



## **NCCRT Webinar: Implementing FIT-based Programs - June 29th, 2016 Additional Questions & Answers**

Presenters: Durado Brooks, MD, MPH and Gloria D. Coronado, PhD

Webinar replay: <http://nccrt.org/webinars/>

### **1. What is the definition of average risk?**

[Dr. Brooks] Men and women are considered to be at average risk for colorectal cancer if they do not have a personal or family history of conditions that would place them at an increased or high risk for the disease. Reference the following webpage to learn more about what conditions are associated an increased or high risk for colorectal cancer:

<http://www.cancer.org/cancer/colonandrectumcancer/moreinformation/colonandrectumcancerearlydetection/colorectal-cancer-early-detection-acs-recommendations>

### **2. Can stool tests detect polyps?**

[Dr. Brooks] Yes. One time testing with high-quality FITs will detect approximately a quarter of advanced adenomas (the types of polyps that have the greatest potential for progression to cancer). Repeating the tests annually (as recommended by all guidelines) may allow for higher detection rates for these lesions. In one study, Cologuard – which combines a stool test for DNA mutations with an FIT – detected 43% of advanced adenomas.

### **3. Do all of the FIT tests mentioned require a physician's order?**

[Dr. Brooks] In most instances a physician order will be required in order to bill for the service. Some states may allow delegation of FIT to other office staff. Check the medical practice act in your state to determine if this is acceptable in your state.

### **4. For an FQHC, which FIT test brand would you recommend as both most cost effective and provide the best result?**

[Dr. Coronado] The 2016 US Preventive Services Task Force recommendations for colorectal cancer screening include a statement that two FIT tests had the strongest evidence to support their use: OC FIT-Chek and OC-Light; both are Polymedco products (<http://jama.jamanetwork.com/article.aspx?articleid=2529486>). Consistent with this recommendation, we have observed OC FIT-Chek to perform similarly in integrated care settings and in community practice settings. The take home message from my presentation is to choose your test well, and monitor the performance of your test over time (by assessing % positivity and issues with patient completion). A high positivity rate likely means that the test is

producing a high number of false positive test results. In turn, more patients are unnecessarily referred to colonoscopy, and can experience colonoscopy-associated harms.

**5. How would a patient with no insurance be able to get a FIT test?**

[Dr. Brooks] Patients that do not have insurance may be able to access free or reduced cost screenings at Federally qualified health centers (FQHCs). Patients that do not have insurance can also inquire about self-pay options at other health care providers. The cost of FITs in most settings is less than \$25 (and substantially less in some environments).

**6. So is there a higher market for mailing out kits versus having the doctors give patient education and then handing them out and having them explained to them?**

[Dr. Coronado] Receiving a doctor's recommendation has been shown in several studies to be an important motivator for patients to undergo cancer screenings. In fact, a study based on research conducted at Kaiser Permanente showed that the highest return rate on FIT kits was among patients who were mailed a test and had a clinic visit in the same year ([www.ncbi.nlm.nih.gov/pubmed/23725359](http://www.ncbi.nlm.nih.gov/pubmed/23725359)). The important message is to remind patients as much as possible – clearly, the clinic visit is a critical opportunity to hand out the test and/or deliver a reminder to a patient who has received one by mail.

**7. We are a non-profit organization, formed out of a local church. Are there studies or advice you have on how we can work with local clinics to increase screenings among African Americans?**

[Dr. Coronado] Good question and I applaud your interest in raising rates of colon cancer screening among African Americans. I have collaborated with a local community organization (Familias en Accion <http://www.familiasenaccion.org/>) to offer FIT testing to uninsured Latinos in the Portland-Metro region. In our program, Kaiser Permanente provided 500 free tests and processing of the test to individuals enrolled in the program. Familias en Accion staff attended health fairs and community events to promote colorectal cancer screening and offer free testing. A computerized tracking system was used to enroll patients and track screening events. Familias en Accion staff handed out nearly all the tests, and about two-thirds were completed and mailed to Kaiser Permanente for processing! The program was a huge success, and showed that in terms of colorectal cancer screening, a community health worker's prompting can be highly effective!

[Dr. Brooks] African Americans have the highest colorectal cancer incidences and mortality rates of all the racial groups in the U.S. Because of this, African Americans are a target audience in the 80% by 2018 effort. In 2014, NCCRT conducted market research to understand how to motivate the unscreened to action. Pages 26-27 of the *80% by 2018 Communications Guidebook* includes findings from this research, and provides recommendations for specific messages and channels to reach African Americans: <http://nccrt.org/wp-content/uploads/CRC-Communications-Guidebook-2016-FINAL-7mb.pdf>

**8. What is the website for Dr. Coronado?**

[Dr. Coronado] Our website is [www.kpchr.org/stopcrc](http://www.kpchr.org/stopcrc).

**9. Has the study described by Dr. Coronado been considered for other areas of the US, i.e. expanded to other geographic areas?**

[Dr. Coronado] We are in the process of providing technical assistance to expand the program to additional clinics in Oregon and Washington. We are also collaborating on a Centers for Disease Control-funded effort to partner with Medicaid Health Plans to deliver direct-mail FIT kits. In this program, the Medicaid Health Plans will pay a mail warehouse to assemble and mail the FIT tests to patients due for screening. In addition, we are designing an implementation guide that provides the tools and resources so that clinic and health plans across the country can implement the program. This guide will be available to the public on the STOP CRC website: [www.kpchr.org/stopcrc](http://www.kpchr.org/stopcrc)

**10. Will STOP CRC have any data on other populations return rate of kits, (other languages spoken)?**

[Dr. Coronado] Yes, we will. We are in the process of compiling our results and will be able to report on this in 4-6 months.

**11. Are the wordless instructions specific to a certain take home test?**

[Dr. Coronado] The wordless instructions that I showed are for the OC FIT-Chek test; however, we have partnered with our clinics to develop wordless instructions for additional tests, including Insure and Consult Diagnostics. You can view these on our website [www.kpchr.org/stopcrc](http://www.kpchr.org/stopcrc) under the Materials link. These instructions are available for public use.

**12. How did patients get their insurance info to the lab that were mailed in for billing?**

[Dr. Coronado] All of our participating clinics that partnered with an outside lab had a direct electronic interface. Clinics generally followed one of two processes: 1) Kits were mailed directly to the lab; and 2) Kits were mailed to the clinic (then sent to the lab). For FIT kits mailed directly to the lab, clinic staff printed a requisition and mailed it with the kit. The requisition contained insurance information. For kits returned to the clinic, a requisition was printed once the kit was returned, and the kit and requisition were mailed to the lab. Our EMR tools identified patients who had had a clinic visit in the past year (in some cases, the clinic shortened this look back period). This relatively short look-back period allowed us to be fairly confident that we had up-to-date insurance status information for patients on our lists.

**13. Do you have any information on the QuickVue iFOB test as far as accuracy? Do you know if this is on the extended list of FITs with published data?**

[Dr. Brooks] The list provided on the webinar slide is the most complete list at present. We are working to determine whether other tests should be included. We have found limited information on QuickVue performance, but have not completed our literature review.

**14. For patients who have difficulty collecting a sample, would it be adequate to collect a stool sample from the toilet paper after they wipe?**

[Dr. Brooks] This would be similar to a sample collected by digital rectal exam, and is not consistent with manufacturers recommended collection methods for any brand of FOBT/FIT.

**15. For a positive FIT that we find out after the fact that "Coumadin level off and had some gum bleeding or dental/oral trauma, etc." is it reasonable to wait a period of time and re-perform FIT test before moving forward to colonoscopy?**

[Dr. Brooks] No. FITs are specific for bleeding from the lower GI tract, so dental/oral bleeding should not cause a positive FIT. In addition, because cancers and polyps often bleed only intermittently it is possible that a repeat FIT could be negative for blood in spite of the presence of a neoplasm. Every positive FIT is cancer until proven otherwise, and therefore requires follow up with colonoscopy.

**16. Can you speak more about the slide that showed the patient preference? Specifically, where the providers followed up with and shared the information? If so what were the responses? Did there seem to be reception/behavior/performance change?**

[Dr. Brooks] Patients in each study arm received counseling from their primary care provider on either FOBT only, colonoscopy only, or were given a choice of each test. No additional reminders to promote screening were provided. There was no information provided in the manuscript regarding feedback to the involved clinicians or their subsequent screening behavior. The full text of the article can be found here:

<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3360917/>

**17. Like the IBCCP, do you envision a similar program for colorectal in the future?**

[Dr. Brooks] The Centers for Disease Control and Prevention's (CDC's) Colorectal Cancer Control Program (CRCCP) is similar to CDC's National Breast and Cervical Cancer Early Detection Program (NBCCEDP). The program currently funds 31 grantees, six of which receive additional funds to provide direct screening services. More information about the program can be found here: <https://www.cdc.gov/cancer/crccp/index.htm>