

Improving Outcomes in Colorectal Cancer Screening

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The Scope of Colorectal Cancer

Estimated new cases, 2016

California, by cancer type

Breast (female)



Lung and bronchus



Prostate



Colorectum



Melanoma of the skin



Non-Hodgkin lymphoma



EXPAND TO SEE ALL DATA

American Cancer Society, 2016

Estimated deaths, 2016

California, by cancer type

Lung and bronchus



Colorectum



Breast (female)



Pancreas



Liver and intrahepatic bile duct



Prostate



EXPAND TO SEE ALL DATA

American Cancer Society, 2016

 **EIGHTYBY2018**
To join this effort visit www.nccrt.org

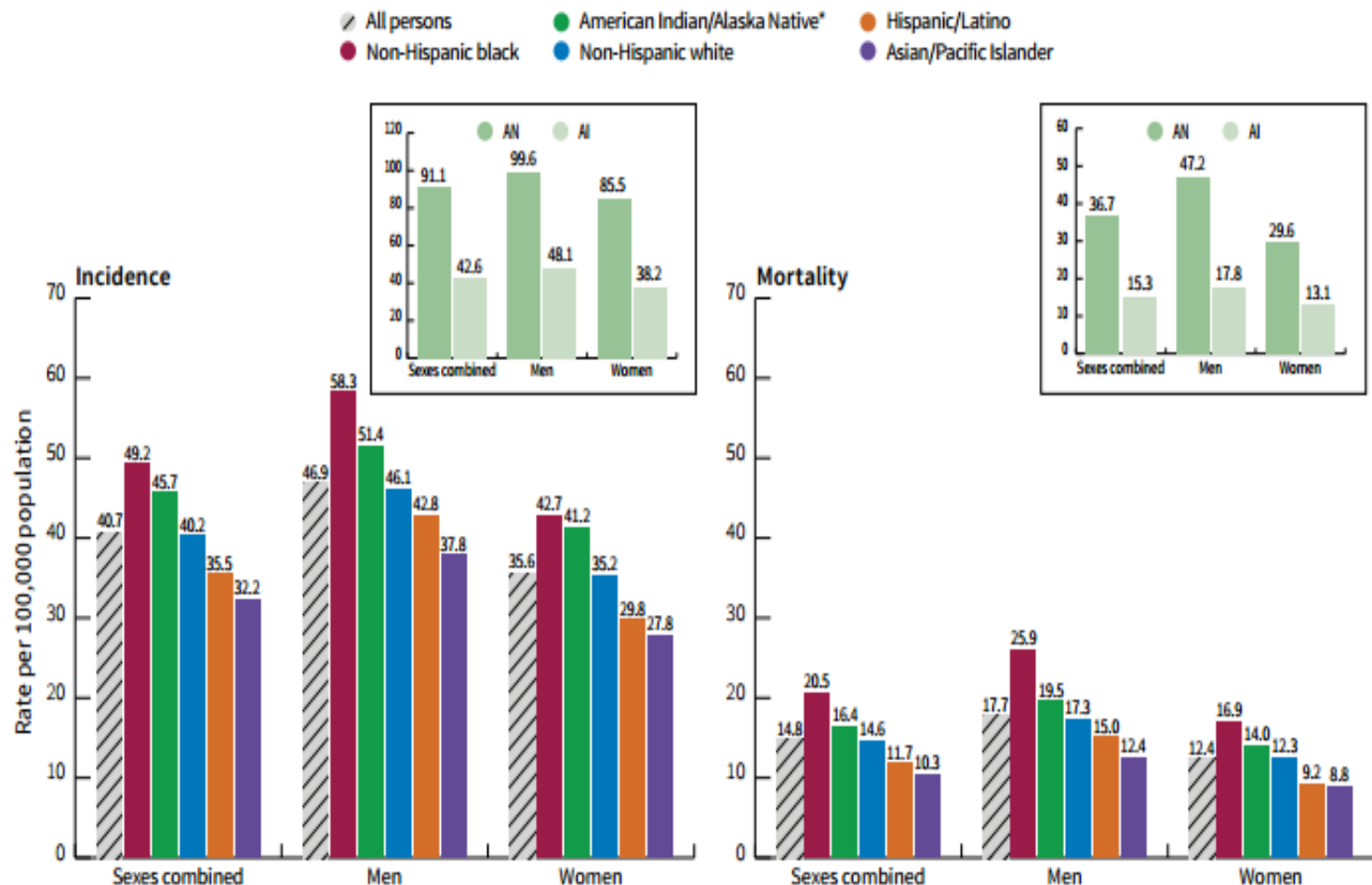


Trends in CRC incidence and mortality

Research suggests that observed declines in incidence and mortality are due in large part to:

- CRC treatment advances
- Screening → detecting cancers at earlier, more treatable stages
- Screening and polyp removal, preventing progression of polyps to invasive cancers
 - NEJM study Feb 2012 showed polyp removal associated with 53% lower risk of CRC death

Figure 3. Colorectal Cancer Incidence (2009-2013) and Mortality (2010-2014) Rates by Race/Ethnicity and Sex, US



AN: Alaska Native; AI: American Indian, excluding Alaska. Rates are age-adjusted to the 2000 US standard population. *Statistics based on data from Contract Health Service Delivery Area (CHSDA) counties; incidence rates exclude data from Kansas.

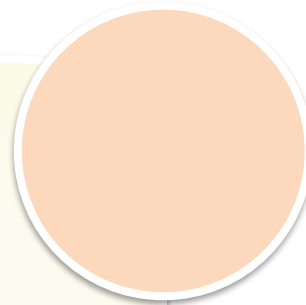
Sources: Incidence – North American Association of Central Cancer Registries (NAACCR), 2016; Alaska Natives only – Surveillance, Epidemiology, and End Results (SEER) Program, 2016. Mortality – National Center for Health Statistics, Centers for Disease Control and Prevention, 2016.

Risk Factors

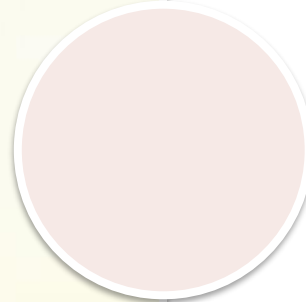
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Non-Modifiable Risk Factors



Age



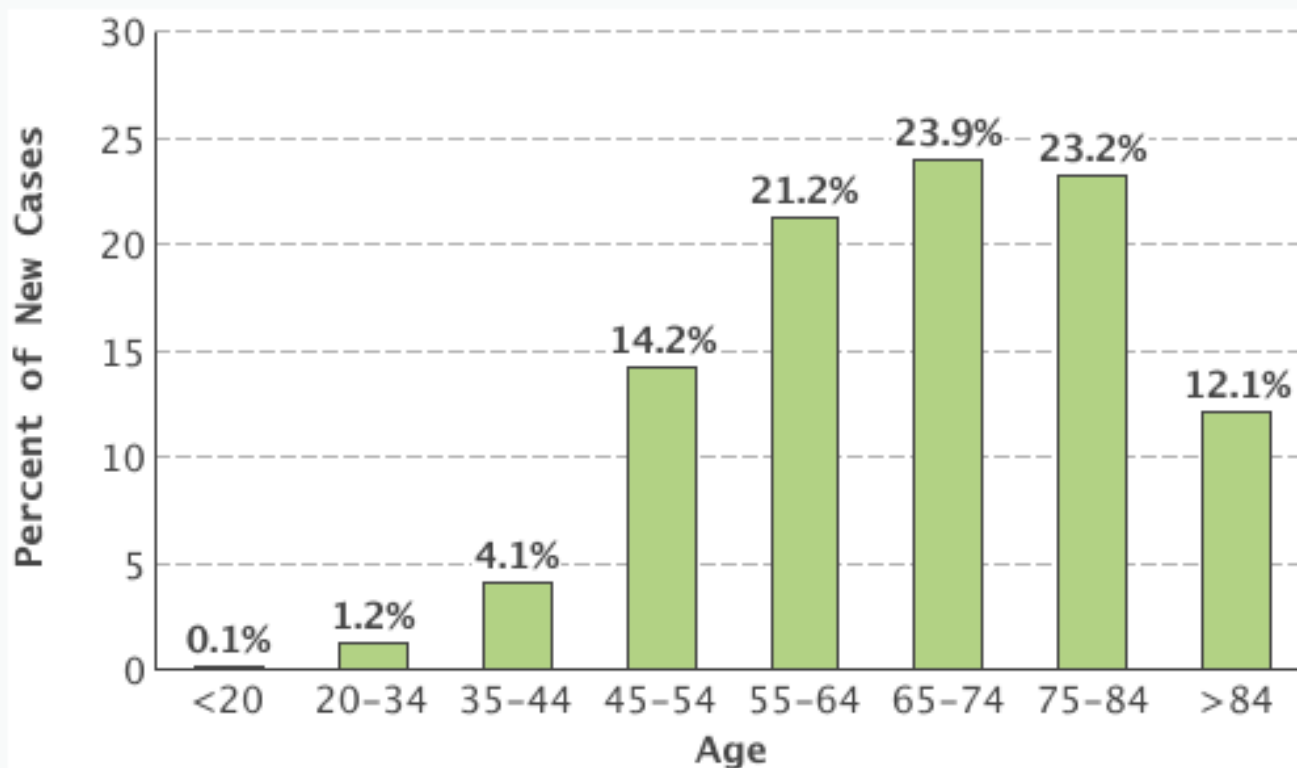
Gender



Race/Ethnicity

Age: the most impactful risk factor

Percent of New Cases by Age Group: Colon and Rectum Cancer



SEER 18 2007-2011, All Races, Both Sexes

CRC screening should begin at age 50 for most people, earlier for those with a family history.

Modifiable risk factors





Modifiable Risk Factors

- Smoking increases risk of CRC by 18%
- Alcohol increases risk of CRC 41%
- Obesity increases risk of CRC 45%
- Diet
 - High intake (>60gm/day) of red, grilled or processed meat increases risk of CRC 35%
 - High intake of fiber DECREASES risk of CRC
 - Dietary supplements – no effect, but food with folate and Vit D/Calcium may decrease risk

National Cancer Institute

<http://www.cancer.gov/cancertopics/pdq/prevention/colorectal/HealthProfessional/page2>

Screening Impact

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Why Screen?

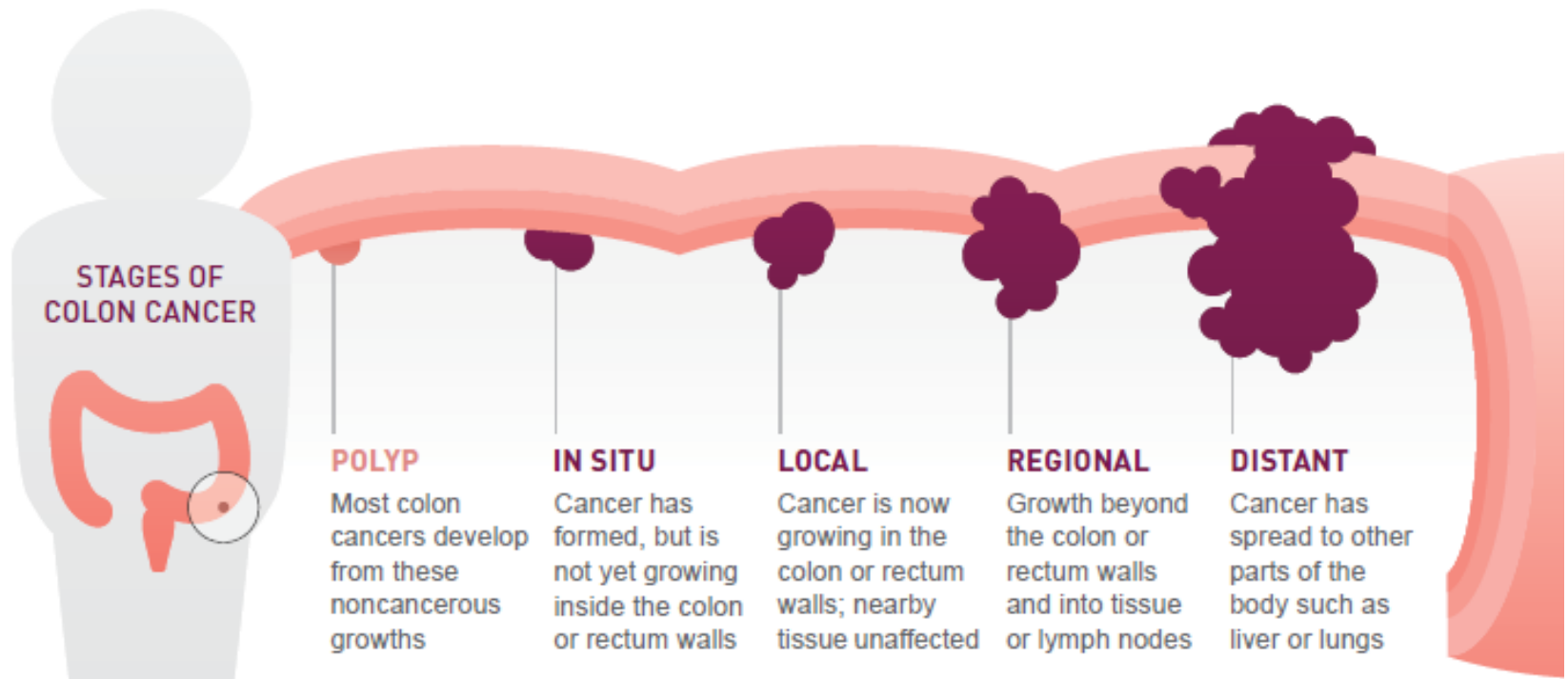
There are two aims of screening:

1. Prevention

Find and remove polyps to prevent cancer

2. Early Detection

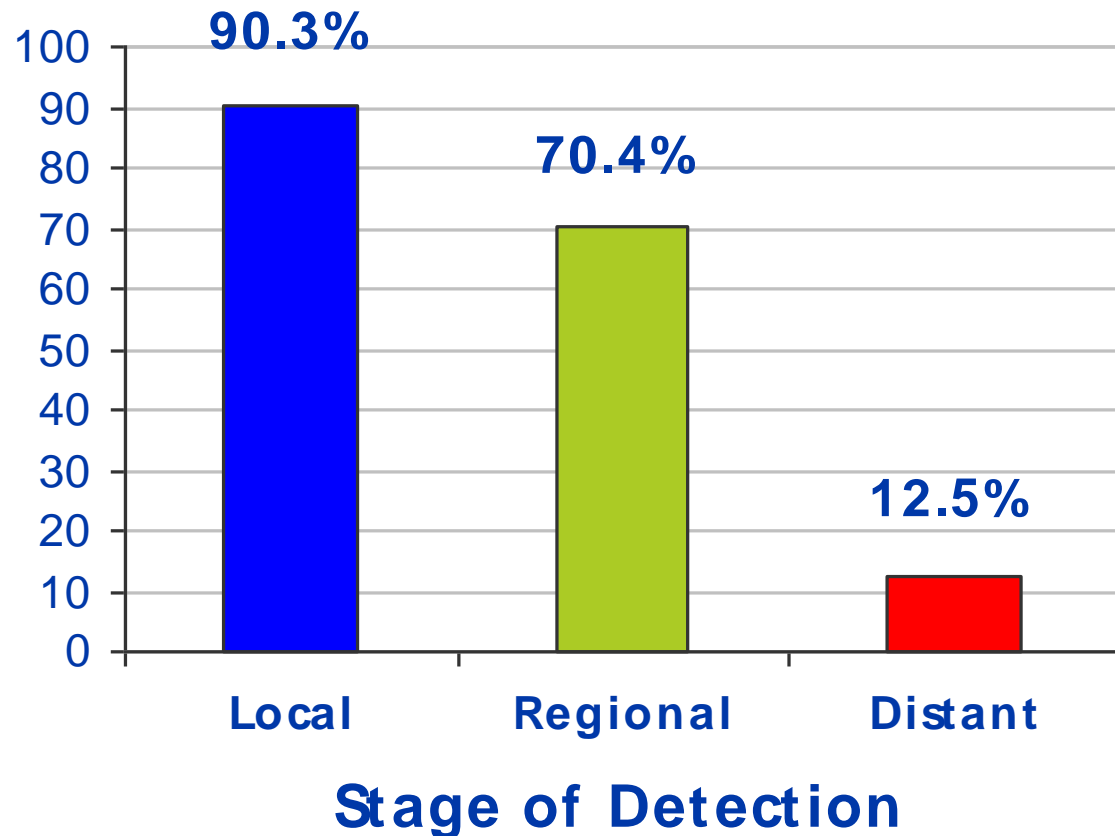
Find cancer in the early stages, when best chance for a cure



Benefits of Screening

Survival Rates by Disease Stage*

**5-yr
Survival**

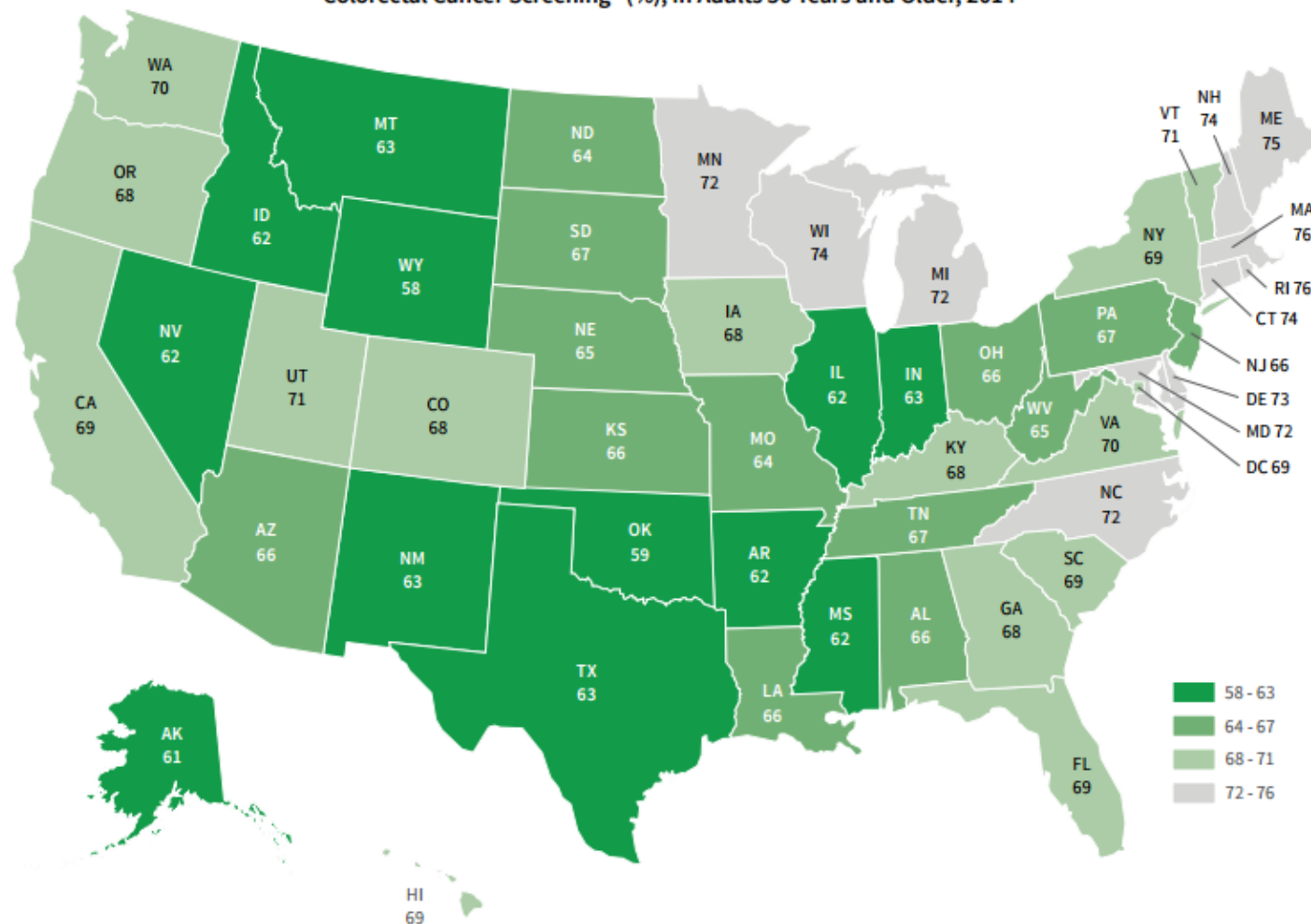


*1996 - 2003



Screening Rates

Colorectal Cancer Screening* (%), in Adults 50 Years and Older, 2014



*A fecal occult blood test within the past year, or sigmoidoscopy within the past five years or colonoscopy within the past 10 years.
 Note: The colorectal cancer screening prevalence estimates do not distinguish between examinations for screening and diagnosis.

Source: Centers for Disease Control and Prevention. Behavioral Risk Factor Surveillance System, 2014. Public use data file.

CRC screening in CA IHS Community Health Centers

- GPRA- 2015
**Colorectal Cancer
Screening Rate-
31.2%**
- UDS- 2015
Colorectal Cancer
Screening rate for
CA FQHC's –
41.2%

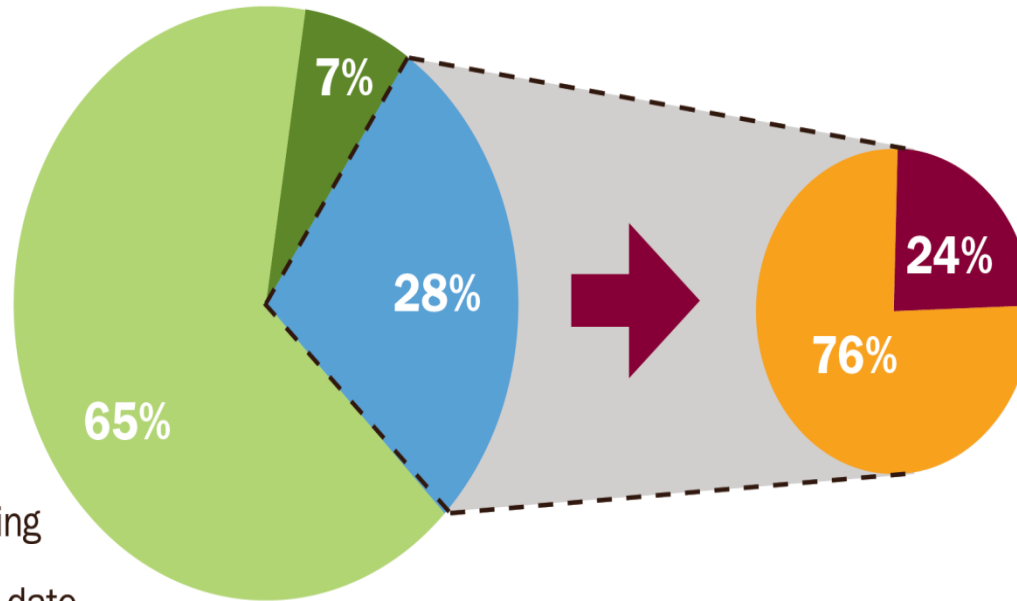


Who's Not Screened?



Testing status
of adults aged
50–75 years

- Up-to-date CRC testing
- Tested but not up-to-date
- Never tested



Insurance status
of never tested
adults aged
50–75 years

- Insured
- Uninsured

SOURCE: Behavioral Risk Factor Surveillance System, 2012





Screening Tests

ACS Screening Guidelines

- **Options for Average risk adults age 50 and older:**
 - **Colonoscopy** every 10 years, or
 - **Flexible sigmoidoscopy (FSIG)** every 5 years, or
 - **Double contrast barium enema (DCBE)** every 5 years, or
 - **CT colonography (CTC)** every 5 years
 - **Guaiaac-based fecal occult blood test (gFOBT)** with high test sensitivity for cancer every year
 - **Fecal immunochemical test (FIT)** with high test sensitivity for cancer every year



USPSTF Recommendations

Population	Recommendation	Grade (What's This?)
Adults aged 50 to 75 years	<p>The USPSTF recommends screening for colorectal cancer starting at age 50 years and continuing until age 75 years.</p> <p>The risks and benefits of different screening methods vary. See the Clinical Considerations section and the Table for details about screening strategies.</p>	A
Adults aged 76 to 85 years	<p>The decision to screen for colorectal cancer in adults aged 76 to 85 years should be an individual one, taking into account the patient's overall health and prior screening history.</p> <ul style="list-style-type: none">• Adults in this age group who have never been screened for colorectal cancer are more likely to benefit.• Screening would be 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.	C



Recommended Screening Tests

ACS and USPSTF

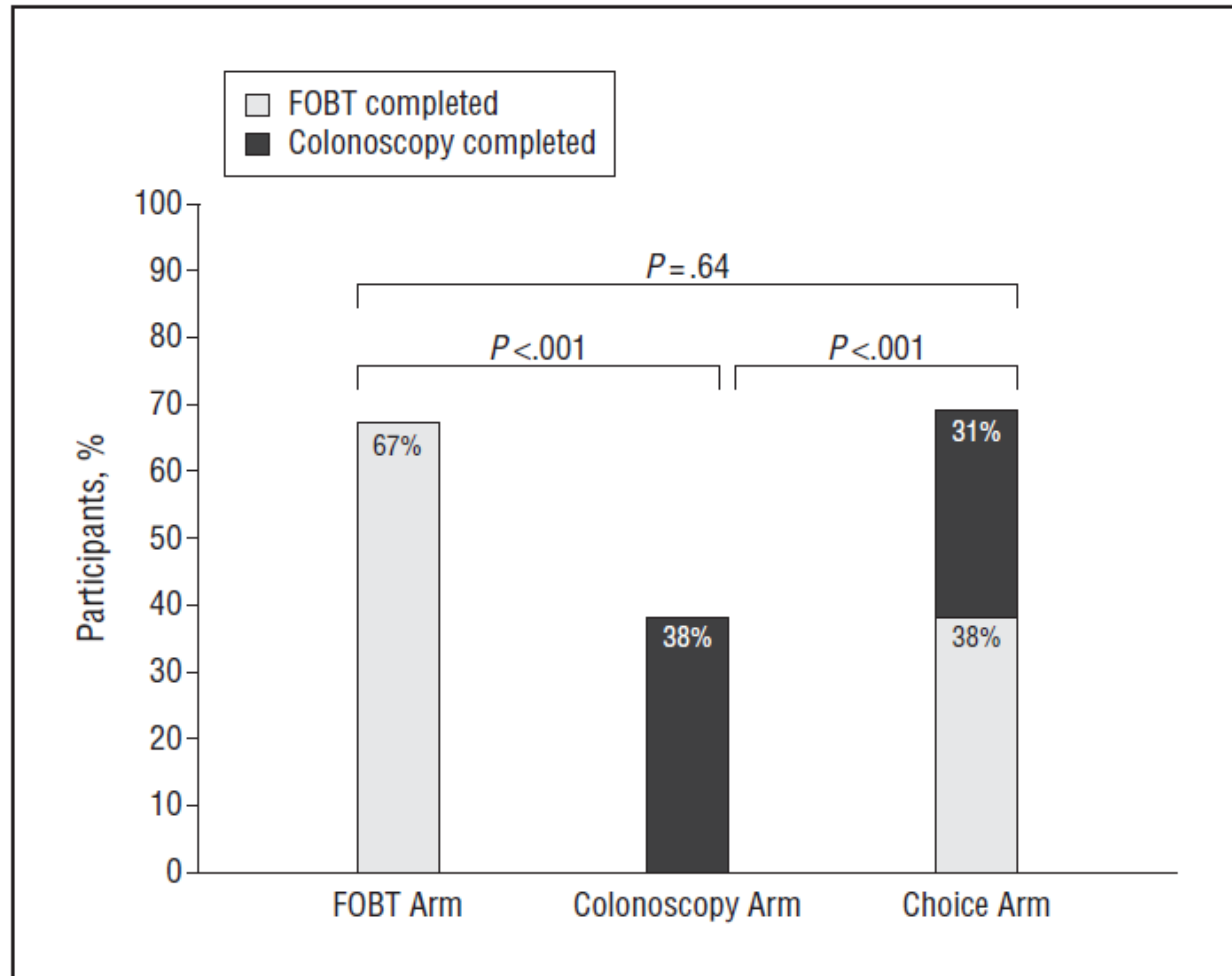
- Colonoscopy
- High Sensitivity Fecal Occult Blood Testing
 - Guaiac
 - Immunochemical
- Flexible Sigmoidoscopy (FSIG)
 - Recent studies support efficacy
 - Availability extremely limited in U.S.

Why Colonoscopy is NOT gold standard

- Evidence does not support “best test” or “gold standard”
- Greater patient requirements for successful completion
- Access
- Patient preference



Patient Preferences



Stool Tests

- Look for hidden blood in stool
- Two major types (but multiple brands)



Stool Test: Guaiac



- Most common type in U.S.
- Best evidence (3 RCT's)
- Need specimens from 3 bowel movements
- Non-specific
- Results influenced by foods and medications
- Older forms (Hemoccult II) have unacceptably low sensitivity
- Better sensitivity with newer versions (Hemoccult Sensa)

Stool Test: Immunochemical (FIT)

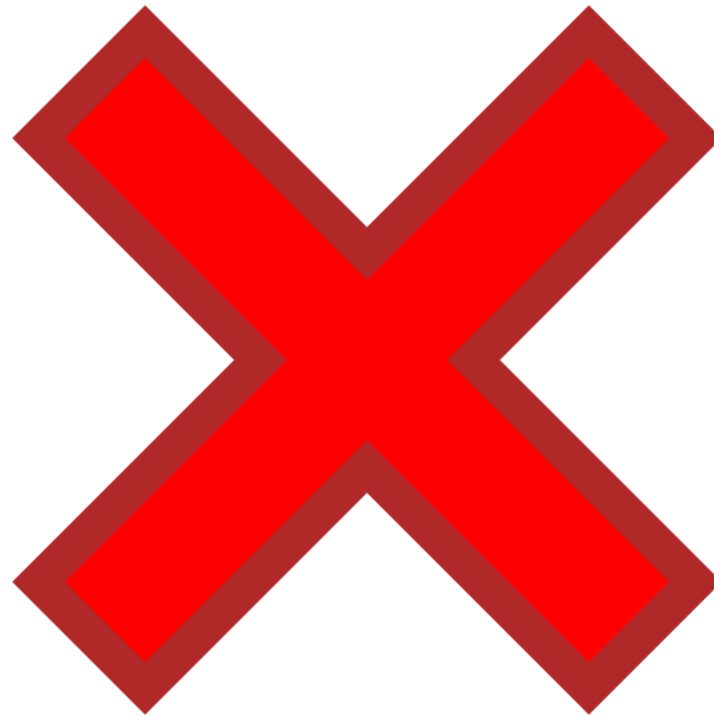
- Specific for human blood and for lower GI bleeding
- Results not influenced by foods or medications
- Some types require only 1 or 2 stool specimens
- Higher sensitivity than older forms of guaiac-based FOBT
- Slightly more costly than guaiac tests



FIT use in the US will likely increase due to recent elimination of guaiac- based testing by LabCorp and Quest Labs

Stool Testing Quality Issues

In-office FOBT is essentially **worthless** as a screening tool for CRC and should never be used for this purpose.





Summary - Stool Testing

- In-office FOBT is essentially worthless as a screening tool for CRC and should never be used.
- CRC screening by FOBT should be performed with high-sensitivity FOBT - either FIT or a highly sensitive gFOBT (such as Hemoccult SENSА).
 - Older, less sensitive guaiac tests (such as Hemoccult II) should not be used for CRC screening.
- Annual testing
- All positive screening tests should be evaluated by colonoscopy

Conclusion and Resources

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How We Work with Primary Care Systems

- Focus on cancer prevention and early detection to support the work that you are already doing and identify any gaps that we can help support.
- We're here as a resource and as consultants on the following:
Colon Cancer • Breast Cancer • Cervical Cancer •
HPV Vaccination • Physical Activity • Nutrition

*Our goal is to ensure your patients stay healthy and informed and that your cancer screening rates are at an optimum.

How We Work with Primary Care Systems

Assistance with implementing recommended
EBIs.

www.thecommunityguide.org

The Guide to Community Preventive Services
THE COMMUNITY GUIDE
What Works to Promote Health

WHAT WORKS

Cancer Prevention and Control:
Cancer Screening

Evidence-Based Interventions for Your Community

TASK FORCE FINDINGS ON CANCER SCREENING THROUGH 2011

The Community Preventive Services Task Force (Task Force) has released the following findings on what works in public health to increase breast, cervical, and colorectal cancer screening rates. These findings are compiled in The Guide to Community Preventive Services (The Community Guide) and listed in the table below. Use the findings to identify strategies and interventions you could use for your community.


Legend for Task Force Findings: ● Recommended ◆ Insufficient Evidence ▲ Recommended Against (See manual for detailed descriptions.)

INTERVENTION STRATEGY	TASK FORCE FINDING		
Increasing Breast, Cervical, and Colorectal Cancer Screening			
Client-oriented screening intervention strategies			
Interventions	Breast Cancer	Cervical Cancer	Colorectal Cancer
Client reminders	●	●	●
Client incentives	◆	◆	◆
Small media	●	●	●
Mass media	◆	◆	◆
Group education	●	◆	◆
One-on-one education	●	●	●
Reducing structural barriers	●	◆	●
Reducing client out-of-pocket costs	●	◆	◆
Provider-oriented screening intervention strategies			
Provider assessment & feedback		●	
Provider incentives		◆	
Provider reminder & recall systems		●	
Promoting informed decision making for cancer screening		◆	

Visit the "Cancer Prevention and Control" page of The Community Guide website at www.thecommunityguide.org/cancer to find summaries of Task Force findings and recommendations on cancer screening. Click on each topic area to find results from the systematic reviews, included studies, evidence gaps, and journal publications.

The Centers for Disease Control and Prevention provides administrative, research, and technical support for the Community Preventive Services Task Force.


American Cancer Society and Primary Care Systems
Partners in Saving Lives



Recommended Evidence Based Interventions for Cancer Screening and
How the American Cancer Society Can Help

Intervention Strategy	Support from the American Cancer Society
Client Reminders	Co-branded Screening Reminder Postcards, Telephone Reminder Scripts, Reminder Letter Templates
Small Media	Patient Education Materials, DVDs, Co-branded Posters
Group Education	Patient Education Materials
One-on-one Education	CHW E-learning Modules, Patient Education Materials, Physician Speakers to Educate Staff
Reducing Structural Barriers	Assistance with Postage Costs*
Reducing Client Out-of-pocket costs, Provider Assessment & Feedback, Provider Reminder & Recall Systems	Technical Assistance

*Based on availability



Resources for Colon Cancer Screening

*Poster



For appointment information, please call your doctor or nurse.
310-392-8636

Para hacer una cita, llame a:
310-392-8636

American Cancer Society

Venice Family Clinic

18074 American Cancer Society Inc. No. 00541

I survived colorectal cancer because I found it early.

Sobrevivi al cáncer colorrectal porque lo detecté a tiempo.

American Cancer Society

Venice Family Clinic

cancer.org | 1.800.227.2345

Reminder:

Colon and rectal cancer (called colorectal cancer) is the third most common cause of cancer death for men and women.

Fecal occult blood test/fecal immunochemical test (FOBT/FIT) testing is one of several colorectal cancer screening tests recommended by the American Cancer Society for adults without any symptoms. This testing should begin at age 50. By getting tested regularly, colorectal cancer can be found early when it is easier to treat.

- ☐ Our records show you are due for your colorectal cancer screening.
- ☐ Our records show you have not returned your FOBT/FIT colorectal cancer screening test kit.

To schedule an appointment or for information on completing your FOBT/FIT kit, please call
310-392-8636

Recordatorio:

El cáncer de colon y de recto (llamado cáncer colorrectal) es la tercera causa principal de muerte por cáncer en los hombres y las mujeres.

Prueba de sangre oculta en las heces fecales / Prueba inmunológica fecal (FOBT/FIT) son uno de los diversos exámenes de detección de cáncer colorrectal recomendados por la Sociedad Americana Contra El Cáncer para los adultos que no presentan síntomas. Este examen debe comenzar a los 50 años. Si se hace los exámenes regularmente, el cáncer colorrectal puede ser detectado a tiempo cuando es más fácil tratarlo.

- ☐ Nuestros registros indican que a usted le corresponde realizarse un examen de cáncer colorrectal.
- ☐ Nuestros registros indican que no ha devuelto la prueba de FOBT/FIT cuyo objetivo es detectar el cáncer colorrectal.

Para hacer una cita o para obtener información acerca de cómo usar el paquete de FOBT/FIT, llame a
310-392-8636

You can help prevent colon cancer.

If you're 50 or older, talk to your doctor about getting screened for colon cancer.

Colon cancer is the second-leading cause of cancer death in the US when men and women are combined, yet it can be prevented or found at an early stage, when it's small and easier to treat. Visit cancer.org/colon or call 1-800-227-2345 to learn more.

American Cancer Society

Venice Family Clinic

cancer.org | 1.800.227.2345
1.866.228.4327 TTY

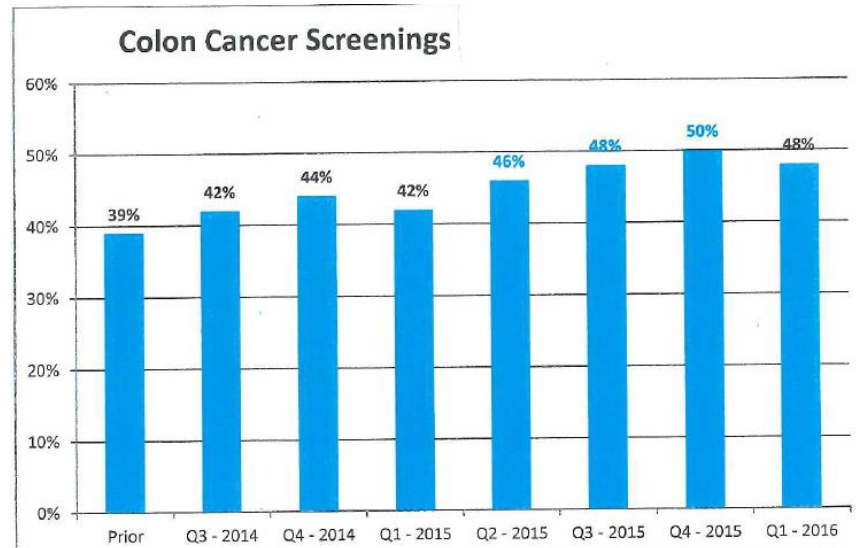
Providing quality primary health care to people in need

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Models used for illustrative purposes only.

Recommended Evidence Based Interventions

Provider Assessment & Feedback

- ❖ Assessing how many patients receive screenings and sharing feedback with providers using a scorecard or other tracking tool



Recommended Evidence Based Interventions

Provider Reminder & Recall Systems

- ❖ Having reminders/recalls as part of the medical record

Pre-Visit/Preventive Screening

General Measures (Patients >18)

Has the patient had a tetanus vaccine within the last 10 years?

Date of Last

Has the patient had a flu vaccine within the last year?

Date of Last

Has the patient ever had a pneumonia shot? (Age>50)

Date of Last

Does the patient have an elevated (>100 mg/dL) LDL?

Last

Has the patient been screened at least once for HIV? (Age 13-64)

Date of Last

Testing not required if patient refused or if positive diagnosis previously confirmed.
☒ Click If Patient Refuses Testing

Elderly Patients (Patients >65)

Has the patient had an occult blood test within the last year? (Patients >50)

Date of Last

Has the patient had a fall risk assessment completed within the last year?

Date of Last

Has the patient had a functional assessment within the last year?

Date of Last

Has the patient had a pain screening within the last year?

Date of Last

Has the patient had a glaucoma screen (dilated exam) within the last year?

Date of Last

Does the patient have advanced directives on file or have they been discussed with the patient?

Discussed?

Is the patient on one or more medications which are considered high risk in the elderly?

Diabetes Screening

Is Diabetes screening appropriate for this patient?

Pre-Diabetic Patients

If pre-diabetic, has the patient had a HgbA1c test within the last year?

Date of Last

Diabetes Patients

Has the patient had a HgbA1c within the last year?

Date of Last

Has the patient had a dilated eye exam within the last year?

Date of Last

Has the patient had a 16-gram microfilm exam within the last year?

Date of Last

Has the patient had screening for nephropathy within the last year?

Date of Last

Has the patient had a urinalysis within the last year?

Date of Last

Has the patient ever been referred to DSME?

Has the patient been referred to DSME within the last two years?

Female Patients

Has the patient had a pap smear within the last two years? (Ages 21 to 64)

Date of Last

Has the patient had a mammogram within the last two years? (Ages 40 to 69)

Date of Last

Has the patient had a bone density within the last two years? (Age >50)

Date of Last

Male Patients

Has the patient had a PSA within the last year? (Age >40)

Date of Last

Has the patient had a bone density within the last two years? (Age >60)

Date of Last

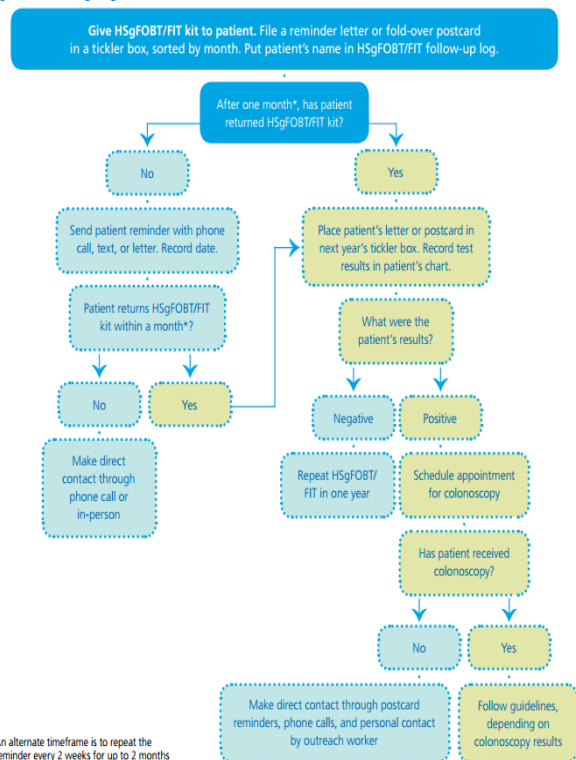
Referrals (Double-Click To Add/Edit)

Referral	Status	Referring

Other Areas of Support

- Work with QI Team to do Process Mapping/Flow

Figure 4. Standing HSGFOBT/FIT flow chart⁴⁴



Sample Office Policy Worksheet:

What is Everyone's Role?

While in the Waiting Room

- Ask the patient to complete a questionnaire to provide information on risk, status, screening history, and attitudes.
- Place informative and attractive posters or fliers in the waiting room or exam rooms as an expression of your own policy and as cues to action.
- Customize the use of educational instructional materials, and reminder tools to suit your practice needs.

Enter staff responsible here: _____

At Patient Check-In

- Have staff ask about preventive care and highlight services that are needed or past due.
- Use preventive care flow sheets and reminder chart stickers.

Enter staff responsible here: _____

During the Visit

- Ask patients about family history and previous screening.
- Let your patients know that getting CRC screening can prevent cancer and save lives.
- Schedule screening before the patients leaves the office.

Enter staff responsible here: _____

This chart can be viewed at: <http://www.cancer.org/acs/groups/content/documents/document/acspc-024588.pdf> -- Page 47

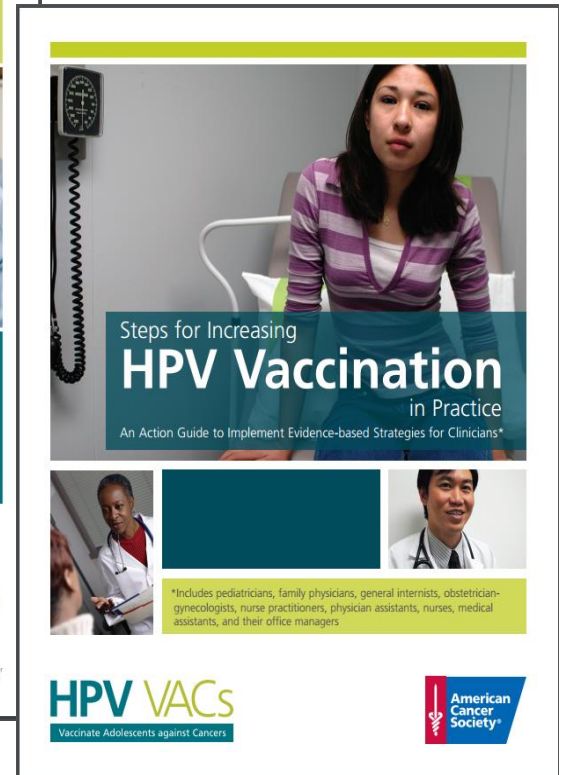
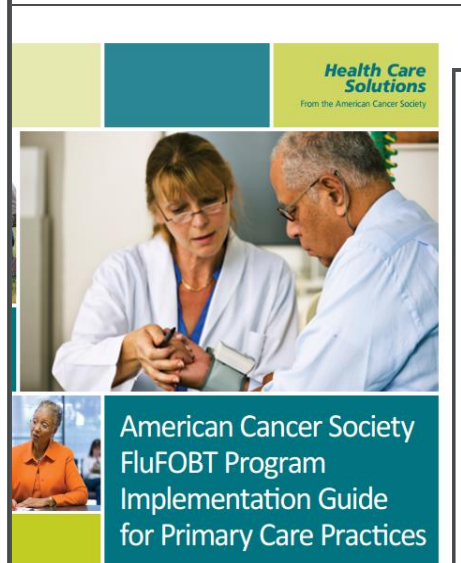
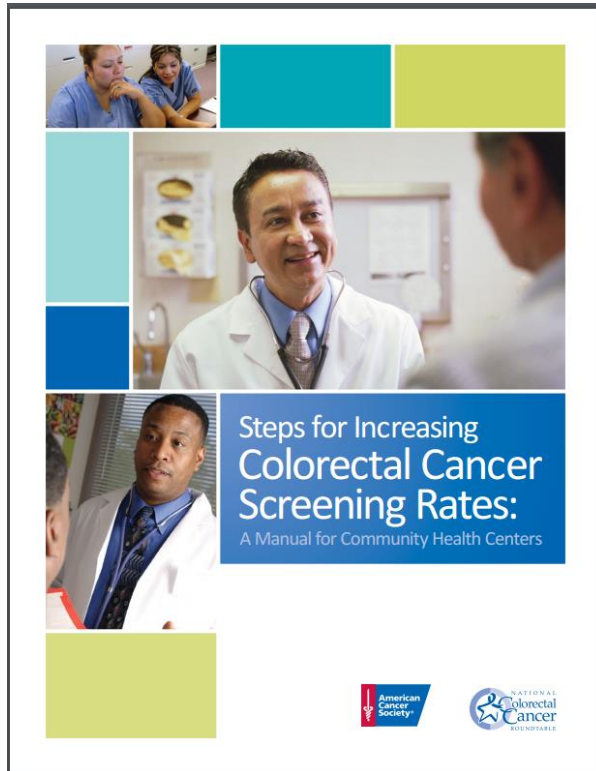
Other Areas of Support

- Coordinate Physician Speakers on Colorectal and Breast Cancer Screening and HPV Vaccination to present to providers.



Primary Care Tools We Offer

Implementation Guides & Manuals





Resources

- American Cancer Society
 - www.cancer.org/colonmd
 - www.cancer.org/professionals
 - Colorectal Cancer Facts and Figures 2014 – 2016:
<http://www.cancer.org/acs/groups/content/documents/document/acspc-042280.pdf>
- National Colorectal Cancer Roundtable
 - www.nccrt.org
- Flu-FIT
 - www.flufit.org





THANK YOU!

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