Addressing When Patients Decline Colorectal Cancer (CRC) Screening

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This guidance was developed through colorectal cancer screening work from the Academic Innovations Collaborative from 28 Harvard-affiliated primary care sites, consulting from CRICO[1] (largest medical professional liability carrier in Massachusetts).

Addressing When Patients Decline CRC Screening[2]
• Recognize patients' right to decline screening; avoid blame.
• Standardize how the organization handles and documents when patients decline.
• Define what constitutes a "true decline" (e.g., checking a box, saying "No" to colonoscopy, having conversation with clinician, confirming with patient after colorectal cancer education, refusing fecal occult blood testing).
• Ensure patients have adequate information to make an informed decision both before and after declining.
• Design process to ensure emphasis on principles and practices of shared decision-making.
• Expire declines every year to reopen discussions and to add patient back to the population due for screening.
• Offer alternate screening options to colonoscopy (sigmoidoscopy, stool testing).
• Loop in risk management staff to determine if there are existing standards/protocols and submit policies/procedures/protocols to risk management for review and approval.
• Base actions and documentation on level of concern. If there's a higher level of concern (i.e., symptoms), there's more burden to document concerns, thought processes, tracking, patient commitments to care, etc. ○ For example, the documentation for someone at average risk who is due for colorectal cancer screening and declines will be very different than for a person at higher risk. Document the nature of the conversations that took place: "You're over 50 and are due for screening." Document offered, declined and informed consent. Compare that to, "I'm very concerned about symptoms/possibility of cancer along with your reluctance to have this test." ○ If at higher risk, document that higher risk factors were discussed with patient. Document why this is important and why it's recommended.
• Consider how to make the process tailored to the patient to overcome individual barriers (e.g., "too busy"); keep checking in with patients (e.g., every six months), and document all reminders.
• Asymptomatic and at average/low risk – may not need a registered/certified letter but still need to document recommendations and what patient does and does not agree to do. If patient says, "I'll schedule," and then doesn't, the clinician/care team still should follow up and track the patient's outcome.

[1] The legal company name of CRICO (Controlled Risk Insurance Company) is The Risk Management Foundation of the Harvard Medical Institutions Incorporated (RMF).
[2] Primary Care Collaboration to Improve Diagnosis and Screening for Colorectal Cancer Screening. Schiff G, Bearden T, Hunt L, Azzara J, Larmon, J, Phillips R, Singer S, Bennett B, Sugarman J, Bitton A, Ellner A. Joint Commission Journal on Quality and Patient Safety, Volume 43, Issue 7: 338-350.