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Colorectal cancer screening

An interview with Dr. Robert Carlson, Hastings, MI

Dr. Carlson with patient, Gerald Bachelder

How do you make sure your eligible patients get screened for colorectal cancer? Do you have a system in place to follow up?

It starts with our team understanding the importance of all preventive measures, including colorectal cancer screening. I have always been excited about this measure as it gives us a chance to significantly impact cancer in our community.

We recognize that all patients over 50 need an annual preventive exam. We measure ourselves on how many patients get the exam completed. More than 95% of patients come in for this exam, which sets the stage for a discussion on their colorectal cancer screening. Before the age of 50, we're setting the expectation that they will get a colonoscopy or other screening for colon cancer.

We have an electronic medical record that allows us to track discrete pieces of information. Our process is a very conscientious effort to make sure all patients are screened in a timely way.

What kind of patient education do you provide on colorectal cancer screening?

I share information with patients on websites, such as WebMD or Choosing Wisely or invite them to seek out different sites about colon cancer and colonoscopy. When we empower patients to lean about things themselves, they usually make the right decision.

I also explain that some tests have false positives and if they opt for the ColoGuard™ or fecal immunochemical test, they may still have to have a colonoscopy.

What are some challenges to getting patients to comply and how to you overcome them?

We give patients three choices – the preferred choice of colonoscopy, the ColoGuard test for those concerned about the procedure or preparation, or a fecal immunochemical test. If someone is pushing back, I dig in and ask why they're afraid. Two of the options for colorectal cancer screening are easy to do.

Fear is a huge driver. We need to be respectful of their choices. Whether it's immunizations or colonoscopy, ask them in a caring way why they're reluctant.

When transportation is a challenge, our care managers have driven patients to their colonoscopy procedures.

The challenge is to first stay true to do what you know is right. Get patients in for their annual exam and be ready to have strategies around the barriers to getting the screening done. Be patient, persistent and consistent. Personalize the screening measure when applicable to the patient's life and relationships. Patients value their kids and grandkids, especially if there might be something that can impact generations.

And use the relationship you have established with the patient to get the screening completed.

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MQIC offers guidance on managing acute low back pain in adults

Many adults will experience low back pain at some point in their life. More than 25% of adults say they've experienced back pain in the past three months, according to the National Institute of Neurological Disorders and Stroke. Most of the time, low back pain is easily treated or will resolve on its own.

Imaging for acute low back pain isn't recommended within the first six weeks, unless certain "red flags," such as infection, spinal fracture and other medical conditions, are present. A conservative approach is generally considered preferable.

In 2018, the Michigan Quality Improvement Consortium published a **guideline** for adults with low back pain or back-related leg symptoms for more than six weeks. Following are some of the focus areas recommended by the consortium when treating patients with low back pain:

- Offer reassurance.
- Perform a physical exam.
- Encourage patients to stay activity within the limits permitted by pain.
- Refer to non-invasive therapy if the patient experiences persistent disability at two weeks.
- Prescribe medication on a time-contingent basis, not a pain-contingent basis.

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Do you have anything else to add?

We have some strategic relationships with GI specialists. If a patient hasn't scheduled the appointment, we call the patient. If we have a collaborative relationship with a particular specialist, he or she calls us to let us know if the patient has scheduled the appointment. We're in a constant feedback loop.

There are certain things I'm less intense about but, in my humble opinion, there's no reason not to do this screening. Every person in our office understands that we don't take no for answer.

We get beyond the no for those who don't want to do it. My goal for everything we're being measured on is 100 percent. You hit what you aim for. That's what our patients pay for and that's what we want to deliver.

New HEDIS blood pressure measure specifications eliminate need for medical record reviews

The controlling high blood pressure HEDIS® measure has been updated to assess patients ages 18 to 85 who had a diagnosis of hypertension and whose blood pressure was adequately controlled (less than 140/90) during the last reading of the year.

Previous CBP HEDIS, or Healthcare Effectiveness Data and Information Set, specifications required medical record reviews to determine if a patient's blood pressure was under control. Now, Blood Pressure CPT Category II results codes will determine compliance.

When you add the correct CPT Category II and ICD-10 codes to your claims, you won't need to include medical records for confirmation. This optimizes time and reduces record-keeping for providers.

To learn more about claims coding to reduce medical record reviews and other measure changes, **view the CBP tip sheet**. Questions about HEDIS compliance? Go to **bcbsm.com/providers** for additional resources.