Kentucky Women's Cancer Screening Program
Minimum Data Elements Descriptions

Minimum Data Elements Collection Desk Manual

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Acknowledgements

We thank the Kentucky Women's Cancer Screening Program's (KWCSP) Quality Assurance Steering Committee members, Kentucky's Local Health Departments, 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.

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A. Introduction and purpose of MDE data manual

This is the second release of the Minimum Data Elements (MDE) data manual by the KWCSP. The purpose of this data manual is to centralize the information needed to collect MDE data for the Program. The intended audience for this MDE data manual is the program staff in local health departments (LHD) in Kentucky responsible for the collection and aggregation of MDEs. This data manual provides a detailed description of sixty two (62) data elements collected through the Program's data collection form, commonly referred to as "ACH-58" form and on the Program data collection screen commonly referred to as the "cancer screen". This manual does not replace the Program's Administrative Reference (AR) and Public Health Practice Reference (PHPR) sections, but supplements them. This manual is a work in progress. We will continue to update this manual based on recommendations from CDC, program stakeholders and from our data analysis. All updates will be forwarded to LHDs before updating this manual. We welcome your suggestions and comments about the contents of this manual.

Minimum Data Elements (MDE)

This Program defines the data elements collected on the ACH-58 form/"Cancer Screen" as the Minimum Data Elements (MDE).

The Program collects MDE data from all 120 LHDs in Kentucky. This data is transmitted through the Cancer Screen to the Kentucky Department for Public Health data management vendor, Custom Data Processing Inc. (CDP) to the Program. Additionally, CDP also includes patient demographic characteristics and information on the LHDs that have provided these MDE records in a standardized format to the Program. The Program receives MDE data file from CDP every month. Based on this data, the Program develops key reports and shares them with the Quality Assurance Committee (QAC) members, CDP, and other stakeholders. LHDs are contacted for any outstanding and pending records or to address any inconsistencies in the MDE data.

MDE data should be collected only on women who are 40 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. The Program collects the MDE data electronically from all LHDs in Kentucky through the "cancer screen". This information should be entered into the Patient Services Reporting System (PSRS) from the ACH-58 form by the support staff, after a nurse completes the form.

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 CDC for implementing the Program.

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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 ACH-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 five sections:

Section A: Breast Screening History Data
Section B: Breast Screening Data
Section C: Mammogram Results Data
Section D: Breast Diagnostic (Work-up Planned) Procedures
Section E: 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 five sections:

Section A: Cervical Screening History Data
Section B: Cervical Screening Data
Section C: Pap Test Results Data
Section D: Cervical Diagnostic (Work-up Planned) Procedures
Section E: Cervical Diagnostic/Follow-up Data

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B. KWCSP Program Staff Contact Information

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C. KWCSP Listserv Information

Instructions to subscribe:

Step 1: Click on the link http://listserv.ky.gov/read/allforums/subscribe?name=kbccp

Step 2: Please enter the following information in the gray box "subscribe to kbccp":

a: E-mail address
b: Name
c: Password

Step 3: Click on the icon "Subscribe" below the gray box on the right hand side.

Step 4: After you subscribe to the listserv, the following message will be displayed on the screen. "You will receive an email acknowledgment in a few minutes".

Step 5: Please click OK button and close the window.

After 24 hours please login into the listserv using the instructions below.

Instructions to login:

Step 1: Please click on the link below.
http://listserv.ky.gov/read/login/?go=http://listserv.ky.gov/read/?forum%3Dkbccp
Please save this link to your favorites.

Step 2: Enter your email ID and click the OK button on the right hand side of your screen.

Step 3: Enter your password and click the OK button on the right hand side of your screen.

Step 4: You will be logged in.

Please contact the data manager for any technical assistance related to subscribing and logging into the Program's listserv. Please see page 6 for contact information.

D. Audit Reports

323: Pap Log
676: Mam Log
1706: Pending breast diagnostic data
1707: Pending cervical diagnostic data
1709: Missing screening data

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

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. 3772), if you are unable to download these reports or have any questions.

E. Core Program Performance Indicator Reports

There are eleven core program performance indicators for the Program. These indicators and standards 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 also important that the Program meets all the indicators as future funding from CDC is based on the Program's compliance with these indicators. The Program will continue to share a health department specific core program performance indicator report semi-annually. The data for this report comes from the MDE data provided to the Program by your LHD.

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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

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Item No: 6

Item Name: **Breast Symptoms? (Self-reported)**

Purpose: To specify breast symptoms reported by the woman.

Type: Numeric

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

Cancer Screen: Symptoms

Contents: 1 = Yes
2 = No

Explanation: This data item notes whether the woman reported breast symptoms or not. The symptoms of interest are a lump, bloody nipple discharge, dimpling, ulceration, or inflammation of the skin. This element provides information regarding what brought the woman to screening, was she asymptomatic, or did she already think she had a problem?

Example: The woman reported breast symptoms: 1.

Notes:

Item No: 7

Item Name: **Prior Mammogram?**

Purpose: To determine if a woman has had a previous mammogram.

Type: Numeric

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

Cancer Screen: Prior Mam

Content:
1 = Yes
2 = No

Explanation: For the first breast record for a woman, this item should be reported as 1 or 2. For subsequent records, Prior Mammogram should be reported as 1.

Example: If a woman had a prior mammogram: 1.

Notes:

Item No: 8

Item Name: **Date of Prior Mammogram**

Purpose: To specify date of previous mammogram.

Type: Numeric

Skip Pattern: If data item 7 (Prior Mammogram) is 1, this data item should be completed; otherwise it should be left blank.

Cancer Screen: MM [ ] YYYY [ ]

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 mammogram.

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

Example: If a previous mammogram was performed in December 2008: 122008.

Notes:

Item No: 9

Item Name: **Clinical Breast Exam (CBE) performed at this visit?**

Purpose: The provider's assessment of the CBE.

Type: Numeric

Skip Pattern: This data item should always be completed.

Cancer Screen: CBE Per

Contents:

If Yes,
1 = Normal
2 = Abnormal

If No,
3 = CBE not needed
4 = CBE needed, but not performed (refused)

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

The woman's opinion should be noted in data item 6 (Breast Symptoms).

If CBE result is a 2, the abnormal follow-up section of the MDEs should be completed, regardless of the initial mammogram findings. If a CBE result is a 1, 3, or 4, 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: 10

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

Purpose: To specify date of the CBE.

Type: Numeric

Skip Pattern: If data item 9 (CBE was performed at this visit?) 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, 2009: 01142009.

Notes:

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Item No: 11

Item Name: **Clinical Breast Exam (CBE) performed by outside provider or other program.**

Purpose: To determine if KWCSP funds were used to pay for CBE exam.

Type: Numeric

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

Cancer Screen: CBE Out

Contents:
1 = Yes
2 = No

Explanation: Report "1" if a CBE was performed through the Family Planning Program, other cost centers, by outside providers or other programs.

Report "2" if a CBE was performed through the KWCSP (813) cost center.

Example: CBE exam was performed through the Family Planning Program: 1.

Notes:

Item No: 12

Item Name: **Date Referred into KWCSP**

Purpose: To specify a CBE referral date.

.

Type: Numeric

Skip Pattern: If data item 11 (CBE performed by outside providers or other programs) was reported as 1, 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 the patient was referred to the KWCSP.

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

Notes:

Item No: 13

Item Name: **Mammogram Ordered at this Visit?**

Purpose: To determine if a mammogram was ordered at this visit.

Type: Numeric

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

Cancer Screen: Mam Ord

Contents:
1 = Yes, Routine screening mammogram ordered
2 = Yes, Screening mammogram ordered (includes short-term follow-up*)
3 = Yes, Diagnostic mammogram ordered (includes short-term follow-up*)
4 = No, Mammogram not performed (referred for other diagnostic services)
5 = No, Mammogram is not performed

* Refer to page 18 for a definition of short-term follow-up.

Explanation: Report "1" if a routine screening mammogram was ordered.

Report "2" if a screening 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 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 "4" if a woman received only a CBE and she goes directly to the diagnostic work-up without having a screening or diagnostic mammogram performed.

Report "5" if 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: 5.

Definition:

Short Term Follow-up: Short term follow-up is defined as cases in which the provider decides that immediate diagnostic work-up is not needed, 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 3 months based on a Pap test results. In the MDEs, the repeat Pap test begins a new MDE record.

The same would hold true if a woman had a mammogram with a Benign result and short term follow-up was recommended. The repeat mammogram would begin a new MDE record.

Notes:

Item No: 14

Item No: **Date Referred (No, Mammogram not performed, referred for diagnostic services)**

Purpose: To specify a diagnostic referral date.

.

Type: Numeric

Skip Pattern: If data item 13 (Mammogram Ordered at this visit?) was reported as 4, this data item should be completed; otherwise it should be left blank.

Cancer Screen: Dx 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 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, 2009 following an abnormal CBE provided on January 10, 2009: 01102009.

Notes:

Item No: 15

Item Name: **Mammogram performed by outside provider or other program**

Purpose: To determine if KWCSP funds were used to pay for the mammogram.

Type: Numeric

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

Cancer Screen: Mam Out

Contents:
1 = Yes
2 = No

Explanation: Report "1" if a mammogram was performed through other cost centers or by outside providers such as Avon or Komen and the woman was referred into the Program for diagnostic evaluation.

Report "2" if a mammogram was performed through KWCSP (813) cost center.

Example: Mammogram was performed through Komen funds: 1.

Notes:

Item No: 16

Item No: **Date Referred into KWCSP**

Purpose: To specify a date when a woman was referred into the KWCSP.

.

Type: Numeric

Skip Pattern: If data item 15 (Mammogram performed by outside provider or program was reported as 1, 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 the patient was referred to the KWCSP.

.

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

Notes:

Item Number: 17

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

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

Type: Numeric

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

Cancer Screen: BI-RADS 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

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 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.

This data item should always be completed even if the initial mammogram is a diagnostic mammogram and not a screening mammogram.

Mammograms with unsatisfactory results must be repeated. The Program will not reimburse for mammograms that have unsatisfactory results. If a woman does not keep an appointment for another mammogram after an unsatisfactory result of the first mammogram, then report data item 13 as "5" (No, mammogram not performed).

Example: Screening mammogram result is Negative: 1.

Notes:

Item Number: 18

Item Name: **Prior Film Comparison Required?**

Purpose: To report if prior film comparison was performed.

Type: Numeric

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

Cancer Screen: Film Com Req

Contents:
1 = Yes
2 = No

Explanation: If data item 17 (Mammogram Results, BIRADS) was reported as 0 (Assessment is Incomplete), this item must be completed; otherwise it should be left blank.

Report "1" if the assessment of initial mammogram is incomplete and the radiologist will require a review of previous mammographic films to make a final interpretation.

Example: Prior Film comparison was required: 1.

Notes:

Item No: 19

Item Name: **Date of Mammogram**

Purpose: To specify date of the initial mammogram.

Type: Numeric

Skip Pattern: If data item 17 (Mammogram Results, BIRADS) is reported, this data item must be completed; otherwise should be left blank.

Cancer Screen: Mam 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 the mammogram.

Explanation: Self-explanatory

Example: Mammogram was performed on January 5, 2009: 01052009.

Notes:

Item No: 20

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 this item is reported as 1, then the abnormal follow-up (mammogram/CBE) section must be completed.

Cancer Screen: Diagnostic Plan

Contents:
1 = Yes
2 = No
3 = Not yet determined.

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 17 (Mammogram Results, BIRADS) is 4, 5 or 6 or if data item 9 (CBE performed at this visit) is 2, this item must be reported as "1" and the abnormal follow-up (breast diagnostic) section must be completed.

The response 3 (Not yet determined) applies only if the mammogram results are pending or the physician has not yet indicated whether diagnostic procedures (work-up) is planned.

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:

Item No: 21

Item Name: **Diagnostic Mammogram (Additional views)**

Purpose: To specify if diagnostic mammogram (additional mammography views) was performed.

Type: Numeric

Skip Pattern: This data item should always be completed if data item 20 (Diagnostic Procedures (work-up) Planned) for breast cancer is reported as 1.

Cancer Screen: Diag Mam

Contents:
1 = Yes
2 = No

Explanation: This data item includes compression views, cone compression, magnification views and diagnostic mammograms.

If the initial mammogram reported in Section C (Mammogram Results Data) is a diagnostic mammogram, then this mammogram data should not be reported in this item. This will eliminate double counting of mammograms in the MDE file.

If additional mammography views are performed more than once for a woman during separate visits in the same screening cycle to obtain imaging outcome, then it is necessary to complete this data item once as a 1 on the ACH-58 form.

If a diagnostic mammogram (additional mammography views) was performed, the results and the date of this diagnostic service should be reported. The date should be reported in the MMDDYYYY format.

Example: The woman had a diagnostic mammogram: 1.

Notes:

Item No: 22

Item Name: **Ultrasound**

Purpose: To specify if an ultrasound was performed.

Type: Numeric

Skip Pattern: This data item should always be completed if data item 20 (Diagnostic Procedures (work-up) Planned) for breast cancer is reported as 1.

Cancer Screen: Ultr

Contents:
1 = Yes
2 = No

Explanation: This data item should be used for the reporting of the ultrasound or sonography.

If an ultrasound was performed, the result and date of this diagnostic service should be reported. The date should be reported in the MMDDYYYY format.

Example: The woman had an ultrasound: 1.

Notes:

Item Number: 23

Item Name: **Film Comparison**

Purpose: To specify if a film comparison was done when required to further evaluate an initial mammogram test result of assessment incomplete.

Type: Numeric

Skip Pattern: This data item should always be completed if the data item 20 (Diagnostic Procedures (work-up) Planned) for breast cancer is reported as 1.

Cancer Screen: Film Com

Contents:
1 = Yes
2 = No

Explanation: Report "1" if film comparison was performed to further evaluate the initial mammogram result.

Report "2" if film comparison was not performed to further evaluate the initial mammogram result.

Film comparisons that are done as part of a standard imaging evaluation should not be reported in this data item. For example, if a radiologist routinely reviews films as part of a through radiological assessment, then this item should be reported as "2".

If a film comparison was performed, the date and result should be reported. The date should be reported in the MMDDYYYY format.

Example: A film comparison was performed: 1.

Notes:

Item Number: 24

Item Name: **Surgical Consult**

Purpose: To specify if a surgical consultation was performed.

Type: Numeric

Skip Pattern: This data item should always be completed if data item 20 (Diagnostic Procedures (work-up) Planned) for breast cancer is reported as 1.

Cancer Screen: Surg Cons

Contents:
1 = Yes
2 = No

Explanation: Report "1" if second opinions, surgical consults and/or CBE was performed by a breast specialist.

Example: The woman had a surgical consult: 1.

Notes:

Item No: 25

Item Name: **Fine Needle/Cyst Aspiration**

Purpose: To specify if a fine needle or cyst aspiration was performed.

Type: Numeric

Skip Pattern: This data item should always be completed if data item 20 (Diagnostic Procedures (work-up) Planned) for breast cancer is reported as 1.

Cancer Screen: Fine/Cyst

Contents:
1 = Yes
2 = No

Explanation: Report "1" if a fine needle or cyst aspiration was performed.

Example: The woman had a cyst aspiration: 1.

Notes:

Item No: 26

Item Name: **Breast Biopsy/Lumpectomy**

Purpose: To specify if breast biopsy or lumpectomy was performed.

Type: Numeric

Skip Pattern: This data item should always be completed if data item 20 (Diagnostic Procedures (work-up) Planned) for breast cancer is reported as 1.

Cancer Screen: Biopsy/Lump

Contents:
1 = Yes
2 = No

Explanation: Report "1" if a breast biopsy or lumpectomy was performed.

Example: The woman did not have breast biopsy: 2.

Notes:

Item No: 27

Item Name: **Other Diagnostic Procedures**

Purpose: To specify if other breast diagnostic procedures were performed to provide a final diagnosis.

Type: Numeric

Skip Pattern: This data item should always be completed if data item 20 (Diagnostic Procedures (work-up) Planned) for breast cancer is reported as 1.

Cancer Screen: Other Dx

Contents:
1 = Yes
2 = No

Explanation: This data item is used to indicate if breast diagnostic procedures other than those specified on the ACH-58 form are performed to determine a final diagnosis for a woman.

This data item should not be used to report definitive treatment such as radical or simple mastectomy.

Examples of procedures that should be included are stereotactic localization, magnetic resonance imaging (MRI), and metastatic work-up such as a bone survey.

Example: Ductogram was performed to help determine a final diagnosis: 1.

Notes:

Item No: 28

Item Name: **Other Diagnostic Procedures (report CPT code)**

Purpose: To specify other breast diagnostic procedures performed.

Type: Numeric

Skip Pattern: This data item should always be completed when data item 27 (Other Diagnostic Procedures) is reported as 1; otherwise it should be left blank.

Cancer Screen: CPT Code A

Contents: Description of other diagnostic procedures (report CPT codes):

Explanation: This data item should be used to report other diagnostic procedures. Use appropriate CPT codes to report the diagnostic procedures.

This data item should not be used to report definitive treatment such as radical or simple mastectomy.

Examples of procedures that can be included are stereotactic localization, magnetic resonance imaging (MRI), and metastatic work-up such as a bone survey.

Example: Ductogram was performed: 76086.

Notes:

Item No: 29

Item Name: **Other Diagnostic Procedures (report CPT code)**

Purpose: To specify other diagnostic procedures.

Type: Numeric

Skip Pattern: This data item **should always** be completed if data item 27 (Other Diagnostic Procedures) is reported as 1; and data item 28 (Other Diagnostic Procedures) is reported and another diagnostic procedure not specified on the ACH-58 form was performed; otherwise it should be left blank.

Cancer Screen: CPT Code B

Contents: Description of other diagnostic procedures performed (report CPT code).

Explanation: This data item should only contain diagnostic procedures (report CPT code only) and not include definitive treatment such as radical or simple mastectomy.

Examples of procedures that can be included are stereotactic localization, magnetic resonance imaging (MRI), and metastatic work-up such as a bone survey.

Example: Stereotactic localization for breast biopsy was performed in addition to ultrasonic guidance for needle biopsy: 76095.

Notes

Item No: 30

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 20 (Diagnostic Procedures (work-up) Planned) for breast cancer is reported as 1.

Cancer Screen: Breast Stat

Contents:
1 = Work-up complete
2 = Work-up pending
3 = Lost to follow-up
4 = 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:

Item No: 31

Item Name: **Date of Final Diagnosis**

Purpose: To specify date of final diagnosis.

Type: Numeric

Skip Pattern: If data item 30 (Status of Breast Diagnosis) is reported as 1, 3 or 4, 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:

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Item No: 32

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 20 (Diagnostic Procedures (work-up) Planned) for breast cancer is reported. as 1 and also if data item 30 (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:

Item No: 33

Item Name: **Treatment Status**

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

Type: Numeric

Skip Pattern: If data item 32 (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 32 (Final Breast Diagnosis) is 3 (Breast Cancer not diagnosed), this item should be left blank.

If data item 32 (Final Breast Diagnosis) is 4 (Lobular Carcinoma In Situ), this item may be completed.

Cancer Screen: Treat Stat

Contents:
1 = Treatment started
2 = Treatment pending
3 = Lost to follow-up
4 = Treatment refused
5 = 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).

Experimental drugs, such as those used in clinical trials, may be reported as "1".

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.

Report "4" in the event the woman chooses a form of non-standard or alternative treatment.

A response of "5' (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.

Following is the 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:

Item No: 34

Item Name: **Date of Treatment Status**

Purpose: To specify date of treatment status.

Type: Numeric

Skip Pattern: If data item 33 (Treatment Status) is 1, 3, 4 or 5, this data item should be completed; otherwise it should be left blank.

Cancer Screen: Treat 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: Refer to explanation in data item 33 (Treatment Status).

Notes:

Item No: 35

Item Name: **Cervix Present**

Purpose: To determine if the woman has a cervix.

Type Numeric

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

Cancer Screen: Cervix Pres

Contents: 1 = Yes
2 = No

Explanation: If no cervix is present, report as 2.

Notes:

Item No: 36

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, prior Pap test should be completed as 1.

Notes:

Item No: 37

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

Purpose: To specify date of prior Pap Test.

Type: Numeric

Skip Pattern: If data item 35 (Prior Pap Test) is 1, this data item should be completed; otherwise it should be blank.

Cancer Screen: MM[ ]YYYY[ ]

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).

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For the first Pap test record for a woman, a date should be provided if data item 35 (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:

Item No: 38

Item Name: **Pap test performed at this visit?**

Purpose: To determine if Pap test was performed at this visit.

Type: Numeric

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

Cancer Screen: Pap Per

Contents:
1 = Yes, Routine Pap test performed
2 = Yes, Pap test is performed (includes short term follow-up Pap test)
3 = No, Pap test is not performed (proceeded directly for HPV testing or diagnostic work-up)
4 = No, Pap test is not performed (includes refused)

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 woman did not have a Pap test and went directly to HPV testing or diagnostic work-up.

Report "4" 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.

If data item 35 (Cervix Present) is reported as "2", this data item should be reported as "4".

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

Notes:

Item No: 39

Item Name: **Pap test performed by outside provider and other program**

Purpose: To determine if KWCSP funds were used to pay for the Pap test.

Type: Numeric

Skip Pattern: This data item should always be completed.

Cancer Screen: Pap Out

Contents:
1 = Yes
2 = No

Explanation: If Pap test was performed through Family Planning program, or other cost centers or by outside providers, this data item should be reported as "1".

If Pap test was performed through the KWCSP (813) cost center, this data item should be reported as "2".

Example: Pap test was performed through KWCSP (813) cost center: 2.

Notes:

Kentucky Women's Cancer Screening Program
Minimum Data Elements Descriptions

Item No: 40

Item No: **Date Referred into KWCSP**

Purpose: To specify a diagnostic referral date.

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Type: Numeric

Skip Pattern: If data item 39 (Pap test was performed by outside providers or other programs) was reported as 1, 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:

Item No: 41

Item Name: **Specimen Adequacy**

Purpose: This data item gives LHDs a way to report specimen adequacy as noted under the Bethesda System.

Type: Numeric

Skip Pattern: If data item 38 (Pap test performed at this visit) was reported as 1, this data item should be completed; otherwise it should be left blank.

Cancer Screen: Specimen Adequacy

Contents: 1 = Satisfactory
2 = Unsatisfactory

Example: The specimen was adequate: 1.

Notes:

Item No: 42

Item Name: **Specimen Type**

Purpose: To indicate how the Pap test specimen was collected.

Type: Numeric

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

Cancer Screen: SpType

Contents: 1 = Conventional Smear
2 = Liquid Based

Explanation: If data item 38 (Pap test performed at this visit?) is reported as 1 or 2, This data item should be completed; otherwise it should be left blank.

Example: Pap specimen was collected using liquid based method: 2.

Notes:

Item No: 43

Item Name: **HPV test performed at this visit?**

Purpose: To indicate if HPV test was performed.

Type: Numeric

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

Cancer Screen: HPV

Contents: 1 = Yes
2 = No

Explanation: Self-explanatory

Example: HPV test was performed: 1.

Notes:

Item No: 44

Item Name: **HPV test date**

Purpose: To specify date of HPV test.

Type: Numeric

Skip Pattern: If data item 43 (HPV test performed at this visit?) is reported as 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 screening Pap test .

Example: If a HPV was performed on January 5, 2009: 01052009.

Explanation: Self-explanatory

Notes:

Item No: 45

Item Name: **HPV test result**

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

Type: Numeric

Skip Pattern: If data item 43 (HPV test performed at this visit?) is reported as 1, this data item should be completed; otherwise, it should be left blank.

Cancer Screen: Rslt

Contents: 1 = Positive
2 = Negative

Explanation: Self-explanatory

Example: HPV test result was positive: 1.

Notes:

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Minimum Data Elements Descriptions

Item No: 46

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 38 (Pap test performed at this visit?) is reported as 1, this data item should be completed; otherwise it should be left blank.

Cancer Screen: Pap Result

Contents:
1 = Negative for Intraepithelial Lesion or Malignancy
2 = Atypical Squamous Cells of Undetermined Significance
3 = Atypical Squamous Cells Cannot Exclude High Grade Lesions
4 = Low Grade SIL
5 = High Grade SIL – Moderate-Severe Dysplasia & Carcinoma In Situ
6 = Squamous Cell Cancer
7 = Others (Describe)
8 = Unsatisfactory
9 = Abnormal Glandular Cells (Atypical (AGC), Endocervical Adenocarcinoma in Situ (AIS), and Adenocarcinoma, Atypical Endometrial).

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.

A response of 9 is used to indicate Atypical endocervical cells, Atypical Endometrial Cells, Atypical Glandular Cells, Atypical Endocervical or Glandular cells favoring neoplastic, Endocervical adenocarcinoma in situ and Adenocarcinoma.

Do not report **Vaginal Pap test** data on the data collection screen.

Notes:

Item No: 47

Item Name: **Pap Test Date**

Purpose: To specify date of Pap test

Type: Numeric

Skip Pattern: If data item 46 (Pap tests results) is from 1 to 9, this data item should be completed; otherwise, it should be left blank.

Cancer Screen: Pap 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 the Pap test.

Example: If a Pap test was performed on January 5, 2009: 01052009.

Explanation: Self-explanatory

Notes:

Item No: 48

Item Name: **Diagnostic Procedures (Work-up) Planned for Cervical Cancer**

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

Type: Numeric

Skip Pattern: If data item 38 (Pap test performed at this visit) is reported as 1, this data item should be completed.
Automatically filled in by the system and can be modified.

If this data item is reported as 1, the abnormal (Pap) follow-up section must be completed.

Cancer Screen: Diagnostic Plan

Contents:
1 = Yes
2 = No
3 = Not yet determined.

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 1 "diagnostic procedures (Work-up) planned on basis of abnormal Pap test" and the abnormal Pap follow-up section must be completed.

The response 3 applies only if the screening results are pending or the physician has not yet indicated whether diagnostic procedure (work-up) is planned.

If data item 35 (Cervix Present?) is reported as 2, this item should be reported as 2.

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

Notes:

Kentucky Women's Cancer Screening Program
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Chapter 3: Cervical Cancer Section D: Cervical Diagnostic (Work-up Planned) Procedures

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Item No: 49

Item Name: **Colposcopy with Biopsy and/or Endocervical Curettage (ECC)**

Purpose: To specify if a colposcopy with biopsy and/or ECC was performed.

Type: Numeric

Skip Pattern: This data item should always be completed if data item 48 (Diagnostic Procedures (work-up) Planned) for cervical cancer is reported as 1.

Cancer Screen: Colpo Bi/ECC

Contents: 1 = Yes
2 = No

Explanation: Self-explanatory

Example: Colposcopy with biopsy was performed: 1.

Notes:

Kentucky Women's Cancer Screening Program
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Chapter 3: Cervical Cancer Section D: Cervical Diagnostic (Work-up Planned) Procedures

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Item No: 50

Item Name: **Colposcopy without Biopsy**

Purpose: To specify if a colposcopy without biopsy was performed.

Type: Numeric

Skip Pattern: This data item should always be completed if data item 48 (Diagnostic Procedures (work-up) Planned) for cervical cancer is reported as 1.

Cancer Screen: Colpo W/O

Contents: 1 = Yes
2 = No

Explanation: Self-explanatory

Example: Colposcopy without biopsy was performed: 1.

Notes:

Item No: 51

Item Name: **Loop Electrode Excision Procedure (LEEP)**

Purpose: To specify if LEEP was performed.

Type: Numeric

Skip Pattern: This data item should always be completed if data item 48 (Diagnostic Procedures (work-up) Planned) for cervical cancer is reported as 1.

Cancer Screen: LEEP

Contents:
1 = Yes
2 = No

Explanation: Self-explanatory

Example: LEEP was performed: 1.

Notes:

Kentucky Women's Cancer Screening Program
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Chapter 3: Cervical Cancer Section D: Cervical Diagnostic (Work-up Planned) Procedures

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Item No: 52

Item Name: **Endocervical Curettage alone (ECC)**

Purpose: To specify if ECC was performed.

Type: Numeric

Skip Pattern: This data item should always be completed if data item 48 (Diagnostic Procedures (work-up) Planned) for cervical cancer is reported as 1.

Cancer Screen: ECC

Contents: 1 = Yes
2 = No

Explanation: Self-explanatory

Example: ECC was performed: 1.

Notes:

Item No: 53

Item Name: **Cold Knife Cone**

Purpose: To specify if cold knife cone was performed.

Type: Numeric

Skip Pattern: This data item should always be completed if data item 43 (Diagnostic Procedures (work-up) Planned) for cervical cancer is reported as 1.

Cancer Screen: Cold Knife

Contents:
1 = Yes
2 = No

Explanation: Self-explanatory

Example: Cold Knife Cone was performed: 1.

Notes:

Item No: 54

Item Name: **GYN Consult**

Purpose: To specify if GYN Consult was performed.

Type: Numeric

Skip Pattern: This data item should always be completed if data item 48 (Diagnostic Procedures (work-up) Planned) for cervical cancer is reported as 1.

Cancer Screen: GYN Cons

Contents:
1 = Yes
2 = No

Explanation: Self-explanatory

Example: GYN Consult was performed: 1.

Notes:

Kentucky Women's Cancer Screening Program
Minimum Data Elements Descriptions

Chapter 3: Cervical Cancer Section D: Cervical Diagnostic (Work-up Planned) Procedures

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Item No: 55

Item Name: **Other Diagnostic Procedures**

Purpose: To specify if other breast diagnostic procedures were performed to provide a final diagnosis.

Type: Numeric

Skip Pattern: This data item should always be completed if data item 48 (Diagnostic Procedures (work-up) Planned) for cervical cancer is reported as 1.

Cancer Screen: Other Dx

Contents: 1 = Yes
2 = No

Explanation: This data item is used to indicate if breast diagnostic procedures other than those specified on the ACH-58 form are performed to determine a final diagnosis for a woman.

This should include diagnostic procedures and not include additional Pap tests or treatment such as cryosurgery, hysterectomy, laser, or cautery. Only procedures such as excision of endocervical polyps, and biopsy of other structures such as vagina and vulva should be reported in this data item. In addition, if cervicography is performed, this could be reported here.

Example: Endometrial biopsy was performed: 1.

Notes:

Item No: 56

Item Name: **Other Diagnostic Procedures (report CPT code)**

Purpose: To specify other breast diagnostic procedures performed.

Type: Numeric

Skip Pattern: This data item should always be completed when data item 55 (Other Diagnostic Procedures) is reported as 1; otherwise it should be left blank.

Cancer Screen: CPT Code A

Contents: Description of other diagnostic procedures (report CPT codes)

Explanation: This data item should be used to report other diagnostic procedures. Use appropriate CPT codes to report the diagnostic procedures.

This should include diagnostic procedures and not include additional Pap tests or treatment such as cryosurgery, hysterectomy, laser, or cautery. Only procedures such as excision of endocervical polyps, and biopsy of other structures such as vagina and vulva should be reported in this data item. In addition, if cervicography is performed, this could be reported here.

Example: Endometrial biopsy was performed: 58100.

Notes:

Kentucky Women's Cancer Screening Program
Minimum Data Elements Descriptions

Chapter 3: Cervical Cancer Section D: Cervical Diagnostic (Work-up Planned) Procedures

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Item No: 57

Item Name: **Other Diagnostic Procedures (report CPT code)**

Purpose: To specify other diagnostic procedures, if performed.

Type: Numeric

Skip Pattern: This data item **should always** be completed if data item 55 (Other Diagnostic Procedures) is reported as 1; and data item 56 (Other Diagnostic Procedures) is reported and another diagnostic procedure not specified on ACH-58 form was performed; otherwise it should be left blank.

Cancer Screen: CPT Code B

Contents: Description of other diagnostic procedures performed (report CPT code).

Explanation: This data item should be used to report other diagnostic procedures. Use appropriate CPT codes to report diagnostic procedures.

This should include diagnostic procedures and not include additional Pap tests or treatment such as cryosurgery, hysterectomy, laser, or cautery. Only procedures such as excision of endocervical polyps, and biopsy of other structures such as vagina and vulva should be reported in this data item. In addition, if cervicography is performed, this could be reported here.

Example: Endometrial biopsy and Laser ablation was performed: 57513.

Notes:

Item No: 58

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 48 (Diagnostic Procedures (work-up) Planned) for cervical cancer is reported as 1.

Cancer Screen: Cervic Stat

Contents:
1 = Work-up complete
2 = Work-up pending
3 = Lost to follow-up
4 = 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:

Kentucky Women's Cancer Screening Program
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Item No: 59

Item Name: **Date of Final Diagnosis**

Purpose: To specify date of final diagnosis.

Type: Numeric

Skip Pattern: If data item 58 (Status of Cervical diagnosis) is reported as 1, 3 or 4, 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, 2009: 11072009.

Notes:

Item No: 60

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 48 (Diagnostic Procedures (work-up) Planned) for cervical cancer is reported as 1 and data item 58 (Status of Cervical Diagnosis) is 1.

Cancer Screen: Final Dx

Contents:
1 = Normal/Benign reaction/Inflammation
2 = HPV/Condylomata /Atypia
3 = CIN I/Mild dysplasia (biopsy diagnosis)
4 = CIN II/Moderate dysplasia (biopsy diagnosis)
5 = CIN III/Severe dysplasia /Carcinoma In Situ (stage 0) (biopsy diagnosis)
6 = Invasive Cervical Carcinoma (biopsy diagnosis)
7 = Others (Describe)

Explanation: The term Invasive Cervical Carcinoma refers to histologic characteristics of tumors found primarily within the cervix. Final diagnoses of Adenocarcinoma of the cervix, Invasive Adenocarcinoma of the cervix, or squamous cell carcinoma of the cervix should be reported as 6 in the MDE file. Final diagnoses of Adenocarcinoma In Situ (AIS) of the cervix should be reported as 5 in the MDEs.

Cancers of the vagina, vulva, ovary, uterus or endometrium detected during cervical screening should only be reported as a final diagnosis of 7 (Other). **Please contact the data manager before you report such cases.**

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.

Item No: 61

Item Name: **Treatment Status**

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

Type: Numeric

Skip Pattern: If data item 60 (Final diagnosis) is 4, 5 or 6, this data item should always be completed.

If data item 60 (Final diagnosis) is 2, 3 or 7, this data item may be completed.

If data item 60 (Final diagnosis) is 1, this data item should be blank.

Cancer Screen: Treat Stat

Contents:
1 = Treatment started
2 = Treatment pending
3 = Lost to follow-up
4 = Treatment refused
5 = 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).

Experimental drugs, such as those used in clinical trials, may be reported as "1".

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.

Report "4" in the event that a woman chooses a form of non-standard or alternative treatment.

A response of "5' (treatment not needed) should be used 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.

List of standard treatment options for CIN II/III/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.

Item No: 62

Item Name: **Date of Treatment Status**

Purpose: To specify date of treatment status.

Type: Numeric

Skip Pattern: If data item 61 (Treatment Status) is 1, 3, 4 or 5, this data item should be completed; otherwise it should be left blank.

Cancer Screen: Treat 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: Refer to the explanation in data item 61 (Treatment Status).

Notes: