Patient Care Colorectal Cancer Screening

i4C Indicator PHC-CAN-005: Patient Care Colorectal Cancer Screening v 2.1

Category: Preventive Health Care/Cancer

Purpose:

This indicator is used to assist with the management of preventive screening for colorectal cancer.

Source:

Based on the CIHI indicator framework, version November 2012, and modified to accommodate new CCO guidelines published in 2019.

Base Population:

All patients age 50 to 74 inclusive, with an Active demographic status recorded in the EMR.

Indicator Segments:

Screening up to date: Count of patients age 50 to 74 WITHOUT a colorectal cancer screening exclusion documented AND WITH at least one of the following:

- An FOBT/FIT screening documented in the past 24 months
- A Sigmoidoscopy documented in the past 60 months
- A Colonoscopy documented in the past 120 months

Screening overdue: Count of patients age 50 to 74 WITHOUT a colorectal cancer screening exclusion documented AND WITHOUT any of the following:

- An FOBT/FIT screening documented in the past 24 months
- A Sigmoidoscopy documented in the past 60 months
- A Colonoscopy documented in the past 120 months

Excluded: Count of patients age 50 to 74 WITH a colorectal cancer screening exclusion documented.

Colorectal Cancer Screening Exclusion can be documented as:

- Any of the following ICD-9 diagnosis codes entered as a current or past diagnosis in the cumulative patient profile:
  - 154: Malignant neoplasm of rectum rectosigmoid junction and anus
  - 153: Malignant neoplasm of colon
  - 555: Regional enteritis
  - 556: Ulcerative enterocolitis
  - V10.05: Personal history of malignant neoplasm of large intestine
- Any of the following text documented as current/past diagnosis within the cumulative patient profile:
  - 'Colon ca'
  - 'colorectal ca'
  - 'bowel ca'
  - 'Crohn'
  - 'Colitis'
  - 'Inflammatory Bowel Disease'

    - 'IBD'
- A text entry of 'colectomy' documented as a procedure within past medical/surgical history of the cumulative patient profile

FOBT/FIT Screening can be documented as a Q133A tracking code that has been submitted for a patient, a report from a sending facility identifying that an FOBT or FIT has been completed, FOBT or FIT results received from a laboratory or entered manually, or as procedures documented within Past Medical/Surgical history in the cumulative patient profile.

Sigmoidoscopy can be documented as a report from a sending facility identifying that a sigmoidoscopy has been completed or as a procedure documented within Past Medical/Surgical history in the cumulative patient profile.

Colonoscopy can be documented as a report from a sending facility identifying that a colonoscopy has been completed or as a procedure documented within Past Medical/Surgical history in the cumulative patient profile.

Suggested Indicator Use:

Physician or practice use of this indicator is to review charts of patients overdue for colorectal cancer screening in order to manage the recall of patients.