Colorectal Cancer Screening Recommendations:

Given the aggressive nature of this cancer, a joint guideline developed by the American Cancer Society (ACS), US Multi-Society Task Force on Colorectal Cancer, and the American College of Radiology (ACR) recommends that screening for colorectal cancer and adenomatous polyps start at age 50 years in asymptomatic men and women. In May 2018, the ACS revised its colorectal screening guidelines, advising that regular screening for people at average risk start at age 45 years. The American College of Gastroenterology (ACG) reports colonoscopy every 10 years beginning at age 50 years, but at age 45 years in African Americans as preferred colorectal cancer prevention test. The ACS further advises that:

- People who are in good health and with a life expectancy of more than 10 years should continue regular colorectal cancer screening through the age of 75.
- For people ages 76 through 85, the decision to be screened should be based on a person's preferences, life expectancy, overall health, and prior screening history. The United States Preventive Services Task force (USPSTF) recommends, for people in this age range, screening is most appropriate among adults who:

    1) Are healthy enough to undergo treatment if colorectal cancer is detected; and,

    2) Do not have comorbid conditions that would significantly limit their life expectancy.

- People over 85 should no longer get colorectal cancer screening.
- Professional organizations recommend that patients with a family history of a first-degree relative with early-onset colorectal cancer or multiple first-degree relatives with the disease, those patients be screened more frequently starting at a younger age, and with colonoscopy

***It is important we assist our persons served and guardians in knowing about these recommendations and the factors that deemed them or their loved one at high-risk vs. average risk so that, with the help of their health care provider, appropriate steps follow to get proper care. If the cancer is diagnosed at a localized stage, the survival rate is 89%.[1] The overall 5-year survival rate for people with colon cancer is 67%, this is why prevention helps to save lives.[1]

Risk Factors:

- The most important risk factor for colorectal cancer is older age, most cases occur after age 50
- A positive family history
- Males
- African Americans and Ashkenazi Jews
- Those with Type II Diabetes

Lifestyle factors that may contribute to an increased risk of colorectal cancer:

- Being overweight or obese
- Not being physically active
- Those with diets high on red meat (such as beef, pork, lamb, or liver), processed meats, low in vitamin D, low fiber diets.
- Smoking
- Heavy alcohol use

Who are at a High Risk for Colorectal Cancer? Those who have:

- A personal history of colorectal cancer or certain types of polyps.

- A personal history of inflammatory bowel disease (ulcerative colitis or Crohn's disease).
- A known family history of a hereditary colorectal cancer syndrome such as familial adenomatous polyposis (FAP) or Lynch syndrome (also known as hereditary non-polyposis colon cancer or HNPCC).
- A personal history of radiation to the abdomen (belly) or pelvic area to treat a prior cancer.

For more information on Risk Factors visit https://www.cancer.org/cancer/colon-rectal-cancer/causes-risks-prevention/risk-factors.html

Colorectal Cancer Screening Tests Include:

A. Stool Based tests:

- Guaiac-based fecal occult blood test (gFOBT) every year
- Fecal immunochemical test (FIT) every year
- Multitargeted stool DNA test (FIT-DNA) every 1-3 years

B. Direct Visualization tests:

- Colonoscopy every 10 years
- CT Colonography every 5 years
- Flexible sigmoidoscopy every 5 years
- Flexible sigmoidoscopy with Fecal immunochemical test

***Disclosure to date--no method of screening for colorectal cancer has been shown to reduce all-cause mortality in any age group. The ACS advices the most important step is to get screened, no matter which test is selected to do so.

Resources:

https://gi.org/education/educating-you-your-colleagues/colorectal-cancer-awareness-education-resources/

https://gi.org/topics/colorectal-cancer/

https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/colorectal-cancer-screening#tab

https://emedicine.medscape.com/article/2500006-overview

https://www.cdc.gov/cancer/colorectal/basic_info/prevention.htm

[1]https://www.cancer.net/cancer-types/colorectal-cancer/statistics

MCCMH Preventive Care Guidelines and Provider Expectations:

Based on the information provided above and in accordance with the American Cancer Society, The College of Gastroenterologists, and the United States Preventive Services Task Force, as it pertains to the goal of promoting early detection of colorectal cancer among our persons served, it is the recommendation from the Chief Medical Office to all in-network and out-of-network providers that:

A. Providers develop a process to educate their direct care staff on the most up to date guidelines and resources related the most up-to-date colorectal cancer preventive recommendations as above described.
B. It is to the discretion of the provider to develop a process that guarantees how persons served and their guardians are being provided education on the subject.
C. Providers may opt to use the "MCCMH Preventive Care Guidelines to Promote Early Detection of Colorectal Cancer" here attached as handouts to their staff, persons served and their guardians as part of their efforts to create awareness on the subject. The use of the 2019-2020 MCCMH educational handout disseminated along with these recommendations is purely optional; however, the expectation of the role they must play on providing this education is not. Providers may develop their own educational materials to achieve this awareness goal always abiding by the appropriate most up to date guidelines from well recognized national organizations and authorities in the field.
D. It is the provider's responsibility to update their educational materials as recognized professional organizations such as the American Cancer Society, the United States Preventive Services Task Force or the CDC among others publish new revised guidelines.
E. Providers should remain aware of the importance of these guidelines and encourage their persons served and their guardians to, at least yearly (following the recommended age of initiated screening) or during the persons served annual physical exam appointment, consult with their health care providers about what screening options based on their age, family history, and health history, they would need to be aware of and consider.
F. Providers and direct care staff must know that only the medical health care provider of the person served is the ultimate authority in determining when a given screening test type is deemed to be appropriate or contraindicated based on having a full understanding of the individual's medical history and family history. It is of paramount importance that the persons served and their guardians also understand this and that they always follow and abide by their health care provider's recommendations.
G. As part of being integrated care advocates, it is important that providers yearly encourage our persons served to stay up to date with their yearly physicals and colorectal screening tests as recommended by their PCP. Providers must have their staff (i.e. supports coordinator) work collaboratively with the individual's medical provider to coordinate that, at minimum yearly (following the recommended age of initiated screening), a discussion about this occurs with the individual/guardian.
H. Providers must develop a process for their direct care staff or supports coordinator to document in the record the instances in which education related to the issue was provided.
I. Granted all the above occur, if a person/guardian were to exercise his/her right to decline the above recommendation, the provider must develop a process for their staff or supports coordinator to not only thoroughly date and document the efforts made to educate and encourage the person's served/their guardian on addressing the issue but also document the stated reason for the person's/guardian's decline.

a. Some appropriate documentation parameters to consider at minimum should include date, name and credentials of the staff providing the education/encouragement. And, when applicable, the reason stated by the person served and/or their guardian in the event they choose to decline the education or recommendations from their health care provider.

b. In the event a medical contraindication/s is/are the reason for a person served to not be a good candidate for continued screening, the provider should make sure they implement a process for their staff or supports coordinator to document those. It is the expectation those instances are clearly documented in the record at the time they are due to revisit each year.

J. In cases of persons served whose cause of death are related to Colorectal Cancer diagnosis or possible complications secondary to it, the documentation of such becomes especially important and necessary when submitting Death Reports or Root Cause Analysis for the review of Critical Risk Management Committee (CRMC).

K. In the event those are not initially submitted by the provider, the CRMC Committee reserves the right to request the provider for this information when conducting the review of a case in which this is deemed to be pertinent and/or critically relevant for the review