data**

Item No: 30

Item Name: ***Pap test results (Bethesda 2001)**

Purpose: To report results of screening Pap test using the 2001 Bethesda System for reporting cervical cytologic diagnoses.

Type: Numeric

Skip Pattern: If data item 26 (Pap test) is reported as 1, 2 or 3 this data item should be completed; otherwise it should be left blank.

Cancer Screen: Pap Results

Contents:
1 = Negative for Intraepithelial Lesion or Malignancy
2 = Atypical Squamous Cells of Undetermined Significance (ASC-US)
3 = Atypical Squamous Cells Cannot Exclude High Grade Lesions (ASC-H)
4 = Low Grade SIL including HPV changes
5 = High Grade SIL
6 = Squamous Cell Carcinoma
7 = Adenocarcinoma or Adenocarcinoma in Situ (AIS)
8 = Unsatisfactory
9 = Abnormal Glandular Cells (Atypical (AGC)

Explanation: A response of 1 is used to indicate there is no cellular evidence of neoplasia whether or not there are any organisms or other non-neoplastic findings such as reactive changes, inflammation or atrophy. A result of hyperkeratosis should be reported as a 1 in the Pap test screening results. Atypia or Atrophic Atypia belongs in category 2.

Notes: Do not report Vaginal Pap test data on the data collection screen.
*Denotes quick reference on back of form

Chapter 3: Cervical Cancer Data **Section B: Pap / HPV Test Results Data**

Item No: 31

Item Name: **Pap date**

Purpose: To specify date of Pap test.

Type: Numeric

Skip Pattern: If data item 30 (Pap test results) is from 1 to 9, this data item should be completed; otherwise, it should be left blank.

Cancer Screen: Pap Dt

Contents: An 8-digit numeric data item of the form MMDDYYYY, where MM is a number from 1 to 12, DD is a number from 1 to 31, and YYYY is the year of the Pap test.

Example: If a Pap test was performed on January 5, 2019: 01052019.

Explanation: Self-explanatory

Notes:

Chapter 3: Cervical Cancer Data **Section B: Pap / HPV Test Results Data**

Item No: 32

Item Name: ***HPV test result**

Purpose: To report results of a high risk HPV test.

Type: Numeric

Skip Pattern: If data item 28 (HPV test) is reported as 1 or 2, this data item should be completed; otherwise, it should be left blank.

Cancer Screen: HPV Results

Contents:
1 = Positive with positive genotyping (types 16 or 18)
2 = Positive with negative genotyping (positive HPV, but not types 16 or 18)
3 = Positive with genotyping not done
4 = Negative
9 = Unknown

Explanation: Self-explanatory

Example: HPV test result was positive with positive genotyping (types 16 or 18): 1.

Notes: *Denotes quick reference on back of form

Chapter 3: Cervical Cancer Data **Section B: Pap / HPV Test Results Data**

Item No: 33

Item Name: **HPV date**

Purpose: To specify the date of HPV test.

Type: Numeric

Skip Pattern: If data item 28 (HPV test?) is reported as 1 or 2, this data item should be completed; otherwise, it should be left blank.

Cancer Screen: HPV Dt

Contents: An 8-digit numeric data item of the form MMDDYYYY, where MM is a number from 1 to 12, DD is a number from 1 to 31, and YYYY is the year of the screening Pap test.

Example: If a HPV was performed on January 5, 2019: 01052019.

Explanation: Self-explanatory

Notes:

Chapter 3: Cervical Cancer Data **Section B: Cervical Diagnostic/Follow-up Data**

Item No: 34

Item Name: **Diagnostic procedures (work-up) planned for Cervical Cancer**

Purpose: To indicate the clinical recommendation for immediate diagnostic procedures (work-up) planned.

Type: Diagnostic Work-up Planned

Skip Pattern: If data item 26 (Pap test) is reported as 1, 2, 3 or 4 this data item should be completed. Automatically filled in by the system and can be modified.
If data item is reported as 1, then the Cervical Diagnostic/Follow-up Data section must be completed.

Cancer Screen: Diagnostic Work-up Planned

Contents: 1 = Yes
2 = No

Explanation: This data item should reflect the clinical recommendation for diagnostic procedures (work-up).

If Pap test results are either 3, 5, 6 or 9, the diagnostic procedures (Work-up) planned for cervical cancer must be set to 1.

Example: Diagnostic procedures (work-up) is planned: 1.

Notes:

Chapter 3: Cervical Cancer Data **Section C: Cervical Diagnostic/Follow-up Data**

Item No: 35

Item Name: **Status of Final Cervical Diagnosis**

Purpose: To specify status of final cervical diagnosis.

Type: Numeric

Skip Pattern: This data item should always be completed if data item 34 (Diagnostic Procedures (work-up) Planned) for cervical cancer is reported as 1.

Cancer Screen: Status of Dx

Contents:
1 = Work-up complete
2 = Lost to follow-up
3 = Work-up refused

Explanation: A status of Work-up complete means that the diagnostic testing is complete, and that final diagnosis and date of final diagnosis are known.

Lost to Follow-up should only be reported when efforts to track the woman have been attempted, but have failed regardless of whether the reason is known (i.e., death, moved). If a woman does not keep an appointment to have the diagnostic procedure, then this data item should be reported as 4.

LHDs should document more detailed information in the medical record about each case reported to the Program as Lost to follow-up/Work-up refused. This documentation should include all tracking efforts.

Notes:

Chapter 3: Cervical Cancer Data **Section C: Cervical Diagnostic/Follow-up Data**

Item No: 36

Item Name: **Date of Final Diagnosis**

Purpose: To specify date of final diagnosis.

Type: Numeric

Skip Pattern: If data item 34 (Status of Cervical diagnosis) is reported as 1, 2 or 3, then this data item should be completed; otherwise it should be left blank.

Cancer Screen: Final Dt

Contents: An 8-digit numeric data item of the form MMDDYYYY, where MM is a number from 1 to 12, DD is a number from 1 to 31, and YYYY is the year of final diagnosis.

Explanation: This data item should be used for reporting the date the clinical diagnosis is made, or the date on which the clinical decision is made that no cancer or cancer is present.

If more than one diagnostic procedure was performed, then use the date of the procedure that provided the definitive diagnosis. The date of final diagnosis is an important outcome measure for the Program.

Measures such as time from screening to diagnosis and time from diagnosis to treatment are calculated using this date.

If a woman dies before the diagnostic work-up is started, enter the date of death as the date of medical record closeout date.

Example: Colposcopy with biopsy (final diagnostic procedure) was performed on November 7, 2019: 11072019.

Notes:

Chapter 3: Cervical Cancer Data **Section C: Cervical Diagnostic/Follow-up Data**

Item No: 37

Item Name: **Final Cervical Diagnosis**

Purpose: To specify final cervical diagnosis

Type: Numeric

Skip Pattern: This data item should always be completed if data item 34 (Diagnostic Procedures (work-up) Planned) for cervical cancer is reported as 1 and data item 35 (Status of Cervical Diagnosis) is 1.

Cancer Screen: Final Dx

Contents:
1 = Normal / Benign Reaction / Inflammation
2 = HPV / Condylomata / Atypia
3 = CIN 1 / Mild dysplasia (biopsy diagnosis)
4 = CIN 2 / Moderate dysplasia (biopsy diagnosis)
5 = CIN 3 / Severe dysplasia /Carcinoma in Situ (stage 0)
6 = Invasive Cervical Carcinoma (biopsy diagnosis)

Explanation: The term Invasive Cervical Carcinoma refers to histologic characteristics of tumors found primarily within the cervix.

Report 5, if final diagnosis is Adenocarcinoma in Situ (AIS) of the cervix. AIS of the cervix is an in situ pre-cancerous condition that requires treatment.

Report 6, if final diagnoses is Adenocarcinoma of the cervix, Invasive Adenocarcinoma of the cervix, or squamous cell carcinoma of the cervix.

Final diagnosis is an important outcome measure for the Program. Thus it is especially important that data be complete, timely, and of high quality.

Example: Patient was diagnosed with CIN I: 3.

Notes:

Chapter 3: Cervical Cancer Data **Section C: Cervical Diagnostic/Follow-up Data**

Item No: 38

Item Name: **Treatment Status**

Purpose: To specify status of standard treatment for precancerous lesions and cervical cancer.

Type: Numeric

Skip Pattern: If data item 37 (Final diagnosis) is 4, 5 or 6, this data item should always be completed.

If data item 37 (Final diagnosis) is 2, 3 or 7, this data item may be completed.

If data item 37 (Final diagnosis) is 1, this data item should be blank.

Cancer Screen: Treatment Status

Contents:
1 = Treatment started
2 = Lost to follow-up
3 = Treatment refused
4 = Treatment not needed

Explanation: The Program requires the reporting of standard or conventional treatments. Non-standard or alternative treatments should not be reported as "1" (Treatment Started).

Report "1" for experimental drugs, such as those used in clinical trials.

Report "2" Lost to Follow-up should only be reported when efforts to track the woman have been attempted, but have failed regardless of whether the reason is known (i.e., death, moved). Also Report "2" in the event that a woman chooses a form of non-standard or alternative treatment

The fact that a woman is referred for standard treatment is NOT a sufficient confirmation that treatment has been started. A woman should be classified as having started treatment when the nurse has confirmed that a plan for standard treatment of the cancer or pre-cancerous lesion has been developed and started.

Treatment Status continued…

Report "4' (treatment not needed) in instances where the doctor and the woman jointly agree that treatment would adversely affect the woman's quality of life. This often occurs with late or end stage cancers.

In some instances, a diagnostic procedure may also constitute treatment. In these cases, the procedure should be reported in the diagnostic procedures section, Date of Final Diagnosis and a Final Diagnosis should be reported.

In few instances, the Date of Final Cervical Diagnosis and Date of Treatment Status may be the same.

A list of standard treatment options for CIN 2/3/CIS or invasive cervical cancer:

Photodynamic therapy (PDT)
Electrocautery
Cryosurgery
Laser
Loop Electrode Excision Procedure (LEEP)
Cone biopsy
Removal of cervical stump; cervicectomy; trachelectomy
Hysterectomy
Radiation Therapy; Branch Therapy
Bilateral Oophorectomy (removal of both ovaries)
Chemotherapy
Hormonal Therapy

Example: Treatment has started: 1.

Notes:

Chapter 3: Cervical Cancer Data **Section C: Cervical Diagnostic/Follow-up Data**

Item No: 39

Item Name: **Date of Treatment Status**

Purpose: To specify date of treatment status.

Type: Numeric

Skip Pattern: If data item 38 (Treatment Status) is 1, 2, 3 or 4, this data item should be completed; otherwise it should be left blank.

Cancer Screen: Treatment Status Dt

Contents: An 8-digit numeric data item of the form MMDDYYYY, where MM is a number from 1 to 12, DD is a number from 1 to 31, and YYYY is the year of treatment status.

Explanation: Self-explanatory

Notes: