The Excellence Report: Quality Measures for Colonoscopy

Quality Measure 1. Preprocedure risk assessment is documented.

Quality Measure 2. A management plan is documented for patients on oral anticoagulants.

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Quality Measure 1. Preprocedure risk assessment is documented.

Inclusions: All colonoscopies are included in this measure.

Exclusions: None

Value measured: Number of cases with documentation of preprocedure risk assessment (ASA classification) and the proportion of cases with each risk level.

Notes for CORI v3 users:

- Preprocedure risk assessment is documented on the Exam Info screen ("ASA Class").

Notes for CORI v4 users:

- Preprocedure risk assessment is documented on the Preprocedure screen ("ASA Classification").

What if these numbers don't seem correct?

- Documentation of ASA Classification is required in CORI v4, but not in CORI v3, where it must be documented in the provided field and not in free text notes. Definitions of the risk levels are provided.

Quality Measure 2. A management plan is documented for patients on oral anticoagulants.

Inclusions: Cases are included in this measure if current use of oral anticoagulant agents by the patient is documented.

Exclusions: None.

Value measured: Number of cases with documentation of an anticoagulation plan for patients currently on oral anticoagulants.

Additional value reported: An additional value reported will be the completeness of documentation of current oral anticoagulant use, i.e. the proportion of all colonoscopies in which either current use or lack of current use of oral anticoagulant agents is documented.

Notes for CORI v3 users:

- Use of Coumadin in the last 30 days can be documented on the History screen ("Coumadin last 30 days?"). Although current use is generally defined as being use in the last 7 days, the documentation of use in the last 30 days will be accepted as an approximation.
- The anticoagulation plan can also be documented on the History screen ("AC Plan").

Notes for CORI v4 users:

- Documentation of the use of anticoagulant agents in the last 30 days, including Coumadin, is a required field on the History screen. Although current use is generally defined as being use in the last 7 days, the documentation of use in the last 30 days will be accepted as an approximation.
- The anticoagulation plan can also be documented on the History screen.

What if these numbers don't seem correct?

- Colonoscopies will be included only if current use (or lack of use) of oral anticoagulant agents is documented in the fields provided, and not in free text notes.
- The anticoagulation plan must be documented in the field provided, not in free text notes.

Quality Measure 3. Sedation medication(s) used and dosages are documented.

Inclusions: All colonoscopies are included in this measure.

Exclusions: None

Value measured: Number of cases for which sedation medications are documented. This includes cases where there is documentation that no sedation medications were given or that there is residual sedation from a prior procedure. In addition, if either general anesthesia or anesthesia monitored by an anesthesiologist or nurse anesthetist is documented, even if no sedation medications are documented in the CORI record, it is assumed that other documentation of sedation medications was created.

Additional value reported: For each sedation medication documented, the proportion in which the dosage is also documented will be reported. If sedation medications are listed and, in addition, there is documentation that no sedation medications were used, this is considered an error in documentation and will be reported.

Notes for CORI v3 users:

- Sedation medications are documented on the Exam Info screen. On this screen, sedation medications and their dosage can be listed and there are checkboxes for "No sedation given" and "Residual sedation present."
- If sedation is managed by anesthesia staff and therefore documented elsewhere, this can be documented by checking either "General Anesthesia" or "Monitored Anesthesia Care" or by choosing 'Anesthesiologist' or 'Nurse Anesthetist' from the "Managed by" menu.
- If medications are listed and "No sedation given" is checked, this will be reported as an error.

Notes for CORI v4 users:

- Sedation medications are documented on the Preprocedure screen. On this screen, sedation medications and their dosage can be listed and there are checkboxes for "No sedation medications given" and "Residual sedation from prior procedure present".
- In addition, other sedation medications can be documented by checking "Other sedation medication" and entering other medications as free text.
- If sedation is managed by anesthesia staff and therefore documented elsewhere, this can be documented by choosing 'General anesthesia' from the "Level of sedation" menu or by choosing either 'Anesthesiologist' or 'Nurse anesthetist' from the "Managed by" menu.
- If medications are given (either listed or in free text) and "No sedation medications given" is checked, this will be reported as an error.
- Medications documented in free text as "Other sedation medications" will not be evaluated for documentation of dosage.

What if these numbers don’t seem correct?

- If sedation medications are documented on another record, such as an anesthesia record, that documentation may not contribute to this measure. The existence of other documentation is assumed only if general or monitored anesthesia care is documented or the sedation medications are managed by anesthesia staff.
- If sedation medications are documented in free text for "Other sedation medications" in CORI v4, those medications are not included in the report on dosage documentation.
- Documentation must be in the fields noted and not in free text fields, such as the Comments textboxes, except as noted above.

Quality Measure 4. Quality of bowel prep is documented.

Inclusions: All colonoscopies are included in this measure.

Exclusions: None

Value measured: Number of cases in which the prep results are documented.

Additional value reported: For cases in which the prep results are documented, the number for which the bowel prep is adequate to detect a polyp > 5 mm will be reported.

Notes for CORI v3 users:

- Bowel prep results are documented on the Exam Info screen ("Prep Results") with four choices, and definitions given.

Notes for CORI v4 users:

- Bowel prep results are documented on the Preprocedure screen ("Prep results") with four choices, and definitions given.

What if these numbers don't seem correct?

- The bowel prep results must be documented in fields provided, not in free text.

Quality Measure 5. When rectal bleeding is present, type and extent of bleeding is documented

Inclusions: Cases are included in this measure if there is an indication of rectal bleeding.

Exclusions: None

Value measured: Number of cases with documentation of the type and extent of rectal bleeding

Notes for CORI v3 users:

- An indication of rectal bleeding is documented by selecting “Hematochezia” as an indication. Other indications may also be selected.
- CORI v3 does not collect data about type and extent in a discrete fashion, so your number meeting this criteria will always be 0.

Notes for CORI v4 users:

- An indication of rectal bleeding is documented by selecting "Hematochezia" as an indication. Other indications may also be selected.
- Type and extent of bleeding are documented on the Hematochezia detail screen, which will open when this indication is selected. Any choice for "Type of bleeding" will meet this measure.

What if these numbers don't seem correct?

- For CORI v3 users, this number will not represent true practice, since type and extent of rectal bleeding can only be documented in free text fields.
- Documentation in free text boxes will not be searched for inclusions, exclusions , or values unless specifically stated. Check to see that all data is documented in one of the specified controlled fields.

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Quality Measure 6. Depth of insertion is documented. The cecum is reached unless there are documented reasons for not reaching this depth of insertion.

Inclusions: All colonoscopies are included in this measure.

Exclusions: None.

Value measured: Cases in which the depth of insertion (i.e. actual depth reached) is documented.

Additional value reported: For cases in which the depth of insertion is documented, proportion in which the cecum is reached will be reported. Procedures for which there should be no expectation of reaching the cecum will be excluded from this analysis, including

- cases which were incomplete,
- had poor bowel prep,
- where the patient has a history of bowel resection,
- procedures with a finding of severe colitis, or
- procedures performed for therapy only, specifically for treatment of a stricture or removal of a large polyp.

The In addition, for cases in which the cecum is reached, the method of documentation will be reported, i.e., whether by statement of depth reached, documentation of landmarks seen, or photodocumentation

Notes for CORI v3 users:

- Depth of insertion is documented on the Exam Info screen ("Extent Reached").
- Document if the procedure was incomplete by either choosing an option from the menu for "Incomplete Due to: " or by entering the reason for incomplete procedure after "Other Reason Incomplete"
- Document if the bowel prep was poor by choosing 'Poor' from the menu for "Prep Results".
- Document a finding of severe colitis on the Findings/Therapy screen by first selecting the involved area, then selecting "Colitis". On the Colitis detail screen, choose 'Severe' for "Activity".
- Document a history of bowel resection on the History screen. First, select 'Gastrointestinal Surgery, Lower' for the system under "Past Medical/Surgical History", then select the surgical procedure previously performed from the options 'Colostomy', 'Left Hemi-Colectomy', 'Right Hemi-Colectomy', 'Segmental Colectomy', 'Terminal Ileum Resection', or 'Total Colectomy'.
- If the procedure was performed for treatment of a stricture or removal of a large polyp, document that on the Indications screen by choosing as a therapeutic intervention either 'Dilation of Stricture' or 'Neoplasia Ablation'. CORI v3 does not easily capture the indication of removal of a large polyp.
- Documentation of landmarks seen can be entered on the Exam Info screen ("Cecum IDed by: ")

Notes for CORI v4 users:

- Depth of insertion is documented on the Procedure screen ("Depth of insertion: Actually reached").
- Document if the procedure was incomplete by answering the required field "Was the procedure completed?" on the Procedure screen.
- Document if the bowel prep was poor on the Preprocedure screen ("Prep results").
- Document a finding of severe colitis on the Finding screen by marking the involved area, then selecting "Mucosal abnormality/Colitis/IBD". On the detail screen which opens, choose 'Severe' from the menu for "Activity".
- Document a history of bowel resection on the History screen. Check "Surgical History" and then choose the appropriate Lower GI procedure.
- Document that the procedure is being performed for treatment of a stricture or removal of a large polyp on the Indications screen. Check either 'Dilation of stricture' or 'Polypectomy of known polyp(s)' under "Therapeutic intervention". There is no easy way to document that the polypectomy is for a large polyp, so this will be assumed.
- Documentation of landmarks seen and photodocumentation are not currently available in CORI v4.

What if these numbers don't seem correct?

- The depth of insertion must be documented in the fields provided, not in free text.
- If you are unable to reach the cecum in the examination because of inability to complete the procedure, poor bowel prep, severe colitis or because of prior bowel resection, these should be noted in the fields provided.
- If the procedure is being performed for a therapeutic intervention which may either limit the ability to complete the procedure (stricture) or preclude the need to (removal of known large polyp), this reason should be noted in the fields provided.

Quality Measure 7. Average examination time for endoscope withdrawal is ≥ 6 minutes for screening colonoscopies where no biopsies or polypectomies are performed.

Inclusions: All screening colonoscopies are included in this measure.

Exclusions: Cases will be excluded from analysis if one or more biopsies or polypectomies was performed during the examination, if the cecum was not reached, or if the colon is not intact.

Value measured: For cases in which endoscope withdrawal time is documented or can be calculated, the average withdrawal time will be reported.

Additional value reported: For all screening colonoscopies without exclusions, the proportion of cases for which withdrawal time is documented will be reported. For cases with withdrawal time documented, the proportion of cases with documentation < 6 minutes, between 6 and 8 minutes, and > 8 minutes will be reported.

Notes for CORI v3 users:

- Withdrawal time can be documented in CORI v3 in two ways. For either, open the Procedure Times screen by clicking on "Procedure Times" on the Exam Info screen. Then either enter a value for "Time for Withdrawal" or enter two values, for "Cecum Reached" and "Proc. Ended". Time for withdrawal can then be calculated.
- Document depth reached on the Exam Info screen ("Extent Reached").
- If the colon is not intact, document this on the History screen. Check "Surgical History" and then choose the appropriate Lower GI procedure.
- Document biopsies on any Findings detail screen by checking "Biopsy taken"; for the Diagnostic Test detail screen, check either "Biopsy taken" or "Random Biopsies".
- Document the biopsy or removal of a polyp by choosing, from the Polyp detail screen, any option for "Procedure", checking "Removed Piecemeal", checking 'Yes' for "Removed?" or checking "Polyp sent to path".
- Document the biopsy or removal of one or more polyps in a polyp cluster by choosing, from the Multiple Polyps detail screen, any option for "Procedure", checking 'Yes' for "Removed?" checking "Polyps sent to path" or entering a value in "# of Polyps Sent to Path".

Notes for CORI v4 users:

- Withdrawal time can be documented on the Procedure screen ("Scope insertion to scope removal:").
- Document depth reached on the Procedure screen ("Depth of Insertion: Actually reached").
- If the colon is not intact, document this on the History screen. Check "Surgical History" and then choose the appropriate Lower GI procedure.
- Document biopsies on any Findings detail screen (when available) by checking "Biopsy taken"

- Document the biopsy or removal of a polyp by checking any of the diagnostic options on the Polyp detail screen or selecting on that screen one of the following options for "Polyp removed?" – 'totally removed', 'partially removed', ' or 'removed piecemeal'.
- Document the biopsy or removal of one or more polyps in a polyp cluster by checking any of the diagnostic options on the Polyp Cluster detail screen or selecting 'Yes' on that screen for "Polyp removed?"

What if these numbers don't seem correct?

- The time from reaching the cecum to withdrawal of the endoscope must be documented in the fields provided, not in free text.
- If you performed a biopsy or polypectomy during the procedure, this must be documented on one of the Finding detail screens as described above.
- To exclude procedures in which the time interval may not be appropriate, be sure to document if the patient does not have an intact colon or if the cecum was not reached on the procedure.

Quality Measure 8. Details of polyps are documented, including details of polyp removal and retrieval

Inclusions: The denominator for this measure is the number of polyps which were found during the procedure. If more than one polyp was found in a single procedure, then each polyp is counted separately.

Exclusions: Polyps which are documented as part of a polyp cluster are not included in this measure.

Value measured: a. The number of polyps for which there was documentation of location, size and morphology (i.e. pedunculated or sessile). b. The number of polyps which were removed; of these the number that were retrieved; of these, the number that were sent to pathology. c. The completeness of removal of all polyps. d. Of polyps that were biopsied but not removed, the number where a tattoo was placed.

Notes for CORI v3 users:

- A finding of a polyp is noted by selecting Polyp from the main Findings page after clicking on the diagram to indicate the location of the polyp.
- Polyps that are documented on the “Multiple Polyps” screen will not be included in this measure.
- Location of the polyp is automatically documented on the Finding Description screen; size of the polyp can be documented either by entering a number of mm size or by checking “Diminutive”; morphology is documented by selecting the appropriate choice from the “Attachment” menu.
- Polyp removal is documented by checking ‘Yes’ for “Removed?” or checking "Removed piecemeal" on the Finding Description screen.
- Polyp retrieval is documented by checking ‘Yes’ for “Retrieved?” on the Finding Description screen.
- Sending the retrieved polyp to pathology is documented by checking “Polyp sent to path” on the Finding Description screen.
- Completeness of removal is not captured in a discrete data field except when "Removed piecemeal" is checked. Your number will always be less than expected on this measure since free text fields will not be searched for this information.
- For polyps which are not removed, biopsy of the polyp can be documented by checking either the 'biopsy without cautery' or 'hot biopsy' procedures.
- Placement of a tattoo cannot be documented in a discrete data field in CORI v3 so your number will always be 0 for this part of the measure.

Notes for CORI v4 users:

- A finding of polyp is noted by selecting Polyp from the main Findings page after clicking on the diagram to indicate the location of the polyp.
- Polyps that are documented as part of a "Polyp cluster" will not be included in this measure.
- Location of the polyp is automatically documented on the Polyp detail screen; size of the polyp can be documented either by entering a number of mm for size or by checking "Diminutive"; morphology is documented by selecting the appropriate choice for "Type".

- Polyp removal is documented by selecting either 'Totally removed', 'Partially removed', or 'Removed piecemeal' from the "Polyp removed?" menu.
- Polyp retrieval is documented by selecting 'Yes' for "Tissue retrieved?"
- Sending the retrieved polyp to pathology is documented by entering one or more pathology IDs.
- For polyps which are not removed, biopsy is indicated by checking either "Biopsy without cautery" or "Biopsy with cautery"
- Placement of a tattoo is documented by checking "Placement of tattoo"

What if these numbers don't seem correct?

- Polyps are included in this measure only if documented individually and not as part of a polyp cluster or multiple polyp finding.
- Documentation in free text boxes will not be searched for inclusions, exclusions , or values unless specifically stated. Check to see that all data is documented in one of the specified controlled fields.
- Because of lack of appropriate discrete data fields in CORI v3, placement of tattoos and completeness of removal measurements cannot be considered accurate.

Quality Measure 9. Intra- and immediate postprocedural complications (to include serious events such as perforation or bleeding requiring intervention) and interventions are documented.

Inclusions: All cases performed during the time period are included in this measure. Results will be stratified by procedures performed for screening vs. non-screening procedures.

Exclusions: None

Value measured: Number of cases where there is documentation of intra- or immediate postprocedural complications and interventions, including documentation that no complications have occurred.

Additional value measured: Of the cases with documentation of complications or lack of complications, the number where a serious complication has occurred, defined as death, or bleeding or perforation requiring an intervention.

Notes for CORI v3 users:

- Intra- and immediate postprocedural complications and interventions are documented on the Interventions/Events page.
- For documentation will be considered to be present if, you must document both complications and interventions on the Intervention/Events page:
    - either N is checked for "Any complications?" or any of the complications is checked, AND
    - either "No Intervention Required" is checked or one of the listed interventions is checked
- Serious complications are identified by
    - checking 'Death' as a complication, or
    - checking 'Bleeding' or 'Perforation,' if any of the "Unplanned Interventions" is also checked.
- A screening examination is documented by selecting any indication under “increased risk screening” or “Average risk screening” with no other indications selected.

Notes for CORI v4 users:

- Intra- and immediate postprocedural complications and interventions are documented on the Events page**.**
- Documentation will be considered to be present if
    - "Were there any unplanned events?" is checked 'No', OR
    - "Were there any unplanned events?" is checked 'Yes', and one or more events must be selected. In addition,
        - "Interventions required?" is checked 'No', OR
        - "Interventions required?" is checked 'Yes' and one or more interventions is selected
- A screening examination is documented by selecting at least one item under "Screening (no prior pathology" or "Familial syndrome" with no other indications selected.

What if these numbers don't seem correct?

- Documentation in free text boxes will not be searched for inclusions, exclusions, or values unless specifically stated. Check to see that all data is documented in one of the specified controlled fields.

Quality Measure 10. Review of pathology reports or results of pathology reports are documented

Inclusions: Cases are included in this measure if any pathology specimens are documented as being submitted.

Exclusions: None

Value measured: The number of these cases where there is documentation either that the pathology report has been reviewed, the pathology report is appended to the procedure report, or the results of the pathology evaluation are documented.

Notes for CORI v3 users:

- Cases with pathology specimens are identified on the Post Exam screen. In order to have submitted specimens appear on this screen, the submission of a sample must be indicated on the appropriate Findings detail screen,
    - for most findings, by checking the "Biopsy taken" checkbox;
    - for Polyp or Multiple Polyp findings, by checking the "Polyp(s) sent to pathology" checkbox
- Results are considered documented when
    - for any pathology specimen, there is an entry for Results", "Modifier", or "Comments" on the Post Exam screen, or
    - if there is text entered into the Pathology Report field.

Notes for CORI v4 users:

- Cases with pathology specimens are identified on the Postprocedure screen. In order to have submitted specimens appear on this screen, you must add a Pathology ID to any of the Findings details screens. Enter an ID by which you can identify a specimen, then click on "Add".
- Results are considered documented when
    - there is an imported pathology report (usually an image or pdf file),
    - the text of the pathology report has been entered into the Import pathology screen, or
    - for any pathology specimen, there is an entry for "Results", "Modifier" or "Comments" on the Postprocedure screen.

What if these numbers don't seem correct?

- Submission of specimens for pathology must be documented from the appropriate Findings detail screen.

Quality Measure 11. Adenoma detection rate in first time screening exams can be determined.

Inclusions: Cases are included in this measure if they were performed for screening, either in average or higher risk patients.

Exclusions: Cases for which there is documentation of a prior Colonoscopy are excluded from this measure.

Value measured: Number of cases where an adenomatous polyp is detected. Any polyp which is >9 mm in diameter is considered to be adenomatous even if no pathological diagnosis is available. In addition, cases where carcinoma or adenocarcinoma is documented will be considered positive for purposes of this quality measure.

Notes for CORI v3 users:

- A screening examination is documented by selecting any indication under “increased risk screening” or “Average risk screening”.
- If any other indications are documented, then the case will not be included in this measure.
- If there is documentation of a prior colonoscopy procedure using the CORI software at the same site, then the case is excluded.
- The finding of an adenomatous polyp can be documented in one of several ways:
    - By documentation in the Pathology section of the Post Exam screen a result for a Polyp of ‘Adenoma’, ‘Adenocarcinoma’, or ‘Carcinoma’
    - If no pathology is documented, then by indicating a size > 9 mm on the Finding Description screen for a Polyp or Multiple polyps
    - If no pathology is documented, by documenting a Tumor with ‘Malignant’ selected from the menu for “Benign/malignant” and 'Suspected' selected from the menu for "Established/Suspected" on the Finding Description screen

Notes for CORI v4 users:

- A screening examnation is documented by selecting at least one item under "Screening (no prior pathology" or "Familial syndrome'.
- If any other indications are documented, then the case will not be included in this measure.
- If there is documentation of a prior colonoscopy procedure using the CORI software at the same site, then the case is excluded.
- The finding of an adenomatous polyp can be documented in one of several ways:
    - By documentation in the pathology section of the Postprocedure page a result of 'Adenoma', 'Adenocarcinoma', or 'Carcinoma'.
    - If no pathology is documented, then by indicating a size > 9 mm on the Polyp detail screen or Polyp Cluster detail screen.
    - If no pathology is documented, by documenting a Tumor/Cancer with 'Suspected malignant' chosen as the description.
- Note that in order to document pathology results on the Postprocedure page, you must enter a pathology ID on the specific finding's detail page.

What if these numbers don't seem correct?

- Screening colonoscopies are only included if there are NO OTHER INDICATIONS. If one of the screening indications and any other indication are marked, then this case will not be included in the measure.
- This measure will likely overestimate the number of first time screening examinations, since many prior examinations will not have been documented using the CORI software.
- Polyps > 9 mm will only be counted as adenomatous if there is NO pathology reported in the Post Exam/Postprocedure sections. If any pathology results are reported, it is assumed that the results of the polyp examination are included.
- Documentation in free text boxes, such as the “Pathology Report” area in CORI v3 will not be searched for inclusions, exclusions , or values unless specifically stated. Check to see that all data is documented in one of the specified controlled fields.

Quality Measure 12. Recommendations for followup colonoscopy are documented.

Inclusions: All cases are included in this measure.

Exclusions: None

Value measured: The number of cases for which there is documentation of the recommended followup colonoscopy interval.

Notes for CORI v3 users:

- The recommended followup colonoscopy interval may be documented on the Treatment Plan screen, "Colon Screen Every (yrs):".

Notes for CORI v4 users:

- The recommended followup colonoscopy interval may be documented in two places:
    - On the Assessment/Plan screen, "Recommended next exam in:" (if interval is given) OR
    - On the Postprocedure screen, "Based on pathology, recommended next exam in:"

What if these numbers don't seem correct?

- Documentation in free text boxes will not be searched for inclusions, exclusions, or values unless specifically stated. Check to see that all data is documented in one of the specified controlled fields.

Quality Measure 13. For average risk patients ≥ 50 years of age with no abnormal findings on screening colonoscopy the recommended screening interval is 10 years.

Inclusions: Cases are included in this measure if they were performed for screening in an average risk patient ≥ 50 years of age and if there are no other indications for the colonoscopy. Higher risk patients are defined as those with a family history of HNPCC or FAP, of colorectal cancer or adenomas in a first degree relative, or a personal history of ovarian or uterine cancer at age < 50.

Exclusions: Besides excluding cases performed on higher risk patients, cases are excluded if

- the cecum was not reached
- the examination was incomplete
- the quality of the bowel prep was inadequate
- a biopsy or polypectomy was performed during the examination (used as an indicator of abnormal findings)

Value measured: Number of cases with documentation of a recommended followup interval and, in those, the recommended interval.

Notes for CORI v3 users:

- A family history of polyps can be easily documented in CORI v3, but not of adenomatous polyps. In addition, for cases with a family history of adenoma that are not associated with a familial syndrome, higher risk is defined as adenomas in a first degree relative only. Since this is information not captured discretely in CORI v3, all cases with documentation of a family history of polyps are considered higher risk. This is documented on the Indications screen ("Fm Hx Polyps").
- Any case with a family history of colorectal cancer (whether or not in a first degree relative) will be considered higher risk. This is documented on the Indications screen ("Fm Hx of Colorectal Cancer").
- Because the age of onset of ovarian or uterine cancer is not easily documented, all cases marked as increased risk screenings due to either disease (i.e. choosing an Indication of Increased risk screening, Personal history of ovarian or uterine cancer) will be considered higher risk.
- An inadequate bowel prep is defined as a choice of ‘poor’ or ‘fair, exam compromised’ for prep results documented on the Exam Info screen.
- Incomplete procedure ("Incomplete due to" or "Other reason incomplete") and depth of insertion ("Extent Reached") are documented on the Exam Info screen.
- The recommended interval must be documented on the Treatment Plan screen (“Colon screen every (yrs):”). If a range is reported, the lower value in the range will be used for this measure.

Notes for CORI v4 users:

- A family history of adenomatous polyps can be documented in CORI v4 by checking "Positive family Hx adenomatous polyps" on the Indications screen. For cases with a family history of adenoma that are not associated with a familial syndrome, higher risk is defined as adenomas in a first degree relative only. However, for this quality measure, all cases with documentation of a family history of adenomatous polyps are considered higher risk.
- All cases with documentation of a family history of colorectal cancer (checking "Positive family Hx of colorectal cancer" on the Indications screen) are considered higher risk.
- A personal history of ovarian or uterine cancer cannot be easily documented and therefore these cases will not be considered higher risk.
- An inadequate bowel prep is defined as a choice of 'Poor – inadequate to detect polyps > 5 mm' for prep results on the Preprocedure screen.
- Completion of the procedure and depth of insertion are documented on the Procedure screen. Neither documentation of cecal landmarks nor photodocumentation of the cecum can be easily accomplished and therefore will not be measured.
- The recommended follow-up interval is found on the Assessment/Plan page. Choose "Recommended next exam in:" and enter the years and/or months.

What if these numbers don't seem correct?

- Screening colonoscopies are only included if there are NO OTHER INDICATIONS. If "Screening" and any other indication are marked, then this case will not be included in the measure.
- Documentation in free text boxes will not be searched for inclusions, exclusions, or values unless specifically stated. Check to see that all data is documented in one of the specified controlled fields.

Quality Measure 14. For post-polypectomy patients undergoing surveillance colonoscopy, if no new polyps are discovered, the recommended surveillance interval is 5-10 years.

Inclusions: Cases are included in this measure if they were performed for surveillance of adenomatous polyps.

Exclusions: Cases are excluded if there was a new polyp found on this examination, if there is a history of HNPCC, if the cecum was not reached or the bowel prep was inadequate on this examination, if the examination was incomplete, or if certain other Findings are noted, all of which may change the recommended surveillance interval.

Value measured: The number of these cases where the recommended surveillance interval is less than 5 years, from 5-10 years, >10 years or not documented.

Notes for CORI v3 users:

- Cases performed for surveillance of adenomatous polyps are recognized by selection of "(Surveillance of) Adenomatous polyps" on the Indications screen and by lack of other indications.
- Cases are excluded if a finding of Polyp or Multiple Polyps is documented.
- HNPCC cannot be discretely recorded in CORI v3, and therefore these cases will not be excluded from the measure.
- Inadequate bowel prep is identified from the Preprocedure screen, when "Prep results" are 'poor'
- Cecal intubation is documented on the Procedure screen "Depth of insertion: Actually reached" by values 'Cecum' or 'Terminal Ileum'
- Incomplete examination is documented on the Exam Info screen either by choosing from the "Incomplete Due to:" menu or by indicating a reason in "Other Reason Incomplete"
- Tumor, Colitis and Crohn's are the only findings to be considered abnormal for purposes of this measure.
- The recommended surveillance interval is documented on the Treatment plan screen ("Colon screen every:")

Notes for CORI v4 users:

- Cases performed for surveillance of adenomatous polyps are recognized by selection of "Adenomatous polyps" on the Indications screen and by lack of other indications.
- Cases are excluded if a finding of Polyp or Polyp Cluster is documented.
- HNPCC is documented on the Indications screen.
- Inadequate bowel prep is identified from the Preprocedure screen, when "Prep results" are 'poor'
- Cecal intubation is documented on the Procedure screen "Depth of insertion: Actually reached" by values 'Cecum' or 'Terminal Ileum'
- Incomplete examination is documented on the Procedure screen by selecting 'No' for "Was the procedure completed?"

- Tumor/Cancer and Mucosal abnormality/Colitis/IBD are the only findings to be considered abnormal for purposes of this measure.
- The recommended surveillance interval is documented on the Assessment/Plan screen ("Recommended next exam in:").

What if these numbers don't seem correct?

- In CORI v3, any cases with HNPCC will be included since this cannot be documented in discrete fields.
- Surveillance colonoscopies are only included if there are NO OTHER INDICATIONS. If Adenomatous polyps and any other indication are marked, then the case will not be included in the measure.
- Documentation in free text boxes will not be searched for inclusions, exclusions, or values unless specifically stated. Check to see that all data is documented in one of the specified controlled fields.

Quality Measure 15. For patients undergoing polypectomy during a screening or post-polypectomy surveillance colonoscopy the recommended surveillance interval is based on worst pathological finding from the current polyp(s).

Inclusions: Cases are included in this measure if they were performed for screening or for surveillance of adenomatous polyps, and a polyp was found on this examination.

Exclusions: Cases are excluded if there is a history of HNPCC, if the cecum was not reached or the bowel prep was inadequate on this examination, if the examination was incomplete, if certain other Findings are noted, or if one or more polyps were incompletely removed on this examination, all of which may change the recommended surveillance interval.

Value measured: The number of these cases where the recommended surveillance interval meets current guidelines:

- 1-2 tubular adenomas of < 1 cm (5-10 years)
- 3-10 adenomas (3 years)
- >10 adenomas (<3 years)
- adenoma with villous features (3 years)
- adenoma >=1 cm (3 years)
- adenoma with high grade dysplasia (3 years)
- sessile adenoma >=2 cm, removed piecemeal (2-6 mos)
- hyperplastic polyp (10 years for screening, 5-10 years for surveillance)

Notes for CORI v3 users:

- Cases performed for surveillance of adenomatous polyps are recognized by selection of "Adenomatous polyps" on the Indications screen and by lack of other indications.
- Cases performed for screening are identified by the selection of any of the Average Risk or Increased Risk Screening indications and by lack of other indications.
- Cases are included if a finding of Polyp or Multiple Polyps is documented.
- HNPCC cannot be discretely recorded in CORI v3, and therefore these cases will not be excluded from the measure.
- Inadequate bowel prep is identified from the Preprocedure screen, when "Prep results" are 'poor'
- Cecal intubation is documented on the Procedure screen "Depth of insertion: Actually reached" by values 'Cecum' or 'Terminal Ileum'
- Incomplete examination is documented on the Exam Info screen either by choosing from the "Incomplete Due to:" menu or by indicating a reason in "Other Reason Incomplete"
- Tumor, Colitis and Crohn's are the only findings to be considered abnormal for purposes of this measure.
- Polyp descriptors are found on the Polyp or Multiple polyp detail screens ("Max Size", "Attachment" and the checkbox "Removed Piecemeal")
- The recommended surveillance interval is documented on the Treatment plan screen ("Colon screen every:")

Notes for CORI v4 users:

- Cases performed for surveillance of adenomatous polyps are recognized by selection of "Adenomatous polyps" on the Indications screen and by lack of other indications.
- Cases performed for screening are identified by the selection of any of the Screening indications and by lack of other indications.
- Cases are included if a finding of Polyp or Polyp Cluster is documented.
- HNPCC is documented on the Indications screen.
- Inadequate bowel prep is identified from the Preprocedure screen, when "Prep results" are 'poor'
- Cecal intubation is documented on the Procedure screen "Depth of insertion: Actually reached" by values 'Cecum' or 'Terminal Ileum'.
- Incomplete examination is documented on the Procedure screen by selecting 'No' for "Was the procedure completed?"
- Tumor/Cancer and Mucosal abnormality/Colitis/IBD are the only findings to be considered abnormal for purposes of this measure.
- Polyp descriptors are found on the Polyp or Polyp cluster detail screens ("Size", "Type" and the menu "Polyp removed?")
- The recommended surveillance interval is documented on the Assessment/Plan screen ("Recommended next exam in:") or on the Postprocedure screen ("Based on pathology, recommended next exam in:")

What if these numbers don't seem correct?

- In CORI v3, any cases with HNPCC will be included since this cannot be documented in discrete fields.
- Screening and surveillance colonoscopies are only included if there are NO OTHER INDICATIONS. If Adenomatous polyps or a screening indication and any other indication are marked, then the case will not be included in the measure.
- Since CORI v3 does not allow documentation of a recommended exam interval of less than one year, the performance for sessile adenomas >= 2 cm may not be accurate.
- This is a particularly difficult quality measure due to the complexity of the logic and amount of data which must be collected. CORI is working to improve documentation of these measures in CORI v4.
- Documentation in free text boxes will not be searched for inclusions, exclusions, or values unless specifically stated. Check to see that all data is documented in one of the specified controlled fields.