Colon Cancer Screening Improvement Assessment: Part 4

	Status of Existing Policy for Cancer Screening			
#	Question	Response	Additional Comments	Documentation
4.1	Is CRC a screening a quality measure you are currently monitoring?			
4.2	Which quality measure do you use? (UDS, NQF0034, HEDIS)			
4.3	Is there an existing policy and/or standing orders in place for colorectal cancer screening?		[REVIEW WRITTEN POLICY]	
4.4	When was the policy or protocol written?			
4.5	How often do you typically review policies/standing orders?			
4.6	How are staff trained or oriented on the policy/protocol?			
4.7	Your policy/procedure includes the following:		[REVIEW WRITTEN POLICY]	
	Use of ACS Approved CRC Screening Tests			
	Which of the following CRC screening tests do you use in house or provide by referral?			
#	Question	Response	Additional Comments	Documentation
4.8	Guaiac based FOBT?		Brand and # of samples needed	
4.9	High sensitivity FOBT? (iFOBT)		Brand and # of samples needed	
4.10	Fecal Immunochemical Testing (FIT)		Brand and # of samples needed	
4.11	Stool DNA (Cologuard)			
4.12	Spiral CT			
4.13	Flexible Sigmoidoscopy			
4.14	Colonoscopy			

4.15	Do you have a standardized tool or method in place to assist patients with shared decision making on what type of screening to use?			
4.16	What are your three top colonoscopy referral sites/practices?			

	Documentation of CRC screening outside of your practice			
#	Question	Response	Additional Comments	Documentation
4.17	Do you ask new patients about CRC screening done outside of your clinic?			
4.18	If a patient has a colonoscopy/ FOBT/ FIT/ Cologuard done outside of the clinic, do you request a copy of the results?			
4.19	Where are the results of tests conducted outside the health center recorded in the EMR?			
4.20	Is it structured or free text data?			
4.21	Is the report scanned into the EMR?			
4.22	Where are the results recorded in the EMR?			
4.23	Is it structured or free text data?			
4.24	Are paper results scanned into the EMR?			
4.25	If paper results are not scanned in to the patients chart, Why not?			
4.26	If the patient had a colonoscopy/FOBT/FIT done outside of the clinic and self-reports the results, do you document it?			

4.27	Who records this?			
4.28	Where is it recorded in the EMR?			
4.29	Is it structured or free text data?			

	Identifying and Documenting Patients for Screening, History and Risk Assessment			
#	Question	Response	Additional Comments	Documentation
4.30	Do you use a Clinical Decision Support tool (DCS) to flag the need for screening?			
4.31	How does that CDS alert appear to the provider? Does it require a response/action - can it be ignored?			
4.32	Are patient's records pre-screened prior to their appointment (i.e., in pre-visit planning) to identify those in need of age-appropriate cancer screening?			
4.33	When are records pre-screened?			
4.44	Is it done consistently for every visit?			
4.45	Who is responsible for pre-screening patient records?			
4.46	Where is this recorded in the EMR?			
4.47	Is it structured or free text data?			
4.48	Who is responsible for conducting the intake of the patient (i.e., vital signs, chief complaint, etc.)?			
4.49	How is colon cancer screening history documented in the EMR?			
4.50	Who discusses and documents family history of Colon cancer? At what age is this history taken? How often is family history updated?			

4.51	Is patient history of adenomatous polyp removal documented in the EMR? Are these patients flagged for rescreening based on recommendation by the colonoscopy provider?			
4.52	Is there anything in place to ensure that patients who have a family history of colorectal cancer are "flagged" or identified for early and more frequent screening recommendations or identified as needing to go directly to colonoscopy?			
4.53	Do you document smoking, obesity, diabetes, IBS, etc. as CRC risk factors?			
4.54	During the visit - how are providers reminded/alerted that a patient is due for CRC screening?			
4.55	Is there a policy to discuss CRC screening needs at all visits, not just wellness or preventive visits?			
	Patient Education and Cultural/Health Literacy			
#	**Question**	**Response**	**Additional Comments**	**Documentation**
4.56	Are patient education materials on the importance of CRC screening available to patients in the **waiting room?**			
4.57	Are patient education materials on the importance of CRC screening available to patients in the **exam room?**			
4.58	Do you have culturally and linguistically appropriate education materials geared to different patient groups/needs?			
	Stool Test Protocols			
#	**Question**	**Response**	**Additional Comments**	**Documentation**

4.59	Are different screening options (FIT, StoolDNA, Scope) discussed with average risk patients (shared decision making) in choosing what type of CRC screening to be used?			
4.6	Do you have a standard protocol for take home FOBT or FIT for colorectal cancer screening at your health center?		[REVIEW WRITTEN POLICY]	
4.61	If FOBT or FIT is used, who gives the kit to the patient?		[ADDITIONAL DETAILS ABOUT PROCESS]	
4.62	Is the FIT/FOBT kit labeled at the time it is given to the patient?			
4.63	Does someone instruct the patient on how to collect and return the sample (i.e. show kit to patient - discuss instructions, discuss how and when to return)			
4.64	Are FIT/FOBT instructions provided in the patients preferred language?			
4.65	How is the FIT/FOBT returned? (self addresses stamped mailer provided, returned in person, self stamped return?)			
4.66	Are patients reminded to return the FIT/FOBT kit? If yes, how are they reminded, and at what interval?			
4.67	Do patients receive more than one reminder? How many? Timing?			
4.68	How and where is the FIT/FOBT order documented in the EMR? By Who? (Structured or Free Text field?)			
4.69	How and where is the COMPLETED FIT/FOBT documented in the EMR? By Who? (Structured or Free Text field?)			
4.70	Are you able to track your FIT/FOBT completion rate?			
4.71	Do you prescribe Cologuard tests for average risk patients?			
4.72	Are you connected to the Cologuard patient portal to track completions and results?			

4.73	**Is the Cologuard prescription documented in your EMR?**			
4.74	**Is the Cologuard return documented in your EMR?**			
4.75	**Is the Cologuard result documented in your EMR?**			
4.76	**Do you do any supplementary patient education or return reminder for Cologuard tests?**			
4.77	**FOBT/FIT or Cologuard of the test result and need for Colonoscopy?**			
4.78	If a patient REFUSES CRC screening - do you document that refusal in the EMR? If so - where?			
4.79	Do you document the reason for refusal in the EMR? If so how?			

	Colonoscopy Protocols and Documentation			
#	**Question**	**Response**	**Additional Comments**	
4.80	**Who makes the colonoscopy referral appointment for patients without insurance?**		**[ADDITIONAL DETAILS ON PROCESS]**	
4.81	**If appointment is made for the patient , do you give patient written documentation of the appointment?**			
4.82	**Where is this information documented in the EMR?**			
4.83	**If the appointment is not made for the patient what is your process to ensure that the patient does the colonoscopy screening?**			
4.84	**Who makes the colonoscopy referral appointment for patients with insurance?**		**[ADDITIONAL DETAILS ON PROCESS]**	
4.85	**Is this done before the patient leaves the health center?**			

4.86	Where is it documented in the EMR?			
4.87	Is it structured or free text data?			
4.88	When is it done?			
4.89	How is this communicated with the patient?			
4.90	Where is it documented in the EMR?			
4.91	Is it structured or free text data?			
4.92	Is this done before the patient leaves the health center?			
4.93	Where is it documented in the EMR?			
4.94	Is it structured or free text data?			
4.95	If appointment is made for the patient , do you give patient written documentation of the appointment?		[ADDITIONAL DETAILS ON PROCESS]	
4.96	When is it done?			
4.97	How is this information communicated with the patient?			
4.98	Where is it documented in the EMR?			
4.99	Is it structured or free text data?			
4.10	Do you follow-up with referrals for colonoscopies to make sure that patients show up for their appointments?		[ADDITIONAL DETAILS ON PROCESS]	
4.10	Who is responsible for this?			
4.10	Where is it documented in the EMR?			
4.10	Is it structured or free text data?			
4.10	If the patient showed up for their appointment, do you inquire about the results?			

4.11	Where is it documented in the EMR?			
4.11	Is it structured or free text data?			
4.11	If the patient was a “no show”, do you contact the patient for another appointment?		[ADDITIONAL DETAILS ON PROCESS]	
4.11	When is patient contacted?			
4.11	Who is responsible for contacting the patient?			
4.11	Where is it documented in the EMR?			
4.11	Is it structured or free text data?			
4.11	Does staff at this clinic do any kind of prep education with the patient?			
4.11	Do you run any type of regular analytic reports? Are any specific to cancer screening or colorectal cancer? Do you have population health module? What vendor?		[ADDITIONAL DETAILS ON PROCESS]	

	Tracking and Monitoring			
#	Question	Response	Additional Comments	
4.114	How are you tracking your referrals for colonoscopies?		[ADDITIONAL DETAILS ON PROCESS]	
4.115	How are FOBT/ FIT results on your patients received by your practice? (Electronically? Hard Copy?)			
4.116	Who is responsible for scanning paper results into the EMR?			
4.117	Are FOBT/FIT results structured data or free text?			
4.118	How are FOBT/ FIT results on your patients transmitted to the ordering provider?		[ADDITIONAL DETAILS ON PROCESS]	
4.119	How are normal results communicated to a patient? Choose all that apply:			
4.120	2			

4.121	Is it structured or free text data?			
4.122	Do patients need to have a follow-up appointment to receive a normal result?			
4.123	Who is responsible for contact the patient?			
4.124	How are abnormal results communicated to the patient?			
4.125	Where is the communication with the patient documented in the EMR?			
4.126	Is it structured or free text data?			
4.127	For patients with abnormal colorectal cancer screening result, what is the process for scheduling follow up? Choose all that apply:			
4.128	Do you track a patient's diagnostic services to ensure the patient has completed all recommended services and has been given a final diagnosis?		[IF YES, WHERE IS IT TRACKED?]	
4.129	Is a final diagnosis recorded in the EHR?			
4.130	Where is it documented?			
4.131	Is it structured or free text?			