

## Background

Colorectal cancer is the fourth most common cancer diagnosed in the United States with about 4.2% of men and women being diagnosed at some point in their lifetime.<sup>1</sup> Currently, the US Preventive Services Task Force recommends to start screening for colorectal cancer at age 50, with some risk factors such as a family history indicating earlier screening.<sup>2</sup> In Washington State of adults aged 50-75, only 63% with commercial insurance and 43% with Medicaid received screening, with variation by county.<sup>3</sup>

## Recommendation Framework

The workgroup's goal is to increase appropriate colorectal cancer screening in Washington State to decrease incidence of and mortality from colorectal cancer.

- Mechanisms to increase appropriate use of colorectal cancer screening including follow-up after a positive stool test
- Reviewing existing guidelines by age and other relevant factors to begin and end screening, including risk factors that indicate earlier screening or need for further diagnostic test
- Appropriate colorectal cancer screening modalities
- Informed decision making around anesthesia during screening, including no anesthesia
- Addressing disparities in colorectal cancer screening rates (e.g., geographic, by race, by payer)

### *Examples from Shared Decision Making Report*

#### *Patients and Family Members*

- Think about your broad health and wellness-related goals (e.g., being able to attend an upcoming family wedding).
- Where different options are available, like the areas noted in this document, give your provider(s) information about your values and preferences and discuss options, tradeoffs, and implications of a decision together.
- Ask about whether a patient decision aid is available.
- Ask your care provider about the test or treatment options available, including the option of “doing nothing” or “watchful waiting.”

#### *Health Care Delivery Organizations and Systems*

- Work with your clinical champion(s) to educate providers about the value of shared decision making and how to have a good conversation that uses the patient decision aid or references the patient decision aid if the aid will be distributed to patients prior to the visit.
- Select one of the 10 clinical areas to pilot (e.g., breast cancer screening).

#### *Providers*

- Participate in skills training. Shared decision making is a learned skill-set that is supported by patient decision aids.

#### *Health Plans and/or Professional Liability Carriers*

- Incorporate shared decision making requirements as standards for value-based models (e.g., Centers of Excellence).

#### *Employers*

- Incorporate shared decision making requirements as standards for value-based contracting (e.g., Centers of Excellence, Accountable Care Organizations).
- Talk to your health plan about the importance of shared decision making and how to report on use of shared decision making including how to ensure appropriate reimbursement.

#### *Washington State Health Care Authority*

- Encourage the patient decision aid developer community to develop patient decision aids for the ten priority areas publicly available at no cost.

## ***Examples from Shared Decision Making Report***

Options for tracking shared decision making are below including those aligning with value-based reimbursement models from the Bree Collaborative and Federal programs:

- **Shared Decision Making Process**

Steward: Massachusetts General Hospital

NQF #2962

*This measure assesses the extent to which health care providers actually involve patients in a decision-making process when there is more than one reasonable option. This proposal is to focus on patients who have undergone any one of seven common, important surgical procedures: total replacement of the knee or hip, lower back surgery for spinal stenosis of herniated disc, radical prostatectomy for prostate cancer, mastectomy for early stage breast cancer or percutaneous coronary intervention (PCI) for stable angina. Patients answer four questions (scored 0 to 4) about their interactions with providers about the decision to have the procedure, and the measure of the extent to which a provider or provider group is practicing shared decision making for a particular procedure is the average score from their responding patients who had the procedure.*

- **Informed, Patient-Centered Hip and Knee Replacement Surgery**

NQF #2958

Steward: Massachusetts General Hospital

*The measure is derived from patient responses to the Hip or Knee Decision Quality Instruments. Participants who have a passing knowledge score (60% or higher) and a clear preference for surgery are considered to have met the criteria for an informed, patient-centered decision. The target population is adult patients who had a primary hip or knee replacement surgery for treatment of hip or knee osteoarthritis.*

## Appendix C: Guideline and Systematic Review Search Results

	Year	Title	Summary or Findings
AHRQ: Research Findings and Reports	2019	<a href="#">Achieving Health Equity in Preventive Services</a>	No eligible studies evaluated effects of provider-specific barriers; 18 studies of population barriers provided low or insufficient evidence regarding insurance coverage, access, age, rural location, low income, language, low health literacy, country of origin, and attitudes. In 12 studies of clinician interventions, screening was higher for colorectal cancer with patient navigation, risk assessment and counseling, educational materials, and decision aids; breast and cervical cancer with reminders involving lay health workers; and cervical cancer with outreach and health education. Clinician-delivered interventions were effective for smoking cessation and weight loss. In 11 studies of health information technologies, automated reminders and electronic decision aids increased colorectal cancer screening, and web- or telephone-based self-monitoring improved weight loss, but other technologies were not effective. In 88 studies of health system interventions, evidence was strongest for patient navigation to increase screening for colorectal (risk ratio [RR] 1.64; 95% confidence interval [CI] 1.42 to 1.92; 22 trials), breast (RR 1.50; 95% CI 1.22 to 1.91; 10 trials), and cervical cancer (RR 1.11; 95% CI 1.05 to 1.19). Screening was also higher for colorectal cancer with telephone calls, prompts, other outreach methods, screening checklists, provider training, and community engagement; breast cancer with lay health workers, patient education, screening checklists, and community engagement; cervical cancer with telephone calls, prompts, and community engagement; and lung cancer with patient navigation. Trials of smoking cessation and obesity education and counseling had mixed results. In populations adversely affected by disparities, evidence is strongest for patient navigation to increase colorectal, breast, and cervical cancer screening; telephone calls and prompts to increase colorectal cancer screening; and reminders including lay health workers encouraging breast cancer screening. Evidence is low or insufficient to determine effects of barriers or effectiveness of other interventions because of lack of studies and methodological limitations of existing studies.
	2016	<a href="#">Improving Cultural Competence to Reduce Health Disparities</a>	None of the included studies measured the effect of cultural competence interventions on health care disparities. Most of the training interventions measured changes in professional attitudes toward the population of interest but did not measure the downstream effect of changing provider beliefs on the care delivered to patients. Interventions that altered existing protocols, empowered patients to interact with the formal health care system, or prompted provider behavior at the point of care were more likely to measure patient-centered outcomes. The medium or high risk of bias of the included studies, the heterogeneity of populations, and the lack of measurement consensus prohibited pooling estimates or commenting about efficacy in a meaningful or responsible way. The term "cultural competence" is not well defined for the LGBT and disability populations, and is often conflated with patient-centered or individualized care. There are many gaps in the literature; many large subpopulations are not represented.

	2012 <a href="#">Fecal DNA Testing in Screening for Colorectal Cancer in Average Risk Adults</a>	Fecal DNA tests have insufficient evidence about its diagnostic accuracy to screen for colorectal cancer in asymptomatic, average-risk patients. There is also insufficient evidence for the harms, analytic validity, and acceptability of testing in comparison to other screening modalities. Existing evidence has little or no applicability to currently available fecal DNA testing.
Cochrane Collection	2012 <a href="#">Narrow band imaging versus conventional white light colonoscopy for the detection of colorectal polyps</a>	We could not find convincing evidence that NBI is significantly better than high definition WLC for the detection of patients with colorectal polyps, or colorectal adenomas. We found evidence that NBI might be better than standard definition WLC and equal to high definition WLC for detection the patients with colorectal polyps, or colorectal adenomas.
	2016 <a href="#">Interventions to encourage uptake of cancer screening for people with severe mental illness</a>	A comprehensive search showed that currently there is no RCT evidence for any method of encouraging cancer screening uptake in people with SMI. No specific approach can therefore be recommended. High-quality, large-scale RCTs are needed urgently to help address the disparity between people with SMI and others in cancer screening uptake.
	2019 <a href="#">Follow-up strategies for patients treated for non-metastatic</a>	The results of our review suggest that there is no overall survival benefit for intensifying the follow-up of patients after curative surgery for colorectal cancer. Although more participants were treated with salvage surgery with curative intent in the intensive follow-up groups, this was not associated with improved survival. Harms related to intensive follow-up and salvage therapy were not well reported.

[colorectal cancer](#)

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| 2013 | <a href="#">Personalised risk communication for informed decision making about taking screening tests</a>    | There is strong evidence from three trials that personalised risk estimates incorporated within communication interventions for screening programmes enhance informed choices. However the evidence for increasing the uptake of such screening tests with similar interventions is weak, and it is not clear if this increase is associated with informed choices. Studies included a diverse range of screening programmes. Therefore, data from this review do not allow us to draw conclusions about the best interventions to deliver personalised risk communication for enhancing informed decisions. The results are dominated by findings from the topic area of mammography and colorectal cancer. Caution is therefore required in generalising from these results, and particularly for clinical topics other than mammography and colorectal cancer screening. |
| 2017 | <a href="#">Strategies for detecting colon cancer in patients with inflammatory bowel disease</a>            | The current data suggest that colonoscopic surveillance in IBD may reduce the development of both CRC and the rate of CRC-associated death through early detection, although the quality of the evidence is very low. The detection of earlier stage CRC in the surveillance group may explain some of the survival benefit observed. RCTs assessing the efficacy of endoscopic surveillance in people with IBD are unlikely to be undertaken due to ethical considerations.  |
| 2017 | <a href="#">Decision aids for people facing health treatment or screening decisions</a>                      | Compared to usual care across a wide variety of decision contexts, people exposed to decision aids feel more knowledgeable, better informed, and clearer about their values, and they probably have a more active role in decision making and more accurate risk perceptions. There is growing evidence that decision aids may improve values-congruent choices. There are no adverse effects on health outcomes or satisfaction. New for this updated is evidence indicating improved knowledge and accurate risk perceptions when decision aids are used either within or in preparation for the consultation. Further research is needed on the effects on adherence with the chosen option, cost-effectiveness, and use with lower literacy populations.  |
| 2013 | <a href="#">Flexible sigmoidoscopy versus faecal occult blood testing for colorectal cancer screening in</a> | There is high quality evidence that both flexible sigmoidoscopy and faecal occult blood testing reduce colorectal cancer mortality when applied as screening tools. There is low quality indirect evidence that screening with either approach reduces colorectal cancer deaths more than the other. Major complications associated with screening require validation from studies with more complete reporting of harms.   |

[asymptomatic individuals](#)

Veterans Administration Evidence-based Synthesis Program

2014 The Effects of Shared Decision Making on Cancer Screening  
 The ideal SDM intervention would enhance Decision Quality (ie, increase knowledge and values clarity) and Impact (ie, increase satisfaction, reduce decision conflict, and have minimal impact on service utilization). The desired impact on Decision Action depends on the screening decision. For decisions about how to screen (such as colorectal cancer screening), the ideal SDM intervention would exert the desired effects on Decision Quality and Impact without reducing measures of Decision Action such as screening intention and behavior. For decisions about whether to screen (such as breast, cervical, and prostate cancer in some age groups and risk categories), the goal is to facilitate personalized decision making based on values and preferences. Hence, there are no desired effects on Decision Action per se in this context.

2013 Patients with Positive Screening Fecal Occult Blood Tests: Evidence Brief on the Delay Between Time to Colonoscopy and Colorectal Cancer Outcomes  
 No direct evidence supports the current VHA policy that requires follow-up colonoscopy to be done within 60 days of a positive screening FOBT. There is very low-strength evidence that longer post-referral delays do not worsen survival or CRC stage in patients with various signs and symptoms. One potential explanation for the nonsignificant results is the potential confounding effects of various symptomatic presentations; such that clinicians may prioritize colonoscopy in those with cancer-specific symptoms, thus obscuring a natural association between increased delays and more advanced cancers.

Health Technology Assessment Program

2008 Virtual colonoscopy or computed tomographic colonography (CTC)  
 Computed Tomographic Colonography (CTC) for routine colorectal cancer screening is not a covered benefit. This decision does not apply to use of CTC for other diagnostic purposes.

Centers for Disease Control and Prevention

Colorectal (Colon) Cancer  
<https://www.cdc.gov/cancer/colorectal/index.htm>

2008

Computed tomography  
(CT) colonography

Given the possible benefits of introducing a widely available minimally-invasive option for colorectal cancer screening, there is considerable interest in CTC.



## References

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<sup>1</sup> National Cancer Institute Surveillance, Epidemiology, and End Results Program. Cancer Stat Facts: Colorectal Cancer. Available: <https://seer.cancer.gov/statfacts/html/colorect.html>.

<sup>2</sup> Centers for Disease Control and Prevention. Colorectal (Colon) Cancer. Available: [www.cdc.gov/cancer/colorectal/basic\\_info/screening/index.htm](http://www.cdc.gov/cancer/colorectal/basic_info/screening/index.htm)

<sup>3</sup> Washington Health Alliance. "As new report shows colorectal cancer rates rising, Washington lags in appropriate screening." August 9, 2017. Available: <https://wahealthalliance.org/as-new-report-shows-colorectal-cancer-rates-rising-washington-lags-in-appropriate-screening/>