ACO 19, STARs - Colorectal Cancer Screening

**Description:** Percentage of adults 50 -75 years of age who had appropriate screening for colorectal cancer.

**Initial Patient Population:**
All patients 50 -75 years of age with a visit during the measurement period.

**Numerator:**
Patients who had at least one or more screenings for colorectal cancer
- The numerator is satisfied by recording a colonoscopy, flexible sigmoidoscopy, FOBT, CPT code, or HCPCS code.
- **Note:** This can be patient reported with the date (year), result finding, test performed.

**Denominator:**
Equals Initial Patient Population

**Denominator Exclusions:**
Documentation of medical reason(s) for not performing colorectal cancer screening (e.g., a diagnosis or past history of total colectomy for colorectal cancer.)

**Note:** Patients are considered to have had an appropriate screening for colorectal cancer if any of the following are documented:
- Fecal occult blood test (FOBT) during the measurement period
- Flexible sigmoidoscopy during the reporting period or the four years prior to the reporting period
- Colonoscopy during the reporting period or the nine years prior to the reporting period
- Do not count digital rectal exams (DRE), FOBT tests performed in an office setting or performed on a sample collected via DRE
Identify missing care gaps by referring to the Flow Sheet in the patients chart.

Missing data
Documenting Fecal Occult Blood Test Collected or Results Received During the Measurement Period

- Enter a lab record for FOBT that your practice utilizes
  
  **Note**: This is not a sample collected during a digital rectal exam.

- Enter specimen test date in the Collection Date field
- Check box “Received” in Results section
- Enter results (Positive/Negative) in structured data field adjacent to the received date
  (Results text field will pull to the Flow Sheet)
- Click “Reviewed”
- Click OK

Note: Follow office protocol for reviewing and resulting labs in terms of which staff are designated to enter results and when relative to provider review. Appropriate party should mark as Received and mark Reviewed.

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Documenting Sigmoidoscopy/Colonoscopy Results Received During the Measurement Period

- Enter Diagnostic Imaging record for Flex Sig or Colonoscopy
- Enter Procedure date
- Check box Results “Received”
- Enter Results, can add additional findings in the Notes field
- Click “Reviewed”
- Click OK
Documenting Exclusions

Document medical reason(s) for not performing colorectal cancer screening (e.g., a diagnosis or past medical history of total colectomy or colorectal cancer)

Example: Problem List entry

Example: Past Medical History entry
Best Practice:
Although not required for satisfying the measure, the supporting clinical documentation should be obtained and scanned to the patient chart when available.

Special Note: Documentation outside of the recommended workflow above may not capture structured data elements required for reporting purposes. (Measure Capture)

Additional resources:

https://www.bannerhealthnetwork.com/ehr
https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Quality-Measures-Standards.html