Colorectal Cancer Screening

Outlines the proper workflow for documenting the completion of a colorectal cancer screening

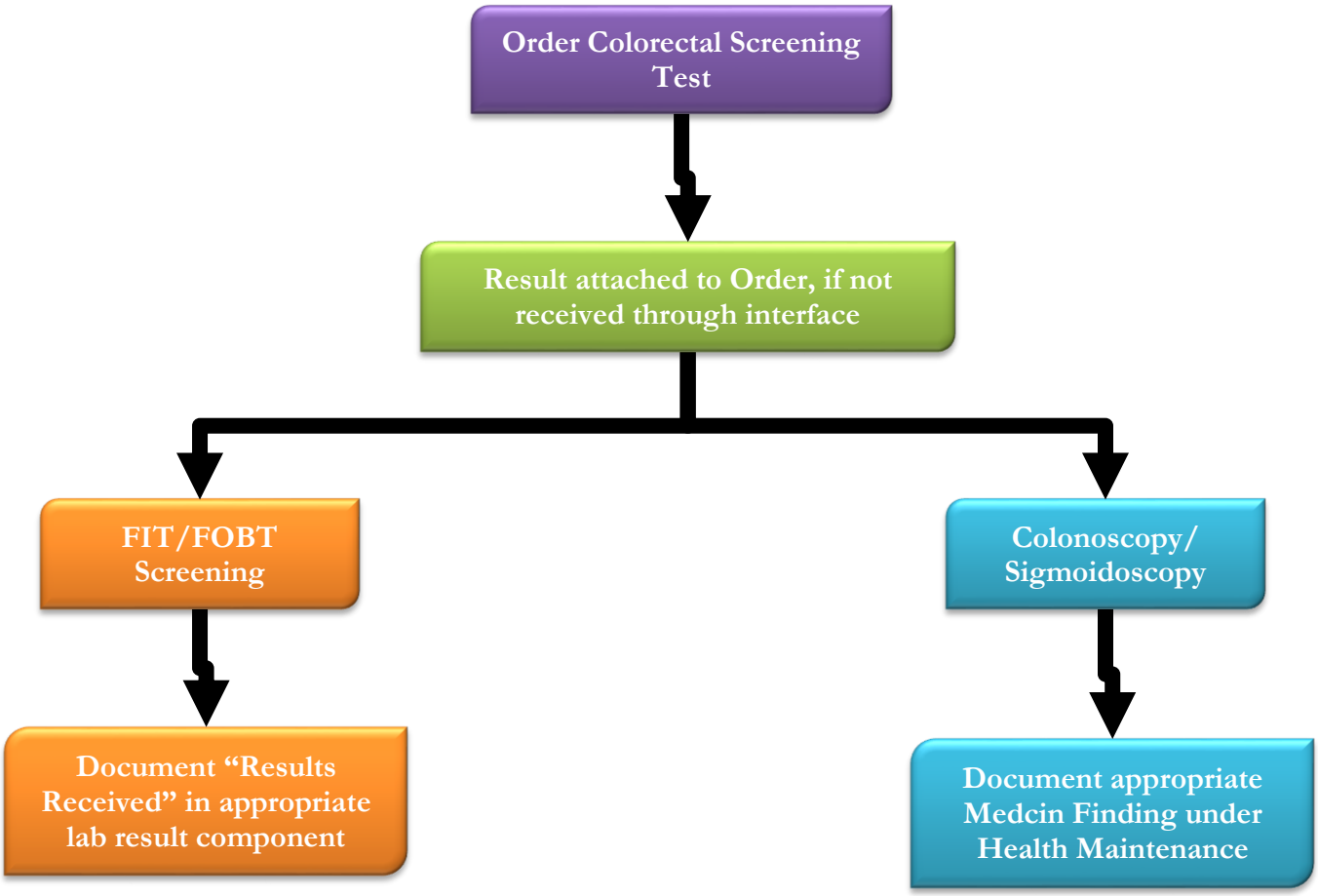
Purpose of Structured Data

- Documenting colorectal cancer screening is a Uniform Data System (UDS) measure and is directly linked with the 2016 Clinical Quality Measure (CQM) 130v4 – Colorectal Cancer Screening (NQF0034)

Description of Measure

- This measure looks at the total percentage of adult patients 50-75 years of age who had appropriate screening for colorectal cancer

Workflow – Overview

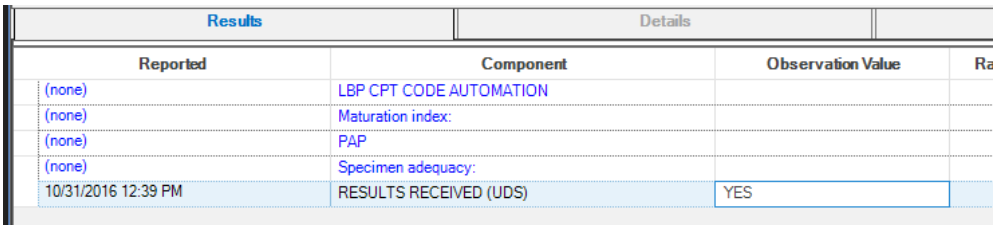


Workflow – Detail (FIT/FOBT)

1. Order the appropriate screening test
    a. Fecal Occult Blood Test (FOBT) during the measurement period
    b. Fecal Immunochemical Test (FIT) during the measurement period

2. When the result is received, if it does not come through the interface, it must be attached to the appropriate order

3. Open the **Order Details** for the screening test that was just performed. In the **Observation Value** for **Results Received (UDS) FOBT-FIT** select **YES**, then **Save & Exit**

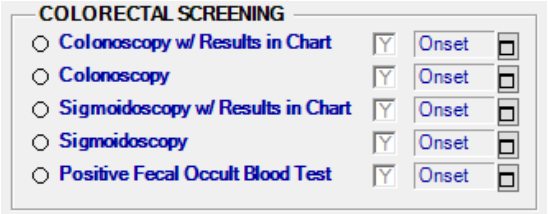


Workflow – Detail (Colonoscopy/Sigmoidoscopy)

1. Order the appropriate screening test
    a. Flexible sigmoidoscopy during the measurement period or the four years prior to the measurement period
    b. Colonoscopy during the measurement period or the nine years prior to the measurement period

2. When the result is received, if it does not come through the interface, it must be attached to the appropriate order
    a. If the patient had the screening test completed by a different provider, a copy of the results must be scanned and attached to the patient's **Misc Index** folder under **Documents** (If the results are not obtained, the patient is considered "non-compliant" for this measure

3. Document the screening was completed and results were received using the appropriate Medcin finding under the **Health Maintenance** tab
    a. **Note:** For each screening test (colonoscopy/sigmoidoscopy) 2 findings have been outlined. 1 for the test name w/ results in chart and 1 for just the test name. Please keep in mind the finding labeled test name w/ results in chart may only be used for patients that have an appropriate screening within the allowable timeframe in which the results are in the chart.
    b. If no results are on the chart, but the patient states they had a colonoscopy/sigmoidoscopy, you can document the appropriate finding and then attempt to secure the result report



Exclusions

- Patients that have an active, inactive, or resolved diagnosis of **Malignant Neoplasm of Colon** or a **Total Colectomy** are excluded from this measure