COASTAL COMMUNITY HEALTH SERVICES POLICIES AND PROCEDURES				
Section: Clinical			**Policy Number: C-32**	
Title: Screening for Colorectal Cancer				
Version: 1			**Approval Date: August 8, 2017**	
Approved By: Medical Director			**Revision Date:--**	
Laws, Regulations &/or Standards Associated With This Policy: ***Centers for Disease Control and Prevention (2014); United States Preventive Services Taskforce (2016); American Cancer Society (2017); American College of Gastroenterology (2009); American Academy of Family Physicians; American College of Physicians***				
Review Dates:				

Purpose: To provide evidence-based guidance on colorectal cancer (CRC) screening for patients of average risk using CCHS for primary care

Definitions: Colorectal cancer is a diverse group of cancers affecting the colon and rectum, including the cecum, ascending colon, transverse colon, descending colon, sigmoid colon and rectum. Most CRC histopathologically is adenocarcinoma, and arises in precancerous serrated or adenomatous polyps. CRC is the second leading cause of cancer death among men and women in the United States. While reductions in mortality from CRC have been achieved over the last 10 years due to increased screening rates, many eligible adults remain unscreened, and maintaining and improving upon these gains will require ongoing engagement and persistence in obtaining screening for eligible adults. Since readily available and accessible screening tools exist, the above organizations all recommend screening appropriate adult men and women, aged 50 - 75 years. This policy applies to adults considered to be at average risk by history and prior screening examinations which may have been completed. It does not apply to high risk patients, such as patients with family history of CRC, familial adenomatous polyposis or hereditary non-polyposis colorectal cancer, and does not apply to patients with symptoms of any kind referable to the gastrointestinal tract. While racial and ethnic disparities do exist in CRC incidence, the above organizations do not recommend starting screening before age 50, except the American College of Gastroenterology, which recommends starting at age 45 in African Americans. The decision to start screening earlier than age 50 must be patient-centered and well-documented in the EMR.

Policy: It is the policy of CCHS to screen all eligible adult patients of average risk between the ages of 50 and 75 for CRC, according to evidence-based guidelines supported by the above organizations.

Procedure:

1. When a patient meeting the above criteria presents as a new or established patient, he or she will be asked about prior CRC screening testing which may have been done. If the patient has had a prior colonoscopy, a copy of the report and any associated pathology reports will be obtained, if possible. Once obtained, the colonoscopy will be recorded in the patient's EMR according to recommended pathway established by eClinicalWorks workflow.
2. If the patient has not been screened, he/she will be offered either referral for colonoscopy or fecal immunohistochemical testing (FIT) for occult blood in the stool.
3. If the patient accepts referral for colonoscopy, the provider will enter a diagnostic imaging order for colonoscopy, and the nursing staff will enter a referral to gastroenterology (GI); both the colonoscopy order and the GI referral will be faxed to the GI office for action. These orders

will be tracked by nursing staff according to existing policy policy (C-1 Referral Management and Tracking).

4. If the patient accepts the recommendation to undergo FIT for occult blood, the provider or nursing staff will enter the lab order "occult blood" using the ICD 10 code (Z12.11) "screening for colon cancer" or equivalent wording. Nursing staff will provide the FIT kit to the patient along with instructions on how to complete the test. The test order will be tracked according to existing policy (L-2 Lab and Diagnostic Test Tracking).
5. Once the colonoscopy has been performed, nursing staff will obtain the report (along with any pathology reports associated with the procedure) and assign to the ordering provider, who will then account for it in the patient's EMR as in #1 above.
6. Once the FIT has been returned to the office, nursing staff will accession it and send to the lab for analysis. The result will return to the ordering provider, and the patient will be notified according to existing policy (L-2 Lab and Diagnostic Test Tracking).
7. If the colonoscopy is normal or negative, the interval for repeat testing is 10 years. If the FIT is negative, the interval for repeat testing is 1 year. If the colonoscopy is not normal, the interval for repeat testing will be determined by the gastroenterologist who performed the test. If the FIT is positive (indicating the presence of occult blood), the patient will be referred to GI for colonoscopy and other testing as indicated.
8. Other acceptable screening tests (recommended repeat interval) include: flexible sigmoidoscopy (every 5 - 10 years); computed tomography colonography (every 5 years); fecal DNA adduct testing (Cologard™) (every 3 years).

Approved:

Medical Director

8/15/17
Date