

ANTHC CRCCP – ELIGIBILITY

Purpose: To establish and define the ANTHC CRCCP eligibility criteria for direct screening services. Eligibility will be determined by patient age, insurance status, income status, and risk status.

Scope: Applicable to all ANTHC CRCCP partner sites.

Policy:

1. Eligible Patients

- A. **Age:** All patients between the ages of 50 and 64 will be eligible for direct screening services. Some patients under the age of 50 may be eligible for direct screening services if at increased risk (see **ANTHC CRCCP Policy 002**).
- B. **Insurance status:** All patients who participate in the ANTHC CRCCP must disclose their insurance status, such as Medicare, Medicaid, private insurance and/or IHS beneficiary. Patients whose insurance does not fully cover CRC screening or who only receive care within the Tribal Health System will be eligible for direct screening services.
- C. **Income status:** All patients who participate in the ANTHC CRCCP must disclose their economic status, including number of persons in household and monthly household income. Patients who are at or below 250% of the Federal Poverty Level will be eligible for direct screening services under the program.
- D. **Risk Status:** All patients who are at average risk, increased risk, or in need of surveillance are eligible for direct screening services.
- a. **Average Risk** is defined as:
- i. No personal or family history of CRC or adenomas;
 - ii. No history of inflammatory bowel disease (Ulcerative Colitis or Crohn’s Disease);
 - iii. No history or suspicion of genetic syndromes such as Familial Adenomatous Polyposis (FAP) or Hereditary Non-Polyposis Colorectal Cancer (HPNCC).
- b. **Increased Risk** is defined as:
- i. A personal history of adenomatous polyps on a previous colonoscopy;
 - ii. A personal history of colorectal cancer; or,
 - iii. A family history of CRC or documented history of adenomatous polyps in a first degree relative or in two or more second degree relatives.

Family History: People with a family history of CRC are eligible for screening with colonoscopy only. See ANTHC CRCCP Policy 002 for recommended screening intervals.

Personal History: People at increased risk for CRC due to a personal history of adenomatous polyps or colorectal cancer are eligible for surveillance with colonoscopy only.

c. **Surveillance** is defined as:

- i. Periodic colonoscopy on a person who has a prior history of adenoma(s) or colorectal cancer for the purpose of removing polyps that were missed on the initial colonoscopy or that developed in the interval since the initial colonoscopy; or

A surveillance colonoscopy is indicated when a patient has a family history of CRC or adenomatous polyps in a first degree relative or in two or more second degree relatives.

Surveillance recommendations will be made on a case-by-case basis by the attending clinician following screening interval guidelines in **ANTHC CRCCP Policy 002**.

2. **Ineligible Patients:** Ineligible patients must be referred for appropriate disease management.

A. **Age:** All patients aged 65 and older are not eligible for direct screening services.

B. **Insurance status:** All patients whose insurance fully covers CRC screening are not eligible for direct screening services.

C. **Income status:** All patients who are above 250% of the Federal Poverty Level are not eligible for direct screening services under the program.

D. **Risk Status:** All patients who have significant gastrointestinal symptoms, who are at high risk, or who have other conditions which preclude CRC screening are not eligible for direct screening services.

a. **Gastrointestinal signs and symptoms** are defined as:

- i. Rectal bleeding, bloody diarrhea, or frank blood in the stool within the past 6 months;
- ii. Significant anemia (i.e. hemoglobin < 10 gm/dl);
- iii. Bleeding that is known or suspected to be due to hemorrhoids after clinical evaluation would not prevent a client from receiving CRC screening services;
- iv. Prolonged change in bowel habits (e.g., diarrhea or constipation for more than two weeks that has not been clinically evaluated);
- v. Persistent abdominal pain;

- vi. Symptoms of bowel obstruction (e.g., abdominal distension, nausea, vomiting, severe constipation); or,
- vii. Significant unintentional weight loss of 10% or more of starting body weight.

b. **High Risk** is defined as:

- i. A genetic diagnosis of Familial Adenomatous Polyposis (FAP) or Hereditary Non-Polyposis Colorectal Cancer (HNPCC);
- ii. A clinical diagnosis or suspicion of FAP or HNPCC; or,
- iii. A history of Inflammatory Bowel Disease (Ulcerative Colitis or Crohn's Disease).

People at high risk for CRC generally require genetic counseling and/or intensive clinical and surveillance services that are beyond the scope of this program.

c. **Other conditions** are defined as:

- i. Life expectancy less than 10 years;
- ii. Advanced age or co-morbidities; or,
- iii. Individuals who would not otherwise tolerate an invasive procedure such as colonoscopy.

ANTHC CRCCP – SCREENING AND SURVEILLANCE INTERVAL POLICY

Purpose: To establish appropriate screening intervals for the CRCCP.

Scope: Applicable to all ANTHC CRCCP partner sites.

Policy:

1. The ANMC Surgery Department CRC Screening and Surveillance Guidelines, published June 2008 (see **Tables 1 – 3**), are based on national recommendations from the American Cancer Society, the U.S. Preventive Services Task Force, the American Gastroenterological Association, and the American Society for Gastrointestinal Endoscopy. These guidelines will be used to determine appropriate follow-up intervals for patient rescreening. See Guidelines below.
2. If these guidelines change, the ANTHC CRCCP screening interval policy will be reviewed by the Medical Advisory Board (MAB).
3. The ANMC Surgery Department will be available to provide clinical consultation as needed.

Table 1: Risk Category Guidelines

Risk Category	Test	Interval
Average risk: (50 or over)	Flexible sigmoidoscopy Colonoscopy	Every five years Every ten years
	FOBT, FIT, DCBE	Not recommended as screening tests
Increased risk/Surveillance: CRC in a first degree relative or in two or more second degree relatives	Colonoscopy at age 40 or ten years before the youngest case in the immediate family	Every five years
Documented adenomatous polyps in a first degree relative or multiple second degree relatives	Colonoscopy at age 50	Every five years

Table II: Colonoscopy Findings Guidelines

Findings	First Step	Next Step
Hyperplastic polyp	Considered normal	Routine screening interval
One or two <1cm adenomas	Surveillance colonoscopy in 5 years	If normal, surveillance colonoscopy every 5-10 years
Three to ten adenomas or any adenoma \geq 1 cm, or any adenoma with villous features, or high grade dysplasia.	Surveillance colonoscopy in 3 years	If normal or 1-2 small adenomas with low grade dysplasia, surveillance colonoscopy every 5 years
Ten or more adenomas	Shorter surveillance interval (<3yr) per clinician recommendations. Consider possible underlying familial syndrome.	Clinical judgment
Sessile adenomas removed piecemeal	Consider short interval follow-up (2-6 mos)	Clinical judgment

Table III: Cancer Follow-Up Schedule Guidelines

	6 months	12 months	18 months	24 months	3 years	4 years	5 years	Every 3 years after year 5
Stage I	Colonoscopy*	Colonoscopy		Colonoscopy			Colonoscopy	Colonoscopy
		Physical Exam, CBC, CMP, CXR		Physical Exam, CBC, CMP, CXR	Physical Exam, CBC, CMP, CXR	Physical Exam, CBC, CMP, CXR	Physical Exam, CBC, CMP, CXR	
Stage II-IV (curative intent)	Colonoscopy*	Colonoscopy		Colonoscopy			Colonoscopy	Colonoscopy
	Physical Exam, CBC, CMP, CEA, CT Chest/abd/pel w IV & Oral contrast	Physical Exam, CBC, CMP, CEA, CT Chest/abd/pel w IV & Oral contrast	Physical Exam, CBC, CMP, CEA, CT Chest/abd/pel w IV & Oral contrast	Physical Exam, CBC, CMP, CEA, CT Chest/abd/pel w IV & Oral contrast	Physical Exam, CBC, CMP, CXR	Physical Exam, CBC, CMP, CXR	Physical Exam, CBC, CMP, CXR	Physical Exam, CBC, CMP, CXR
Stage IV (non-curative)	FOLLOW-UP AS APPROPRIATE							

Other Notes: *Patients who do not have a complete colonoscopy at time of diagnosis will require a complete colonoscopy at 6 months. All patients treated with curative intent will have their follow-up performed by the surgery department for the first 2 years and thereafter, whenever a colonoscopy is needed. Other follow-up will be performed by the primary care provider.

ANTHC CRCCP – PROGRAM QUALITY INDICATORS

Purpose: To establish ANTHC CRCCP service quality indicators and quality of care measures for endoscopy.

Scope: Applicable to all ANTHC CRCCP sites.

Policy:

1. Allowable Screening Tests

Only screening options recommended by the U.S. Preventive Services Task Force (USPSTF) (available at www.ahrq.gov/clinic/uspstf/uspstfcol.htm) will be used in the CRCCP. Those options currently include:

- i. High-sensitivity guaiac FOBT (gFOBT) annually;
- ii. High-sensitivity immunochemical FOBT (iFOBT), also referred to as fecal immunochemical tests (FIT) annually;
- iii. Sigmoidoscopy every 5 years, with FOBT every 3 years; and,
- iv. Colonoscopy every 10 years.

Due to high CRC incidence and mortality rates, as well as the high prevalence of *H. pylori* stomach infections, which is anecdotally associated with a higher false positive rate, the ANTHC CRCCP MAB discourages the use of FOBT in the Alaska Native population.

2. Screening Priority Population

Percent of new patients screened who are at average risk for CRC must be $\geq 75\%$.

Percent of average risk new patients screened who are aged 50 years and older must be $\geq 95\%$.

3. Completeness and timeliness of Clinical Follow-up

Percent of abnormal test results with diagnostic follow-up completed must be $\geq 90\%$.

Percent of diagnosed cancer with treatment initiated must be $\geq 90\%$.

Positive sigmoidoscopy or DCBE tests must be followed up with colonoscopy within 90 days.

If utilized, positive FOBT/FIT tests should be followed up within 30 days. The follow-up will be based on the clinical judgment of the attending provider.

Cancers diagnosed must have treatment initiated within 60 days.

5. Colonoscopy Quality Measures

Colonoscopy quality standards are based on national recommendations from the U.S. Multi-Society Task Force on Colorectal Cancer (2002).

- i. Bowel preparation.
 - a. Documentation of adequacy of bowel preparation in procedure report.
 - b. If bowel preparation is inadequate, additional education will be given to the patient and they will be scheduled for a repeat examination.
- ii. Cecal Intubation.
 - a. Documentation of cecal intubation in the procedure report.
 - b. Method of determination.
 - c. If cecum cannot be reached, clinician will consider a DCBE procedure.
- iii. Documentation of number, type, and location of polyps found.
- iv. Documentation of complications (occurring within 30 days of procedure).
 - a. Types of complications:
 1. Bleeding;
 2. Cardiopulmonary events (hypotension, hypoxia, arrhythmia, etc);
 3. Complications related to anesthesia;
 4. Perforation;
 5. Excessive abdominal pain;
 6. Emergency room visit or hospital admission; or
 7. Death.
 - b. Complications will be documented and reported to ANTHC using the Medical Complications Reporting Form.
- v. Reversal agents used/cardiorespiratory problems requiring intervention.
- vi. Scope withdrawal time.
- vii. Documentation of biopsies and recommended follow-up.

6. Quality Performance Monitoring

Quality measures will be collected by partner sites and reported to ANTHC in order to monitor the performance of the ANTHC CRCCP. ANTHC will provide assistance to partner sites in order to correct any quality issues identified. However, the partner site will be responsible for demonstrating corrective action within a reasonable period of time.

ANTHC CRCCP – PATIENT REMINDER POLICY

Purpose: To establish ANTHC CRCCP patient reminder guidelines for how many attempts are to be made before patient is considered to be “lost to follow-up,” “screening refused”, or “treatment refused.”

Scope: Applicable to all ANTHC CRCCP partner sites.

Policy:

1. Attempts will be made to encourage patients to get screened before patients are considered to have refused screening. The number of attempts will be determined by risk status. If patient declines screening they will not be contacted for a period of one (1) year.

The minimum number of attempts to contact patients will include three phone calls followed by one certified letter with a copy sent to the village clinic and primary care provider.

2. If abnormal findings are detected, attempts will be made to contact the patient to schedule follow-up care.

The minimum number of attempts to contact patients will include three phone calls followed by one certified letter with a copy to the village clinic, PCP and regional Tribal Health Organization Clinical Director.

If these attempts are unsuccessful, patients will be considered “lost to follow-up” or “treatment refused” for the purposes of the ANTHC CRCCP.

3. Staff of village clinics, sub-regional clinics, and/or regional Tribal Health Organizations may be contacted to assist with locating patients.

ANTHC CRCCP – PROVISION OF SCREENING SERVICES

Purpose: To establish and define the ANTHC CRCCP procedures for the provision of screening services.

Scope: Applicable to all ANTHC CRCCP partner sites.

Policy:

1. All procedures will be documented using CRCCP data documentation forms and reported to ANTHC. Data will be reported monthly.

2. Enrollment into Health Insurance

For each patient the following steps will be taken to ensure that they are enrolled into any applicable health insurance programs.

- a. Review patient insurance information
- b. Check for private insurance and document
- c. Check for Medicaid and Medicare eligibility and enroll patient if eligible
- d. Document if patient declines Medicaid and/or Medicare
- e. Document final insurance status

3. Patient In-reach and Outreach

- a. Patients who remain uninsured will be outreached to for screening using electronic medical records.
- b. Each partner site will identify and integrate the CRCCP into an existing chronic disease prevention program such as:
 - i. BCCEDP
 - ii. WISE WOMEN
 - iii. Diabetes Prevention and Control
- c. Each partner site will provide in-reach to chronic disease prevention program participants.
- d. If not already present, patient support services (such as Patient Navigator/Case Manager) will be identified/established at each partner site to assist patients referred to endoscopic services in order to support screening adherence and facilitate access to diagnostic and treatment services, as needed.
- e. All patient outreach efforts will be tracked using a partner site-specific database or an ANTHC-provided Microsoft Access database and will be reported to ANTHC quarterly as part of the quarterly progress report.

4. Screening

- a. Each patient will either have identified a primary care provider or be enrolled with a primary care provider prior to receiving screening.
- b. Each patient will be clinically evaluated prior to CRC screening (see Policy 1: Eligibility).

- c. Patients who are determined to be clinically ineligible will be referred to appropriate care.
- d. Existing tracking systems will be used to assure appropriate follow-up for participants needing diagnostic and treatment services including newly insured patients.
- e. Existing health records systems will be used to contact patients for appropriate follow-up and give patients results of screening tests.

5. Laboratory Services and Follow-up

- a. Existing pathology laboratories will receive and process pathology specimens and screening tests.
- b. Laboratories will document that they meet national CLIA standards.
- c. Existing referral systems will ensure timely access to diagnostic testing.
- d. Existing referral systems will be used to ensure timely medical treatment for persons diagnosed with CRC or who experience complications due to screening or diagnostic procedures.
- e. Existing resources (e.g. financial, in-kind) available at partner sites or established referral facilities will be used for the treatment of cancer diagnosis or complications arising from CRCCP participation.

ANTHC CRCCP – IDENTIFICATION OF EXISTING HEALTH SYSTEMS SERVING UNINSURED PERSONS

Purpose: To establish and define the ANTHC CRCCP procedures for referral for uninsured Alaska Native and American Indian persons.

Scope: Applicable to all ANTHC CRCCP partner sites.

Background:

ANTHC has a Self-Governance Agreement (the Alaska Tribal Health Compact) with the Indian Health Service for management of all statewide health services formerly provided by that agency for all Alaska Native people.

ANTHC has further developed an Alaska Tribal Health System Memorandum of Understanding that defines the essential components of the Alaska Tribal Health System, the commitments of Tribal Health Organizations regarding health services, and to ensure that all Alaska Native people have access to a comprehensive, integrated, tribally-controlled health care delivery system.

The Alaska Tribal Health System (ATHS) is a large hub and spoke network of village-based clinics, subregional clinics, regional hospitals, and a large secondary and tertiary care facility (Alaska Native Medical Center, ANMC).

The Alaska Tribal Health System serves uninsured, underinsured and low-income Alaska Native and American Indian people.

Policy:

1. The ANTHC CRCCP partner sites will establish procedures for referring program eligible clients to existing CRC screening opportunities within the Alaska Tribal Health System.
2. The ANTHC CRCCP will track patients of the program who are referred and screened within the Alaska Tribal Health System.
3. The ANTHC CRCCP will provide technical assistance to the referral health systems to ensure quality CRC screening service delivery (see **Policy 3: Program Quality Indicators**).

ANTHC CRCCP – CLINICAL AND COST DATA COLLECTION AND TRACKING

Purpose: To establish and define the ANTHC CRCCP procedures for ensuring clinical and cost data collection and tracking.

Scope: Applicable to all ANTHC CRCCP partner sites. ANTHC will be responsible for the development of tracking systems, data collection forms, and reporting of data to the CDC. Partner sites will be responsible for data collection and reporting to ANTHC.

Policy:

1. ANTHC will establish a system to collect and report patient level clinical data for Colorectal Clinical Data Elements reporting using the CDC CaST system.
2. ANTHC will submit a final draft of data collection forms for review by the CDC and IMS.
3. ANTHC will establish procedures to collect activity-based cost center data and report using the Cost Assessment Tool (CAT).
4. ANTHC will provide partner sites with the Medical Complications Reporting Form.
5. Partner sites will be required to use the Medical Complications Reporting Form to report serious complications requiring hospitalizations occurring within 30 days of CRC screening.
6. ANTHC will submit data on any serious medical complications arising out of program participation to CDC within 60 days of CRC screening.

ANTHC CRCCP – DATA CONFIDENTIALITY

Purpose: To establish ANTHC CRCCP data confidentiality guidelines.

Scope: Applicable to all ANTHC CRCCP partner sites.

Policy:

To ensure that ANTHC CRCCP partner sites implement general principles for electronic protected health information (EPHI) security to protect any reasonable foreseeable threats to the integrity, confidentiality and accessibility of EPHI and business critical data.

ANTHC CRCCP partner sites are committed to ensuring compliance with all applicable security standards for the Health Insurance Portability and Accountability Act (HIPAA) and applicable provisions of the Federal Privacy Act of 1974.

In addition to the specific policies listed below, ANTHC CRCCP partner sites will comply with all relevant ANTHC data privacy and confidentiality policies.

1. MANAGEMENT RESPONSIBILITY

ANTHC CRCCP partner site Managers and Supervisors are responsible for validating computer information system access requirements of their staff according to their job functions and also ensuring minimum necessary standards are adhered to. ANTHC CRCCP partner site Managers and Supervisors are also responsible to ensure Non-Employees comply with all data confidentiality guidelines.

2. INFORMATION SYSTEMS SECURITY

The information security policy applies to all information assets, including for example:

- 2.1 Information entered, processed, stored and output in electronic form, including that transmitted through networks and other communications mechanisms such as electronic mail (email), Internet and intranet, facsimile (fax) and digital telephone systems (collectively called “data”);
- 2.2 Technological communications systems plus the associated activities and environments supporting business processes;
- 2.3 Information assets and assets for which there is an actual or implied duty of care, such as customer and employee data.

3. ADMINISTRATIVE SAFEGUARDS

3.1 Workforce Security

3.1.1 Managers are responsible to develop and implement procedures to ensure that all their workforce members have appropriate access to electronic protected health information (EPHI) and access is removed when an individual transfers, terminates employment or ends his or her affiliation with ANTHC CRCCP partner sites.

3.1.2 Managers shall implement procedures for the authorization and/or supervision of workforce members who work with EPHI or in location where it might be accessed.

4. WORKSTATION USE

4.1 Workplace Security

4.1.1 ANTHC CRCCP partner site Managers and Supervisors are responsible to provide physical safeguards to restrict unauthorized access to EPHI via workstations, including portable devices. Such safeguards include but are not limited to;

- 4.1.1.1 Placement of the equipment in an area that is continuously monitored; and,
- 4.1.1.2 Physical devices that limit viewing of the information displayed on a workstation, for example privacy screens; timeouts (auto logoffs) of individual electronic sessions; and use of screensavers.

5. PROTECTED HEALTH INFORMATION AND ELECTRONIC EMAIL USAGE

5.1 Email containing protected health information (PHI) sent via the Internet must be encrypted. Sending PHI through any instant messaging technology is prohibited.

5.2 Messages with PHI or clinical content must be transmitted only to those individuals with a need to know. Clinical content must meet the minimum necessary standard as provided for in ANTHC CRCCP partner site privacy and security policies.

5.3 The sending of emails containing PHI must be transmitted consistent with applicable law.