Reigniting CRC Screening as Communities Face and Respond to the COVID-19 Pandemic

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2:00 PM ET

@NCCRTnews
Purpose of Today’s Webinar

• Provide an overview of the NCCRT’s new playbook on colorectal cancer screening during the COVID-19 pandemic

• Discuss the immediate and longer term implications from the pandemic

• Begin unpacking how to activate around the playbook and find areas of opportunity

• Q&A
Presenters

- **Rachel Issaka, MD, MAS** — Assistant Professor, Fred Hutchinson Cancer Research Center & the University of Washington

- **Steven Itzkowitz, MD, FACP, FACG, AGAF** — Professor of Medicine and Oncological Sciences Director, Gastroenterology Fellowship Program Icahn School of Medicine at Mount Sinai; NCCRT Steering Committee Member
  - Financial Disclosure: Dr. Itzkowitz receives consulting fees and research support from Exact Sciences and research support from Colon Cancer Alliance.

- **Michael Sapienza** — CEO, Colorectal Cancer Alliance

- **Ma Somsouk, MD, MAS, AGAF** — Professor of Medicine, Division of Gastroenterology, UCSF Center for Vulnerable Populations, SF Cancer Initiative

- **Richard Wender, MD** — Chair, National Colorectal Cancer Roundtable; Department of Family and Community Medicine, Sidney Kimmel Medical College, Thomas Jefferson University
Virtual Housekeeping

• The event is being recorded. The replay and slides will be made available on www.nccrt.org within a few days.

• All participants are muted.

• Submit questions through the Q&A box at any time. Use the chat box for general comments and technical questions only.

• Please complete our evaluation.

• Slides will be sent out in a follow-up email.
Level-Setting ...

Since March 2020
Remembering our March 2020 Goals and Successes

• **March 5, 2020** – Hosted our 5th annual March Colorectal Cancer Awareness signature broadcast

• National, State, and Local events planned for all of March

• March 2020 was truly shaping up to be one of our most momentous and united colorectal cancer awareness months ever
The Nation Responds to COVID-19

- **March 13, 2020** – U.S. national emergency was declared due to COVID-19.
- **March 14** - Surgeon General advised hospitals to postpone all elective surgeries
- **March 15** – joint GI societies recommendation to all GI endoscopy and clinical practices “Strongly consider rescheduling elective non-urgent endoscopic procedures”
- **Mid-March** – American Cancer Society recommends “No one should go to a healthcare facility for routine cancer screening until further notification”
- These recommendations applied to people at average risk of cancer who do not have any signs or symptoms of cancer.
Early Implications and Modeling
The COVID-19 pandemic has led to unprecedented drops in breast, colorectal, and cervical cancer screenings.

- Decreases of 83 - 90% compared to three-year averages.
- The resulting backlog of cancer screenings will pose significant challenges for health systems as they adopt new processes and protocols necessary to safely restart screening.

Diagnostics used to screen and monitor cancer have dropped dramatically due to postponement of non-essential visits.

Exhibit 14: Reduction in Diagnostic Testing Procedures, Week Ending April 10 Compared to February 2020

Source: IQVIA Real World Claims, April 17, 2020

ESTIMATES OF DELAYED/MISSED CANCER DIAGNOSES

Over 22 million screening tests for five common tumors may be disrupted, risking delayed or missed diagnoses for 80,000 patients

Exhibit 15: Modeled Impact of Reduced Screening Tests Three Months Ending June 5, 2020

- **Breast**: 42 Mn annually, -69% fewer due to COVID, 36,000 delayed cancer diagnoses due to COVID
- **Cervical**: 79 Mn annually, -67% fewer due to COVID, 2,500 patients
- **Colorectal**: 9.5 Mn annually, -72% fewer due to COVID, 18,800 patients
- **Lung**: 700K annually, -30% fewer due to COVID, 450 patients
- **Prostate**: 4.3 Mn annually, -48% fewer due to COVID, 22,500 patients

Over 22 million screening tests and over 80,000 positive cancer diagnosis potentially delayed

18,800 delayed CRC diagnoses
Modeling the effect of COVID-19 on Cancer Screening and Treatment

Modeled cumulative excess deaths from colorectal and breast cancers, 2020 to 2030*

https://science.sciencemag.org/content/368/6497/1290
Long-term Barriers & Challenges to Screening
Challenges – New, old, and growing

1. The exacerbation of screening inequities.
2. Staggering loss of employment and health insurance nationwide.
3. Complexities of moving to telemedicine and other changes to health system processes.
4. Patient fear, reluctance, and a sense of being overwhelmed with public health messaging.
5. Varied local policies and ordinances due to fluctuating COVID-19 hotspots.
NCCRT Community Reacts

- Co-hosted **expert panel on stool testing amidst the pandemic**
  - May 5 w/ Colorectal Cancer Alliance

- Published **CRC screening and COVID-19 Playbook**
  - June 30

- Webinar with Playbook lead authors
  - July 23
As rates of infection and life-threatening illness have been averted or significantly diminished, various areas around the country have eased restrictions on “elective” medical care.

- Most “return to screening” recommendations target facilities and specialty care audiences
- NCCRT developed guidance for primary care providers and public health

Recovery through Alignment
Despite the challenges we face during the pandemic, colorectal cancer remains a public health priority, and we must provide the public with safe opportunities to detect colorectal polyps and prevent cancer.

Issue Summary
- Screening disparities are already evident and likely to increase as a result of the COVID-19 pandemic
- Fewer primary care and gastroenterology visits and limits to endoscopy capacity are likely to persist
- Due to the availability of multiple screening test options, CRC screening presents a unique opportunity
- A multi-pronged approach can help regain momentum in reducing the public health impact from colorectal cancer
Deep Dive Topic: The impact of COVID-19 on colorectal cancer disparities

• COVID-19 related pauses in medical care, as well as shifts in resource allocation and workforce deployment, threaten decades worth of work to improve CRC disparities in medically underserved populations

• FQHCs and community health centers are even more resource constrained

• Areas of impact for the underserved:
  • Screening participation
  • Follow-up of abnormal stool-based tests
  • Community-based research
  • Community engagement
  • Advocacy

Learn More: https://www.giejournal.org/article/S0016-5107(20)34468-0/pdf
Activating the CRC Fighting Community

• Confidently reassure patients about the safety and importance of colorectal cancer screening
• Encourage use of non-invasive screening modalities as appropriate
• Increase use of mailed FIT outreach programs
• Identify GI, primary care, and community partnerships
• Extend CRC awareness events year-round
• Seek timely and innovative opportunities to serve medically underserved populations
Aligning Statement 2
Lead Author: Ma Somsouk, MD, MAS, AGAF

Colonoscopy remains safe, is a good option for screening, and is quickly reopening around the country, but identifying patients who should receive higher priority for colonoscopic screening is a critical step.

Issue Summary

- Prioritization of the patient population is and will continue to be essential
- Endoscopy units must be committed to a plan to address and allay patient fears
- Clinical and non-clinical CRC screening stakeholders need to communicate within their communities about any hindrances or access limitations in health systems
- Local policies may not only vary, but change depending on community needs and COVID case fluctuations

Learn More: The United States Multi-Society Task Force recommends measures to reduce the risk of transmitting COVID-19 infection during endoscopic procedures
Deep Dive: Prioritization of patient population

• For those at the highest risk, access to colonoscopy should be prioritized.

• Higher priority for access to screening colonoscopy:
  • Those with abnormal stool-based cancer screens;
  • Patients with a family history of adenomas or cancer;
  • Patients with inflammatory bowel disease; and,
  • Patients with a genetic syndrome that elevates risk for colorectal cancer.

• Patients at average risk for colorectal cancer or those due for surveillance colonoscopy should be assigned lower priority, other screening options can be promoted.

More on Resuming Elective Procedures

CMS
American Gastroenterological Association
American College of Gastroenterology

American Society of Gastrointestinal Endoscopy
American College of Radiology
Joint Statement: American College of Surgeons, et al
Activating the CRC Fighting Community

• Confidently reassure patients about the safety of visiting a health facility to receive health care of any kind, and the safety of colonoscopy during the COVID era.

• Strengthen community partnerships between primary care and GI

• Primary care providers will need to be aware of the level of burden (if any) experienced by local endoscopy facilities

• Community organizations and coalitions will need to understand the communication priorities from local health systems and facilities to better disseminate messages that promote colorectal cancer screening options
Aligning Statement 3

Lead Author: Steven Itzkowitz, MD, FACP, FACG, AGAF

During a time when availability of elective screening colonoscopy may be limited by the COVID-19 pandemic, colorectal cancer screening can be safely offered through at-home stool-based tests.

Issue Summary

- There are several safe, effective, and guideline-endorsed tests to screen for colorectal cancer
- Stool-based tests are convenient for patients, especially in areas of high COVID prevalence.
- The vast majority of insurances cover these tests.
- The tests can reach those living in rural or hard-to-reach locations (mailed programs)
- A positive (abnormal) test must be referred promptly for colonoscopy because a delay of six months or longer after an abnormal FIT result is associated with higher rates of advanced adenomas and late-stage colorectal cancer.
Stool-Based CRC Screening Tests

Fecal Immunochemical Test (FIT; ELISA)

Multi-Target Stool DNA (FIT-DNA) (Hgb; 10 DNA markers)

Fecal Occult Blood Test (FOBT; Guaiac)

Learn More: The NCCRT’s Clinicians Reference provides guidance on high-quality stool testing.
Deep Dive Topic: Stool-Based Programs

- Must be considered a “program”, not simply a test.
- Systems should be in place for: ordering and distributing the test; making sure it gets done; obtaining results; acting on both positive and negative results.
- Both FIT and mt-sDNA tests must be ordered by a clinician, most commonly the patient’s primary care clinicians, although the tests can be ordered through urgent care centers, retail clinics, or independent telehealth providers.

A positive stool-based test:
- Prompt referral to colonoscopy (e.g. delay >6 months after positive FIT = worse outcomes)
- Requires close communication between primary care and GI practices.
- A positive test without colonoscopy is an “incomplete” screening round.

A negative stool-based test must be repeated:
- FIT, or hsFOBT -- Q1Y
- Multi-target sDNA -- Q3Y
FIT:
Many Steps for Programmatic Adherence

Slide courtesy of David Lieberman, MD.

More on mail-based outreach >>>
Activating the CRC Fighting Community

1. Discuss with your patients (within your community) that stool-based tests are important and effective options for CRC screening.

2. Stool tests are safe, even in areas of high COVID prevalence.

3. Understand how FOBT, FIT, and multi-target stool DNA testing are being conducted in your environment.

4. Develop tracking and reminder systems.

5. Establish and maintain close communication between primary care and colonoscopy practices.
Gaining momentum and reigniting screening activities and public messaging will be highly dependent upon local regulatory requirements, public health priorities, and policy change.

**Issue Summary**

- Enhanced patient protections, while necessary, will create added barriers for already apprehensive unscreened patient populations (causing further delay).

- Some practice changes implemented in response to the pandemic will likely remain a permanent element of our healthcare environment *(e.g. telehealth visits)*.

- Finding ways to provide continued access to care for the millions of individuals who have lost their jobs and the associated health care is an important area of focus.

- An essential policy opportunity to aid our recovery efforts is the elimination of financial barriers to the completion of screening.
Deep Dive Topic: Public Messaging

- A first requirement in reigniting screening activities across the U.S. is realizing that simply re-opening facilities and offering screening will not be enough.

- Some of the new safety measures may exacerbate patient fears and create the impression that these environments are “crawling with COVID-19.”

- Providers and facilities will need to find compelling messages to remind patients that these measures are designed to protect everyone and are not in place because of any identified risk in the facility.

- Learn More: NCCRT Guide on messaging the unscreened >>>
Screening During COVID–19 Next Steps

1. A comprehensive national **public awareness campaign** through multimedia channels urging people to get screened; directed at both general public and primary care.

2. Action-oriented **personalized navigation website** to provide information on screenings, including location, type of screening, availability, and full navigation for positive stool-based tests based on recommendations from white paper and previous forums.
Activating the CRC Fighting Community

• Confidently reassure patients about the safety and importance of colorectal cancer screening

• Extend CRC awareness events to year-round

• Implementation of screening via telehealth requires new approaches, best practices, and lessons learned (e.g. arranging and tracking screening consultations and referrals and for disseminating stool tests for screening)

• Due to the consequences of the pandemic, including a potentially greater adoption of stool-based testing as well as a growing number of newly unemployed and uninsured individuals, it is imperative to address unfair payment policy in CRC screening.

• Shift advocacy events and policy campaigns to virtual platforms whenever possible

• Use social media platforms, calls, and letters to connect with policy makers
Please submit your questions in the Q&A box.
Thank You!

To follow NCCRT on social media:
Twitter: @NCCRTnews  #80inEveryCommunity
Facebook: www.facebook.com/coloncancerroundtable

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