CRC Screening Initiative

Sign up to participate!

Contact Michelle Seitz, QI Project Manager, at mseitz@pafp.com or 717-885-6929

Webcast Tip Sheets

These 3 CME webcasts are part of a multi-year effort by PA IPIP with the Pennsylvania DOH to improve CRC screening rates

Colorectal Cancer is the second leading cause of cancer deaths in Pennsylvania and the nation. The CDC has set the very aggressive goal for improving screening rate to 80% by the year 2014. Our hope is to begin to improve physician referral rates for all patients in the 50-75 age range as we strive to reach that 80% goal. Visit www.pafp.com/IPIP to watch free CME webcasts and improve CRC screening in your practice! Click here to access the 3 CRC Screening Initiative webcasts.

What are our Goals for Colorectal Cancer Screening and How Can We Get There?

By Mona Sarfaty, MD, MPH, FAAFP, Thomas Jefferson University

- **The Pennsylvania goals for colorectal cancer (CRC) screening are:**

a. To screen 80% of the adult population ages 50-75 by 2014 (up from the current rate of 63%).

b. To decrease the incidence of late-stage CRC diagnoses among Pennsylvania adults ages 50-75 to 44% by 2014 from the current rate of 47%.

- **Over the last decade, the incidence of CRC has declined as screening rates have risen at the state and national levels.**
  However, the Pennsylvania state incidence is higher than the national incidence. The state death rate is also above the average for the U.S.

- **Previously, there were more late stage incident cases than early stage cases. With the rise in screening and early detection, there are now 1% more early stage than late stage cases (47.5% vs. 46.5%).**

- **A recommendation from a physician has been identified most consistently, directly and indirectly, as the factor of prime influence in determining whether an individual is screened or not. The evidence for this is diverse, based on analysis of large data bases from population based surveys, statewide cancer surveys from several states, practice based.**

- **Maximizing screening requires delivering a physician recommendation to every eligible patient. This means utilizing every opportunity to make the recommendation to the patient. Screening recommendations should be given at every visit, not just during a check-up or complete physical. This will generally require making better use of other staff in the office.**

a. Caution: A single stool blood test in the office is NOT an accepted screening test for CRC.

b. Caution: A rectal exam is not an accepted screening test for CRC.

- **The Patient Centered Medical Home model can help providers incorporate evidence-based strategies that can raise screening rates. These strategies include reminders to providers, reminders to patients, audits and feedback, and result tracking.**

- **Specific features of the Patient Centered Medical Home model include:**
  - -- Improved access
  - -- Patient Tracking and use of Registries, which includes use of age/risk flow sheets
  - -- Care Management which includes reminders
  - -- Patient Self-Management & Support, including helping patients follow-through on screening
  - -- Test Tracking which means getting a result to the patient for every ordered test
  - -- Referral Tracking which means getting a result for every referral given
  - -- Performance Reporting and Improvement to document the change in screening rates

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TIP SHEET

Colorectal Cancer Screening Guidelines

By Richard Wender, MD, Thomas Jefferson University

Everyone Needs To Be Screened

Unlike the controversy surrounding screening for other cancers, all major guidelines groups agree that every person, age 50 and over with a reasonable life expectancy, needs to be screened for colon cancer. And people at increased risk may need to begin screening at a younger age. Some individuals are at very high risk, such as individuals with inflammatory bowel disease and individuals with multiple family members who developed colon cancer or polyps at a young age. Those individuals may need genetic testing and close monitoring by a gastroenterologist with frequent colonoscopy.

Screening Guidelines

Although the USPSTF and the ACS guidelines do include some differences in recommendations, fundamentally both guideline groups present essentially identical recommendations. For individuals at average risk for colon cancer, begin screening at age 50. Both groups recommend a menu of screening options. All average risk patients should be screened with one of the following options:

1. Fecal occult blood test performed using a guiac methodology or fecal immunochemical testing, which detects human globin every year
2. Flexible sigmoidoscopy every 5 years
3. Flexible sigmoidoscopy every 5 years plus FOBT/FIT every year
4. Colonoscopy every 10 years

In addition, the ACS, Multisociety GI group and American College of Radiology guideline endorse double contract barium enema every five years and C-T colonography every five years. DCBE is rarely used and the only insurance-supported indication for C-T colongraphy is for people with incomplete colonoscopy. So in effect, FOBT/FIT or colonoscopy are the only two commonly used and readily available options for routine screening.

Is There a Preferred Option?

The ACS guideline argues that prevention should take priority over early detection and thus gives greater emphasis to tests that have higher sensitivity for polyps. These include the structural examinations of colonoscopy, sigmoidoscopy and colonography.

The USPSTF argues that comparative data does not exist and that the best test is the one that gets done. In fact, modeling data provided to the USPSTF suggests that FOBT or FIT every year or FOBT/FIT plus sigmoidoscopy is at least as effective as colonoscopy every 10 years assuming 100% patient adherence. The comparative ease of obtaining a colonoscopy every 10 years as opposed to a stool blood test every year has certainly been an important factor in fueling the national shift towards colonoscopy as the most commonly performed test.

Are there certain tests that should not be done?

Both guidelines endorse using only highly sensitive stool blood tests such as Hemoccult Sensa or one of several Fecal Immunochemical Tests (FITs). Less sensitive guiac tests such as Hemoccult II should no longer be used. So every office needs to know which stool test they are using.

More and more evidence shows the superiority of the FIT tests over guiac-based testing. All offices should consider adopting one of the evidence-based FIT tests as their preferred approach to stool blood testing.

Even more importantly, several studies show that many clinicians continue to “screen” patients using a stool blood test performed at the time of a digital rectal examination. This approach is not recommended by any guideline group and is actively discouraged. Why? Because it doesn’t work! It is very insensitive for cancer, let alone polyps. If you are currently doing this test, stop and switch to an evidence-based approach.

What are the key steps to increasing screening rates in your practice?

Unlike chronic disease management which demands clinician judgment, most of the steps necessary to implement cancer screening are best performed by non-clinicians. The primary care clinician must do one thing: recommend screening for every patient! That recommendation makes a huge difference in whether or not a patient is screened. Virtually every other step can be carried out by team members: patient outreach, test ordering, patient instructions and education, maintenance of a cancer screening registry and issuing of reminders. Five basic principles of colon cancer screening must be followed if a practice hopes to achieve very high screening rates:

1. Every practice must have a system in place to make sure that every eligible patient receives a recommendation to be screened at every opportunity. Every patient, every time. Office protocols, office reminders, and use of the team are necessary to make this happen.

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Colorectal Cancer Screening Guidelines

2. If a practice only recommends screening for those patients who are making office visits but do not have systems to identify and reach out to all patients who are enrolled in the practice, it's impossible to reach very high screening rates. Population outreach is vital to cancer screening. Remember that these patients may not be ill in any way and may not be too interested in receiving health care. Outreach is vital. This demands having a list of eligible patients and keeping track of their screening status: a cancer screening patient registry.

3. Every practice must have the capacity to recommend both a stool blood test or colonoscopy. Many patients will not agree to a colonoscopy but will accept stool blood testing. This is not a bad thing. The newer FOBT/FIT tests are a great approach to screening – just as effective as colonoscopy as long as they are repeated every year and all abnormals are followed up with colonoscopy.

4. If a patient is asked to schedule a colonoscopy when they get home rather than scheduling it while they are in the office, only about half the patients will actually make the call. It is vital to have an easy hand off to the colonoscopists with a one-step scheduling procedure.

5. If patients are given a stool blood kit to do at home, but return rates are not tracked and reminders aren't in place, less than half of the stool tests will be returned. Again, having a team-based system with technology that supports use of reminders and tracking is an important facilitator to screening.

Increasing colon cancer screening rates is one of the great public health opportunities in primary care practice. Nothing is more powerful than a physician recommendation. You and your team hold the key to achieving remarkable screening rates of over 80%. If we can achieve 80% screening rates in Pennsylvania, we can make a major dent in the colon cancer disease burden currently facing our citizens.

QUIZ — ***Click here to quickly test your CRC screening knowledge***

How to Increase Colorectal Cancer Screening Rates in Practice: A Primary Care Clinician's Evidence-based Toolbox and Guide

By Carmen E. Guerra, MD, MSCE, FACP,
University of Pennsylvania School of Medicine

Colorectal cancer incidence and mortality

Colorectal cancer (CRC) is the third most common cancer in U.S., and the second deadliest. There are nearly 150,000 new cases and close to 49,000 deaths yearly nationwide. The average lifetime risk of CRC approaches 6% (1 in 18). The incidence is decreasing and mortality is decreasing over the recent years. This trend is in large part due increased use of screening and early detection tests.

Risk factors for CRC are:

- Age
- A personal history of CRC or polyps
- A family history of CRC or polyps
- Inflammatory bowel disease for more than 8 years
- African American Race
- Ashkenazi Jewish Ethnicity
- High fat diet
- Low rates of physical activity
- Obesity
- Tobacco use
- Heavy alcohol consumption
- Diabetes

Pathogenesis

Most CRCs develop from adenomatous polyps. However, only 10% of adenomas progress to cancer. "Dwell time" is approximately 10 years. A prolonged dwell time allows for screening and intervention.

CRC screening and surveillance guidelines

The U.S. Preventive Services Task Force (USPSTF) recommends colorectal cancer screening to average risk patients between the ages of 50-75 with:

• FOBT • Colonoscopy • Flexible sigmoidoscopy

(This is a Grade A recommendation, and the details can be found at www.ahrq.gov/clinic/uspstf/uspscolo.htm.)

The USPSTF recommends against routine screening for colorectal cancer in adults age 76 to 85 years. There may be considerations that support colorectal cancer screening in an individual patient *(Grade: C Recommendation)* and against screening for colorectal cancer in adults older than age 85 years *(Grade: D Recommendation)*.

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How to Increase Colorectal Cancer Screening Rates in Practice: A Primary Care Clinician's Evidence-based Toolbox and Guide

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The USPSTF guidelines state the evidence is insufficient to assess the benefits and harms of CT colonography and fecal DNA testing as screening modalities for colorectal cancer.

Important points about FOBT

- High sensitivity immunochemical FOBT (also known as "iFOBT" or "FIT" tests) which detect globin rather than heme and are more sensitive and specific should be used.
  - -- "FIT" tests include HemeSelect, QuickVue, iFOB, FOBGold, Automated SENTiFOB or OC Auto 80 - Automated iFOBT.
- The digital exam is NOT a recommended CRC screening strategy.
- A single office FOBT is not adequate screening for CRC.
- A positive FOBT should never be repeated; it should always be followed up by colonoscopy.
- FOBT is not adequate surveillance for patients with a history of adenomas or a 1st degree relative with colorectal cancer.

CRC screening rates in the U.S.

In 2006, 60.8% of respondents aged >50 years reported having had a FOBT within 1 year or lower endoscopy within 10 years preceeding the survey *(CDC. Use of Colorectal Cancer Tests – United States, 2002, 2004 and 2006. MMWR Weekly 57(10): 253-258).* In Pennsylvania, 63% of eligible patients have been screened for colorectal cancer.

Barriers to recommending CRC screening cited by physicians can be divided into three categories: patient, provider and system. *(Guerra, CE et al. Barriers to Physician Recommendation of Colorectal Cancer Screening. J Gen Intern Med. 2007; 22(12):1681-8.)*

Examples are:

- Patient: comorbidity, previous refusal of screening, language barriers, distrust, patient already under the care of a GI specialist, perceived lack of patient acceptability
- Physician: forgetfulness, outdated knowledge of guidelines, fatigue
- System: scheduling only acute care visits, lack of time, too many active issues and/or patient concerns, discussion of CRCS is lengthier than other screening tests, lack of reminder systems, absence of reliable test tracking system, lack of insurance coverage, delays in colonoscopy scheduling Interventions are needed to address patient, physician and system level barriers

One tool in helping to design interventions at all three levels is "How to Increase Colorectal Cancer Screening Rates in Practice: A Primary Care Clinician's Evidence-based Toolbox and Guide" by Mona Sarfaty, MD. Practices can access the interactive on-line version at www.cancer.org/aspx/pcmanual/default.aspx.

This is an educational guide and compendium of tools to increase primary care providers' recommendation of CRC screening. It contains four critical chapters.

Essential 1: Importance and Barriers of Physician Recommendation reviews why clinicians should screen for CRC. Those reasons are:

- -- Screening prevents CRC and reduces mortality
- -- Insurance reporting requirements (HEDIS®)
- -- Increasingly used in Pay for Performance plans
- -- Malpractice suits involving missed diagnosis of CRC are costly
- -- CME credit is offered by many organizations for increasing CRC screening rates

Essential 2: An Office Policy. This guide shows clinicians how to design and develop an office policy that is required to systematically offer CRC screening to every eligible patient. The policy takes into account:

- -- Patient CRC risk level: average, increased, high
- -- Local medical resources
- -- Insurance coverage
- -- Patient test preferences

Essential 3: A Reminder System is required to implement the office policy systematically. The toolbox contains reminders for patients and providers including modifiable patient reminder letters, postcards, prescriptions, pamphlets, DVDs, videos, websites, a list of agencies that have available educational material included in Toolbox, telephone and in-person scripts.

Reminders for clinicians include: chart stickers, problem lists, screening schedules/flow sheets, integrated summary, paper tracking templates, link to the free Electronic Medical Record (Vista-Office Electronic Health Record and a link to the AC-group/IOM requirements for EMRs for providers considering purchase of an EMR, tracking databases including paper and electronic (COMMAND, PECS2), audit and feedback with how-to instructions, ticklers, comparison to provider national benchmarks and targets.

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How to Increase Colorectal Cancer Screening Rates in Practice: A Primary Care Clinician's Evidence-based Toolbox and Guide

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Essential 4: An Effective Communication System is based on Prochaska and DiClemente's Transtheoretical Model. It states that individuals who are candidates for making a health behavior change (to undergo CRC screening) do so in different "stages of readiness." Individuals in:

- **Stage 1:** have never heard of CRC screening and require education
- **Stage 2:** have heard of but are not considering CRC screening and require ex amination of the barriers
- **Stage 3:** have heard of and are considering CRC screening, but are not ready to
- **Stage 4:** have heard of, have considered and are ready to schedule CRC screening and require practical "how-to-schedule and prepare" information
- **Stage 0**: have heard of but refuse to undergo CRC screening and should be re-approached in the future again about CRC screening because patients can cycle out of stage 0

The Toolbox shows clinicians how we can use this model to more effectively and efficiently communicate with patients about CRC screening.

Summary

Every eligible, average-risk patient should receive a recommendation for CRCS. This is most likely to occur if:

- The provider or staff provides a personalized recommendation to each patient.
- There is an office policy that takes into account patient risk, local medical resources, insurance coverage and patient preferences.
- There are reminder systems in place targeting providers/staff and patients to ensure that each patient receives a CRCS recommendation from their provider.
- There is effective, stage-based communication.

The Toolbox contains many tools to support a consistent recommendation to each eligible patient. Access these tools at www.cancer.org/colonmd.

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