National Colorectal Cancer Roundtable

• National coalition of public, private, and voluntary organizations whose mission is to advance colorectal cancer control efforts by improving communication, coordination, and collaboration among health agencies, medical-professional organizations, and the public.

• Co-Founded by ACS and CDC in 1997

• Goal: increase the use of recommended colorectal cancer screening tests in at-risk populations

• Community Health Center taskgroup develops strategies and tools for CHCs

www.nccrt.org
ACS and Community Health Centers

- ACS has prioritized the need to effectively partner with CHCs
- Viewed as an ACS signature program
- More than **100 staff** across the country whose primary responsibility is establishing relationships and providing support to CHCs and state Primary Care Associations
- A multitude of tools and resources have been created, and more are in development
- Grant opportunities available

Collaboration with NACHC

Strategy document outlining the challenges to screening, highlighting successful programs and processes, and recommending ways in which partner organizations can assist health centers in achieving their cancer-screening goals.

*CA: A Cancer Journal for Clinicians, 2013*
Eight page guide introduces clinicians and staff to concepts and tools provided in the full Toolkit

Contains links to the full Toolkit, tools and resources

Not colorectal-specific; practical, action-oriented assistance that can be used in the office to improve screening rates for multiple cancer sites (colorectal, breast and cervical)

Available at http://nccrt.org/about/provider-education/crc-clinician-guide/
Community Health Center Version

- Customized to meet unique needs of patients and providers in these settings
  - Step-by-step guidance on how to implement office systems change
- Developed by UNC researcher Dr. Catherine Rowheder (rohweder@email.unc.edu, 919-966-6879)

Funding for this project was provided by the University Cancer Research Fund of The UNC Lineberger Comprehensive Cancer Center

Staff Involvement

- Key Point.....the clinicians cannot do it all!
- Time that patients spend with non-clinician staff is underutilized
- Standing orders can empower nurses, intake staff, etc. to distribute educational materials, schedule appointments, etc.
- Involve staff in meetings to discuss progress in achieving office goals for improving the delivery of preventive services
Why are 40% of at-risk individuals not screened?
Why patients aren’t getting screened 
(according to Physicians)

Table 4 Perceived barriers by primary care physicians in Arizona to ordering CRC screening tests

<table>
<thead>
<tr>
<th>Barriers</th>
<th>Ranked #1</th>
<th>Ranked #2</th>
<th>Ranked #3</th>
<th>Total votes (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient reluctance to undergo screening procedures</td>
<td>501</td>
<td>229</td>
<td>83</td>
<td>813 (83)</td>
</tr>
<tr>
<td>Patient fear of procedure or results</td>
<td>183</td>
<td>279</td>
<td>180</td>
<td>642 (65)</td>
</tr>
<tr>
<td>Patient lacks insurance coverage for screening procedure</td>
<td>188</td>
<td>147</td>
<td>173</td>
<td>508 (52)</td>
</tr>
<tr>
<td>Time constraints</td>
<td>42</td>
<td>55</td>
<td>107</td>
<td>204 (21)</td>
</tr>
<tr>
<td>Logistical problems for the patient</td>
<td>20</td>
<td>55</td>
<td>118</td>
<td>193 (20)</td>
</tr>
<tr>
<td>Lack of reimbursement for ordering or performing procedures</td>
<td>38</td>
<td>45</td>
<td>53</td>
<td>136 (14)</td>
</tr>
<tr>
<td>Decreased availability of screening tests</td>
<td>36</td>
<td>22</td>
<td>51</td>
<td>109 (11)</td>
</tr>
<tr>
<td>Other</td>
<td>27</td>
<td>7</td>
<td>17</td>
<td>51 (5)</td>
</tr>
<tr>
<td>Your familiarity with current guidelines</td>
<td>4</td>
<td>1</td>
<td>4</td>
<td>9 (1)</td>
</tr>
</tbody>
</table>

Cancer Causes Control, 2011

Why patients aren’t getting screened 
(according to Patients)

“My doctor never talked to me about it!”
Essential #1: Explore how your practice will assess a patient’s risk status and receptivity to screening.

Essential #1: Determine the screening tests and related messages you and your staff will share with patients.

#1: Make a Recommendation

Recognize potential barriers to screening

Recommendation discussions must be sensitive to and address:

- Fear of cancer diagnosis
  - Perception that cancer is a “death sentence”
- Lack of understanding of need for asymptomatic screening
- Misconceptions about cancer causes and risks
- Embarrassment
- Concern over discomfort
- Cultural issues
- Patient preferences
Risk Assessment

- Making appropriate screening recommendation requires accurate assessment of each patient’s risk status

- Individual Risk Levels
  - Average
  - Increased
  - High

### Individual Risk Based on Family History of CRC

<table>
<thead>
<tr>
<th>Familial Setting</th>
<th>Approximate lifetime risk of colon cancer</th>
</tr>
</thead>
<tbody>
<tr>
<td>No history of colorectal cancer or adenoma</td>
<td>0%</td>
</tr>
<tr>
<td>One second or third-degree relative with CRC</td>
<td>About a 1.5 fold increase</td>
</tr>
<tr>
<td>One first-degree relative with an adenomatous polyp</td>
<td>About a 2 fold increase</td>
</tr>
<tr>
<td>One first-degree relative with colon cancer*</td>
<td>About a 2-3 fold increase</td>
</tr>
<tr>
<td>Two second-degree relatives with colon cancer</td>
<td>About a 2-3 fold increase</td>
</tr>
<tr>
<td>Two first-degree relatives with colon cancer*</td>
<td>About a 2-3 fold increase</td>
</tr>
<tr>
<td>First-degree relative with CRC diagnosed at &lt; 50 years</td>
<td>About a 3-4 fold increase</td>
</tr>
</tbody>
</table>

* First-degree relatives include parents, siblings, and children.
Second-degree relatives include grandparents, aunts, and uncles.
Third-degree relatives include great-grandparents and cousins.
Questions to Determine Risk

- Have you or any members of your family had colorectal cancer?
- Have you or any members of your family had an adenomatous polyp?
- Has any member of your family had a CRC or an adenomatous polyp when they were under the age of 50? (If yes, consider a hereditary syndrome.)
- Do you have a history of Crohn’s disease or ulcerative colitis (more than eight years)?
- Do you or any members of your family have a history of cancer of the endometrium, small bowel, ureter, or renal pelvis? (If yes, consider hereditary non-polyposis colorectal cancer [HNPCC])
#2 Develop a Screening Policy

**Essential #2:**
Create a standard course of action for screenings, document it, and share it.

**Essential #2:**
Compile a list of screening resources and determine the screening capacity available in your community.

### Common Sense Colorectal Cancer Screening Recommendations¹ at a Glance

<table>
<thead>
<tr>
<th>Risk Category</th>
<th>Age to Begin Screening</th>
<th>Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average risk</td>
<td>&lt; Age 50</td>
<td>No screening needed</td>
</tr>
<tr>
<td>No risk factors</td>
<td>≥ Age 50</td>
<td>Screen with any one of the following options:</td>
</tr>
<tr>
<td>No symptoms¹</td>
<td></td>
<td>Tests That Find Polyps and Cancer</td>
</tr>
<tr>
<td></td>
<td></td>
<td>FS q 5 yrs¹</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CS q 10 yrs</td>
</tr>
<tr>
<td></td>
<td></td>
<td>DRE q 3 yrs</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CTC q 5 yrs</td>
</tr>
<tr>
<td></td>
<td></td>
<td>OB</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Tests That Primarily Find Cancer</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CT q 1 yr²</td>
</tr>
<tr>
<td></td>
<td></td>
<td>FIT q 1 yr²</td>
</tr>
<tr>
<td></td>
<td></td>
<td>eDNA²</td>
</tr>
<tr>
<td>Increased risk</td>
<td>Age 40 or 10 years younger than the earliest diagnosis in the family, whichever comes first</td>
<td>Colonoscopy¹</td>
</tr>
<tr>
<td>CRC or adenomasus polyp in a first-degree relative¹</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Highest risk</td>
<td>Any age</td>
<td>Needs specialty evaluation and colonoscopy¹</td>
</tr>
<tr>
<td>Personal history for ≥ 8 years of Crohns disease or ulcerative colitis or a hereditary syndrome (HNPCC or FAP, AFA)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Why patients aren’t getting screened (according to Physicians)

Cancer Causes Control, 2011

Physician’s Recommendations

Cancer Causes Control (2011) 22:1277-1287
Overutilization of Colonoscopy

- Among 24,000 Medicare beneficiaries who had normal colonoscopy from 2001-2003, 46.2 percent had a repeat colonoscopy in seven years (Goodwin J, et al. *Arch Intern Med*, May 11, 2011)
- Among 12,071 Medicare beneficiaries (ages 70+) who underwent polypectomy/biopsy from 2001-2004, 45.7 percent had a repeat colonoscopy in five years (Cooper G, et al. *Cancer* 2013; DOI: 10.1002/cncr.27990)

Office Screening Policy

Factors to Consider in Your Office Policy

1. Individual Risk Level ("risk stratification")
2. Medical resources (e.g. location and accessibility of endoscopy facilities)
3. Insurance (deductible? copay? resources for uninsured?)
   a. Impact of Affordable Care Act on preventive services
4. State and federal program policies and processes (CDC program,...)
5. Patient preferences/options
Standing orders

- Standing orders allow nursing staff or medical assistants to discuss CRC screening options, provide FOBT/FIT kits and instructions, and submit referrals for screening colonoscopy have been demonstrated to increase CRC screening rates.
- Staff training on risk assessment, components of the screening discussion, ... is essential for a successful program.
- Check State practice regulations.

J Am Board Fam Med 2009

Standing Orders

STANDING ORDERS FOR COLORECTAL CANCER SCREENING

Steps:
Under this standing order medical assistants and RNs with proper training may order a fecal occult blood test (FOBT), fecal immunochemical test (FIT), or hemoccult to screen for colorectal cancer for clients who meet these criteria.

Purpose:
Colorectal cancer (cancer of the colon or rectum) often begins as polyps, which are small growths inside the lining of the colon. While most polyps are harmless, some may turn into cancer. Colorectal cancer is the third most common cancer found in men and women in the United States. The lifetime risk for developing colorectal cancer is roughly 1 in 20.

The main purpose of colorectal cancer screening is to detect occult or hidden blood that may be present in the stool. The presence of blood may or may not be a sign of cancer. If blood is found, a colonoscopy is needed to detect the cause of bleeding. 9 out of 10 colorectal cancer deaths can be prevented through regular screening.

Procedure:
1. Identify adults in need of regular colorectal cancer screening:
   a. Average risk clients (medical assistant may perform screening) no family history of colorectal cancer or adenomatous polyps

Medical Director: 
Printed Name: 
Signature: 

Effective date: 
Date reviewed: 
Date revised: 

San Francisco Health Plan
#3 Be Persistent with Reminders

Determine how your practice will notify patient and physician when screening and follow up is due.

Ensure that your system tracks test results and uses reminder prompts for patients and providers.

Clinician Reminder Types

- Alerts – “Flags” placed in or on chart
- Chart Prompts
  - Problem lists
  - Screening schedules
  - Integrated summaries
- Electronic Medical Record Reminders
Chart Prompt

Electronic Medical Record (EMR)

- Tremendous potential
  - Registry functions
  - Population management tools/resources

However the potential is often not met
EMRs and CRC Screening

- Surveyed CHC clinicians, QI and IT staff
- Multiple barriers to effective use identified
  - EMR system issues
  - CHC resources
  - Organizational
- High performing models and best practices

Follow up Reminders

- Track test completion, reports, appropriate follow up for positives
  - EMR
  - “Tickler” System
  - Logs and Tracking
- Requires staff time and commitment
- Ideal role for navigators/community health workers

Patient Reminders

- Two types
  1. Education
  2. Cues to action

Office Wall Chart

- Screening guidelines for Breast, Cervical, Colon, Prostate and other cancers
- General lifestyle/prevention
  - Tobacco cessation
  - Healthy diet
  - Weight, etc
- English and Spanish
Patient Education

Get Tested For Colon Cancer: Here's How.

An 7-minute video reviewing options for colorectal cancer screening tests, including test preparation.

Available as DVD, or you can refer patients to the URL to view from their personal computer.

Template Letters

MAIN STREET MEDICAL

Dear [Name],

Our office has made a commitment to promote the health of its members, and to provide education regarding preventive health measures that you can take to maintain a healthy lifestyle. We believe regular medical check-ups, as well as regular screening for colorectal cancer, can help prevent the development of colorectal cancer.

The American Cancer Society recommends that average risk individuals choose one of the following options for colorectal cancer screening:

1. Fecal Occult Blood Test (FOBT) every 1-2 years
2. Flexible sigmoidoscopy every 5 years
3. CT colonography (virtual colonoscopy) every 5 years

If the test is positive, a colonoscopy should be done.

"If the test is negative, a colonoscopy should be done if the test is positive."

The tests are designed to detect early cancers and polyps are prevented. If these facts are not covered in your usual care, we hope you will take the opportunity to have one of these more invasive tests. Talk to your doctor about which test is best for you.

We have also included your reference to an informational pamphlet on colorectal cancer. Should you have any questions about this pamphlet or colorectal cancer screening tests, please contact us. Thank you for taking time to take care of your health.

Sincerely,

Medical Director

[Template Letter Example]
Reminder Fold-Over Postcard

Dear (Name):

Colon cancer is the second leading cause of cancer-related deaths in the United States, and men and women are equally at risk. The good news is that colorectal cancer can be prevented or detected early and death from colon cancer can be prevented if screening is done on a regular basis.

Our records indicate that it is time for your annual physical and cancer screening. Please call your primary care physician, at XXX-XXX-XXXX so that you can schedule an appointment at your earliest convenience.

Sincerely,

Telephone Reminder Scripts

**gFOBT/FIT Follow-up Phone Script for Average-Risk Individuals**

**Introduction:**
Good morning/afternoon. May I speak with _______? 
(Note: Due to HIPAA regulations, the conversation should not proceed unless speaking directly with the patient.)

My name is ______________ and I am calling from ______________.

You recently received a stool test for colon cancer screening.

Did you have any questions about the test?

We are calling everyone who received one of these to see if there is any way we can help you complete the test.

1. "Have you had the chance to complete and mail your kit?"

   If the answer is YES, get the approximate date to ensure that the test will be valid, and get the approximate date of receipt. Thank the participant and let him or her know that you will mail them the results.

   If the answer is NO, ask the following question.
#4 Measure Practice Progress

**Essential #4:** Discuss how your screening system is working during regular staff meetings and make adjustments as needed.

**Essential #4:** Have staff conduct a screening audit or contact a local company that can perform such a service.

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**Tracking Practice Progress**

- Determine your baseline
- Set Realistic Goals
- Chart audits or other tracking measures (i.e. EHR reports)
- Provide staff-specific feedback on performance
- Seek patient feedback
- Identify strengths and weaknesses, barriers, opportunities to improve efficiency
- Track progress and periodically reassess goals
New Resource!

http://ncrt.org/about/provider-education/manual-for-community-health-centers-2/

How might a Community Health Center benefit by using this manual?

1. Helps practices increase CRC screening rates through a team based, systematic approach
2. Helps increase rates for UDS measure
3. Trains staff on a quality improvement processes that apply to other preventive services
4. Implements field-tested processes created by experts
5. Strengthens relationships with other community partners
Step #1 Make A Plan

Determine Baseline Screening Rates
- Identify your patients due for screening
- Identify patients who received screening
- Calculate the baseline screening rate
- Improve the accuracy of the baseline screening rate

Design Your Practice’s Screening Strategy
- Choose a screening method
- Use a high sensitivity stool-based test
- Understand insurance complexities.
- Calculate the clinic’s need for colonoscopy
- Consider a direct endoscopy referral system

Step #2 Assemble A Team

Form An Internal CHC Leadership Team
- Identify an internal champion
- Define roles of internal champions
- Utilize patient navigators
- Define roles of patient navigators
- Agree on team tasks

Partner with Colonoscopists
- Identify a physician champion

Step #3 Get Patients Screened

Prepare The Clinic
- Conduct a risk assessment

Prepare The Patient
- Provide patient education materials

Make A Recommendation
- Convince reluctant patients to get screened

Ensure Quality Screening for Stool-Based Screening Program

Track Return Rates and Follow-Up

Measure and Improve Performance

Step #4 Coordinate Care Across The Continuum

Coordinate Follow-Up After Colonoscopy
- Establish a medical neighborhood

Tools, Templates and Resources

- Worksheets for completing action steps
- Patient Education Materials
- Guidelines on CRC Screening (ACS, USPSTF)
- Patient Navigation (Training Programs)
- Electronic Health Records screen shots and tips
- Practice Management
Flu + Stool testing

(A.K.A. “FluFIT”)

CRC Screening Outreach During Annual Flu Shot Activities (“FluFIT”)

- Combines CRC screening with annual flu shot campaigns
- Practice/ Clinic staff provide FOBT/FIT kits to eligible patients when they get their annual flu shot
  - Either a high sensitivity FOBT or a FIT kit can be used for the program
- Patient completes specimen collection at home and returns kit to doctor’s office or mails kit to the lab for processing
Potential Benefits of FluFIT

- Reaches patients at a time each year when they are already thinking about prevention
- Creates a seasonal focus on cancer screening that may add to other screening efforts
- Time-efficient way to expand team based care and involve non-physician staff in screening activities
- Educates patients that “just like a flu shot, you need FOBT/FIT every year”

*Slide courtesy of M. Potter, MD*

FluFIT

- **FLU-FOBT/FIT Interventions**
  - Have been tailored and results replicated in:
    - (1) primary care underserved settings,
    - (2) high volume managed care flu shot clinics
    - (3) commercial pharmacies where flu shots are increasingly provided
  - Can be done with limited resources
  - Leads to higher screening rates
American Cancer Society FluFOBT Program
Implementation Guide and Materials

www.cancer.org/flufobt

What’s in the ACS FluFOBT Program
Implementation Guide?

- Background information on colorectal cancer and FluFOBT
- Patient eligibility criteria
- Colorectal cancer screening recommendations
- Patient education
- Guidance on setting up your FluFOBT Program
- Implementation recommendations and resources
- Example advertising and tracking tools
Other FluFOBT Information and Materials

http://flufobt.org

Mailed Screening Outreach
Mailed Outreach

- Mailed invitations to CRC screening to patients from safety net hospital clinic who were not up to date with screening
  - Group 1 – mailed no-cost FIT kit
  - Group 2 – mailed invitation to no-cost colonoscopy
  - Group 3 – usual care, consisting of opportunistic PCP visit–based screening

- FIT and colonoscopy outreach groups received telephone follow-up to promote test completion.

Figure 2. CRC Screening Participation For Usual Care, Colonoscopy Outreach, and FIT Outreach

![Chart showing CRC screening participation rates for Usual Care, Colonoscopy Outreach, and FIT Outreach.](chart.png)

CRC indicates colorectal cancer; FIT, fecal immunochemical test.

*JAMA Int Med 2013*
Screening Navigation

Patient Navigation

Navigator models may include:
- mailed or phone call reminders to patients to aid FOBT kit returns
- assistance with scheduling colonoscopy
- bowel preparation instructions
- appointment reminders
- More expansive models may include:
  - assistance with transportation
  - translation services
  - referral to other social services
CRC Screening Navigation

Screening Navigation

Intervention patients were:

- 4 times more likely to be up to date with CRC screening (43% vs 11%)

80% Colon Cancer Screening Rate By 2018
100 organizations have pledged to deliver coordinated, quality CRC screening and follow-up care to all people

www.cancer.org/colonmd
www.cancer.org/professionals
Cancer Resource Network

The American Cancer Society is available 24 hours a day, 7 days a week, to help guide you through every step of a cancer experience.

1-800-227-2345 cancer.org

Easy to understand information to help your patients make decisions about their care.

Referral for day-to-day questions such as financial, insurance, transportation, and lodging.

Connection to others who have been there for emotional support.