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
2.1	2020-06-15	• Indicator Segment Query Notes updated to provide clarification in distinguishing between codes /text used to identify procedures and codes/text to identify diagnoses.within screening exclusions criteria. • Layout of definition file changed to improve readability of indicator segment properties • Description and User Help content now contained in separate document. Description and User Help attributes in definition now contain wording to confirm content is kept separately

2. INDICATOR DEFINITION

2.1 Indicator Properties

PROPERTY	VALUE
Indicator ID	PHC-CAN-005
Indicator Name	Patient Care Colorectal Cancer Screening
Indicator Version	2.1
Date Published	2020-06-15
Description	Indicator description is part of the User Help content, now maintained in a separate document within the i4C Dashboard Indictor Library.
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 or Bar Chart
Indicator Graphic Notes	

PROPERTY	VALUE
Indicator User Help	User Help content is now maintained in a separate document within the i4C Dashboard Indicator Library.
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.* **Colorectal Cancer Screening Exclusion** is any of the following documented in the EMR: • A coded ICD-9 diagnosis of 153* (Malignant neoplasm of colon), 154* (Malignant neoplasm of rectum rectosigmoid junction and anus), 555* (Regional enteritis), 556* (Ulcerative enterocolitis), or V10.05 (Personal history of malignant neoplasm of large intestine) captured in Diagnosis/Problem *(DE06.004)* within *Ongoing Health (DE06.004)* or *Past Medical & Surgical (DE07.004)*; • A text entry of 'Colon ca', 'colorectal ca', 'bowel ca', 'Crohn', 'Colitis', 'Inflammatory Bowel Disease', or 'IBD' captured in Diagnosis/Problem within *Ongoing Health (DE06.004)* or *Past Medical & Surgical (DE07.004)*; • A text entry of 'Colectomy' captured in Procedure *(DE07.006)* within *Past Medical & Surgical*; • Any additional documentation method representing best practice workflow(s) identified and supported across practices within a specific EMR. ICD-9 and ICD-10 are hierarchical coding systems built on general categories and (optional) specific subcategories. A **dot separator** is used to separate category from subcategory in representing a code. Some EMR offerings omit the dot separator in representing codes in data capture and EMR data searches. For these EMRs, vendors will omit the dot separator in searches and queries. A category code followed by an asterisk (e.g., 154*) means that the search should include the high-level category (154) along with all subcategories within the hierarchy (e.g., 154.0, 154.1, etc.) **FOBT/FIT** is any of the following documented in the EMR: • A *Q133A* Tracking Code that has been billed for the patient • A result captured within Laboratory Test Results (DE10) for an FOBT or 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. • A report received from a sending facility identifying an FOBT or FIT has been completed either by report name, report categorization or report content • An FOBT or FIT captured in Procedure *(DE07.006)* within *Past Medical & Surgical.* • Any additional documentation method representing best practice workflow(s) identified and supported across practices within a specific EMR.

PROPERTY	VALUE
	Colonoscopy is any of the following documented in the EMR: • A report received from a sending facility identifying a colonoscopy has been completed either by report name, report categorization or report content ; • A colonoscopy captured in Procedure *(DE07.006)* within *Past Medical & Surgical* • Any additional documentation method representing best practice workflow(s) identified and supported across practices within a specific EMR. **Sigmoidoscopy** is any of the following documented in the EMR: • A report received from a sending facility identifying a sigmoidoscopy has been completed either by report name, report categorization or report content; • A sigmoidoscopy captured in Procedure *(DE07.006)* within *Past Medical & Surgical*; • Any additional documentation method representing best practice workflow(s) identified and supported across practices within a specific EMR.
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).* **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.)

PROPERTY	VALUE
	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. **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*).

2.2 Indicator Segment Properties

Indicator Segment ID	Indicator Segment Label	Display Indicator Segment	Indicator Segment Query Criteria	Patient List Criteria
1	Screening up to date	Yes	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)	**Mandatory** Patient Name Unique Patient Identifier Patient Date of Birth **Optional** 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
2	Screening Overdue	Yes	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	**Mandatory** Patient Name Unique Patient Identifier Patient Date of Birth **Optional** 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

Indicator Segment ID	Indicator Segment Label	Display Indicator Segment	Indicator Segment Query Criteria	Patient List Criteria
3	Excluded	Yes	COUNT OF: Active patients age 50-74 inclusive AND WITH a documented colorectal cancer screening exclusion	**Mandatory** Patient Name Unique Patient Identifier Patient Date of Birth **Optional** 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