Department of Veterans Affairs
Veterans Health Administration
Washington, DC 20420

VHA DIRECTIVE 1015
Transmittal Sheet
April 3, 2020

COLORECTAL CANCER SCREENING

1. REASON FOR ISSUE: This Veterans Health Administration (VHA) directive provides policy on average-risk colorectal cancer (CRC) screening and follow-up for Veterans with a positive screening test in Department of Veterans Affairs (VA) medical facilities.

2. SUMMARY OF MAJOR CHANGES: This directive updates the responsibilities of the VA medical facility Director in paragraph 5 regarding the monitoring of the quality of colonoscopy, as well as adding recommendations for colonoscopy documentation and guidance on the use of CRC screening clinical reminders and reports.

3. RELATED ISSUES: None.

4. RESPONSIBLE OFFICE: The Office of Specialty Care Services (10P11) is responsible for the content of this directive. Questions may be addressed to the National Program Director for Gastroenterology at VHAGIProgramDirector@va.gov.

5. RECISSIONS: VHA Directive 1015, Colorectal Cancer Screening, dated December 30, 2014, is rescinded.

6. RECERTIFICATION: This VHA directive is scheduled for recertification on or before the last working day of April 2025. This VHA directive will continue to serve as national VHA policy until it is recertified or rescinded.

BY DIRECTION OF THE OFFICE OF THE UNDER SECRETARY FOR HEALTH:

/s/ Lucille B. Beck, PhD
Deputy Under Secretary for
Health for Policy and Services

NOTE: *All references herein to VA and VHA documents incorporate by reference subsequent VA and VHA documents on the same or similar subject matter.*

DISTRIBUTION: Emailed to the VHA Publications Distribution List on May 11, 2020.

CONTENTS

COLORECTAL CANCER SCREENING

COLORECTAL CANCER SCREENING

1. PURPOSE

This Veterans Health Administration (VHA) directive provides policy on average-risk colorectal cancer (CRC) screening and follow-up for Veterans with a positive screening test in Department of Veterans Affairs (VA) medical facilities. **AUTHORITY:** Title 38 United States Code (U.S.C.) 7301(b).

2. BACKGROUND

a. CRC is the third most common cancer among American men and women, and the second leading cause of cancer death. CRC screening detects early-stage cancer and pre-cancerous polyps (e.g., adenomas and sessile serrated polyps) and has been proven to reduce CRC mortality and incidence. The lengthy preclinical phase of CRC development allows opportunities for clinicians to successfully detect cancer and intervene at a curable or treatable stage through screening.

b. Twenty percent of CRC occurs in patients with specific risk factors, such as a family history of CRC and inflammatory bowel disease.

c. The VHA Clinical Preventive Services Guidance Statement on Colorectal Cancer Screening states that there are multiple acceptable methods of CRC screening that have similar efficacies. There is insufficient evidence to recommend one screening strategy over another as each strategy has certain advantages and disadvantages. There are no head-to-head studies comparing the approved strategies, though large-scale studies comparing the fecal immunochemical test (FIT) to screening colonoscopy are ongoing. Some health care organizations have chosen to endorse mass screening of their population using the non-invasive FIT due to its widespread availability and acceptance. There is some evidence to suggest that offering individuals a choice of two screening tests will improve overall adherence. However, it has not been demonstrated that offering additional screening options results in appreciably improved adherence.

d. The increasing demand for colonoscopy as the primary method for CRC screening and prevention, coupled with the burden of disease and the cost of treatment for CRC, make CRC screening in VA medical facilities a high priority.

e. This increasing demand also raises concerns for overuse of colonoscopy. Overuse of colonoscopy has been well-documented in VHA for both screening and post-polypectomy surveillance. Overuse exposes Veterans to unnecessary risk and reduces others' access to colonoscopy.

f. VA is actively researching the question of the relative efficacy of colonoscopy versus FIT with the Colonoscopy versus FIT in Reducing Mortality (CONFIRM) from a CRC Study. The study randomized 50,000 Veterans to either FIT or colonoscopy for CRC screening and is now following them for 10 years to determine the rates of colon cancer mortality and incidence. For more information visit: https://www.clinicaltrials.gov/ct2/show/NCT01239082?term=CONFIRM.

3. DEFINITIONS

a. **Average-risk Veteran.** Average-risk Veterans are those with neither a family history of CRC nor other risk factors or symptoms that warrant surveillance or diagnostic colonoscopy.

b. **Boston Bowel Preparation Score.** The Boston Bowel Preparation Score (BBPS) assesses quality of bowel preparation during colonoscopy after all cleansing maneuvers are completed by the endoscopist. Each region of the colon receives a "segment score" from 0 to 3 and these segment scores are summed for a total BBPS score ranging from 0 to 9. The maximum BBPS score for a perfectly clean colon without any residual liquid is 9 and the minimum BBPS score for an unprepared colon is 0. A score of at least 2 in each of the three segments is generally considered to be adequate for high quality colonoscopy.

c. **Colorectal Cancer Screening.** CRC screening is the performance of a test to detect the presence of CRC in asymptomatic individuals. For additional screening information please see: http://vaww.prevention.va.gov/CPS/Colorectal_Cancer_Screening.asp. ***NOTE:*** *This is an internal VA Web site that is not available to the public.*

d. **Colorectal Cancer Screening and Surveillance Reminder System.** The colorectal cancer screening and surveillance (CRC S/S) reminder system is a set of reminders that are imbedded into the electronic health record (EHR) to facilitate appropriate CRC S/S. The current VA CRC S/S reminder system includes reminders for average risk screening, diagnostic evaluation of a positive FIT, reminders when a surveillance colonoscopy is due and a "gap reminder" to assure that Veterans who have undergone colonoscopy have a documented plan for subsequent CRC screening and/or surveillance. This reminder system is supported by a collection of VHA Support Service Center Capital (VSSC) reports that facilitate population health management by the provider, their Patient Aligned Care Team (PACT) or higher levels of the health care system (e.g., Group Practice Managers, Quality Managers). The CRC S/S Clinical Reports can be found here: https://reports.vssc.med.va.gov/ReportServer/Pages/ReportViewer.aspx?/PC/CRCS/CRCSS_LandingPage&rs:Command=Render. ***NOTE:*** *This is an internal VA Web site that is not available to the public.*

e. **Colonoscopic Surveillance.** Colonoscopic surveillance is the performance of colonoscopy in individuals at increased risk due to a prior history of adenomatous polyps, CRC or other underlying medical condition (e.g., inflammatory bowel disease). Guidelines for screening are not applicable to individuals who warrant colonoscopic surveillance.

f. **Electronic Health Record.** EHR is the digital collection of patient health information resulting from clinical patient care, medical testing, and other care-related activities. Authorized VA health care providers may access EHR to facilitate and document medical care. EHR comprises existing and forthcoming VA software

including Computerized Patient Record System (CPRS), Veterans Information Systems and Technology Architecture (VistA), and Cerner platforms. ***NOTE:*** *The purpose of this definition is to adopt a short, general term (EHR) to use in VHA national policy in place of software-specific terms while VA transitions platforms*.

g. **High-risk Veteran.** High risk Veterans are Veterans with a family history of CRC or other familial cancer syndrome (e.g., Lynch syndrome) and those who warrant colonoscopic surveillance for other reasons (e.g., patients with a personal history of colorectal adenomas, CRC, or inflammatory bowel disease).

h. **Overuse.** Overuse refers to use of a medical service where the potential harm likely exceeds the potential benefit (e.g., screening colonoscopy in an 87-year-old).

4. POLICY

It is VHA policy to recommend CRC screening to average-risk Veterans in accordance with VHA clinical preventive services guidance, coordinated by the VHA National Center for Health Promotion and Disease Prevention (NCP).

5. RESPONSIBILITIES

a. **Under Secretary for Health.** The Under Secretary for Health is responsible for ensuring overall VHA compliance with this directive.

b. **Principal Deputy Under Secretary for Health.** The Principal Deputy Under Secretary for Health is responsible for maintaining VSSC CRC Screening and Surveillance Reports.

c. **Deputy Under Secretary for Health for Operations and Management.** The Deputy Under Secretary for Health for Operations and Management is responsible for:

(1) Communicating the contents of this directive to each of the Veterans Integrated Services Networks (VISNs).

(2) Ensuring that each VISN Director has the sufficient resources to implement this directive in all VA medical facilities within that VISN.

(3) Providing oversight of VISNs to assure compliance with this directive, relevant standards, and applicable regulations.

d. **Deputy Under Secretary for Health for Policy and Services.** The Deputy Under Secretary for Health for Policy and Services is responsible for supporting the implementation and oversight of this directive across VHA.

e. **National Program Director, Gastroenterology.** The National Program Director for Gastroenterology is responsible for:

(1) Providing guidance and technical assistance to VA medical facilities about CRC S/S. These functions occur through national conference calls, individual program consultation as requested, Web resources, clinical tools, and other means.

(2) Monitoring of evidence-based guidelines relevant to published literature and recommendations from the U.S. Preventive Services Task Force and other national guideline groups. As new evidence-based recommendations are published, the National Program Director works collaboratively with national program offices, such as VHA NCP, and evaluates the need for new or revised policies, clinical tools, and processes that may be integrated into CRC S/S for Veterans across VHA. See: http://vaww.prevention.va.gov/CPS/Colorectal_Cancer_Screening.asp. ***NOTE:*** *This is an internal VA Web site that is not available to the public.*

f. **Veterans Integrated Services Network Director.** Each VISN Director is responsible for:

(1) Ensuring a comprehensive, evidence-based, population approach to CRC screening.

(2) Ensuring that CRC surveillance is implemented at all VA medical facilities in the VISN.

(3) Ensuring all minimal CRC screening program requirements are in place and sustained.

(4) Ensuring that all VA medical facilities within the VISN comply with this directive.

g. **VA Medical Facility Director.** Each VA medical facility Director is responsible for:

(1) Ensuring that appropriate resources are allocated to deliver CRC screening and follow-up to eligible Veterans by their VA medical facility

(2) Providing oversight to ensure that VA medical facility staff comply with this directive.

h. **VA Medical Facility Chief of Staff or Associate Director for Patient Care Services.** The VA medical facility Chief of Staff or Associate Director for Patient Care Services are responsible for:

(1) Ensuring personnel (e.g., nurses, quality managers) are assigned to address the VSSC CRC Screening and Surveillance Reports as described below.

(2) Ensuring the CRC S/S reminder system is used to enhance CRC S/S efforts. This includes:

(a) Ensuring VA medical facility staff who are involved with the CRC S/S reminder system are aware of training opportunities and tools to use these reminders and reports, as appropriate for their role.

(b) Ensuring CRC S/S results and recommendations, including those generated from community care colonoscopy referrals, are addressed in the CRC S/S reminder system.

(c) Assigning personnel (e.g., PACT care coordinators or case managers, non-PACT RN navigators, and quality managers) to review and act on the VSSC CRC Screening and Surveillance Reports found here: https://reports.vssc.med.va.gov/ReportServer/Pages/ReportViewer.aspx?/PC/CRCS/CRCSS_LandingPage&rs:Command=Render e. ***NOTE:*** *This is an internal VA Web site that is not available to the public.*

(d) Tracking the VSSC CRC Screening and Surveillance Reports as part of the VA medical facility quality management process for CRC screening. ***NOTE:*** *This CRC S/S reminder system supports average risk screening, diagnostic evaluation after an abnormal non-colonoscopic screening test, and surveillance colonoscopy follow-up. Use of the reminder system provides Veterans a safety net by helping clinicians identify Veterans who are due or overdue for a CRC screening action. Recommendations for optimizing CRC screening can be found here:* https://dvagov.sharepoint.com/sites/VHANGP/CRC%20Directive%201015/SitePages/Home.aspx. *This is an internal VA Web site that is not available to the public.*

(3) Ensuring that VHA Directive 1232(2), Consult Processes and Procedures, dated August 24, 2016, is followed for documenting attempts to schedule diagnostic colonoscopy and for canceling of consults after non-response or no-shows for colonoscopy.

(4) Ensuring quality of colonoscopy is monitored at least every 6 months as part of an ongoing quality assurance program, including the Ongoing Profession Practice Evaluation for all providers performing colonoscopy, irrespective of specialty. Colonoscopy quality metrics have been shown to be associated with important patient outcomes, such as risk of CRC incidence and mortality after colonoscopy. See the SharePoint site for recommended colonoscopy quality monitors: https://dvagov.sharepoint.com/sites/VHANGP/CRC%20Directive%201015/SitePages/Home.aspx. ***NOTE:*** *This is an internal VA Web site that is not available to the public.*

(5) Ensuring newly diagnosed CRC is managed appropriately. After CRC is discovered (e.g., positive pathology results), an evaluation is performed for follow up with a general surgeon, colorectal surgeon, oncologist or other appropriate provider for initiation of treatment planning.

i. **VA Medical Facility Chief of Pathology and Laboratory Services.** The VA medical facility Chief of Pathology and Laboratory Services is responsible for ensuring that VHA laboratory Fecal Occult Blood Test (FOBT) or FIT testing is completed and accurately recorded according to VA laboratory reporting guidelines found at the

following link: http://vaww.prevention.va.gov/docs/LABORATORY_REPORTING_OF_FECAL_OCCULT_BLOOD_TESTING_110510.pdf. ***NOTE:*** *This is an internal VA Web that is site not available to the public.*

j. **VA Medical Facility Patient Aligned Care Team.** When assigned by the VA medical facility Chief of Staff or Associate Director for Patient Care Services, the VA medical facility PACT is responsible for reviewing and utilizing the VSSC CRC Screening and Surveillance Reports, as defined here: https://reports.vssc.med.va.gov/ReportServer/Pages/ReportViewer.aspx?/PC/CRCS/CRCSS_LandingPage&rs:Command=Render. ***NOTE:*** *This is an internal VA Web that is site not available to the public.*

k. **VA Health Care Providers.** The VA health care provider who orders CRC screening tests is responsible for:

(1) Ensuring Veterans are informed about the different options available for CRC screening, including the risks and benefits of the different options, as well as the option of no screening. ***NOTE:*** *Veterans generally make a shared decision about screening with their primary care provider. Veterans may find the provision of a brochure or video about screening choices helpful in increasing their knowledge about screening options. Veterans with severe cognitive, musculoskeletal, or neurological impairments may have difficulty with one or more of the screening methods. Therefore, Veterans who would have difficulty completing one screening method, but who are still medically appropriate for CRC screening, must be offered an alternative screening method.*

(2) Informing the Veteran of the result, and if the test is abnormal, documenting the follow-up plan in the EHR and initiating action when appropriate. Notification should occur in accordance with VHA Directive 1088, Communicating Test Results to Providers and Patients, dated October 7, 2015.

(3) Allowing time to answer any questions a Veteran has about the different types of CRC screening. A provider may preferentially recommend any one of the approved CRC screening options.

l. **Colonoscopy Providers.** Colonoscopy providers are responsible for:

(1) Assessing if colonoscopy is indicated, prior to scheduling. This responsibility can be delegated to nurses with appropriate training and supervision.

(2) Ensuring safe and effective bowel preparation regimens are prescribed prior to colonoscopy. Recommendations for improving the quality of bowel preparation for colonoscopy can be found on the National Gastroenterology Program SharePoint site: https://dvagov.sharepoint.com/sites/VHANGP/CRC%20Directive%201015/SitePages/Home.aspx. ***NOTE:*** *This is an internal VA Web site that is not available to the public*.

(3) Ensuring the patient's informed consent is obtained in accordance with VHA Handbook 1004.01(2), Informed Consent for Clinical Treatments and Procedures, dated August 14, 2009.

(4) Performing a high-quality colonoscopy. Recommended colonoscopy quality monitors can be found on the National Gastroenterology Program SharePoint site: https://dvagov.sharepoint.com/sites/VHANGP/CRC%20Directive%201015/SitePages/Home.aspx. ***NOTE:*** *This is an internal VA Web site that is not available to the public.*

(5) Ensuring colonoscopy documentation meets the minimum requirements as detailed in Appendix A.

(6) Conveying colonoscopy findings and recommendations for management to the Veteran in compliance with VHA Directive 1088 and ensuring the recommendations are entered into the CRCS/S clinical reminder system. These findings include biopsy results and related recommendations for management, screening, or surveillance. ***NOTE:*** *With appropriate training and supervision, a gastroenterology nurse practitioner, physician assistant or gastroenterology fellow may participate in this notification process in accordance with VHA Directive 1088.*

6. TRAINING

There are no formal training requirements associated with this directive. However, training modules regarding CRC Reminders can be found here: https://vaww.infoshare.va.gov/sites/chio/NCRW/NCR/SitePages/National%20Colorectal%20Cancer%20Screening%20Reminders.aspx. ***NOTE:*** *This is an internal VA Web that is site not available to the public.*

7. RECORDS MANAGEMENT

All records regardless of format (e.g., paper, electronic, electronic systems) created in this directive shall be managed per the National Archives and Records Administration (NARA) approved records schedules found in VA Records Control Schedule 10-1. Questions regarding any aspect of records management should be addressed to the appropriate Records Manager or Records Liaison.

8. REFERENCES

a. VHA Directive 1073, Moderate Sedation by Non-Anesthesia Providers, dated December 30, 2014.

b. VHA Directive 1088, Communicating Test Results to Providers and Patients, dated October 7, 2015.

c. VHA Directive 1232(2), Consult Processes and Procedures, dated August 24, 2016.

d. VHA Handbook 1004.01(2), Informed Consent for Clinical Treatments, dated August 14, 2009.

e. Department of Veterans Affairs. Laboratory Reporting of Fecal Occult Blood Testing. (2010): http://vaww.prevention.va.gov/docs/LABORATORY_REPORTING_OF_FECAL_OCCULT_BLOOD_TESTING_110510.pdf. ***NOTE:*** *This is an internal VA Web site that is not available to the public*.

f. Dominitz JA and Robertson DJ, Ahnen DJ, et al. (2017). Colonoscopy versus fecal immunochemical test in reducing mortality from colorectal cancer (CONFIRM): Rational for study design. Am J Gastroenterol. 112(11): 1736-1746.

g. Inadomi JM, Vijan S, Janz NK, et al. (2012). Adherence to colorectal cancer screening: a randomized clinical trial of competing strategies. Arch Intern Med 172(7): 575-582.

h. Murphy CC, Sandler RS, Grubber JM et al. (2016). Underuse and Overuse of Colonoscopy for Repeat Screening and Surveillance in the Veterans Health Administration. Clin Gastroenterol Hepatol. 14(3): 436-444.e1.

i. Partin MR, Powell AA, Burgess DJ, Wilt TJ. (2012). Bringing an organizational perspective to the optimal number of CRC screening options debate. J Gen Intern Med. 27(3): 376-80.

j. Saini SD, Powell AA, Dominitz JA, et al. (2016). Developing and Testing an Electronic Measure of Screening Colonoscopy Overuse in a Large Integrated Healthcare System. J Gen Intern Med. 31 Suppl 1: 53-60.

k. Schonberg MA, Davis RB, McCarthy EP, Marcantonio ER. (2009) Index to predict 5-year mortality of community-dwelling adults aged 65 and older using data from the National Health Interview Study. J Gen Intern Med. 24(10): 1115.

l. U.S. Preventive Services Task Force, Bibbins-Domingo K, Grossman DC, et al. (2016). Screening for colorectal cancer: US Preventive Services Task Force Recommendation Statement. JAMA. 315(23): 2564-2575.

m. Volk RJ, Leal VB, Jacobs LE, et al. (2018) From guideline to practice: New shared decision-making tools for colorectal cancer screening from the American Cancer Society. CA Cancer J Clin. 68: 246-249.

APPENDIX A

REQUIREMENTS FOR COLONOSCOPY DOCUMENTATION

Accurate and complete documentation of colonoscopy procedural details facilitates both clear communication among providers and quality assurance programs. Efficient documentation of the recommended data elements may best be achieved through implementation of endoscopic report generating software with required fields for key subject areas. In the absence of this software, template notes may facilitate this process. Image management software is also required for photo-documentation of endoscopic findings. The recommended elements for complete colonoscopy documentation include:

1. Informed consent in accordance with Veterans Health Administration (VHA) Handbook 1004.01(2), Informed Consent for Clinical Treatments, dated August 14, 2009.

2. Pre-procedure "time out" in accordance with VHA Directive 1073, Moderate Sedation by Non-Anesthesia Providers, dated December 30, 2014.

3. Pre-procedure history and physical. When moderate sedation is used, required elements of the history and physical are detailed in the VHA Directive 1073.

4. Indication for procedure. For example, screening, surveillance of previous neoplasia, surveillance of ulcerative colitis or Crohn's colitis, evaluation of an abnormal test results (specify abnormal test), evaluation of symptoms (specify symptom).

5. Technical description of the procedure:

a. Procedure performed (e.g. colonoscopy with biopsy);

b. Sedation details (e.g. medication, dose, route of administration);

c. Documentation of adequacy of bowel preparation quality after all intraprocedural cleaning has been completed. Use of a validated bowel preparation scale is highly recommended (e.g., the Boston Bowel Preparation Score);

d. Extent of examination (depth of insertion) with photo-documentation of cecal landmarks, when the cecum is reached. If the cecum is not reached, documentation of the reason for the incomplete exam is recommended (e.g., poor bowel preparation, patient discomfort, stricture);

e. Duration of the examination, including the withdrawal time. Withdrawal time is defined as the time spent examining the colon between the cecum and the rectum;

f. Whether or not rectal retroflexion was performed, and if so, findings;

g. Type of instrument used, including the specific instrument identifier (e.g., serial number).

6. Colonoscopy findings, such as:

a. Polyps. Inclusion of a description of each polyp's size, location, method of removal, completeness of removal and pathology specimen identifier is strongly encouraged as it can facilitate subsequent clinical decision making;

b. Mass;

c. Mucosal abnormalities (e.g., colitis);

d. Other findings (e.g., diverticulosis, stricture).

7. List of unplanned events and interventions for these events.

8. Patient tolerance of the procedure.

9. Assessment of procedure results.

10. Recommendations, including any follow-up plans, such as:

a. Discharge instructions, including but not limited to:

(1) Change in medications (especially antiplatelet and anticoagulant medications);

(2) Dietary restrictions;

(3) Activity restrictions.

b. Planned follow-up procedures:

(1) Include a statement if surveillance recommendations will be made only after pathology results have been obtained. Once pathology results are available, document surveillance recommendations in the electronic health record and convey them to the patient, in accordance with VHA Directive 1088, Communicating Test Results to Providers and Patients, dated October 7, 2015. The Colorectal Cancer Screening and Surveillance (CRC S/S) reminder system is updated through completion of appropriate documentation in the electronic health record (EHR).

(2) If no further CRC screening or surveillance is recommended (e.g., due to comorbidity), document this in the CRC S/S reminder system.

NOTE: *The colonoscopy procedure report does not need to independently contain each of the data elements listed above. For example, some elements may be found in the nursing records, or in separate documentation (e.g., the informed consent document and pre-procedure history and physical).*