



# Optimizing Clinical Workflows to Facilitate Complete Colorectal Cancer Screenings

## Screen Utah Workgroup 2 Final Recommendations

This work was convened and supported by the One Utah Health Collaborative. Workgroup 2 was facilitated by Comagine Health and this report was developed by Leavitt Partners, a Health Management Associates (HMA) company, and with contributions from stakeholders across Utah. The contents are those of the author(s) and do not necessarily reflect the official views of, nor constitute an endorsement by, these organizations.

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As part of the One Utah Health Collaborative’s Screen Utah initiative, Workgroup 2 brings together a coalition of healthcare professionals, healthcare organizations, payers, and policy experts united by a common goal: **to connect patients to the right screening test at the right time**. Rooted in the guiding principles of the [Utah Model of Care](#)—affordability, quality, and trust—this group is focused on closing persistent gaps in colorectal cancer (CRC) screening by strengthening the clinical processes that connect patients to timely, appropriate preventive services.

Foundational to the Screen Utah initiative is the commitment to building systems that support a complete CRC screening—which includes an initial screening test plus any necessary follow-up, including colonoscopy and related services. For clinicians, this means **designing workflows that not only initiate screening but also ensure follow-through, documentation, and coordination across the care continuum**. It also requires clear and accurate documentation that communicates clinical intent to payers, so screenings are properly coded as preventive and patients are protected from unnecessary cost-sharing.

Building on the foundational [work of Workgroup 1](#), which clarified coverage policies and coding practices to eliminate cost-sharing for complete CRC screenings, Workgroup 2 aims to integrate those policies into the systems and processes that guide care delivery. Our focus in Workgroup 2 has been on the clinical side of screening: how care teams proactively prompt, document, code, communicate, and follow up on CRC screening in real-world settings.

We believe that reimbursement policy alone—while critical—cannot close the gap; closing reimbursement gaps must be paired with consistent, well-designed workflows that ensure patients move smoothly from initial screening to follow-up care with timely, clear, patient-centered approaches.

To do this, Utah’s healthcare teams must take deliberate steps to redesign workflows that are efficient, consistent, and human-centered for patients, families, and care team members.

**By embedding these practices into everyday clinical routines, Utah’s care teams can transform CRC screening from a fragmented process into a coordinated and effective experience that saves lives and strengthens trust in the healthcare system.**

## Consensus-Based Recommendations to Optimize Clinical Care Workflows

To ensure that every Utahn receives the right CRC screening test at the right time, Workgroup 2 calls on all stakeholders—clinicians, health systems, payers, and care teams—to take collective action. The following recommendations are designed to align clinical workflows with evidence-based guidelines and support a seamless, patient-centered screening experience from start to finish.



### **Educate practitioners**—including primary care providers—on:

- CRC screening guidelines for a complete screening and recommended intervals.
- Risk stratification and screening modality coaching.



### **Define team roles clearly** to support a coordinated screening process:

- Assign responsibilities for education, ordering, scheduling, and follow-up.
- Use standing orders and workflows that support screening at every encounter.



### **Integrate CRC screening into whole-person care:**

- Embed screening into Annual Wellness Visits and chronic care management.
- Ensure workflows for rural, uninsured, and high-risk populations.



### **Adopt best practices in patient communication** across the screening continuum:

- Use consistent messaging during outreach, education, and follow-up.
- Coordinate communication across team members to reinforce the importance of screening.



### **Engage patients in shared decision-making** by:

- Apply motivational interviewing techniques to explore concerns and build trust.
- Offer personalized screening recommendations based on risk, access, and preference.
- Use culturally responsive dialogue to overcome negative perceptions and improve completion rates.



### **Train care teams and coding professionals on documentation practices that:**

- Clearly communicate clinical intent to payers.
- Support accurate coding as preventive care (e.g., use of Modifier 33).
- Avoid misclassification of surveillance or follow-up procedures as diagnostic.



### **Leverage health IT and EHR decision support** to:

- Embed reminders, standing orders and prompts based on screening intervals and risk factors.
- Automate scheduling, follow-up tracking, and patient outreach.
- Build dashboards to monitor screening completion and follow-up rates.



### **Measure and report outcomes:**

- Track key metrics such as return rates, follow-up rates, and overall completion.
- Use data to drive continuous improvement and share success stories.

## Clarifying Complete Colorectal Cancer Screening (and Why it Matters)

A complete CRC screening is a coordinated clinical process that includes both the initial screening test and any necessary follow-up procedures to confirm results and prevent disease progression. It is not a single encounter, but a continuum of care that requires intentional workflows, informed providers, and engaged patients.

National guidelines recommend beginning screening at age 45 for average-risk adults, or earlier for those with risk factors.

To support this, clinicians must ensure that:

- Patients are offered the appropriate initial screening test that matches their risk and preferences, such as:
  - Non-invasive stool-based tests (e.g., FIT, FOBT, Cologuard)
  - Imaging (e.g., CT colonography)
  - Direct visualization exams (colonoscopy)
- If the initial test is positive and was not a colonoscopy, a follow-up colonoscopy is:
  - Ordered and scheduled promptly
  - Documented and coded as part of the preventive screening process
  - Inclusive of clinically appropriate services such as polyp removal, biopsy, pathology, or anesthesia
- Documentation clearly communicates clinical intent, so that payers recognize the full screening process as preventive and patients are not burdened with unexpected costs.

By embracing this definition and aligning clinical workflows accordingly, providers can ensure that patients not only begin the screening process—but complete it. This approach strengthens care quality, improves outcomes, and supports a more consistent and equitable experience for all Utahns.

## What Utah Organizations Can Do

To ensure that every Utahn receives a complete colorectal cancer screening, all stakeholders must contribute to building systems that support clinical excellence, patient engagement, and reliable follow-through.

Changes within these organizations could include:

### Practitioners and Clinical Teams

- **Adopt workflows that guide patients through the full screening** continuum—from initial test to follow-up and resolution.
- **Customize EHRs** to include prompts, order sets, and documentation fields that reflect the definition of complete screening and support team-based care.
- **Create or enhance communication, follow-up, and reminder processes** such as timely reminders, tickler files for positive result follow up, and multiple pathways for communication.
- **Provide ongoing education and training to care teams** on screening guidelines, risk stratification, and documentation practices that communicate clinical intent and support accurate coding.
- **Use best practices in patient informed shared decision-making**, including motivational interviewing and culturally responsive techniques, to help patients understand their options and complete the screening process.

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- **Track screening outcomes and patient successes** using dashboards and follow-up systems to monitor completion rates and identify areas for improvement.

### Health Systems

- **Invest in both technology and human infrastructure**—such as care coordinators, navigators, and training programs—to support screening workflows.
- **Allow care teams and patient representatives to co-design** and refine screening processes that facilitate the screening continuum.
- **Share performance data across clinics and departments** to identify high-performing teams, spread best practices, and support continuous improvement.

### Payers and Benefit Managers

- **Clarify with providers how to document clinical intent** that aligns with preventive screening reimbursement. Monitor claims to identify outliers of diagnostic billing.
- **Collaborate with providers to share aggregate data** that highlights gaps in screening completion and follow-up, enabling targeted workflow improvements.
- **Participate in clinical education efforts** to better understand clinical workflows and identify opportunities for alignment and partnership.
- **Proactively reach out to beneficiaries** to inform of benefits and screening recommendations.

### Public Health and State Leaders

- **Participate in peer learning sessions and statewide education campaigns** to support clinical teams in implementing best practices and overcoming barriers.
- **Integrate CRC screening into broader public health initiatives**, such as chronic disease management, preventive care outreach, and health equity efforts.
- **Take actionable steps to ensure all Utahns can access screenings**, regardless of insurance type.

By implementing the clinical systems needed to support a complete screening, Workgroup 2 believes Utah is poised to make meaningful progress in ensuring that every Utahn has access to the right screening at the right time.

This work reflects a shared commitment across Utah to improve health outcomes through better workflows, stronger communication, and more coordinated care. The recommendations presented here were shaped by the insights and expertise of clinicians, public health leaders, and system innovators, and patient advocates.

The path forward is clear, and the opportunity is ours: to act together, to lead boldly, and to ensure that no Utahn is left behind in the fight against colorectal cancer.

This workgroup includes:

- **American Cancer Society** – Allie Bain, Associate Director, State Partnerships; Morgan Marietti, Associate Director, Cancer Center Partnerships
- **Association for Utah Community Health (AUCH)** – Mckenzie Dangerfield, Clinical Practice Coach; Tracey Siaperas, Research Liaison
- **Cigna Healthcare** – Dr. Doug Smith, Chief Medical Officer, Market Medical Executive

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- **Comagine Health** – Dave Cook, State Director of Systemwide Quality Improvement – *Workgroup 2 Facilitator*
- **Granger Medical Clinic** – Dr. Corey Neerings, Family Medicine Physician
- **HCA Mountain Division** – Emily Blamire, Regional Vice President of Oncology Services
- **Health Choice Utah** – Dr. Richard Ferguson, Chief Medical Officer
- **Health Management Associates** – Patricia Doxey, Associate Principal
- **Intermountain Health** – Dr. Nathan Merriman, Interim Senior Medical Director Surgical Specialties Digestive Health Clinical Program; Christopher Chandler, Technical Manager, GI Professional Coding and Reimbursement; Erica Groves, Senior Consultant, Professional Coding and Reimbursement; Katie Swenson, Executive Clinical Director, Surgical Specialties-Digestive Health Clinical Program
- **Ogden Clinic** – Carrie Jernigan, Director of Clinical Quality; Kate Story, Quality Supervisor; Stacy Geddes, Coding Manager
- **Optum Care Network** – Dr. Christopher Valentine, Medical Director
- **SelectHealth** – Amy Bone, Quality Consultant
- **Tanner Clinic** – Jenny Ayala, Clinical Supervisor/Operational Specialist
- **University of Utah Health** – Dr. John Inadomi, Department Chair of Internal Medicine; Emily Carlson, Sr. Quality Improvement Manager

# Appendices

## Appendix A: Screen Utah Background

Screen Utah is a statewide initiative committed to increasing colorectal cancer (CRC) screening rates by ensuring that every eligible Utahn receives the right test, at the right time, with the right care team. The initiative is grounded in the principles of the Utah Model of Care—affordability, quality, and trust—and reflects a shared commitment across the state to improve health outcomes through collaborative, data-driven, and patient-centered approaches.

As part of this effort, the One Utah Health Collaborative has convened two workgroups. Workgroup 1, supported by Leavitt Partners, a Health Management Associates company, focused on clarifying coverage policies and coding practices to reduce financial and administrative barriers to CRC screening.

Workgroup 2 builds on that foundation by focusing on the clinical side of the screening journey. Convened in the summer of 2025 and facilitated by Comagine Health, Workgroup 2 brought together local, regional, and national clinical experts to examine workflow gaps, barriers, and best practices in CRC screening.

Workgroup 1 clarified *what* should be covered and *why*—setting a policy and reimbursement framework aligned with clinical guidelines. Workgroup 2 focused on *how* to make this framework operational by discussing workflows that enable timely screening and follow-up.

Their intersection is critical: without supportive clinical workflows, clarified policies may not reach the patient. Likewise, without consistent reimbursement policies, workflow improvements may be undermined by unexpected cost-sharing and administrative roadblocks. Together, the workgroups aim to deliver a more seamless, person-centered CRC screening experience in Utah.

Priority areas identified by the Workgroup 2 include:

- Strengthening clinical workflows to support complete screening.
- Educating clinicians on guidelines, documentation, and communication strategies.
- Engaging patients through shared decision-making, motivational interviewing, and culturally responsive outreach.
- Building systems to remind, follow-up and track outcomes and ensure comprehensive care.

This work reflects the spirit of the Utah Model of Care: aligning clinical excellence with operational efficiency, and building trust through coordinated, patient-centered care.

### Appendix B: Designing Workflows to Reduce Patient Barriers

Reducing barriers to CRC screening requires more than education: it demands intentional, well-designed workflows that support patients throughout their screening journey. These workflows should be co-designed with input from clinical teams, documentation staff, billing departments, schedulers, and (when possible) patients themselves.

#### Workflow Development Best Practices

The Workgroup 2 discussed the following regarding workflows:

##### Set the Vision with the Clinical Team

Remind teams why this work matters: screening saves lives. When detected early, colorectal cancer has a 90% five-year survival rate—compared to just 25% when detected at later stages (American Cancer Society). Grounding the team in this purpose helps sustain motivation and focus.

##### Identify and Solve for Workflow Breakdowns

Start by mapping the current screening process and identifying where breakdowns occur. Then, problem-solve around those gaps by asking:

- Is the issue related to **process** or **technology** (e.g., unclear steps)?
- Is it a **people** issue (e.g., unclear roles or education gaps)?
- Is it a **communication** issue (e.g., inconsistent messaging)?
- Is it a matter of **patient engagement** (e.g., confusion, fear, or lack of follow-up)?

Make a concrete plan for resolving points of friction by assessing who, what, how, where, and when. For example, the care team if a FIT or mt-sDNA test is positive, follow-up with colonoscopy must be scheduled promptly. Decide for who will be the one to be notified and follow-up, what the follow-up should be, how it should be communicated to the patient, where the follow-up can be scheduled, and the timeline for scheduling.

##### Prioritize Follow-Up & Coordination

Care coordination is critical and tracking systems need to be in place to monitor progress. Clear next steps should be defined by the care team and communicated effectively to the patient, with roles assigned and follow-up processes in place to ensure completion.

- Build in coordination with labs to ensure follow-up is flagged.
- Use “tickler files” or automated alerts to ensure no patient is lost to follow-up—and build in double-checks wherever possible.
- While Exact Sciences provides robust reminders, clinics must maintain their own internal follow-up systems to ensure patients complete the process.

##### Embrace Team-Based Care, including Patients

Engage the full care team, including medical assistants, nurses, clinicians, schedulers, coders, and navigators. When each team member understands their role and communicates consistently, patients are more likely to feel supported, informed, and motivated to complete screening.

Treat patients and their families as active teammates in the screening process. Use a variable speed model—slow down when needed to clarify concerns, explain options, and creatively overcome barriers.

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## **Focus on Whole-Person Care**

Rather than treating CRC screening as a standalone task, embed it within a holistic care strategy that considers the full spectrum of a patient's health. Acute care visits, annual wellness visits, and value-based care models allow teams to address preventive screenings alongside chronic disease management and patient goals. When EHRs and dashboards are used effectively, they support a whole-person view that keeps CRC screening visible and actionable.

## **Measure Outcomes and Celebrate Success**

Track key metrics—such as test return rates, follow-up completion, and overall screening rates—and use that data to improve workflows. Just as importantly, celebrate patient success stories. Highlighting real outcomes reinforces the impact of this work and builds momentum across teams.

## **Build in Flexibility, Patient-Centeredness**

Workflows should be designed to work for as many patients as possible—but they should not be so rigid that care teams are unable to respond to individual needs. Teams must be empowered to adapt when necessary: whether that means clarifying instructions, rescheduling a missed test, or offering a different screening option. These cases should be the exception, not the norm. If breakdowns are consistently occurring at specific points or for specific patient types, it is a signal that the workflow itself may need to be adjusted. Do not be afraid to revise processes when they are not serving patients well. Workflows should serve patients—not the other way around.

## **A Model Workflow**

A key part of Workgroup 2's effort was the development of a model workflow for CRC screening, built through collaborative discussion and input from clinical experts across Utah.

The group focused on identifying pressure points (moments in the screening process where patients commonly fall off track) and worked together to problem-solve around them. These discussions emphasized the importance of understanding whether breakdowns stem from process design, team roles, communication gaps, or patient engagement. Workgroup members also noted the importance of encouraging flexible, team-driven solutions that prioritize helping patients move forward.

By co-designing workflows with clinical staff, documentation and billing teams, schedulers, and patients, when possible, the workgroup aimed to create systems that are both dependable and responsive to real-world challenges.



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## Appendix C: CRC Screening Guidelines & Patient Risk

While major CRC screening guidelines agree on initiating screening at age 45 for average-risk adults and emphasize the importance of early detection, differences in scope and emphasis across these guidelines can create inconsistencies in how screening is delivered, documented, and communicated to patients.

The United States Preventive Services Task Force (USPSTF) focuses on average-risk populations. Specialty organizations like the American College of Gastroenterology (ACG) and the National Comprehensive Cancer Network (NCCN) provide more detailed guidance for high-risk individuals, including those with a family history or prior polyps.

Clinical workflows should consider the indication for both average and high-risk populations, documenting a patient’s risk level and the clinical intent behind a screening recommendation. This can reduce confusion for care teams, take advantage of opportunities for early detection, and improve follow-up, particularly for patients who fall outside the average-risk category.

Workgroup 2 identified this variation as a meaningful opportunity to improve alignment across clinical practice, medical education, and documentation standards. Clinical teams are encouraged to:

- **Clarify how high-risk individuals are identified and managed**, including earlier and more frequent screening intervals.
- **Standardize documentation practices** to clearly reflect patient risk status and screening intent, to align care teams and downstream processes (e.g., scheduling, coding, follow-up).
- **Ensure follow-up procedures are embedded into workflows** as part of the complete screening process, not treated as separate or optional steps.

While flexible sigmoidoscopy remains listed as an accepted screening option in several national guidelines, Workgroup 2 members expressed reservations about recommending it in practice due to limited use and patient preference for other tests.

Guideline Body	Recommended Age Range (Average Risk)	Prioritized Modalities	Alternative Modalities	High-Risk Population Guidance	Notable Points
<a href="#">United States Preventive Services Task Force (USPSTF)</a>	45-75 (Grade B); 76-85 (Grade C, individualized)	Colonoscopy (10 years), FIT (annually), Stool DNA-FIT (1-3 years)	CT colonography (5 years), Flexible sigmoidoscopy (5 years), Flexible sigmoidoscopy (10 years) + annual FIT	Applies to average risk adults; high-risk individuals (family history, genetic syndromes) are outside the scope of this recommendation	Emphasizes evidence-based screening to reduce mortality; multiple options to accommodate patient preferences
<a href="#">American Cancer Society (ACS)</a>	Start at 45; continue through 75; 76+ based on individual factors	Colonoscopy (10 years), FIT (annually), Stool DNA-FIT (1-3 years)	CT colonography (5 years), Flexible sigmoidoscopy (5 years)	Recommends earlier and more frequent screening for high-risk individuals	Importance of early detection and multiple modalities to increase adherence

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Guideline Body	Recommended Age Range (Average Risk)	Prioritized Modalities	Alternative Modalities	High-Risk Population Guidance	Notable Points
<a href="#"><u>National Comprehensive Cancer Network (NCCN)</u></a>	Start at 45 for average risk	Colonoscopy (10 years), FIT (annually)	CT colonography (5 years), Flexible sigmoidoscopy (5 years)	Provides some stratification for high-risk individuals, primarily earlier and more frequent screenings	Risk-adapted screening strategies; emphasizes individualized care plans
<a href="#"><u>American College of Gastroenterology (ACG)</u></a>	Start at 45 for average risk	Colonoscopy (10 years), FIT (annually)	Stool DNA-FIT (1-3 years), CT colonography (5 years), Flexible sigmoidoscopy (5 years)	Earlier screening for high-risk individuals (40), including those with family history or genetic syndromes	Prioritizes colonoscopy and FIT; underscores importance of high-quality colonoscopies
<a href="#"><u>United States Multi-Society Task Force on CRC (USMSTF)</u></a>	Start at 45 for average risk	Colonoscopy (10 years), FIT (annually)	Stool DNA-FIT (3 years), CT colonography (5 years), Flexible sigmoidoscopy (5-10 years)	Advises high-risk individuals to consult healthcare providers for personalized screening plans	Focuses on public health initiatives to increase screening rates
<a href="#"><u>U.S. Centers for Disease Control and Prevention (CDC)</u></a>	Aligns with USPSTF	Aligns with USPSTF	Aligns with USPSTF	Advises high-risk individuals to consult healthcare providers for personalized screening plans	Focuses on public health initiatives to increase screening rates

## **Appendix D: Communicating with Patients About CRC Screening**

Effective communication is essential to ensuring patients understand, accept, and complete CRC screenings. Workgroup 2 identified several best practices and resources to support care teams in engaging patients across diverse settings and populations.

### **Leverage Creative and Targeted Communication**

Use tailored messaging that resonates with patients' values, preferences, and cultural backgrounds. Creative approaches—such as storytelling, video, and digital outreach—can increase engagement and follow-through.

Communication resources identified by Workgroup 2 include:

- **Intermountain Healthcare's Shoreline App** includes impactful [video content](#) that helps patients understand the importance of screening.
- The **National Cancer Institute's Evidence-Based Cancer Control Programs** has reminder templates and call scripts.
- The **American Cancer Society's CRC Communication Guidebook** (2017) remains a relevant resource for framing conversations and outreach strategies.
- The **ACS Rural Guidebook (2025)** provides strategies for increasing screening in rural and frontier communities.
- ACS has also developed **companion guides for high-risk populations**, including [Hispanics/Latinos](#) and [Asian Americans](#).
- Intermountain Health's colonoscopy prep videos ([Colon Cancer Screening at Intermountain](#)) and [handout](#) for more information (in English and Spanish). Here is the [University of Utah Health page](#) with handouts and videos.
- Kaiser Permanente's [Mailed FIT Outreach for Colorectal Cancer Screening](#)

### **Support Digital Outreach**

Digital communication—such as text messages, emails, and app-based reminders—is often more effective than mailed outreach. One successful strategy combined digital outreach with an “update your information” campaign, allowing patients to confirm contact details and immediately schedule or request screening kits online. Web-based tools that include **risk calculators** and **direct scheduling options** are especially impactful.

### **Initial Encounter Best Practices**

The initial patient encounter sets the tone for the entire CRC screening journey. Establishing clear workflows at this stage—supported by team-based communication and simple digital tools—can significantly improve patient understanding, engagement, and follow-through.

- **Embed prompts in the EHR** to initiate CRC screening conversations and make screening part of standing orders.
- **Use multiple messages from different team members** to reinforce the importance of screening. For example, a medical assistant may introduce the topic and explain options, followed by a clinician who continues the conversation: “You’ve already talked with [MA] about screening—let’s go deeper.”
- **Encourage patients to set digital reminders** using their phones or smart assistants (e.g., Siri, Alexa) to support follow-through in the future.

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## Follow-Up Communication

Effective communication doesn't end with the initial screening conversation, it must extend into follow-up and care coordination.

- **Implement tracking systems** that integrate CRC screening into existing clinic follow-up workflows. Most clinics already have processes for managing lab results or chronic care follow-up; CRC screening should be added to these systems with clear steps to strengthen and error-proof the process.
- **Close the loop on test results**, especially when a non-invasive test such as FIT or mt-sDNA (e.g., Cologuard) returns a positive result. A follow-up colonoscopy is essential and must be scheduled promptly. This step **cannot be dropped**. Build in **double-checks** or automated alerts to ensure that every positive result is acted upon.
- **Assign clear roles** within the care team to manage follow-up communication, scheduling, and documentation. Patients should receive timely outreach, clear instructions, and reassurance that their care is being coordinated.
- **Make sure the patient knows what to do (and plans to do it)**. This includes instructions for successfully completing screening tests and preparing effectively for a colonoscopy. Discuss their likelihood of completing next steps and problem-solve barriers.

## Honor Patient Partnership

Shared decision-making is a collaborative process in which clinicians and patients work together to choose the screening option that best aligns with the patient's values, preferences, and health goals. This approach is especially important in CRC screening, where multiple effective options exist and patient follow-through is critical.

Move away from over emphasizing one screening modality and instead focus on what works best for the individual patient and their risk. Communicate that multiple effective options exist—such as FIT, Cologuard, and colonoscopy—and help patients choose based on their **risk level, preferences, lifestyle, and access to care**. Reinforce that **the most important test is the one the patient will complete**.

Motivational interviewing is a powerful technique that supports this process by helping patients explore their own motivations, address ambivalence, and overcome barriers to action. Rather than persuading or directing patients toward specific tests, clinicians can use open-ended questions, reflective listening, and affirmations to guide patients toward informed, confident decisions.

These approaches:

- **Show respect** for the patient's autonomy and lived experience.
- **Honor the partnership** between patient and clinician by creating space for dialogue and shared understanding.
- **Improve outcomes** by increasing screening uptake, reducing no-shows, and fostering long-term engagement in preventive care.

By embedding shared decision-making and motivational interviewing into CRC screening conversations, care teams can create a more personalized, empowering experience—one that leads to higher completion rates and stronger relationships between patients and the healthcare system.

## Appendix E: Reflecting a Complete Screening in Documentation Practices

Accurate documentation and coding are essential clinical responsibilities that directly affect whether patients experience expected costs, confusion, or mistrust. When coding does not reflect the clinical intent of a *screening*, patients may incur significant costs for services they believed were preventive, undermining their confidence in the care team and the health system.

### Common Breakdowns

- **Reclassifying follow-up as diagnostic:** When a patient completes a stool-based test (e.g., FIT or mt-sDNA) and receives a positive result, the follow-up colonoscopy is clinically part of the screening process. However, if documentation is unclear, it may be misclassified as diagnostic, triggering cost-sharing and patient frustration.
- **Coding based on procedure instead of intent:** If a screening colonoscopy includes polyp removal, biopsy, or anesthesia, it may be inadvertently reclassified as diagnostic unless documentation and modifiers (e.g., Modifier 33) specify the procedure began as preventive.
- **Symptom-based diagnoses without context:** Documenting symptoms like rectal bleeding or abdominal pain—without clarifying that the procedure was initiated as a preventive screening—can lead to misclassification. Clinicians should note when symptoms are incidental and not the primary reason for the screening.
- **Surveillance vs. screening confusion:** Patients with a history of polyps or other risk factors may undergo surveillance colonoscopies as part of regular screening that align with their risk. Inconsistent documentation or unclear definitions can result in denials or unexpected bills.
- **Facility vs. professional coding discrepancies:** When hospitals and individual clinicians use different coding systems or interpret guidelines differently, mismatched claims can lead to reprocessing, delays, and surprise bills.

### Clinical Opportunities for Improvement

To protect patients and reduce administrative burden, clinical teams could:

- **Document clinical intent clearly:** Note whether a procedure is preventive (including the surveillance of polyps) or diagnostic—and why. Use consistent language and modifiers to reflect the screening intent.
- **Educate clinicians and coders together:** Ensure that clinicians, coding professionals, and billing staff share a mutual understanding of CRC screening guidelines and documentation standards. Clarify that follow-up colonoscopies after positive home-based tests are part of the “complete screening” preventive process and align on expectations for what should be considered a screening.
- **Build coding prompts into workflows:** Use EHR prompts and validation rules to flag potential mismatches between documentation and coding before claims are submitted.
- **Empower teams to ask questions:** Encourage staff to review documentation and clarify intent when needed. A brief conversation can prevent a costly error or mismatched expectations. This should include a discussion with the clinician and possibly the patient when a coder believes that a procedure should instead be coded as a diagnostic test.
- **Track and learn from mistakes:** If certain coding errors or patient complaints are recurring, treat them as workflow issues, not isolated mistakes. Adjust processes to prevent future breakdowns.