Arizona Care Network

Colorectal Cancer Screening

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 as[1]:

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

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