



Colorectal Cancer Screening Information for Providers

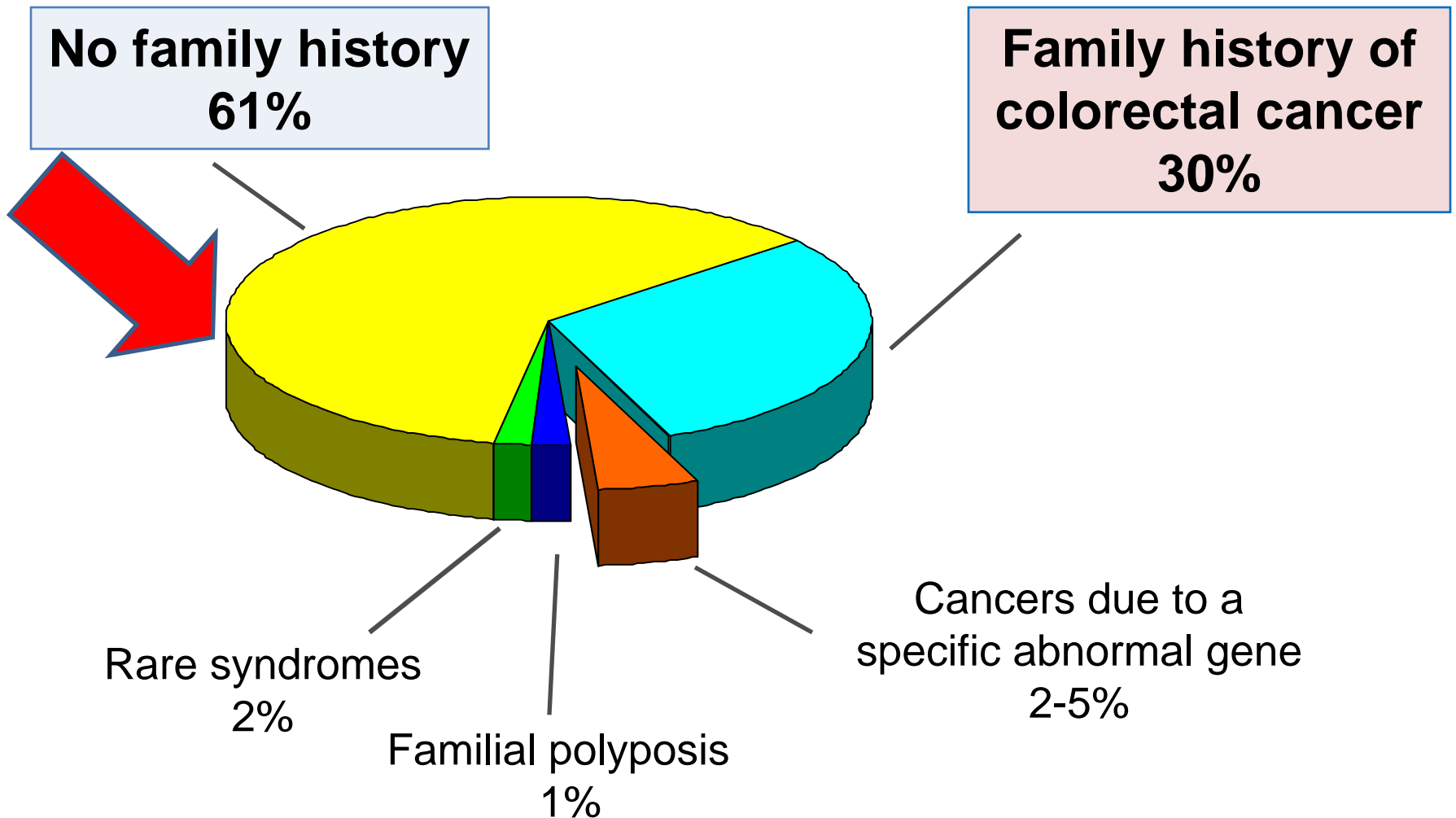
Objectives for Participants

- Describe changes in the updated U.S. Preventive Services Task Force (USPSTF) guidelines for colorectal cancer (CRC) screening
- Describe one or more barriers to screening that you had not been aware of
- Identify one or more practice changes that would increase screening
- PCPs and gastroenterologists: select one change to implement

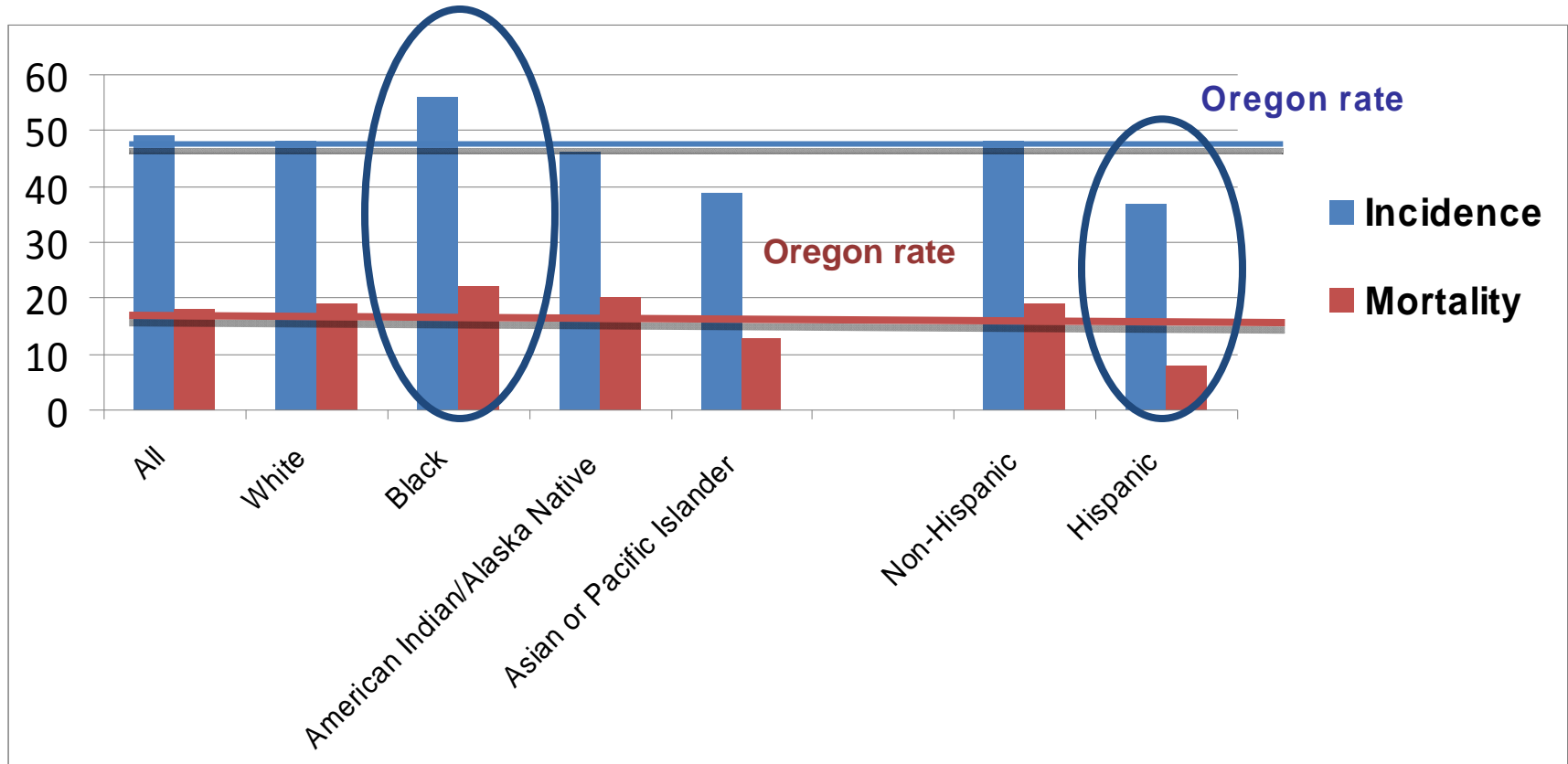


Overview of Colorectal Cancer Incidence and Mortality

Who gets colorectal cancer?



Colon Cancer Incidence and Mortality in Oregon by Race and Ethnicity, 1996–2005



Source: *Cancer in Oregon, 2005*

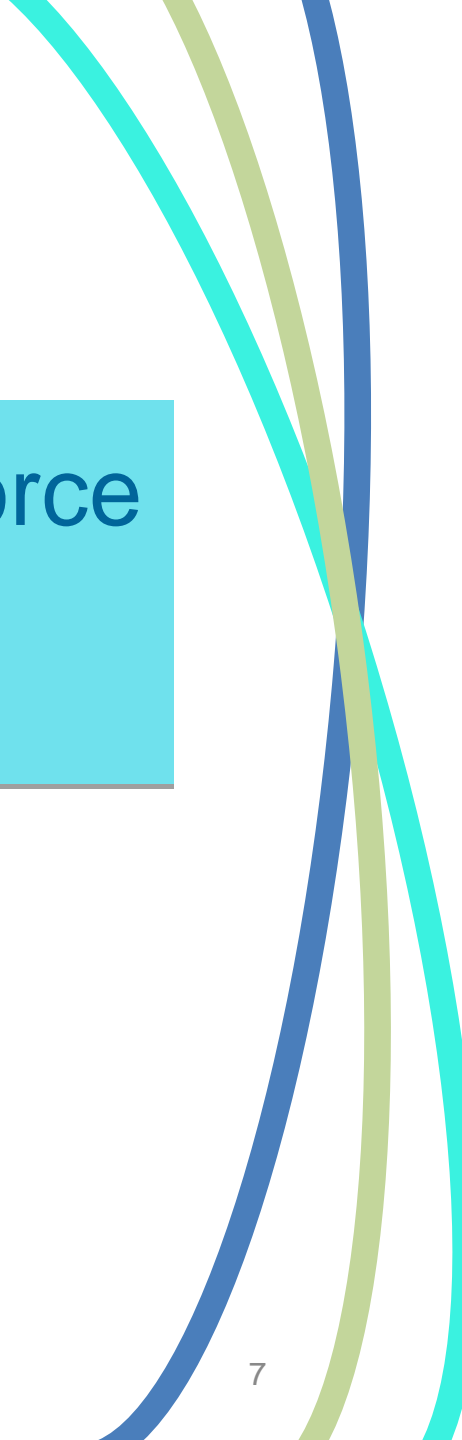
Colorectal Cancer in Oregon, 1999–2005*

County Rates Compared with Oregon Average	Lower	Higher
Incidence	Lane Washington	Lincoln Marion North Central
Mortality	Lane	Clatsop Marion

Source: *Cancer in Oregon, 2005*

*Age-adjusted incidence rates: Oregon (2005): 45.7%
 Age-adjusted mortality rates: Oregon (2005): 16.6%

U.S. (2004): 49.5%
 U.S. (2004): 16.5%



U.S. Preventive Services Task Force Screening Guidelines Updated October 2008

USPSTF Guidelines for Routine Screening

Average-Risk Population: Age 50–75*

Prevention

Colonoscopy
every 10 years

OR

Sigmoidoscopy
every 5 years, with
FOBT every 3 years

**Prevention
Early
detection**

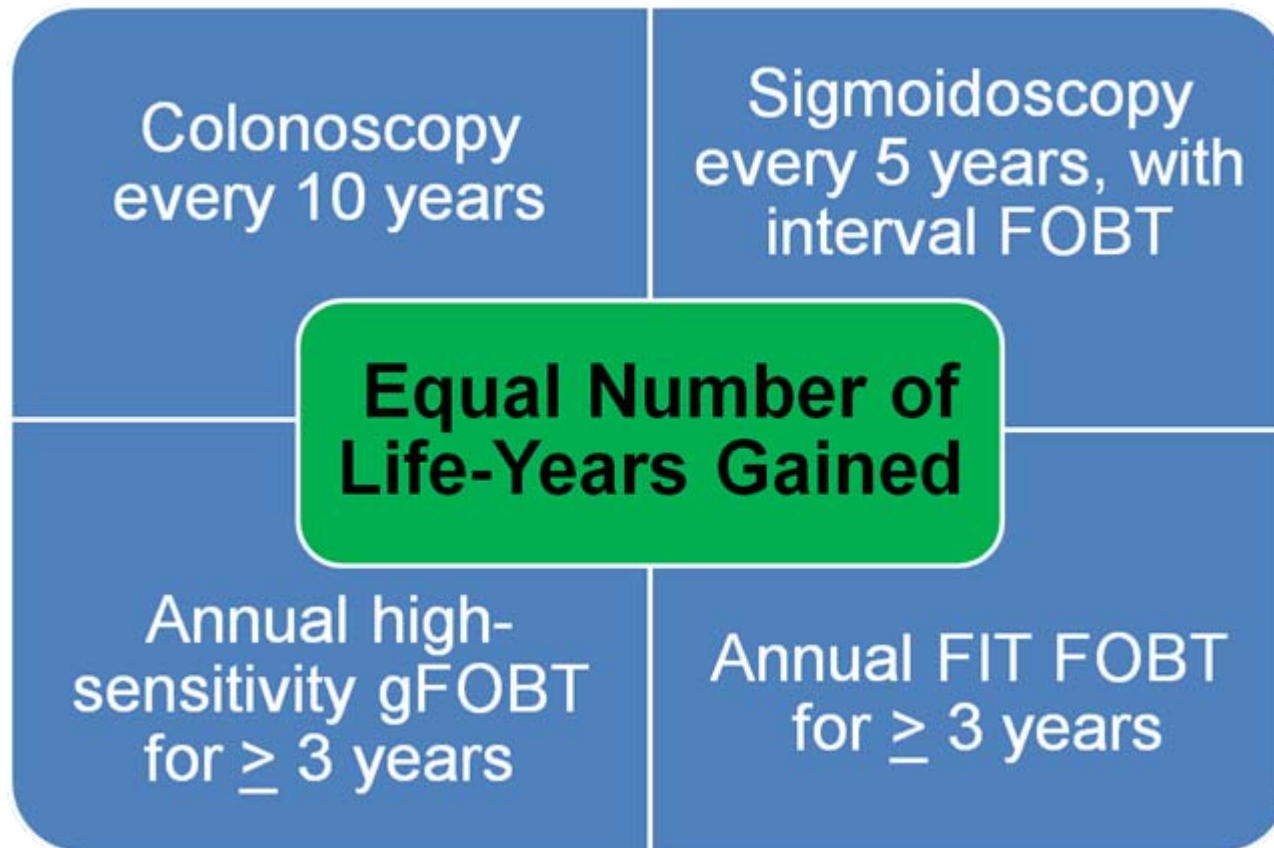
OR

**Early
detection**

High-sensitivity FOBT
annually for 3 years

* Screen based on patient health and life expectancy age 76–85 and not after age 85

Rationale for Recommendations



* Findings of decision analysis performed for the U.S. Preventive Services Task Force for screening by all methods at various intervals.

American College of Gastroenterology Recommendations for African Americans

Colonoscopy
every 10 years,
beginning at age 45

Colon cancer in African Americans

- High incidence
- Early onset
- High prevalence of right-sided lesions
- High mortality relative to stage at diagnosis, except in the VA system

CT Colonography

- A promising new non-invasive test
 - Same preparation as for colonoscopy
 - Requires colonoscopy for removal of large polyps
- Currently covered by some private insurance plans but not by Medicare
- Not considered by most experts to be ready for “prime time”

Relative Benefits of Screening for CRC vs. for Breast Cancer

CRC

- 2nd leading cause of cancer deaths in Oregon in 2005
- Cost of treatment: \$8.4 billion
- > 60% of deaths preventable by routine screening

- \$11,890 to \$29,725 per life-year saved

Breast cancer

- 2nd leading cause of cancer death among Oregon women in 2005
- Cost of treatment: ~\$7 billion
- 20%–25% of deaths preventable by screening every 1–2 years during a 10-year period

- \$36,924 per life-year saved

The *best test*
is the one
that gets done

* Approximately 250–270 life-years saved per 1000 people screened



Colorectal Cancer Screening in Oregon

Screening Barriers Attributable to Providers

Medical records

- Ineffective tracking systems

Cost

- Education and reminders
- FOBT billable only if returned by the patient

Belief system

- Colonoscopy is the only test that should be recommended—yet many cannot access or afford the test

Screening Barriers Attributable to Patients

Underestimation of

- CRC risk
- Value of screening

Overestimation of

- Discomfort
- Risk
- Prior screening

Fear that cancer will be diagnosed

More Screening Barriers Attributable to Patients

Access

- Regular primary care provider
- Gastroenterologists

Cost

- Insurance coverage status
- High Co-pays
- Knowledge of options

Literacy

Distrust of the healthcare system

How colonoscopy information might look to a patient with limited literacy

Your naicisyhp has dednemmoer that you have a ypocsonoloc. Ypocsonoloc is a test for noloc recnac. It sevlovni gnitresni a elbixelf gniweiv epocs into your mutcer. You must drink a laiceps diuqil the thgin erofeb the noitanimaxe to naelc out your noloc.

Strategies That Increase Adherence to CRC Screening Recommendations

Tip #1: Patient education

Tip #2: Staff training

Tip #3: Reminder systems

Tip #4: Patient agreement to complete and return FOBT

Tip #5: Let the patient decide

Source: Adapted from a fact sheet provided by Beckman Coulter, 2003.

Tip #1: Education That Matters

Clear and realistic explanation of testing

Notification process

Follow-up plan for failure to complete test or abnormal findings

Colorectal Cancer Risk Assessment Tool

<http://www.cancer.gov/colorectalcancerrisk/default.aspx>



National Cancer Institute

U.S. National Institutes of Health | www.cancer.gov

Colorectal Cancer Risk Assessment Tool

An Interactive Tool for Measuring the Risk of Colorectal Cancer

nci-banner



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[Colorectal Cancer Risk and Protective Factors](#)

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The Colorectal Cancer Risk Assessment Tool estimates the risk that a non-Hispanic white man or woman ages 50-85 will develop [colorectal cancer](#). It is an interactive tool designed by scientists at the National Cancer Institute (NCI), the University of Utah, and the Kaiser Permanente Medical Care Program of Northern California. See [About the Tool](#) for more information.

Results (Colorectal Cancer Risk)

[About the results](#)

***Reminder:** The Colorectal Cancer Risk Assessment Tool was designed for use by health professionals and their patients. If you are not a health professional, you are encouraged to discuss these results and your personal risk of colorectal cancer with your healthcare provider. The results are calculated based on data from non-Hispanic white men and women ages 50 to 85+.*

Race/Ethnicity: Non-Hispanic white

Gender: Female

Age: 64

Tip #2: Staff Training

Tip #3: Reminder Systems

It takes a practice team and a community...

- *Screen for Life*: Katie Couric and Jimmy Smits
- Staff distributes FOBT kits and scheduling endoscopies
- Staff makes appointments for screening tests
- Staff uses all opportunities to encourage and remind people to complete tests
- Staff shares positive personal anecdotes about screening tests and prevention

Tip #4: Patient Contract

FOBT completion rate of 75%

- 11,501 patients
- Release form stating that the patient had received the test kit and agreed to return it to the physician

Source: Paaso BT. Community-based colorectal cancer screening. *Point of Care*. 2002;1(1):20–27.

Tip #5: Let the Patient Decide

Shared decision making

- Explain guidelines and screening test options
- Engage patient in reflection on
 - Values and preferences
 - Barriers and facilitators to screening
- Explore solutions
- Develop strategies for follow up and monitor adherence

Take-Home Messages

- Colorectal cancer is a preventable disease
- The best test is the one that gets done...
 - Colonoscopy, sigmoidoscopy with interval high-sensitivity FOBT, and annual high-sensitivity FOBT all save equal numbers of life-years
- Collaborative decision making with patients can eliminate barriers and increase screening rates

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