

PATIENT POPULATION: Adults 45-75 years of age, all payers

NUMERATOR COMPLIANCE: Per HEDIS®, Adults 45-75 years of age who had an appropriate screening for colorectal cancer screening. Appropriate screenings are defined as¹:

COLORECTAL CANCER SCREENING TYPE*	TIME PERIOD
Fecal Occult Blood Test (i.e., gFOBT, FIT).....	Within the last year
Stool DNA Test (i.e., Cologuard).....	Within the last 3 years
Flexible Sigmoidoscopy.....	Within the last 5 years
Computed Tomography Colonography.....	Within the last 5 years
Colonoscopy.....	Within the last 10 years

EXCLUSIONS

- » Patients with a diagnosis or past history of total colectomy or colorectal cancer
- » See HEDIS® specification for further exclusions

DOCUMENTATION REQUIREMENTS

- A note in the medical record indicating the date, type, and result of colorectal cancer screening
- » A result is not required if the documentation is clearly part of the member’s “medical history”; documented in the **medical history section**
 - » **Pathology reports** are acceptable
 - » Documentation can be completed during a **telehealth encounter**
 - » **Result/Findings:** Documentation of “normal” or “abnormal” is acceptable

COMMON DOCUMENTATION INSUFFICIENCIES

- » Utilizing patient questionnaires that do not capture type of screening; or patient does not provide complete information
- » Visit note documentation does not specify type of screening and date, i.e., “Col Screening 1/19”, “Colorectal Cancer Screening is current”
- » Failing to document findings/results i.e., documenting “Colonoscopy 2016”, or “Colonoscopy is current” in the assessment and plan section of the note
- » Digital Rectal Exams (DRE) or FOBT tests performed in an office setting, or performed on a sample collected via DRE do not meet the intent of this measure

¹ HEDIS® stands for Healthcare Effectiveness Data and Information Set and is a registered trademark of the National Committee for Quality Assurance (NCQA)

BEST PRACTICES

- 1 On annual wellness visit forms, include colorectal cancer screening question – with screening type, date (year), and findings. Ensure this form contains patient name and date of birth and is scanned into medical record.
- 2 Upload colorectal cancer screening reports and/or notes into your EMR and label clearly for easy identification
- 3 Document colorectal cancer screenings in patient medical history section with type of screening, date, and result
- 4 Ensure workflows are in place to notify and remind providers of when a patient’s next screening is due and to discuss with patients in advance. Utilize ACN Provider Portal when chart prepping.
- 5 Make follow-up phone calls if patients have not completed their screening. Utilize care gap lists to identify non-compliant patients.
- 6 Educate patients on the risks of colorectal cancer and various screening types
- 7 Our Care Coordination team can provide your patients with individualized support. To refer a patient:

(602) 406-7226

CareCoordination@azcarenetwork.org

