

Colorectal Cancer Screening Information for Providers

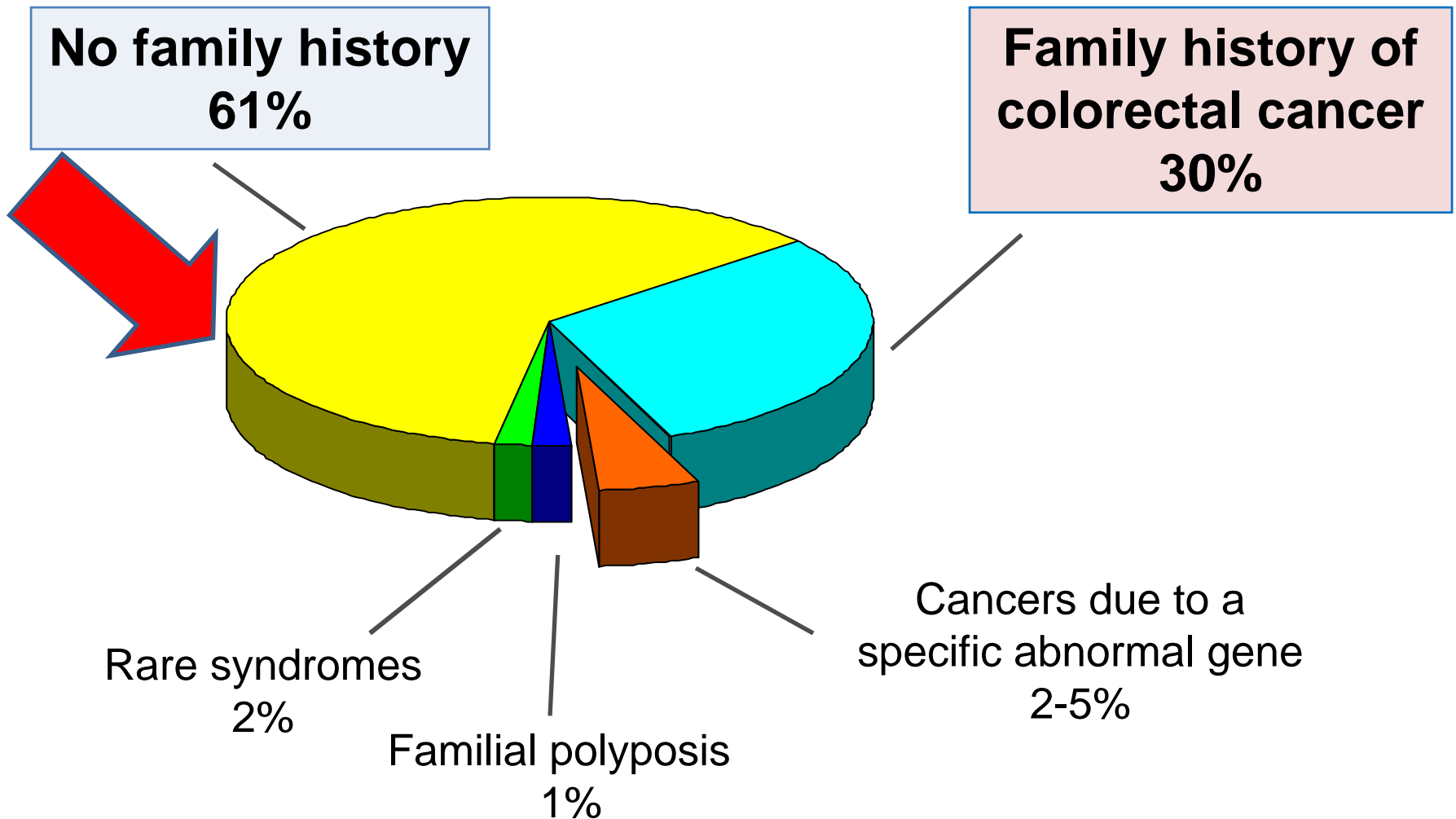
Objectives for Participants

- 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

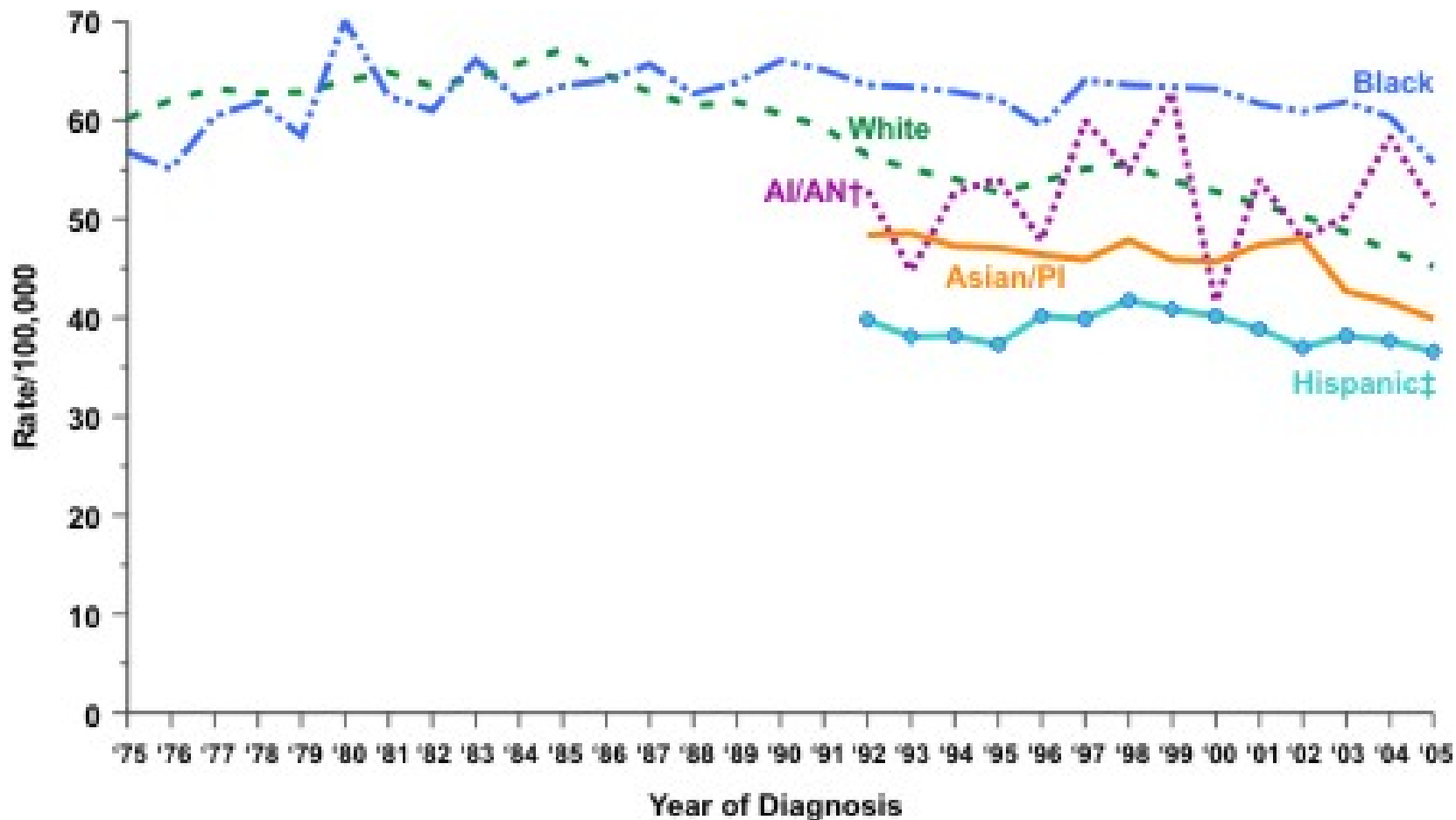


Overview of Colorectal Cancer Incidence and Mortality

Who gets colorectal cancer?

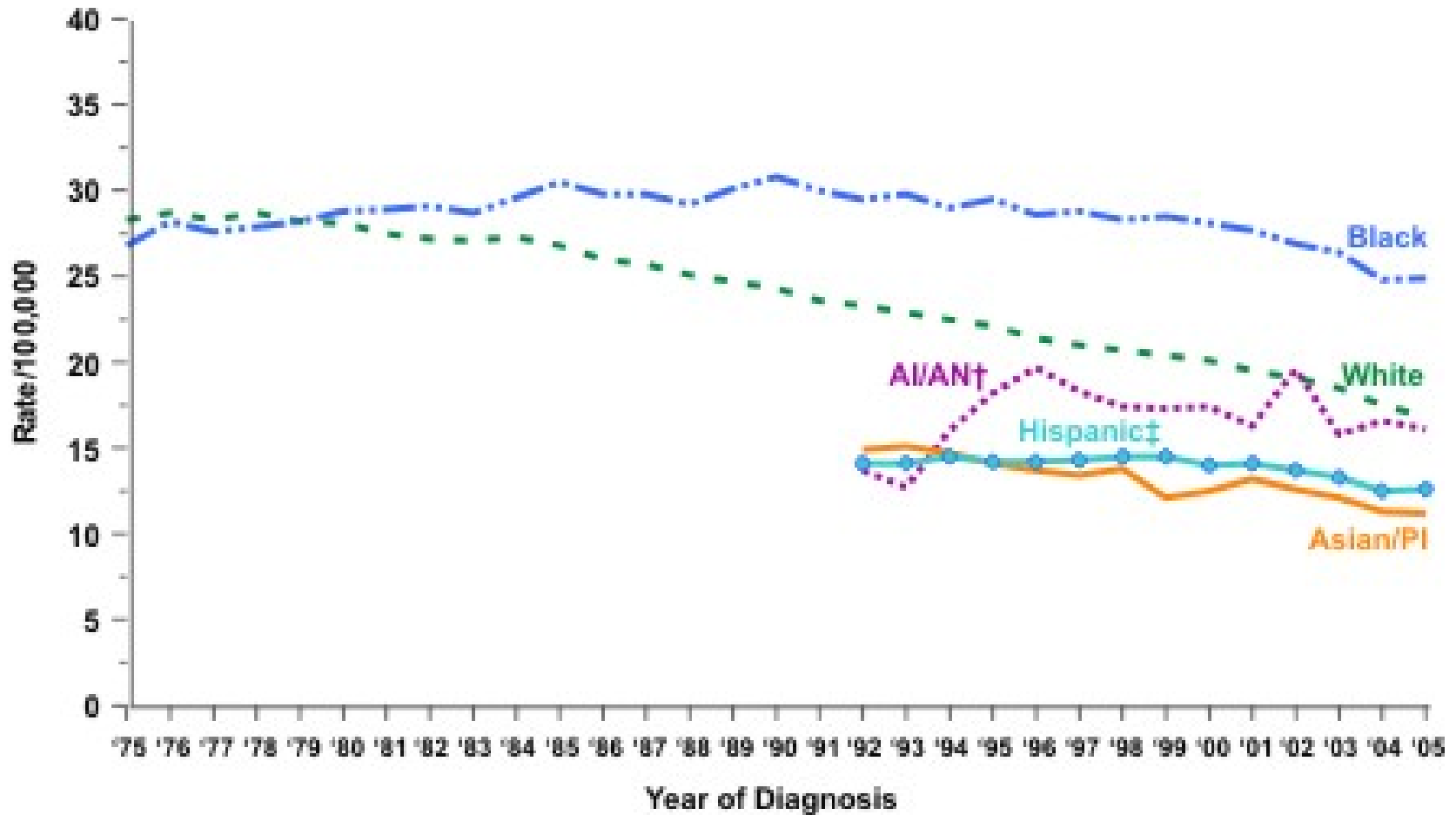


U.S. Colorectal Cancer Incidence by Race and Year of Diagnosis: 1975–2005



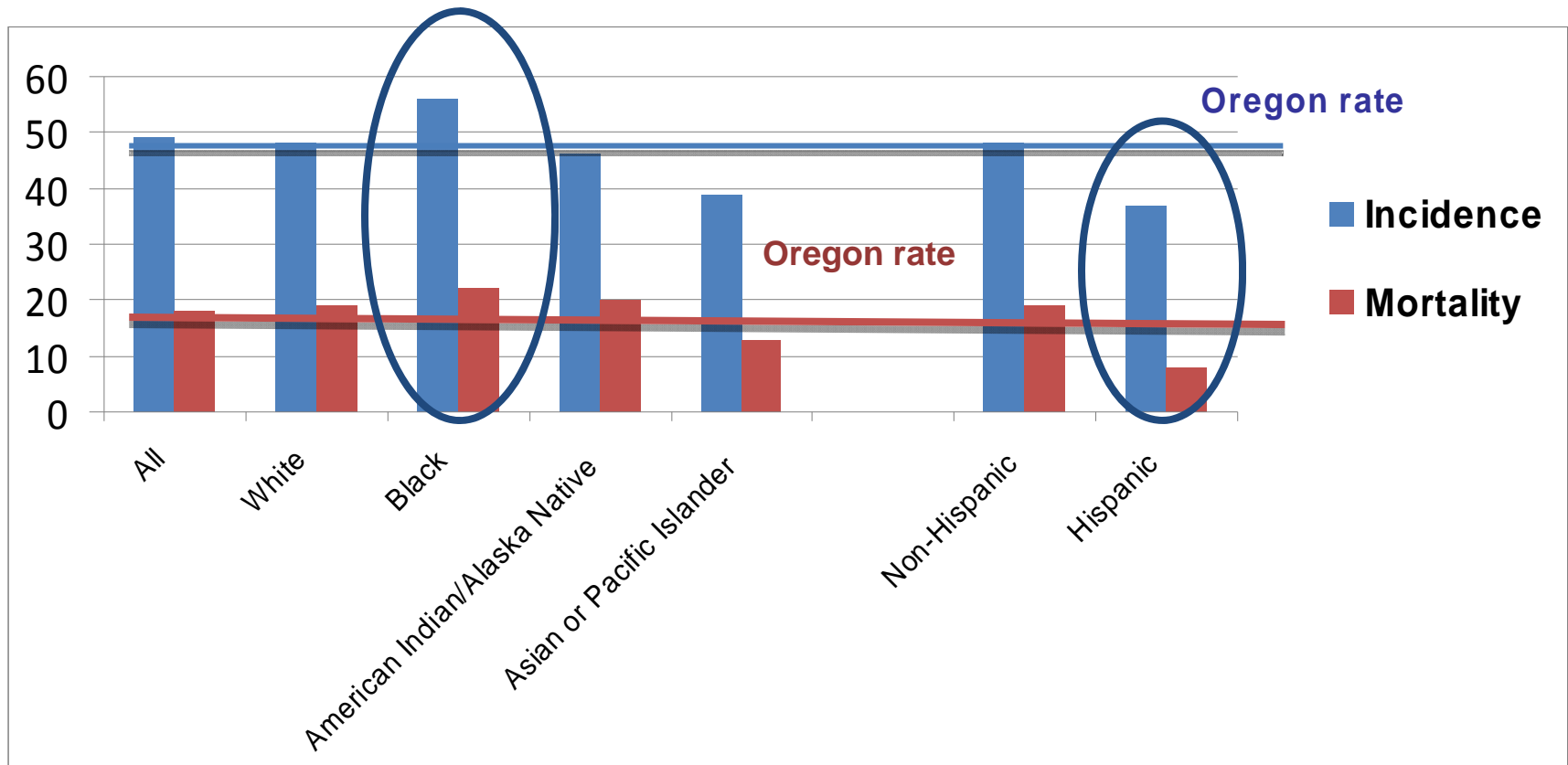
Source: National Center for Health Statistics (NCHS) <http://www.cdc.gov/cancer/colorectal/statistics/race.htm>

U.S. Colorectal Cancer Mortality by Race and Year of Diagnosis: 1975–2005



Source: National Center for Health Statistics (NCHS) <http://www.cdc.gov/cancer/colorectal/statistics/race.htm>

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

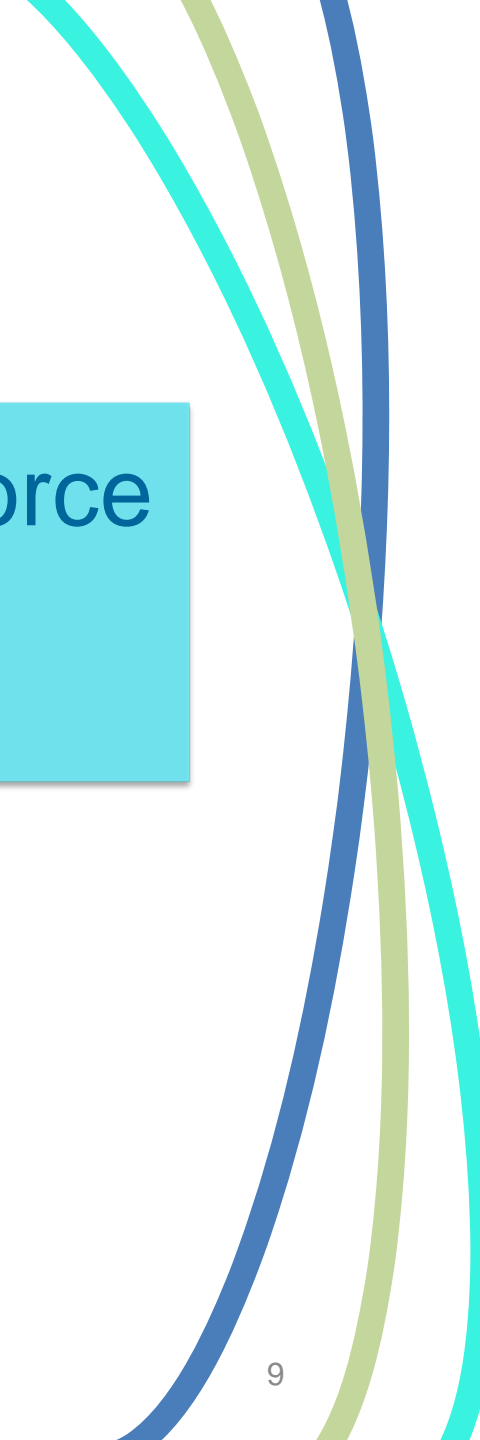
Source: *Cancer in Oregon, 2005*

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

U.S. (2004): 49.5%

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

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**

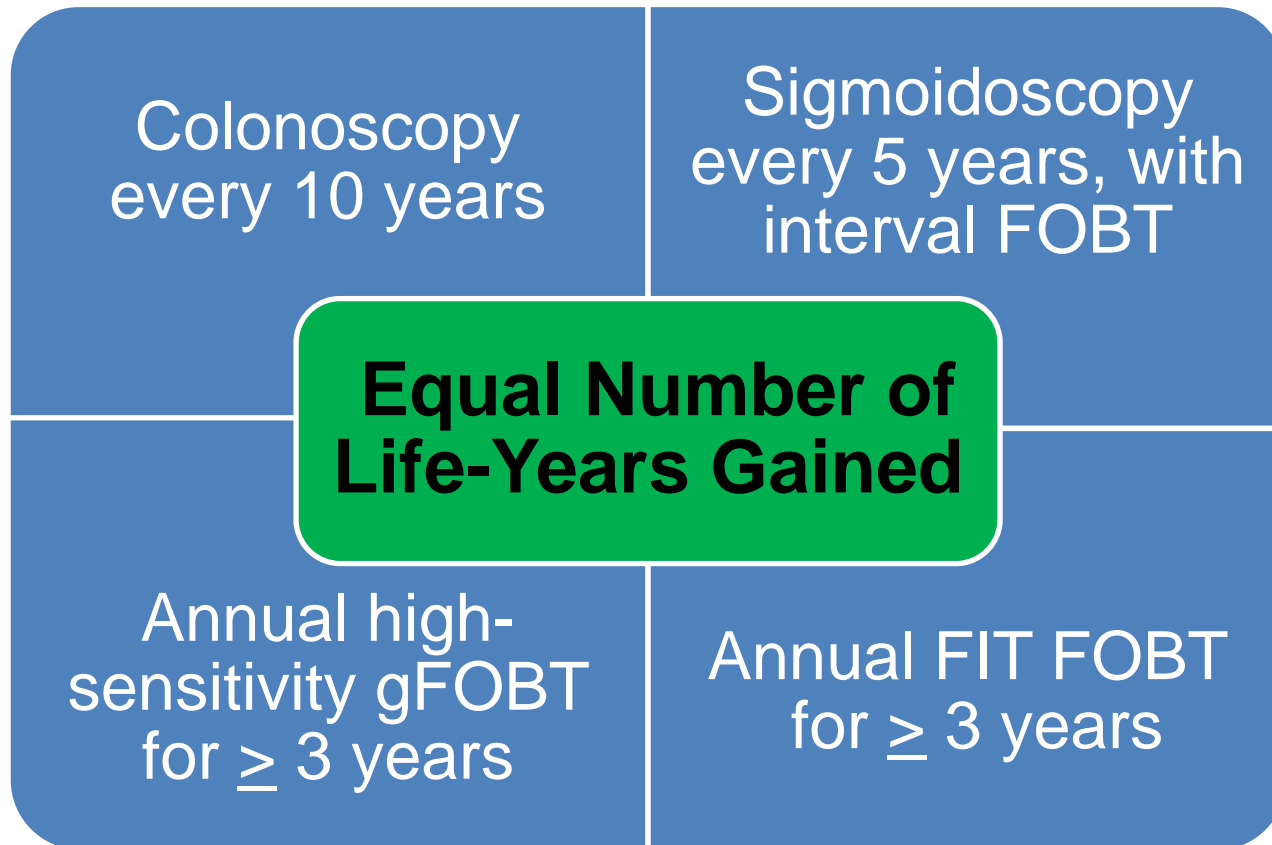
OR

**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

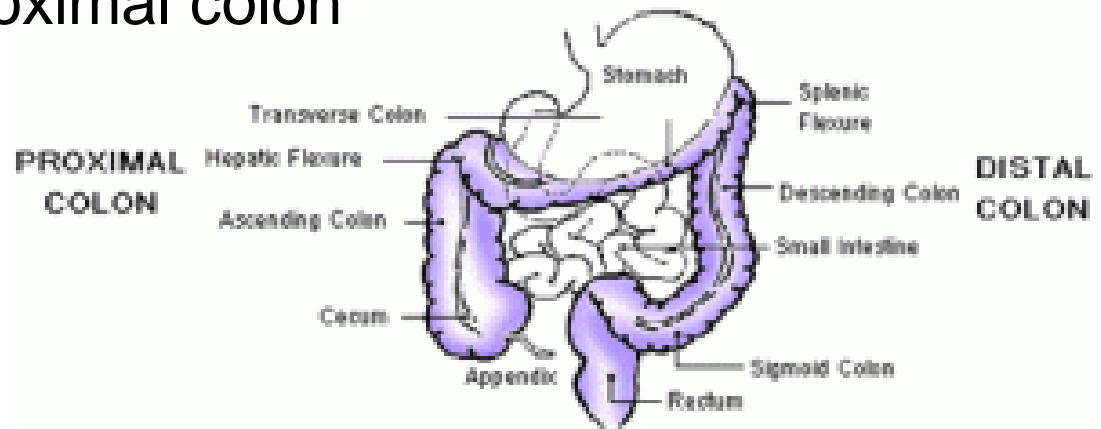
Rationale for Recommendations



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

Higher Prevalence of Large Polyps in African Americans

- 2 years' colonoscopy data from 67 GI practices found colorectal adenomas ≥ 9 mm in 6.2% of Whites and 7.7% of African Americans (AAs)
 - ~ 13% greater incidence for AA men
 - ~ 62% greater incidence for AA women
- AAs over 60 were more likely than Whites to have large adenomas in the proximal colon



Source: Centers for Disease Control and Prevention, 2006.

Source: Lieberman DA et al. *JAMA*. 2008;300(12):1417–1422.

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

The New York Times

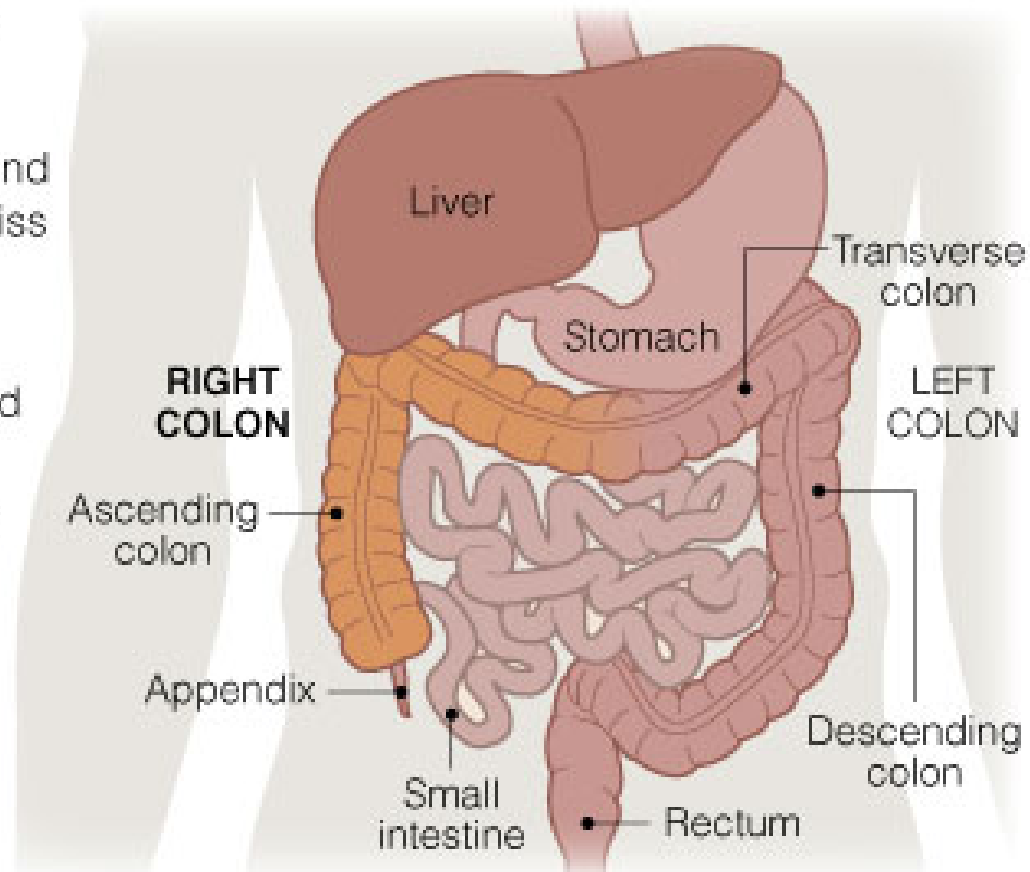
December 16, 2008

Imperfect Test For a Cancer

A Canadian study found that colonoscopies miss more cancers than previously thought.

Colonoscopies missed nearly all cancers in the right colon, where cancers are harder to detect, and roughly a third of cancers arising in the left colon.

Source: *Annals of Internal Medicine*



THE NEW YORK TIMES

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

Oregon BRFSS 2006

Self-Reported Data*

Home FOBT in the prior 12 months	29%
Sigmoidoscopy or colonoscopy in the prior 5 years/10 years, respectively	50% / 57%

*Proportion of patients age 50 and older who reported receiving a test.

Medicare Claims Data

Oregon CRC Screening Rates, 2005

State	Demographics	Tests during calendar year 2005					Met guideline
		Any Test	Colon- oscopy	Endos- copy	FOBT	Sigmoid- oscopy	12/31/05
							Current in Medicare*
Oregon	Ages 50–64	11.9	7.5	7.8	4.8	0.5	27.7
Oregon	Ages 65–74	17.4	10.0	10.4	8.2	0.7	41.7
Oregon	All	15.5	8.4	8.9	7.7	0.7	41.4
Connecticut	All	23.2	10.3	10.6	15	0.8	49.8
Maine	All	20.6	10.5	10.8	10.8	0.7	49.8

Source: The Carolinas Center for Medical Excellence. Colorectal Cancer: Testing in the Medicare Population for 1998–2005.

*CIM (Current in Medicare): Medicare enrollees in the denominator who have at least one Medicare-paid claim for FOBT during the calendar year OR sigmoidoscopy or double contrast barium enema during the calendar year or 4 years prior OR colonoscopy during the calendar year or up to 9 years prior.

Performance Update

Medicare patients meeting screening guidelines as of 3/31/08:*

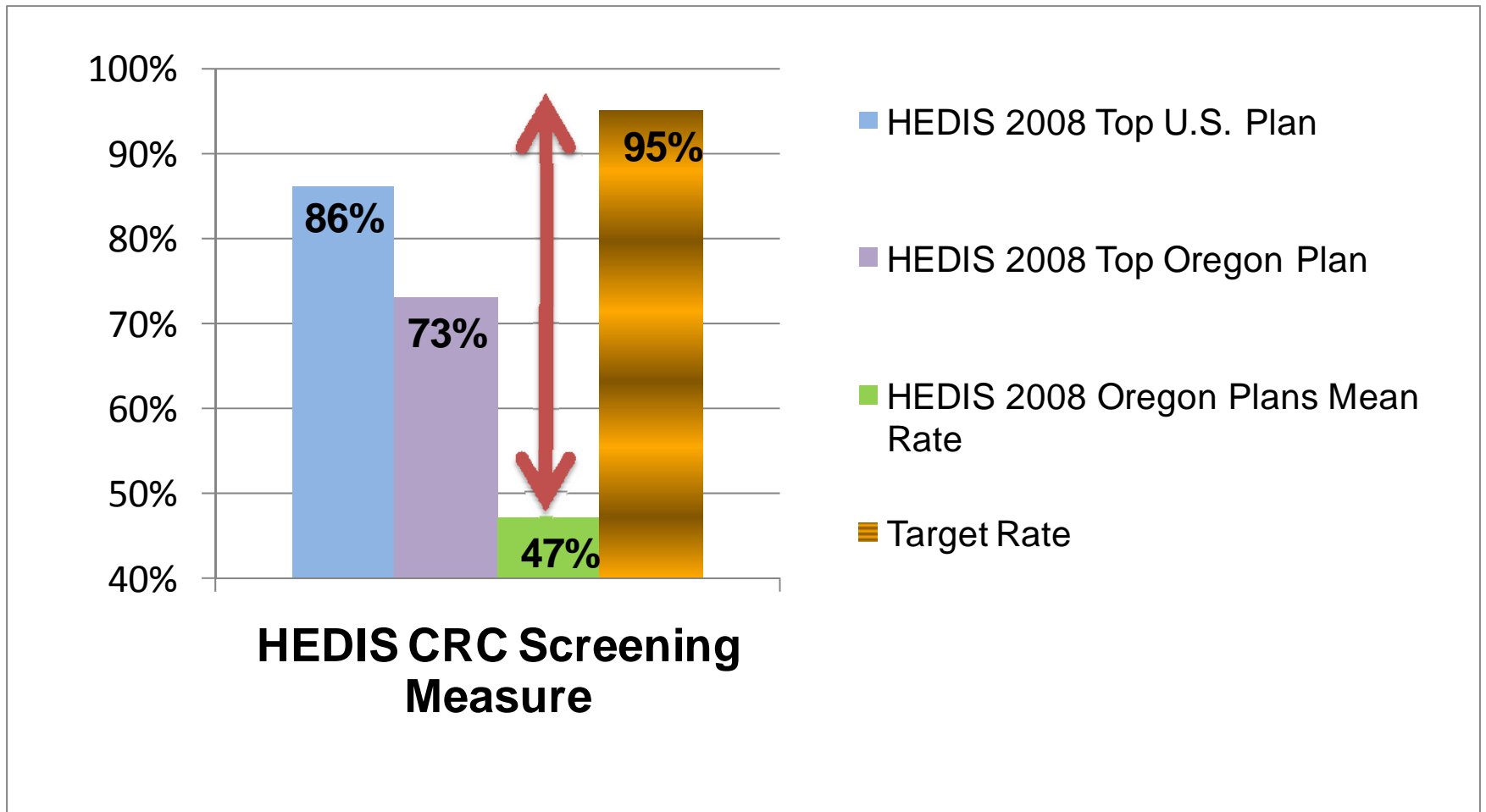
- U.S. rate 49.8%
- Oregon rate 45.8%

Oregon remains
below average

*Medicare does not have claims for sigmoidoscopies and colonoscopies performed prior to age 65 or during managed care coverage.

HEDIS® CRC Screening Measure

What is, and what is possible...



Source: HEDIS Public Use Files. Data include 5 plans with rates reflecting combined OR/WA data

Oregon 2005 Screening Rates for Medicare Beneficiaries

<input type="checkbox"/> African American	35 %
<input type="checkbox"/> Asian	33%
<input type="checkbox"/> Caucasian	46%
<input type="checkbox"/> Hispanic	28%
<input type="checkbox"/> Native American	35%
<input type="checkbox"/> Other	35%

National Goals for CRC Screening

Are these goals bold enough?

Objective

1998 Baseline

2010 Target

Adults >50 years who have received a FOBT in the preceding 2 years

35%

50%

Adults >50 years who have ever received a flexible sigmoidoscopy

37%

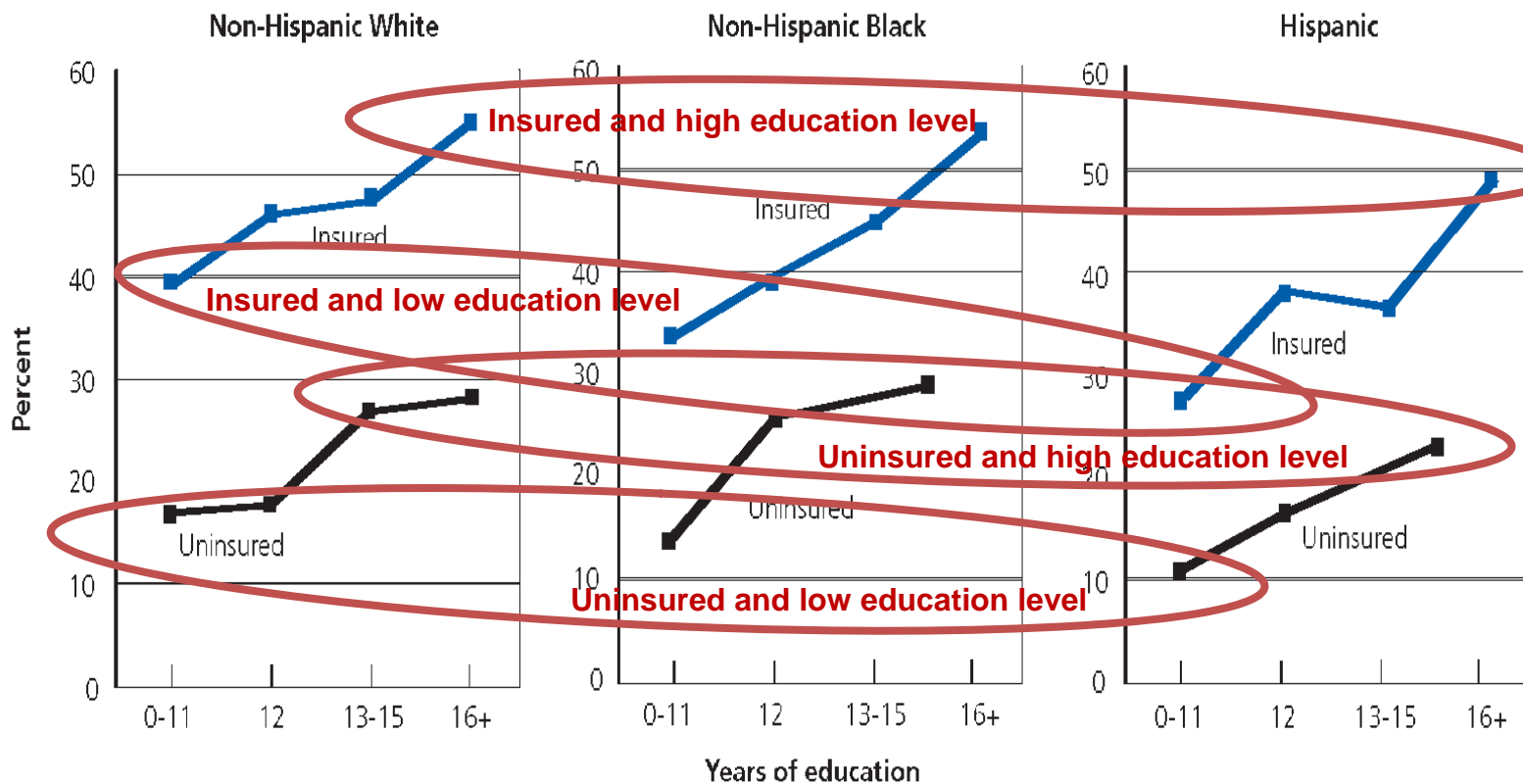
50%



Colorectal Cancer Screening Barriers

Insurance Status and Education

Figure 9. Colorectal Cancer Screening*, Ages 50-64 Years, by Race/Ethnicity, Years of Education, and Insurance Status, 2003-2005



*Either a fecal occult blood test within the past year or an endoscopy within the past 10 years.

†Groups have been combined (years of education 13+) due to small sample sizes.

Source: National Health Interview Survey 2003 and 2005, National Center for Health Statistics, Centers for Disease Control and Prevention, 2006.

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

FOBT Return Rates

Efficacy of FOBT hinges on annual testing

Poor adherence limits success of FOBT testing programs (i.e., low return rates)

- Clinical trials: average completion rate of 50%
- Population-based interventions: < 25%
- 3 U.S. screening programs: 35% to 50%
- Low rates for those with high risk for CRC

Source: Adapted from Dubé CE et al. *Clinical Communication for Male Cancer Screening*. © 2003 Brown University..

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

“Ninety million people in the United States, nearly half the population, have difficulty understanding and using health information.”

“As a result, patients often take medicines on erratic schedules, miss follow-up appointments, and do not understand instructions like ‘take on an empty stomach.’”

Source: National Network of Libraries of Medicine. Health Literacy (web page), 2008.

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.



Overcoming Barriers to Screening

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

- Risk assessment tailored to the patient
- Educational materials
- Positive messages about the tests
 - Most patients report that it's not as bad as they thought it would be

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



> [Risk Calculator](#)

[About the Tool](#)

[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

Tip #1: Education That Matters

Modifiable risk factors

- Sedentary lifestyle
- High alcohol intake
- Low fruit and vegetable intake
- A low-fiber and high-fat diet
- Overweight and obesity
- Tobacco use

Source: CDC. http://www.cdc.gov/cancer/Colorectal/basic_info/risk_factors.htm

Tip #1: Education That Matters

Clear and realistic explanation of testing

- Discomfort to expect
- Expected duration
- Return to work
- Need for friend or family member to accompany
- Preparation options

Notification process

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

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

Strategies That Increase Adherence to CRC Screening Recommendations

Tip #1: Patient education

Tip #2: Staff training

Tip #3: Reminder systems

Tip #4: Patient “release form” or contract—
agreement to complete and return FOBT

Tip #5: Let the patient decide

Tip #6: Take advantage of all opportunities,
such as offering FOBT kits during flu clinics
(increased screening from 57% to 84%)

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

Objectives for Participants

Can you

- describe the updated USPSTF guidelines for colorectal cancer (CRC) screening?
- name one or more barriers to screening?
- identify one or more changes that increase CRC screening?

Have you

- identified a change that would “work” in your practice?

Questions



Issues Related to African Americans and Hispanics

Which group has the highest CRC incidence rate?

- African American
- Asian
- Caucasian
- Hispanic
- Native American
- Other

Which group has the highest CRC incidence rate?

African American

Asian

Caucasian

Hispanic

Native American

Other

Which Oregon population has the lowest CRC screening rate?

- African American
- Asian
- Caucasian
- Hispanic
- Native American
- Other

Which Oregon population has the lowest CRC screening rate?

- African American 35 %
- Asian 33%
- Caucasian 46%
- Hispanic 28%**
- Native American 35%
- Other 35%

Racial Gap Widens as Colorectal Cancer Death Rate Drops

- 1980 Colon cancer death rates higher for Whites than for African Americans(AAs)
- 2000 Incidence rates 20%–25% lower than peak of 1985 for Whites and flat for AAs
- 2005 Colon cancer death rates 48% higher for AAs than for Whites except in the VA system
- 2008 Screening rates lower for average and high-risk AAs than for similar-risk Whites, mostly due to lower rates of colonoscopy (overall OR = 0.89 vs. 0.70 for AA men and women)

Patient Education for African Americans

Which information source is **most likely** to motivate African Americans to undergoing screening?

- Public service messages
- Family and friends
- Healthcare provider

Source: Katz ML et al. Colorectal cancer screening among African American church members: A qualitative and quantitative study of patient–provider communication *BMC Public Health* 2004;4:62doi

Patient Education

Which information source is **most likely** to motivate African Americans to undergoing screening?

- Public service messages
- Family and friends
- Healthcare provider**

Note: Higher screening rates are associated with

- Having a regular PCP
- Providing a calendar with faith-based messages about screening to church attendees

Screening Barriers Specific to African Americans

- Lack of knowledge about CRC screening
- Low perceived need for screening
- Lack of regular primary care provider
- Healthcare providers' failure to recommend screening
- Lack of primary care provider time for discussion of tests and recommendations
- Discomfort about talking about CRC and screening

Screening Barriers Specific to African Americans

- Failure of primary care provider tracking to ensure follow-through on screening recommendations
- Mistrust of healthcare system and healthcare providers
- Lack of knowledge about family history (not often discussed within the family)
- Cost (e.g., insurance status, co-pays, time off work, childcare)

What proportion of African Americans who reported having undergone screening said that a physician had recommended screening?

- 85%
- 65%
- 45%

What proportion of African Americans who reported having undergone screening said that a physician had recommended screening?

85%

65%

45%

Impact of Treatment Disparities

- 20% to 40% increased risk of death in African American patients compared with Whites, independent of known prognostic factors*
- No difference among VA patients (equal access to treatment)

*Source: Ward SH et al. Increasing colorectal cancer screening among African Americans: linking risk perception to interventions targeting patients, communities and clinicians. *J Natl Med Assoc.* 2008;100(6):748–758.



Pictures of FOBT Tests

High-Sensitivity FOBT Options



Immunochemical tests—No drug or diet interference



High-sensitivity guaiac test—
Interference from Vitamin C (false negatives) and
from plant peroxidase and red meat (false positives)