Colorectal Cancer Screening Data Sets

What are they and what do they tell us?

July 30th, 2015
Webinar
Purpose of Today’s Webinar

• Provide an overview of five major data sets that track colorectal cancer screening: BRFSS, NHIS, HEDIS, UDS and Medicare claims data

• Answer key questions about each data set, such as:
  – How to access
  – What they measure
  – Strengths and weaknesses of each,

• Help you understand when you might use each in your work

• Q&A
Presenters:

Andi Dwyer (Moderator)
Co-Chair, National Colorectal Cancer Evidence Based Education and Outreach Task Group
University of Colorado, Denver School of Public Health

Djenaba Joseph, MD, MPH
Medical Director
Colorectal Cancer Control Program at CDC

Carrie Klabunde, PhD
Office of Disease Prevention
Office of the Director at National Institutes of Health
Presenters (continued):

Mary Barton, MD, MPP
Vice President of Performance Measurement
NCQA

Laura Makaroff, DO
Senior Clinical Advisor
Office of Quality Improvement
HRSA  Bureau of Primary Health Care

Matt Allison
Health Systems, American Cancer Society
Behavioral Risk Factor Surveillance System (BRFSS)

Djenaba A. Joseph, MD, MPH
CDR, U.S. Public Health Service
Medical Director, Colorectal Cancer Control Program
Division of Cancer Prevention and Control
Centers for Disease Control and Prevention
Overview

- Established 1984

- Cross-sectional telephone survey
  - Conducted by state health departments
  - Landline and cellular telephones
  - Technical and methodological assistance from CDC

- Collects state data about U.S. residents regarding
  - Health-related risk behaviors
  - Chronic health conditions
  - Use of preventive services
How often is data collected?

- **BRFSS**
  - Annual
  - Core questions
    - Fixed, rotating, and emerging
  - Optional modules
  - State added questions

- **CRC questions**
  - Rotating core, even years (2012, 2014, etc.)
What is measured?

- FOBT
- Sigmoidoscopy
- Colonoscopy
- Fixed time interval responses (within the past year, 2 years, 3 years, 5 years, 10 years, more than 10 years ago)
CRC screening prevalence

Behavioral Risk Factor Surveillance System

BRFSS Statistical Briefs

BRFSS data users can refer to these documents for additional guidance on conducting analyses. These references focus on specific topics and are presented in two tracks: Track A (organized by specific topics) and, when the documents become available. Track B: Analytical Methods Briefs.

Program-specific, Topic-related Briefs (Track A)

- Data User's Guide to the BRFSS Sugar-Sweetened Beverage Questions [PDF - 385 KB]
- BRFSS Statistical Brief on Cancer Screening Questions [PDF - 649 KB]
- Guide to analyze Physical Activity Rotating Core [PDF - 7 MB]
- 2012 BRFSS Cognitive Impairment Module Questions [PDF - 316 KB]
- Surveillance of Fruit and Vegetable Intake Using the Behavioral Risk Factor Surveillance System [PDF - 281 KB]
What gets reported?

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Up-to-date with CRC screening†</th>
<th>Colonoscopy within 10 years</th>
<th>FOBT within 1 year</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>(95% CI)</td>
<td>%</td>
</tr>
<tr>
<td>Overall</td>
<td>65.1</td>
<td>(64.7–65.5)</td>
<td>61.7</td>
</tr>
<tr>
<td>Age (yrs)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>50–64</td>
<td>60.0</td>
<td>(59.5–60.5)</td>
<td>56.4</td>
</tr>
<tr>
<td>65–75</td>
<td>76.8</td>
<td>(76.2–77.4)</td>
<td>73.9</td>
</tr>
<tr>
<td>Sex</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Men</td>
<td>63.9</td>
<td>(63.2–64.5)</td>
<td>60.5</td>
</tr>
<tr>
<td>Women</td>
<td>66.2</td>
<td>(65.7–66.8)</td>
<td>62.8</td>
</tr>
<tr>
<td>Race</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>65.9</td>
<td>(65.4–66.3)</td>
<td>62.7</td>
</tr>
<tr>
<td>Black</td>
<td>65.5</td>
<td>(64.2–66.9)</td>
<td>62.1</td>
</tr>
<tr>
<td>Asian/Pacific Islander</td>
<td>63.2</td>
<td>(58.9–67.2)</td>
<td>54.6</td>
</tr>
<tr>
<td>American Indian/Alaska Native</td>
<td>54.5</td>
<td>(50.8–58.2)</td>
<td>49.5</td>
</tr>
<tr>
<td>Other/Multiracial</td>
<td>51.2</td>
<td>(47.7–54.7)</td>
<td>49.1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Up-to-date with CRC screening</th>
<th>Screened but not up-to-date</th>
<th>Never screened</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>% (95% CI)</td>
<td>% (95% CI)</td>
<td>% (95% CI)</td>
</tr>
<tr>
<td>Overall</td>
<td>65.1 (64.7–65.5)</td>
<td>7.2 (7.0–7.5)</td>
<td>27.7 (27.3–28.1)</td>
</tr>
<tr>
<td>Age (yrs)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>50–64</td>
<td>60.0 (59.5–60.5)</td>
<td>7.0 (6.7–7.3)</td>
<td>33.0 (32.5–33.5)</td>
</tr>
<tr>
<td>65–75</td>
<td>76.8 (76.2–77.4)</td>
<td>7.8 (7.5–8.1)</td>
<td>15.4 (14.8–15.9)</td>
</tr>
<tr>
<td>Sex</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Men</td>
<td>63.9 (63.2–64.5)</td>
<td>6.5 (6.2–6.9)</td>
<td>29.6 (29.0–30.2)</td>
</tr>
<tr>
<td>Women</td>
<td>66.2 (65.7–66.8)</td>
<td>7.9 (7.6–8.2)</td>
<td>25.9 (25.4–26.4)</td>
</tr>
<tr>
<td>Race</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>65.9 (65.4–66.3)</td>
<td>7.5 (7.2–7.7)</td>
<td>26.7 (26.3–27.1)</td>
</tr>
<tr>
<td>Black</td>
<td>65.5 (64.2–66.9)</td>
<td>5.9 (5.3–6.6)</td>
<td>28.5 (27.2–29.9)</td>
</tr>
<tr>
<td>Asian/Pacific Islander</td>
<td>63.2 (58.9–67.2)</td>
<td>6.6 (4.7–9.3)</td>
<td>30.2 (26.4–34.3)</td>
</tr>
<tr>
<td>American Indian/Alaska Native</td>
<td>54.5 (50.8–58.2)</td>
<td>6.2 (4.9–7.7)</td>
<td>39.3 (35.6–43.1)</td>
</tr>
<tr>
<td>Other/Multiracial</td>
<td>51.2 (47.7–54.7)</td>
<td>6.0 (4.7–7.6)</td>
<td>42.9 (39.4–46.4)</td>
</tr>
</tbody>
</table>
How is the data accessed?

http://www.cdc.gov/brfss
How is the data accessed?

http://www.cdc.gov/brfss
### Data Files

There are 475,687 records for 2012. More information on participation is available in the [States Conducting Surveillance by Year table](https://www.cdc.gov/). The data files are provided in ASCII and SAS Transport formats.

**2012 BRFSS Data (ASCII)**  
Data released July 2013  
This file for the combined landline and cell phone data set is in ASCII format. It has a fixed record length of 1582 positions.

**2012 BRFSS Data (SAS Transport)**  
Data released July 2013  
This file for the combined landline and cell phone data set was exported from SAS V8.2 in the XPT transport format. This file contains 359 variables. This format can be imported into SPSS or STATA. Please note: some of the variable labels get truncated in the process of converting to the XPT format so they may be slightly different from what is on the SASOUT.12.SAS program.

### Variable Layout

Format information on variable name by column position.

### SAS Resources

The following files are included for use with SAS software developed by SAS Institute, Inc. The SAS files are programs that can be read using any text editor. Save SAS files as plain text files.

- **Format12.sas**  
  SAS for Windows program used to generate the 2012 format library.

- **TRANSPT.SAS**  
  SAS for Windows program to convert the XPT (SAS Transport) file into
In 1984, the Centers for Disease Control and Prevention (CDC) initiated the state-based Behavioral Risk Factor Surveillance System (BRFSS)—a cross-sectional telephone survey that state health departments conduct monthly over landline telephones and cellular telephones with a standardized questionnaire and technical and methodologic assistance from CDC. BRFSS is used to collect prevalence data among adult U.S. residents regarding their risk behaviors and preventive health practices that can affect their health status. Respondent data are forwarded to CDC to be aggregated for each state, returned with standard tabulations, and published at year’s end by each state. In 2011, more than 500,000 interviews were conducted in the states, the District of Columbia, and participating U.S. territories and other geographic areas.

The BRFSS Data User Guide

The BRFSS Data User Guide [PDF: 208 KB] is intended to provide a brief overview of BRFSS to data users. Specific information regarding data quality, response and/or cooperation rates, or calling outcome can be found in the Summary Data Quality Report produced each year in conjunction with the annual data release. Data users needing more information about comparability across years should refer to the annual Comparability of Data document, particularly before using the data to conduct trend analyses.

2013 SURVEY DATA AND DOCUMENTATION

The 2013 BRFSS data continues to reflect the changes initially made in 2012.

SMART: BRFSS CITY AND COUNTY DATA AND DOCUMENTATION
SMART: BRFSS City and County Data and Documentation

CDC analyzes BRFSS data for metropolitan and micropolitan statistical areas (MMSAs), to provide localized health information that can help public health practitioners identify local emerging health problems, plan and evaluate local responses, and efficiently allocate resources to specific needs.

The Selected Metropolitan/Micropolitan Area Risk Trends of BRFSS SMART BRFSS uses BRFSS data to provide prevalence rates for selected conditions and behaviors for cities and their surrounding counties. For the corresponding annual questionnaires used to collect this information, see the Questionnaires section of this site. For other data sets, see the Annual Survey Data and BRFSS Maps (GIS) sections of this site. To access SMART trends and charts, see the SMART: BRFSS City and County Database.

For more information on MMSAs and SMART BRFSS, see the SMART FAQs. To find information about SMART weighting procedures, calculated variables, and other technical information, please refer to the data and documentation provided with each SMART Data Set, by collection year.

2011 - 2012 SMART Data and Documentation

- 2012 Data
- 2011 Data
- 2010 Data
- 2009 Data
- 2008 Data

2002 - 2010 SMART Data and Documentation
Advantages

- State-based
  - County level data
- Large dataset
- Validated questions
- Standardized
Disadvantages

- Tends to over-estimate screening prevalence
- Cannot differentiate screening vs. diagnostic/follow-up
- Self-reported data
- Limited tests
- Change in weighting methodology starting 2011
  - Cannot analyze trends across change
How is BRFSS used?

Understanding Barriers to Colorectal Cancer Screening in Kentucky.
Redmond Knight, Kanotra, Siamah, Jones, Thompson, Thomas-Cox

Abstract

INTRODUCTION: Colorectal cancer screening rates have increased significantly in Kentucky, from 35% in 1999 to 66% in 2012. A continued improvement in screening requires identification of existing barriers and implementation of interventions to address barriers.

METHODS: The state of Kentucky added a question to the 2012 Kentucky Behavioral Risk Factor Surveillance System survey for respondents aged 50 years or older who answered no to ever having been screened for colorectal cancer by colonoscopy or sigmoidoscopy to assess the reasons why respondents had not been screened. Combined responses constituted 4 categories: attitudes and beliefs, health care provider and health care systems barriers, cost, and other. Prevalence estimates for barriers were calculated by using raking weights and were stratified by race/ethnicity, sex, education, income, and health insurance coverage. Logistic regression estimated odds ratios for barriers to screening.

RESULTS: The most common barriers in all areas were related to attitudes and beliefs, followed by health care provider and systems, and cost. Non-Hispanic whites and respondents with more than a high school education were more likely to choose attitudes and beliefs as a barrier than were non-Hispanic blacks and those with less than a high school education. Respondents with low incomes and with no insurance were significantly more likely to select cost as a barrier. No significant associations were observed between demographic variables and the selection of a health care provider and a health care system.

CONCLUSION: Barriers related to education, race/ethnicity, income, and insurance coverage should be considered when designing interventions. Expansion of Medicaid and implementation of the Affordable Care Act in Kentucky could have an impact on reducing these barriers.
Questions?
dajoseph@cdc.gov

For more information please contact Centers for Disease Control and Prevention
1600 Clifton Road NE, Atlanta, GA 30333
Telephone, 1-800-CDC-INFO (232-4636)/TTY: 1-888-232-6348
E-mail: cdcinfo@cdc.gov  Web: www.cdc.gov

The findings and conclusions in this report are those of the authors and do not necessarily represent the official position of the Centers for Disease Control and Prevention.
CRC Screening Data Sets: National Health Interview Survey

Carrie Klabunde, Ph.D.
Office of Disease Prevention
Office of the Director
National Institutes of Health

NCCRT 80% by 2018 Webinar
July 30, 2015
About the National Health Interview Survey (NHIS)

- Principal source of information on the health of the U.S. population.
- Conducted by the National Center for Health Statistics (NCHS) among a nationally-representative sample of households every year since 1957.
- Data collected through in-person interviews of 75,000-100,000 individuals by trained interviewers from the U.S. Census Bureau.
- An NHIS interview takes about an hour to conduct. The questionnaire has two main parts:
  1. Core items—unchanged from year to year
  2. Supplemental questions that change depending on current issues and sponsors
  3. Cancer Control Supplement is the source of CRC screening data
NHIS Cancer Control Supplements

- Sponsored by the National Cancer Institute (NCI) since 1987.
- CDC’s Division of Cancer Prevention and Control has co-sponsored since 2000.
- Used to collect nationally-representative information on cancer screening and prevention behaviors (i.e., tobacco use, diet, physical activity, genetic counseling, etc.).
- Full supplement fielded every five years to approximately 35,000 adults.
- Interim supplements are fielded at the mid-point of the 5 year intervals to monitor cancer screening and new/emerging cancer control issues (e.g., HPV vaccine use).
Significance of NHIS CRC Screening Data

- Covers the major CRC screening modalities:
  - FOBT (distinguishes between home and office-based testing)
  - Sigmoidoscopy
  - Colonoscopy
  - CT colonography (in 2010 and 2015)

- For each modality, ability to determine:
  - Ever had the test
  - When had most recent test
  - Main reason for having the test
  - For respondents who are not up-to-date with screening:
    - Whether they received a doctor recommendation to be tested
    - Which CRC screening tests were recommended
NHIS Covariates Available for CRC Screening Analyses

**Sociodemographics:**
- Age
- Sex
- Race/ethnicity
- Marital status
- Educational attainment
- Family income
- Immigration status
- Employment

**Health Care Access:**
- Health insurance
- Usual source of care
- Physician visits

**Health Behaviors:**
- Diet, including fruit & vegetable consumption
- Alcohol use
- Physical activity
- Screening for other cancers: breast, cervical, prostate

**Health Status:**
- Body Mass Index (BMI)
- General health status self-rating
- Personal & family history of cancer
- Comorbid health conditions
- Smoking history
- Activity limitations

**Geography:**
- Census region is publicly available. State-level and urban/rural estimates may be obtained upon request through NCHS Research Data Center
NHIS Advantages & Disadvantages

**Advantages:**
- Large sample size that gives national estimates
- High response rate (>60%)
- Detailed questions on CRC screening
- Rich set of covariates for assessing CRC screening use
- Can examine trends over time
- Designated data source for Healthy People monitoring
- Items are cognitively tested and widely analyzed
- Survey datasets are publicly available and well-documented

**Disadvantages:**
- Working with NHIS public use datasets requires some programming ability (end-user must decide how to create screening and other variables)
- Access to data at geographic units smaller than Census region requires explicit permission and working with NCHS Research Data Center
Timeline for NHIS CCS Data

- 2015 NHIS is currently in the field (January-December).
- First half of 2016: NCHS will work on data cleaning, quality checks, and dataset preparation.
- Estimated timeframe for 2015 NHIS public use dataset release: June 2016
Percentage of adults up-to-date with screening for breast, cervical and colorectal cancers, by test, sex and year – United States, 2000-2013 (NHIS)

Abbreviations: CRC = colorectal cancer; Pap = Papanicolaou
*Among women aged 21-65 with no prior hysterectomy.
†Among women aged 50-74.
‡Among persons aged 50-75.

Source: Sabatino et al. (2015), MMWR, 64 (17): 464-468
Useful Websites

- National Health Interview Survey homepage (contains questionnaires, datasets, and related documentation):
  - www.cdc.gov/nchs/nhis.htm

- National Center for Health Statistics Research Data Center (provides access to restricted data):
  - www.cdc.gov/rdc

- About the NHIS Cancer Control Supplement:
  - Healthcaredelivery.cancer.gov/nhis/what.html

- State-based survey patterned on the NHIS: California Health Interview Survey (CHIS)--
  - www.cdph.ca.gov/data/surveys/Pages/CHIS.aspx
HEDIS and the National Committee for Quality Assurance

Mary B. Barton, MD MPP
Vice President, Performance Measurement
What is NCQA?
• NCQA is 25 years old this year
• We accredit health care insurance plans, holding them accountable for quality via the reporting of performance measures
• Measures in HEDIS® cover most insured patients in the US
• Include measures relevant to young and old, mostly related to ambulatory care
• Prevention including a Colorectal Cancer Screening measure

HEDIS ® is a registered trademark of NCQA
Colorectal Cancer screening measure

- **Denominator**: adults aged 50 – 75 years
- **Continuously enrolled for two years**
- **Receipt of**
  - FOBT within 2 years
  - Flexible Sigmoidoscopy within 5 years
  - Colonoscopy within 10 years
Transparency and Public Reporting

- Measures reported annually in June on data covering prior year
- Published each fall in Quality Compass
- Publicly available (by subscription)
- Results presented by plan with local/regional or national benchmarks
# NCQA HEDIS Report

**SAMPLE REPORT FROM COMMERCIAL PLANS IN CALIFORNIA, 2015 DATA**

## Colorectal Cancer Screening

<table>
<thead>
<tr>
<th>Insurance Plan</th>
<th>Average Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kaiser - CA (Southern CA) - HMO</td>
<td>81.75</td>
</tr>
<tr>
<td>Kaiser - CA (Northern CA) - HMO</td>
<td>80.29</td>
</tr>
<tr>
<td>Blue Shield of California - HMO/POS</td>
<td>70.03</td>
</tr>
<tr>
<td>Western Health Advantage - HMO</td>
<td>69.27</td>
</tr>
<tr>
<td>UnitedHealthcare of California - HMO</td>
<td>68.72</td>
</tr>
<tr>
<td>Chinese Community Health Plan - HMO</td>
<td>67.35</td>
</tr>
<tr>
<td>Anthem Blue Cross - HMO/POS</td>
<td>67.12</td>
</tr>
<tr>
<td>Cigna - CA - HMO/POS</td>
<td>66.56</td>
</tr>
<tr>
<td>SHP - HMO</td>
<td>65.34</td>
</tr>
<tr>
<td>Health Net of California, Inc. - HMO/POS</td>
<td>65.21</td>
</tr>
<tr>
<td>Anthem Blue Cross - PPO</td>
<td>62.78</td>
</tr>
<tr>
<td>Astria California - HMO/POS</td>
<td>61.83</td>
</tr>
<tr>
<td>UHIC CA - PPO</td>
<td>59.15</td>
</tr>
<tr>
<td>ALCIC California - PPO</td>
<td>58.11</td>
</tr>
<tr>
<td>CGIC - CA - PPO</td>
<td>57.21</td>
</tr>
<tr>
<td>Blue Shield of California - PPO</td>
<td>56.02</td>
</tr>
<tr>
<td>UHIC AL - PPO</td>
<td>52.96</td>
</tr>
<tr>
<td>Health Net Life Insurance Comp - PPO</td>
<td>51.11</td>
</tr>
<tr>
<td>Amera Health for Health - HMO</td>
<td>49.54</td>
</tr>
<tr>
<td>SHL - PPO</td>
<td>38.42</td>
</tr>
<tr>
<td>SAMBA - CAHPS Sum Only - PPO</td>
<td>ND</td>
</tr>
</tbody>
</table>
Considerations

• Advantages:
  – Results updated annually
  – Based on claims or medical records, may be more accurate than patient recall via survey

• Disadvantages:
  – Potential for under-ascertainment with chart review approach
  – Covers only the insured population
  – Burden (to health plans) of chart review measures
Horizon for this measure

- Long look back period means that many organizations use chart review of sample of patients
- Broader use of electronic health records hold promise for measures such as this, that rely on more detailed information than available in a claims dataset
Where to get the data

- **www.ncqa.org**
- **Quality Compass:** [http://www.ncqa.org/qualitycompass.asp](http://www.ncqa.org/qualitycompass.asp)
- Questions: Mary Barton  barton@ncqa.org
Colorectal Cancer Screening Rates and the Uniform Data System (UDS)

July 30, 2015

Laura Makaroff, D.O.
Senior Clinical Advisor
Office of Quality Improvement, Bureau of Primary Health Care
Health Resources and Services Administration
U.S. Department of Health and Human Services
Improve the health of the Nation’s underserved communities and vulnerable populations by assuring access to comprehensive, culturally competent, quality primary health care services.
Primary Care: Key Strategies

- Increase access to primary health care services for underserved populations
- Modernize the primary health care safety net infrastructure and delivery system
- Promote a performance-driven and innovative organizational culture
- Improve health outcomes for patients

Increase

Modernize

Promote

Improve
2013 HEALTH CENTER IMPACT

PROGRAM GRANTEES

SERVED 21.7 MILLION PATIENTS

- 93% Below 200% poverty
- 72% Below 100% poverty
- 35% Uninsured

1,131,414 homeless individuals
861,120 agricultural workers
227,665 residents of public housing

LOOK-ALIKES

SERVED 1 MILLION PATIENTS

- 93% Below 200% poverty
- 74% Below 100% poverty
- 32% Uninsured

20,011 homeless individuals
10,681 agricultural workers

PROVIDED 86 MILLION PATIENTS VISITS

in 1,202 organizations across more than 9,208 service sites

EMPLOYED MORE THAN 156 THOUSAND STAFF

including 10,733 physicians, 8,156 nurse practitioners, physicians assistants, and certified nurse

PROVIDED 4 MILLION PATIENTS VISITS

in 100 organizations across more than 310 service sites

EMPLOYED MORE THAN 6 THOUSAND STAFF

including 588 physicians, 325 nurse practitioners, physicians assistants, and certified nurse midwives
Health Center Program

Increase Access - National Presence
What is the UDS?

Standardized set of data reported by health centers:

– PHS Section 330 Grantees– Community Health Centers (CHC), Migrant Health Centers (MHC), Health Care for the Homeless (HCH) and Public Housing Primary Care Program (PHPC)
– Health Center Look-alikes
– Urban Indian Health programs
Why is the UDS Important?

• UDS data are used by the Bureau of Primary Health Care (BPHC) to:
  – Ensure compliance with legislative and regulatory requirements
  – Report program achievements
  – Monitor performance and identify TA needs

• UDS data are used by health centers to monitor and improve performance

• UDS data describes patient populations served by health centers
What Data is Collected in the UDS?

- The UDS is comprised of 12 tables and an Appendix (EHR capabilities, PCMH, Accreditation etc.)
- Captures annual, aggregate data at the health center organization level

<table>
<thead>
<tr>
<th>Table</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ZIP Codes</td>
<td>Patients by ZIP code (by primary medical insurance)</td>
</tr>
</tbody>
</table>
| 3A, 3B, 4 | 3A: Patients by age and gender  
            3B: Patients by race and ethnicity  
            4: Patients by income, insurance, and target populations                |
| 5         | Utilization and staffing                                                     |
| 5A        | Tenure for health center staff                                              |
| 6A        | Selected diagnoses and services                                              |
| 6B        | Quality of care indicators                                                  |
| 7         | Health outcomes and disparities                                              |
| 8A        | Financial costs                                                             |
| 9D        | Patient related revenue                                                     |
| 9E        | Other revenue                                                               |
Percentage of patients aged 50 to 75 who had appropriate screening for colorectal cancer

- **Numerator**: Number of patients aged 51 through 74 with appropriate screening for colorectal cancer.
- **Denominator**: Number of patients who were aged 51 through 74 at some point during the measurement year, who had at least one medical visit during the reporting year.
Colorectal Cancer Screening
Health Center National Average and HP 2020 Goal

- UDS 2012: 30.2%
- UDS 2013: 32.6%
- HP 2020 Goal: 70.5%
HRSA-Funded Health Center Colorectal Cancer Screening Rates
UDS 2013

Colorectal Cancer Screening Rate

- Greater than 70%
- 50-70%
- 30-50%
- 10-30%
- Less than 10%

Number of Health Center Program Grantees

CRC Screening
Health Center National Average
Annual UDS Performance Data publicly available at:
http://bphc.hrsa.gov/datereporting/index.html

UDS Website:
http://bphc.hrsa.gov/datereporting/reporting/index.html
- Reporting Resources
- UDS Training Resources

UDS Mapper: www.udsmapper.org
- HRSA has developed a mapping and support tool driven primarily from data within the UDS
- Webinar trainings on using Mapper functionality available: http://www.udsmapper.org/webinars.cfm
Thank You!

Laura Makaroff
Senior Clinical Advisor
Office of Quality Improvement
Bureau of Primary Health Care
Health Resources and Services Administration
U.S. Department of Health and Human Services
301-594-4479
lmakaroff@hrsa.gov
Using Medicare Data for CRC
Medicare Dataset Overview

- Mainly 65+
- 6-8 month data lag for claims processing
- Updates typically available quarterly
- Can breakdown screening by test, race, ethnicity, zip code, county, and provider
- Available through ResDAC or QIO
- Research Identifiable Files are available for custom reports
- Used by CMS to calculate provider reimbursement
Dataset issues

• Only 65+ age group
• Patient attribution can be difficult
• No record of screening before Medicare coverage
How to get it

• Talk to your state QIO
  • http://www.ahqa.org/quality-improvement-organizations

• Provide basic report specifications

• Contact ResDAC
  • http://www.resdac.org/about-resdac/contact-us
Example by County and Test

Statewide Monitoring - CRC Time Frame: 07/01/2012 - 06/30/2013
Race=All_Race

<table>
<thead>
<tr>
<th>County_Name</th>
<th>Denominator</th>
<th>Numerator</th>
<th>Rate</th>
<th>Denominator</th>
<th>Numerator</th>
<th>Rate</th>
<th>Denominator</th>
<th>Numerator</th>
<th>Rate</th>
<th>Denominator</th>
<th>Numerator</th>
<th>Rate</th>
<th>Denominator</th>
<th>Numerator</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>AUTauga</td>
<td>3830</td>
<td>2044</td>
<td>53.37%</td>
<td>277</td>
<td>7.23%</td>
<td></td>
<td>1928</td>
<td>50.34%</td>
<td>85</td>
<td>2.22%</td>
<td>65</td>
<td>1.70%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Baldwin</td>
<td>17932</td>
<td>9502</td>
<td>52.99%</td>
<td>1068</td>
<td>5.96%</td>
<td></td>
<td>9045</td>
<td>50.44%</td>
<td>348</td>
<td>1.94%</td>
<td>205</td>
<td>1.65%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Barbour</td>
<td>2833</td>
<td>1389</td>
<td>49.03%</td>
<td>140</td>
<td>4.94%</td>
<td></td>
<td>1336</td>
<td>47.16%</td>
<td>48</td>
<td>1.69%</td>
<td>46</td>
<td>1.62%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bibb</td>
<td>1830</td>
<td>905</td>
<td>49.45%</td>
<td>72</td>
<td>3.93%</td>
<td></td>
<td>869</td>
<td>47.49%</td>
<td>54</td>
<td>2.95%</td>
<td>24</td>
<td>1.31%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blount</td>
<td>3289</td>
<td>1709</td>
<td>51.96%</td>
<td>191</td>
<td>3.81%</td>
<td></td>
<td>1638</td>
<td>49.80%</td>
<td>87</td>
<td>2.65%</td>
<td>54</td>
<td>1.64%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bullock</td>
<td>692</td>
<td>353</td>
<td>51.30%</td>
<td>37</td>
<td>5.33%</td>
<td></td>
<td>347</td>
<td>50.14%</td>
<td>14</td>
<td>2.02%</td>
<td>6</td>
<td>0.87%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Butler</td>
<td>2527</td>
<td>1190</td>
<td>47.09%</td>
<td>123</td>
<td>4.87%</td>
<td></td>
<td>1133</td>
<td>44.84%</td>
<td>63</td>
<td>2.49%</td>
<td>89</td>
<td>3.52%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Calhoun</td>
<td>14372</td>
<td>7023</td>
<td>48.87%</td>
<td>709</td>
<td>5.56%</td>
<td></td>
<td>6675</td>
<td>46.44%</td>
<td>402</td>
<td>2.80%</td>
<td>243</td>
<td>1.69%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chambers</td>
<td>4552</td>
<td>2391</td>
<td>52.53%</td>
<td>97</td>
<td>2.13%</td>
<td></td>
<td>2325</td>
<td>51.08%</td>
<td>119</td>
<td>2.61%</td>
<td>45</td>
<td>0.99%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cherokee</td>
<td>2835</td>
<td>1437</td>
<td>50.69%</td>
<td>130</td>
<td>4.59%</td>
<td></td>
<td>1370</td>
<td>48.32%</td>
<td>66</td>
<td>2.33%</td>
<td>83</td>
<td>2.93%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chilton</td>
<td>2638</td>
<td>1339</td>
<td>50.38%</td>
<td>78</td>
<td>2.93%</td>
<td></td>
<td>1300</td>
<td>48.91%</td>
<td>82</td>
<td>3.09%</td>
<td>30</td>
<td>1.13%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Choctaw</td>
<td>2131</td>
<td>1003</td>
<td>47.07%</td>
<td>78</td>
<td>3.66%</td>
<td></td>
<td>956</td>
<td>44.86%</td>
<td>48</td>
<td>2.23%</td>
<td>29</td>
<td>1.36%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clarke</td>
<td>3182</td>
<td>1433</td>
<td>45.03%</td>
<td>61</td>
<td>1.92%</td>
<td></td>
<td>1396</td>
<td>43.87%</td>
<td>51</td>
<td>1.60%</td>
<td>30</td>
<td>0.94%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clay</td>
<td>1767</td>
<td>809</td>
<td>45.78%</td>
<td>184</td>
<td>10.41%</td>
<td></td>
<td>703</td>
<td>39.78%</td>
<td>43</td>
<td>2.43%</td>
<td>38</td>
<td>2.15%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cleburne</td>
<td>1817</td>
<td>818</td>
<td>45.02%</td>
<td>98</td>
<td>5.39%</td>
<td></td>
<td>766</td>
<td>42.16%</td>
<td>44</td>
<td>2.42%</td>
<td>25</td>
<td>1.38%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coffee</td>
<td>5458</td>
<td>2822</td>
<td>53.54%</td>
<td>145</td>
<td>2.66%</td>
<td></td>
<td>2843</td>
<td>52.00%</td>
<td>123</td>
<td>2.25%</td>
<td>59</td>
<td>1.08%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Colbert</td>
<td>7296</td>
<td>3930</td>
<td>53.87%</td>
<td>257</td>
<td>3.52%</td>
<td></td>
<td>3803</td>
<td>52.12%</td>
<td>222</td>
<td>3.04%</td>
<td>128</td>
<td>1.75%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Conecuh</td>
<td>1832</td>
<td>914</td>
<td>49.89%</td>
<td>103</td>
<td>5.62%</td>
<td></td>
<td>866</td>
<td>47.27%</td>
<td>40</td>
<td>2.18%</td>
<td>57</td>
<td>3.11%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coosa</td>
<td>1463</td>
<td>695</td>
<td>47.71%</td>
<td>79</td>
<td>3.40%</td>
<td></td>
<td>651</td>
<td>44.50%</td>
<td>48</td>
<td>3.28%</td>
<td>17</td>
<td>1.16%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Covington</td>
<td>5580</td>
<td>2818</td>
<td>50.50%</td>
<td>279</td>
<td>5.00%</td>
<td></td>
<td>2701</td>
<td>48.41%</td>
<td>101</td>
<td>1.81%</td>
<td>143</td>
<td>2.56%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crenshaw</td>
<td>1654</td>
<td>794</td>
<td>48.00%</td>
<td>106</td>
<td>6.41%</td>
<td></td>
<td>750</td>
<td>45.34%</td>
<td>30</td>
<td>1.81%</td>
<td>28</td>
<td>1.69%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Example by Zip Code

**Statewide Monitoring - CRC Time Frame: 07/01/2012 - 06/30/2013**

**Age: 50 - 80**

<table>
<thead>
<tr>
<th>Interim22</th>
<th>Any Test</th>
<th>FOBT</th>
<th>Colonoscopy</th>
<th>Sigmoidoscopy</th>
<th>Barium Enema</th>
</tr>
</thead>
<tbody>
<tr>
<td>County_Zip</td>
<td>Den</td>
<td>Num</td>
<td>Rate</td>
<td>Num</td>
<td>Rate</td>
</tr>
<tr>
<td>Autauga-36003</td>
<td>All_Race</td>
<td>138</td>
<td>77</td>
<td>55.80%</td>
<td>11</td>
</tr>
<tr>
<td></td>
<td>Black</td>
<td>52</td>
<td>34</td>
<td>65.38%</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>White</td>
<td>85</td>
<td>43</td>
<td>50.59%</td>
<td>8</td>
</tr>
<tr>
<td>Autauga-36006</td>
<td>All_Race</td>
<td>99</td>
<td>44</td>
<td>44.44%</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Black</td>
<td>16</td>
<td>7</td>
<td>43.75%</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>White</td>
<td>83</td>
<td>37</td>
<td>44.58%</td>
<td>3</td>
</tr>
<tr>
<td>Autauga-36008</td>
<td>All_Race</td>
<td>9</td>
<td>7</td>
<td>77.78%</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>White</td>
<td>8</td>
<td>6</td>
<td>75.00%</td>
<td>1</td>
</tr>
<tr>
<td>Autauga-36051</td>
<td>All_Race</td>
<td>155</td>
<td>74</td>
<td>47.74%</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>Black</td>
<td>20</td>
<td>5</td>
<td>25.00%</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>White</td>
<td>134</td>
<td>68</td>
<td>50.75%</td>
<td>10</td>
</tr>
<tr>
<td>Autauga-36066</td>
<td>All_Race</td>
<td>1464</td>
<td>826</td>
<td>56.42%</td>
<td>124</td>
</tr>
<tr>
<td></td>
<td>Black</td>
<td>67</td>
<td>29</td>
<td>43.28%</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>White</td>
<td>1377</td>
<td>788</td>
<td>57.23%</td>
<td>117</td>
</tr>
<tr>
<td>Autauga-36067</td>
<td>All_Race</td>
<td>1778</td>
<td>924</td>
<td>51.97%</td>
<td>123</td>
</tr>
<tr>
<td></td>
<td>Black</td>
<td>223</td>
<td>110</td>
<td>49.33%</td>
<td>11</td>
</tr>
<tr>
<td></td>
<td>White</td>
<td>1557</td>
<td>808</td>
<td>52.57%</td>
<td>112</td>
</tr>
<tr>
<td>Autauga-36068</td>
<td>All_Race</td>
<td>130</td>
<td>59</td>
<td>45.38%</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>Black</td>
<td>21</td>
<td>9</td>
<td>42.86%</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>White</td>
<td>107</td>
<td>48</td>
<td>44.86%</td>
<td>7</td>
</tr>
<tr>
<td>Autauga-36749</td>
<td>All_Race</td>
<td>104</td>
<td>45</td>
<td>43.27%</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Black</td>
<td>45</td>
<td>22</td>
<td>48.89%</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>White</td>
<td>59</td>
<td>23</td>
<td>38.98%</td>
<td>0</td>
</tr>
</tbody>
</table>
Example Provider Scorecard

Percent of Colorectal Cancer Screening - Any Test (FOBT, Sigmoidoscopy, Colonoscopy, Barium Enema)
Example Screening Rate Mapping
Thank You!

- Today’s speakers
- Wilder Research
- NCCRT Evidence-based Education & Outreach Task Group

This webinar series was made possible in part by funding from the Centers for Disease Control and Prevention Cooperative Agreement Number 5U38DP004969-02. The views expressed in the materials and by speakers and moderators do not necessarily reflect the official policies of the Dept. of Health and Human Services.
Join us for our next webinar on evaluating social media
Tuesday, August 11th at 2:30pm EST

For more information contact:
Mary Doroshenk, MA
Mary.doroshenk@cancer.org

To follow NCCRT on social media:
Twitter: @nccrtnews
Facebook: http://www.facebook.com/coloncancerroundtable