Patient Care Colorectal Cancer Screening

OntarioMD i4C Dashboard Indicator

For more information regarding OntarioMD Indicators or the EMR i4C Dashboard Specification, please refer to:

https://www.ontariomd.ca/emr-certification/emr-specification/ontariomd-indicator-library

1. VERSION HISTORY

INDICATOR VERSION	PUBLICATION DATE	REMARKS
1.0	2019-02-18	• Initial release
2.0	2019-07-09	• Indicator Segment Query Criteria changed to reflect new colorectal cancer screening guidelines as of June 2019 (transition from FOBT to FIT as a primary screening test) • Add a new optional Patient List column to display the latest Q133A tracking code submitted for billing, independent of when the last screening was captured in the EMR • Added Indicator ID, Indicator Segment ID and Display Indicator Segment properties • Changed format and content of Indicator User Help • Changed format of Source property • Indicator Segment IDs re-sequenced to provide consistency across indicators • Indicator Segment Query Criteria clarifies that query result from a segment should produce a count of patients

2. INDICATOR DEFINITION

2.1 Indicator Properties

PROPERTY	VALUE
Indicator ID	PHC-CAN-005
Indicator Name	Patient Care Colorectal Cancer Screening
Indicator Version	2.0
Date Published	2019-07-09
Description	**Purpose:** This indicator is used to assist with the management of preventive screening for colorectal cancer. **Base Population:** All patients age 50 to 74 inclusive, with an Active demographic status recorded in the EMR. **Indicator Segments:** Indicator segments provide the following patient summaries: • Count of patients, who are not excluded from screening, with screening up to date (FOBT or FIT within the past 2 years OR Sigmoidoscopy within the 5 years OR Colonoscopy within the past 10 years); • Count of patients, who are not excluded from screening, with screening overdue; • Count of patients who are excluded from screening. **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.

PROPERTY	VALUE
	Measurements of Interest: Percentage of patients with screening up to date out all patients with either screening up to date or screening overdue.
Source	CIHI
Source Description	Based on the CIHI indicator framework, version November 2012, and modified to accommodate new CCO guidelines published in 2019.
Status	Active
Category	Preventive Health Care
Subcategory	Cancer
Indicator Order	5
Indicator Graphic Type	Pie Chart, Bar Chart
Indicator Graphic Notes	
Indicator User Help	**Adults 50-74: Colorectal Cancer Screening** **Purpose:** This indicator is used to assist with the management of preventive screening for colorectal cancer. **Base Population:** All patients age 50 to 74 inclusive, with an Active demographic status recorded in the EMR.

PROPERTY	VALUE
	Indicator Segments: Indicator segments provide the following patient summaries: • Count of patients, who are not excluded from screening, with screening up to date (FOBT or FIT within the past 2 years OR Sigmoidoscopy within the 5 years OR Colonoscopy within the past 10 years); • Count of patients, who are not excluded from screening, with screening overdue; • Count of patients who are excluded from screening. **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. **Measurements of Interest:** Percentage of patients with screening up to date out all patients with either screening up to date or screening overdue.

PROPERTY	VALUE
	Metric Criteria: *Screening overdue*[1]**:** Patients WITHOUT an FOBT or FIT documented or Q133A tracking code billed in the last 24 months and WITHOUT a Sigmoidoscopy report documented in the last 5 years and WITHOUT a Colonoscopy report documented in the last 10 years, and who are NOT excluded. *Screening up to date*[2]**:** Patients WITH an FOBT or FIT documented or Q133A tracking code billed in the last 24 months or WITH a Sigmoidoscopy report documented in the last 5 years or WITH a Colonoscopy report documented in the last 10 years, and who are NOT excluded. *Excluded*[3]**:** Patients WITH any of the following diagnoses documented as text: • Colon ca • colorectal ca • bowel ca • Crohn • Colitis • Inflammatory Bowel Disease • IBD • colectomy OR WITH any of the following diagnoses coded: • 154: Malignant neoplasm of rectum rectosigmoid junction and anus (ICD-9) • 153: Malignant neoplasm of colon (ICD-9)

[1] Implementer may include EMR-specific information on the workflow for documenting FOBT, colonoscopy, and sigmoidoscopy.

[2] Implementer may include EMR-specific information on the workflow for documenting FOBT, colonoscopy, and sigmoidoscopy.

[3] Implementer may include EMR-specific information on the workflow(s) for documenting pap exclusions.

PROPERTY	VALUE
	• 555: Regional enteritis (ICD-9) • 556: Ulcerative enterocolitis (ICD-9) • V10.05: Personal history of malignant neoplasm of large intestine (ICD-9)

2.2 Indicator Segment Properties

PROPERTY	VALUE	VALUE	VALUE
Indicator Segment ID	1	2	3
Indicator Segment Label	Screening up to date	Screening overdue	Excluded
Display Indicator Segment	Yes	Yes	Yes
Indicator Segment Query Criteria	**COUNT OF:** Active patients age 50-74 inclusive **AND** WITHOUT a documented colorectal cancer screening exclusion **AND** WITH (A documented Fecal Occult Blood Test (FOBT) or Fecal Immunochemical Test (FIT) in the last 24 months inclusive **OR** A documented Sigmoidoscopy within the last 60 months inclusive **OR** A documented Colonoscopy within the last 120 months inclusive)	**COUNT OF:** Active patients age 50-74 inclusive **AND** WITHOUT a documented colorectal cancer screening exclusion **AND** WITHOUT a documented Fecal Occult Blood Test (FOBT) or Fecal Immunochemical Test (FIT) in the last 24 months inclusive **AND** WITHOUT a documented Sigmoidoscopy within the last 60 months inclusive **AND** WITHOUT a documented Colonoscopy within the last 120 months inclusive	**COUNT OF:** Active patients age 50-74 inclusive **AND** WITH a documented colorectal cancer screening exclusion
Indicator Segment Query Notes	**Active Patients** are patients identified as 'Active' in the Patient Status data element *(DE01.016)* within *Patient Demographics.* **Patient Age** can be calculated based on the difference between the current date and the patient's date of birth captured in the Date of Birth data element *(DE01.007)* within *Patient Demographics.*		

PROPERTY	VALUE	VALUE	VALUE
	Colorectal Cancer Screening Exclusion can be documented as: Any of the following coded diagnoses captured in the Diagnosis/Problem data element *(DE06.004)* within *Ongoing Health*: 154, 153, 555, 556, or V10.05 *(ICD-9 Coding System)* **OR** Any of the following text diagnoses or problems captured in the Diagnosis/Problem data element within *Ongoing Health (DE06.004)* or *Past Medical & Surgical (DE07.004)*: “Colon ca,” “colorectal ca,” “bowel ca,” "Crohn," "Colitis," "Inflammatory Bowel Disease," "IBD," or “colectomy.” **OR** Any additional documentation method representing best practice workflow(s) identified and supported across practices within a specific EMR. **FOBT** can be documented as: A *Q133A* Tracking Code that has been billed for the patient **OR** A Result captured within Laboratory Test Results (DE10) for an FOBT. Test names may be identified using EMR's proprietary test names, laboratory proprietary test codes or test names, or LOINC codes which cross-reference test names across different EMR and laboratory test names. **OR** A report received from a sending facility identifying an FOBT has been completed either by report name, report categorization or report content **OR** An FOBT captured in the Procedure data element *(DE07.006)* within *Past Medical & Surgical* **OR** Any additional documentation method representing best practice workflow(s) identified and supported across practices within a specific EMR.		

PROPERTY	VALUE	VALUE	VALUE
	FIT can be documented as a Result captured within Laboratory Test Results (DE10) for a FIT. Test names may be identified using EMR's proprietary test names, laboratory proprietary test codes or test names, or LOINC codes which cross-reference test names across different EMR and laboratory test names. *(Note: As of 2019/06/23, FIT will replace FOBT in screening guidelines. Queries should only search for FOBT screenings prior to this date, but search for either FIT or FOBT screenings starting on this date.)* **Colonoscopy** can be documented as A report received from a sending facility identifying a colonoscopy has been completed either by report name, report categorization or report content **OR** A colonoscopy captured in the Procedure data element (DE07.006) within *Past Medical & Surgical* **OR** Any additional documentation method representing best practice workflow(s) identified and supported across practices within a specific EMR. **Sigmoidoscopy** can be documented as A report received from a sending facility identifying a sigmoidoscopy has been completed either by report name, report categorization or report content **OR** A sigmoidoscopy captured in the Procedure data element (DE07.006) within *Past Medical & Surgical* **OR** Any additional documentation method representing best practice workflow(s) identified and supported across practices within a specific EMR.		

PROPERTY	VALUE	VALUE	VALUE
Patient List Criteria	**Mandatory** Patient Name Unique Patient Identifier **Optional** Patient Date of Birth Patient Age Patient Phone Number Patient Enrollment Status Patient Enrollment Status Date Latest FOBT or FIT Latest Tracking Code Latest Colonoscopy Latest Sigmoidoscopy Last Seen Date Next Appointment Date	**Mandatory** Patient Name Unique Patient Identifier **Optional** Patient Date of Birth Patient Age Patient Phone Number Patient Enrollment Status Patient Enrollment Status Date Latest FOBT or FIT Latest Tracking Code Latest Colonoscopy Latest Sigmoidoscopy Last Seen Date Next Appointment Date	**Mandatory** Patient Name Unique Patient Identifier **Optional** Patient Date of Birth Patient Age Patient Phone Number Patient Enrollment Status Patient Enrollment Status Date Latest FOBT or FIT Latest Tracking Code Latest Colonoscopy Latest Sigmoidoscopy Last Seen Date Next Appointment Date Latest Colorectal Cancer Screening Exclusion Service Code
Patient List Notes	**Patient Name** is a combination of First Name *(DE01.003)* and Last Name *(DE01.002)* data items from *Patient Demographics*. Names may be displayed either as separate columns or concatenated into one column. **Unique Patient Identifier** is any data item from *Patient Demographics* that can be used by a physician or clinic to uniquely identify a patient when displayed. Examples include Health Card Number *(DE01.008*) or Chart Number *(DE01.012).*		

PROPERTY	VALUE	VALUE	VALUE
	Patient Date of Birth is captured into *Patient Demographics* as Date of Birth *(DE01.007).* **Patient Age** is calculated data item representing the difference between the current date and Date of Birth *(DE01.007)* from *Patient Demographics*. Age should be displayed in years. **Patient Phone Number** is the preferred phone number for contacting a patient, and may include Residence Phone *(DE02.007),* Cell Phone *(DE02.008)* or Work Phone *(DE02.009)* from *Patient Address*. **Patient Enrollment Status** represents whether the patient is currently enrolled, was enrolled but has been terminated, or has never been enrolled, and is captured into *Patient Demographics* as Enrollment Status *(DE01.019).* **Patient Enrollment Status Date** represents the date when a patient has been most recently enrolled or terminated by the clinic. If the patient is currently enrolled, then the date displayed will be the Enrollment Date *(DE01.020)* from *Patient Demographics.* If the patient is currently terminated, then the date displayed will be the Enrollment Termination Date *(DE01.021)* from *Patient Demographics*. If the patient has never been enrolled, then the date will be displayed as a null or blank value. **Latest FOBT or FIT** represents the result and/or date from the latest documented FOBT or FIT. This may also include a column displaying how the test was documented (e.g., billing code, screening report, lab result, past medical history procedure, etc.) **Latest Tracking Code** is a date representing the last time a Q133A tracking code has been billed for the patient (independent of *latest FOBT or FIT*, which may be identified by criteria other than tracking code.) **Latest Colonoscopy** represents the result and/or date from the latest documented Colonoscopy. **Latest Sigmoidoscopy** represents the result and/or date from the latest documented Sigmoidoscopy.		

PROPERTY	VALUE	VALUE	VALUE
	Latest Colorectal Cancer Screening Exclusion Service Code is a date representing the last time a *Q142A* Service Code has been billed for the patient. **Last Seen Date** is a date representing the last time a patient was seen by the physician or another clinician within the clinic. This may be based on *Appointment Date/Time (DE15.001)*, where appointments with status of 'No Show', 'Cancelled', or 'Deleted' are excluded, or this may be based on any additional documentation supported by the EMR to track when a patient has last been seen (e.g., encounter notes). **Next Appointment Date** is a date representing the next time a patient is scheduled to be seen by the physician or another clinician within the clinic. This may be based on *Appointment Date/Time (DE15.001*).		