Colorectal Cancer Screening and Tools for your Practice

American Cancer Society
And
National Colorectal Cancer Roundtable
Colorectal Cancer

- The third most common cancer in U.S.
- 148,800 new cases in 2008
- The second deadliest cancer
- 49,960 deaths nationwide
- More than 1 million Americans living with colorectal cancer
Colorectal Cancer Risk Factors

- **Age**
  - 90% of cases occur in people 50 and older

- **Gender**
  - slight male predominance, but common in both men and women

- **Race/Ethnicity**
  - African Americans have highest incidence and mortality rate of all groups in U.S., Hispanics the lowest (with considerable variation depending on country of origin)
  - Increased rates also documented in Alaska Natives, some American Indian tribes, Ashkenazi Jews
Risk Factors (continued)

- *Increased risk with:*
  - Personal history of inflammatory bowel disease, adenomatous polyps or colon cancer
  - Family history of adenomatous polyps, colon cancer, other conditions

- **Individuals with these risk factors may require earlier and more intensive screening**

The remainder of this talk will focus on screening recommendations for those at *average risk*
Colorectal Cancer

- Sporadic (average risk) (65%–85%)
- Family history (10%–30%)
- Hereditary nonpolyposis colorectal cancer (HNPCC) (5%)
- Familial adenomatous polyposis (FAP) (1%)
- Rare syndromes (<0.1%)
Risk Factor - Polyps

Different types:

- **Hyperplastic**
  - minimal cancer potential

- **Adenomatous**
  - approximately 90% of colon and rectal cancers arise from adenomas
Normal to Adenoma to Carcinoma

Human colon carcinogenesis progresses by the dysplasia/adenoma to carcinoma pathway
Benefits of Screening

- **Cancer Prevention**
  - Removal of pre-cancerous polyps prevent cancer (unique aspect of colon cancer screening)

- **Improved survival**
  - Early detection markedly improves chances of long term survival

- **Cost-effective**
  - Cost of CRC screening compares favorably to many other common interventions (i.e. mammograms)
  - Treatment costs for advanced disease have risen greatly in recent years
Benefits of Screening

Survival Rates by Disease Stage

5-yr Survival

89.8% Local
67.7% Regional
10.3% Distant

*1996 - 2003
Colorectal Screening Rates

- Just 40% of colorectal cancers are detected at the earliest stage.
- A little more than half* of Americans over age 50 report having had a recent colorectal cancer screening test.
- Slow but steady improvement in these numbers over the past decade.

*varies based on data source
Colorectal Screening Rates Low: Reasons (according to Patients)

- Low awareness of CRC as a personal health threat
- Lack of knowledge of screening benefits
- Fear, embarrassment, discomfort
- Time
- Cost
- Access
- “My doctor never talked to me about it!”
So, What is the Problem?

- Medical practice is demand (patient) driven
- Practice demands are numerous/diverse
- Few practices currently have mechanisms to assure that every eligible patient gets a recommendation for screening.
- Screening rates are less for persons with less education, no health insurance, lower SES.*

*Lack of health insurance is a strong predictor of screening status. Higher co-pays and deductibles also lead to decreased screening rates.
Tools and Resources
Evidence-Based Toolkit and Guide to Increase Colorectal Cancer Screening Rates

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

*Including Family Physicians, General Internists, Obstetrician-Gynecologists, Nurse Practitioners, Physician Assistants and Nurse Office Managers

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EDITORS
Karen Peterson, PhD
Richard Wender, MD

Developed by National Colorectal Cancer Roundtable

Goals of this Guide:

- To inform clinicians and their office managers who deliver primary care about their opportunity to prevent colorectal cancer with appropriate screening
- To encourage primary care providers to decrease the mortality and morbidity of colorectal cancer (CRC) and other cancers through appropriate screening
- To facilitate efforts of office-based clinicians to reduce disparities by applying screening guidelines on a universal basis to the age-appropriate population
- To improve preventive care in primary care practices through use of the strategies and tools presented in this guide

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Four Essentials for Improved Screening Rates

1. Your Recommendation
2. An Office Policy
   A. An Office Policy is Vital
   B. Fit the Policy to Your Practice
      • Determine Individual Risk Level
      • Identify Local Medical Resources
      • Assess Insurance Coverage
      • Consider Patient Preference
      • Attend to Office Implementation
3. An Office Reminder System
   A. Options for Patients: Education and Cues to Action
   B. Options for Physicians:
      • Chart Prompts
      • Audits and Feedback
      • Ticklers and Logs
      • Staff Assignments
4. An Effective Communication System
   A. Options for Action
      • Stage-based Communication
      • Shared Decisions, Informed Decisions, Decision Aids
      • Staff Involvement
Q: Why focus on primary care practice?

- We have it in our power to improve the screening rate.
  ‘This is our sphere of influence.’

- 80-90% of people >age 50 see an MD each year
The important role of the physician’s advice in cancer screening has been repeatedly documented.

The doctor’s advice is usually cited as the most important reason that an adult has had a recent screening test.

The most common reason cited for not having had a screening test is that the doctor has not recommended it.

Other reasons are “proxies” for lack of physician endorsement.

1. The positive impact of advice from a doctor to get cancer screening is well documented.

2. The magnitude of a clinician’s impact is considerable: State surveys have shown that 90% of people who reported a physician recommendation for CRC testing were screened vs. 17% of those who reported no provider recommendation, and 72% of those whose physician recommended an FOBT completed it vs. 8% of those whose physician had not.

3. Every clinician has seen patients who should have received, but did not receive, cancer screening. A consistent and reliable recommendation will result if three other essential elements – an office policy, a reminder system, an effective communication system – are part of the practice.

4. The positive effect of a doctor’s advice is limited to those who have access to a doctor or a usual source of care. All patients need a usual source of care.

5. To prevent CRC and reduce mortality, the recommendation must include a referral for complete diagnostic exam where the FOBT or flexible sigmoidoscopy screening test is positive.
Q: Is a Doctor’s Recommendation Really That Useful?

Aren’t we bucking human nature with this one?

Adapted from Jack Tippit, Saturday Evening Post
Yes. Unequivocally!

Multiple studies have shown that a physician’s recommendation is the most consistently influential factor in cancer screening.
Goal = Recommendation to each eligible patient

- Requires an opportunistic/global approach*
  - Don’t limit efforts to “check-ups”
- Requires a system that doesn’t depend on the doctor alone
- An opportunistic approach doesn’t justify an in-office FOBT which has negative evidence.

Essential # 2: An Office Policy

- An office policy is vital
- Only a systematic approach can insure that the physician’s recommendation is delivered to all patients
- An office policy is the foundation of a systematic approach
An Office Policy states the intent of the practice

- Tangible, maintains consistency,
- Prerequisite for reliable, reproducible practice
  - Algorithms easiest policies to follow
  - Beware: one size does not fit all practices!
  - Beware: one size does not fit all patients!
Factors to Consider in Your Office Policy

- Individual Risk Level ("risk stratification")
- Medical resources (endoscopy available?)
- Insurance (insured? covered? deductible? copay?)
- Patient Preference
  
  Patients do have preferences
  We often neglect to ask about them
  We won’t know unless we ask
Sample Screening Algorithm

Assess Risk: Person & Family

Average Risk = no family hx of CRC or adenomatous polyp

- < 50 yrs: Do Not Screen
- ≥ 50 yrs: Screen*

* Options
FOBT at home qyr
Flex sig q5yr
FOBT + flex sig
DCBE q5-10 yrs
Colonoscopy q10 yrs

Increased or High Risk = + family or personal hx of CRC or adenomatous polyp, IBD or HNPCC related cancer

+ Personal History
- Adenoma
- CRC
- IBD**

+ Family History
- Germline Syndrome
- Adenoma or Cancer

If + Diagnosis by Colonoscopy
- Surveillance Colonoscopy

Childhood Screening

Screen 10 yrs before youngest relative or age 40

** IBD refers to inflammatory bowel disease for eight years.
Essential # 2: An Office Policy

Central Question: Risk Level

Individual Risk Levels

- Average
- Increased
- High
Q: How Many at Increased Risk?

A: Many more than we usually think.

- Too much emphasis in the past on the “average risk” person, assumed to represent the vast majority.

- In fact, with CRC, 25-35% of the population is at increased risk.
U.S. adults reported prevalence of family history (biological parents, siblings, or children) of colorectal cancer (NHIS, 2000)

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<th>Age</th>
<th>Family Hx of CRC (%)</th>
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<td>50-59</td>
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<td>Total</td>
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Chart review of 995 patients in primary care setting…

- Cancer family history was collected in 679 patients (68%)

- Among these 679, only 414 (61%) had specific information about the affected relative and the cancer diagnosis
Of 995 patients……

- Among all adults with a 1st degree relative with colorectal cancer, age at diagnosis was present in only 51% of charts
- Age of 2nd degree relatives with colorectal cancer was present in only 32% of charts
- No patients who might be candidates for early colonoscopy were identified
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). Check the criteria.)
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<th>Risk Category</th>
<th>Age to Screen</th>
<th>Recommendation</th>
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<td><strong>Average Risk</strong></td>
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<td>• radiologic studies</td>
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<td><strong>Increased Risk</strong></td>
<td>Age 40 or 10 years prior to earliest diagnosis in family</td>
<td>Colonoscopy</td>
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<td>CRC/Adenoma in a 1º relative</td>
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<td><strong>High Risk</strong></td>
<td>Any age</td>
<td>Specialty referral, colonoscopy, +/- genetic test</td>
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<td>Familial syndrome or</td>
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<td>IBD&gt;8 years</td>
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Reminder systems are “Cues to Action”

Reminder systems can be directed at patients, clinicians, or both

Reminder systems can be simple, or complex, with the more complex systems having the greatest benefit
Interventions to Increase Preventive Care

Why are Reminder Systems So Important?

- Opportunistic (i.e., coincidental) preventive care is inherently unproductive
  - Encounter based, not population based
  - Situational context of encounter is a limiting factor
  - High potential for omission or error (preoccupation, forgetfulness, lack of familiarity with recommendations, or non-evidence based policy)
  - Partial adherence is more likely than complete adherence
  - More complex situations (follow-up, greater risk, etc.) are less likely to be properly addressed
Examples of Reminder Systems

### Chart Prompts
- Preventive services list in each chart
- Office staff can pull charts before patient visits and identify what services are needed
- Stickers or other “flags” can efficiently identify “who needs which services.”

### Electronic Reminder Systems (EMRs)
- Computer systems are more common for scheduling and billing, less so for EMR’s
- ERS’s are more effective than paper based systems, but they are more expensive, and require a considerable investment of time and commitment
Physician Reminder Types

- **Chart Prompts**
  - Problem lists
  - Screening schedules
  - Integrated summaries

- **Alerts - placed in chart**

- **Follow-Up Reminders**
  - Tickler System
  - Logs and Tracking

- **Electronic Reminder Systems**
# Chart Audit Template

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<th>Name</th>
<th>ID</th>
<th>Date</th>
<th>Gender</th>
<th>Race</th>
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<th>FOBT</th>
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<th>Flexible Sigmoidoscopy</th>
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### Adult Female Age 50 to 65 Preventive Care Flow Sheet

**Patient Name**

**DOB**

| DATE | HEALTH GUIDELINES | 50 | 51 | 52 | 53 | 54 | 55 | 56 | 57 | 58 | 59 | 60 | 61 | 62 | 63 | 64 | 65 | 66 | 67 | 68 |
|------|-------------------|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|
|      | Abuse             |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
|      | Advance directives|    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
|      | Breast self-exam  |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
|      | Calcium           |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
|      | Dental health     |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
|      | Drugs/alcohol     |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
|      | Estrogen          |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
|      | HIV/AIDS          |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
|      | Injuries          |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
|      | Mental health/depression | | | | | | | | | | | | | | | | | | | | | |
|      | Nutrition         |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
|      | Occupational health | | | | | | | | | | | | | | | | | | | | | |
|      | Physical activity |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
|      | Sexual behavior   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
|      | Tobacco           |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
|      | UV exposure       |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
|      | Violence & guns   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |

⚠️ = Discussed w/ patient

### Examination & Tests

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<td>STD screening</td>
<td>Sexually active</td>
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<td>Stool test (home)</td>
<td>Annual ≥50y</td>
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<td>Breast exam</td>
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<td>Mammogram</td>
<td>Annual</td>
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<td>Flex, Sig, CTC, DCBE</td>
<td>≥50y q4y</td>
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<td>Colonoscopy</td>
<td>≤50y q8y/HIGH RISK</td>
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Patient Reminders

- Two types
  1. Cues to action
  2. Education
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 colon 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,
Dear ______________________

According to our records, you indicated that either you or a family member who is under age 60 has a history of colorectal polyps or cancer. This medical history places you at increased risk for colorectal cancer. Because of this, it is advisable that you have a colonoscopy now.

If you had a negative FOBT test, you still need a colonoscopy.

A colonoscopy is a procedure that must be done by a gastroenterologist or a surgeon at an endoscopy center or hospital. This test will allow a doctor to look inside the entire colon (large intestine) to check for a polyp or cancer.

If you do not have health insurance, please do not let this keep you from getting a colonoscopy. We can assist you with scheduling a colonoscopy or finding a doctor who will see you. Please call ______________ to set up an appointment if you have questions.

If you have health insurance (or Medicare/Medicaid), our office will refer you for a colonoscopy. To obtain the referral call or take this letter with you to your next doctor’s appointment.

Thank you for taking care of your health and following through on this important test.

Sincerely,

Medical Director
Essential # 4: An Effective Communication System

- Bottom Line….Today there is less time, and primary care clinicians are expected to do more

- Skillful Communication Strategies Save Time and Resources

- Communication systems increase delivery of clear advice, without increasing time pressures on the staff
Stage-Based Communication Strategies

A Decision Stage Model for CRC Screening

- **Stage 1**
  - Never heard of CRC Screening

- **Stage 2**
  - Heard of but not considering CRC Screening at this time

- **Stage 3**
  - Heard of and considered CRC Screening

- **Stage 4**
  - Heard of and decided to do CRC Screening

- **Stage 0**
  - Decide against CRC Screening
Shared Decisions, Informed Decisions, and Decision Aids

- Most clinicians appreciate the value of shared decision making, but it is commonly neglected, and commonly not done well.
- It is important to explore patient preferences and uncertainties, and provide advice accordingly…failure to explore patient preferences leads to wasted time and recommendations that may not fit their preferences.
- Materials can help prepare patients for the process of shared decision making, or to reach decisions on their own.
Staff Involvement

- Key Point.....the Doctor Can’t Do It All
- The time that patients spend with non-physician staff is underutilized
- Standing orders can empower nurses, PA’s, intake staff, etc. to distribute materials, distribute patient surveys to be completed in the waiting room, stool blood cards, schedule appointments for colonoscopy, etc.
- Involve staff in meetings to discuss progress in achieving office goals for improving the delivery of preventive services
Communication Within the Office

**ESSENTIAL #4: An Effective Communication System**

<table>
<thead>
<tr>
<th>Internal Practice Questionnaire</th>
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<tbody>
<tr>
<td><strong>Goals</strong></td>
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<tr>
<td>Are we functioning in alignment with our greater purpose? Our vision?</td>
</tr>
<tr>
<td>Do we need to reevaluate our goals?</td>
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<tr>
<td>What is working well? Why?</td>
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<tr>
<td>What is not working? Why?</td>
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<tr>
<td>What can be done differently?</td>
</tr>
<tr>
<td>Are we providing the services we said we wanted to provide?</td>
</tr>
<tr>
<td>Should we reevaluate the services we offer?</td>
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<tr>
<td><strong>Materials</strong></td>
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<tr>
<td>How do the cancer prevention materials fit our needs?</td>
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<tr>
<td>Should we modify any of the cancer prevention materials?</td>
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<tr>
<td><strong>Documentation</strong></td>
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<tr>
<td>Are we documenting the services we provide?</td>
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<tr>
<td><strong>Staff Performance and Satisfaction</strong></td>
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<tr>
<td>How are the staff performing their functions?</td>
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<tr>
<td>Are staff stepping in where needed?</td>
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<td>Are staff working together as a team?</td>
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<tr>
<td>Are all staff contributing suggestions?</td>
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</table>
Tracking the Office Progress

- Set Realistic Goals
- Repeat chart audits
- Staff specific feedback on performance
- Practice specific measures, and Reassessment of Goals
- Identify strengths and weaknesses, barriers, opportunities to improve efficiency
- **Above all, seek patient feedback**
The Tool Kit Contains Ready to Use “Tools”

- Step-by-step guidance on how to implement office systems
- Forms and templates
- Web Sites
- The Tool Kit will be updated on a regular basis

Available at www.cancer.org/colonmd
"The barrier to reducing the number of deaths from colorectal cancer is not a lack of scientific data but a lack of organizational, financial, and societal commitment"

Daniel K. Podolsky, MD (NEJM, July 2000)
Thank You!