2021 NCCRT Annual Meeting – November 15-17

NATIONAL Colorectal Cancer ROUNDTABLE

80% IN EVERY COMMUNITY

Thank you for joining!
The session will begin shortly.

Ensuring Follow up to Abnormal Stool Tests: Overview of the Problem, the Policy Landscape, and the Best Practices From the Field

Tuesday, November 16, 1:50 PM

Ensuring Follow-Up to Abnormal Stool Tests

Francis Colangelo
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Molly McDonnell
Fight Colorectal Cancer

Michelle Tropper
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Zufall Health

Ensuring Follow Up to Abnormal Stool Tests:

Overview of the Problem and Clinical Implications

Fola P. May MD PhD MPhil

Vatche & Tamar Manoukian Division of Digestive Diseases at UCLA

UCLA Jonsson Comprehensive Cancer Center

Veterans Health Administration

UCLA Health

@drfolamay

CRC Screening Modalities

Stool-based strategies

High-sensitivity FOBT

Fecal Immunochemical Test (FIT)

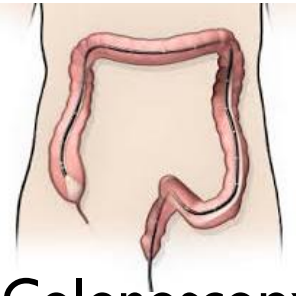
Stool DNA-FIT

Serology

Direct-visualization techniques

CT Colonography

Flexible Sigmoidoscopy



Colonoscopy

Capsule

Urine

Stool-Based CRC Screening Modalities

High-sensitivity FOBT

Annual

Sensitivity, CRC: 68%;
Sensitivity, adenoma≥1cm: 11%;
Specificity: 97%

Fecal Immunochemical Test (FIT)

Annual

Sensitivity, CRC: 74%;
Sensitivity, adenoma≥1cm: 22%;
Specificity: 97%

Stool DNA-FIT

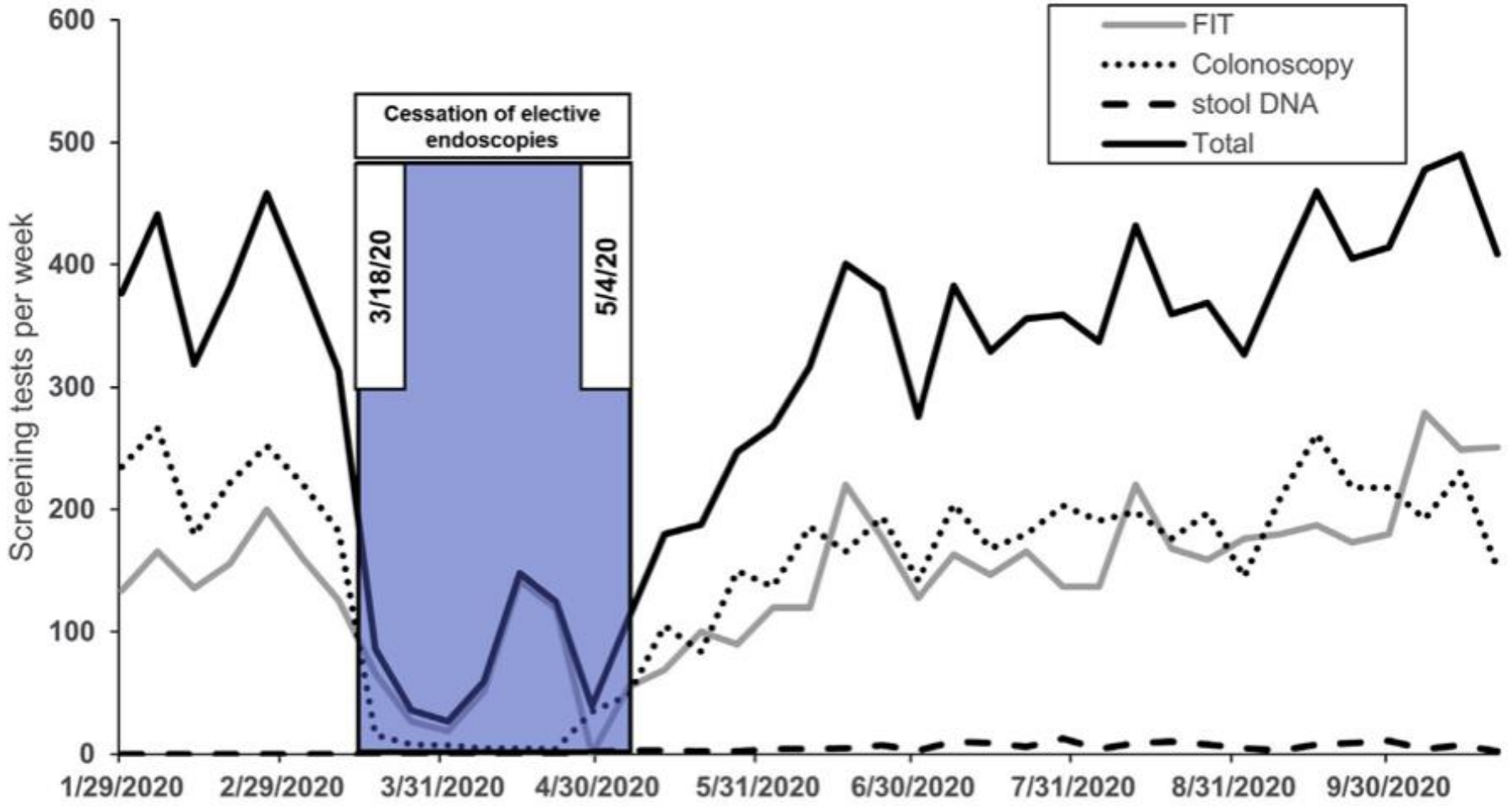
Every 1-3 years

Sensitivity, CRC: 94%;
Sensitivity, adenoma≥1cm: 42%;
Specificity: 91%

Health systems with > 80% CRC screening rates embrace at least one stool-based screening modality.

Knudsen AB et al. JAMA. 2021.
Lin JS et sl. Evidence Synthesis No. 202. AHRQ Publication No. 20-05271-EF-1; 2021.

Trends During COVID-19 Pandemic

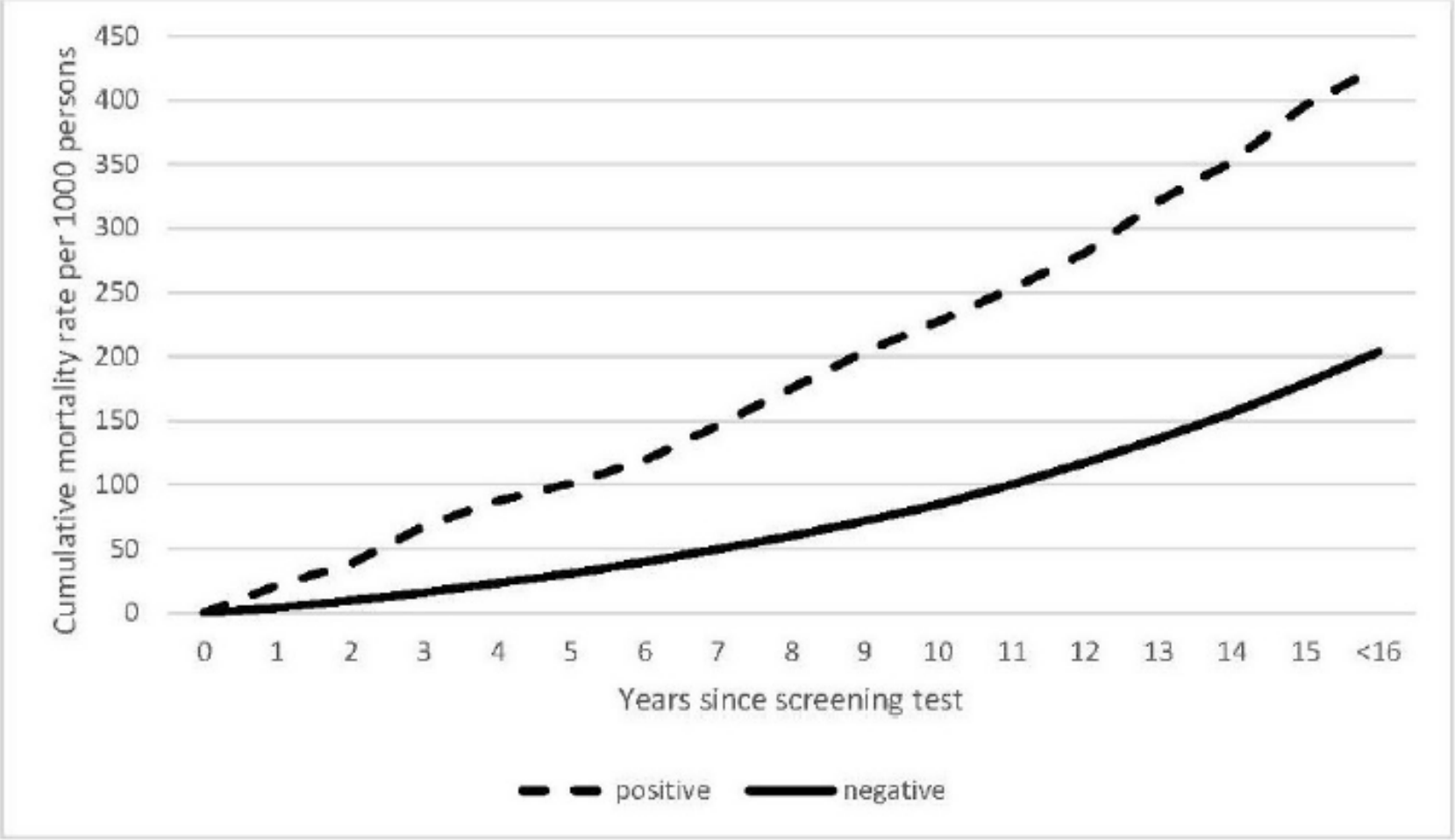


Myint et al. Gastro. 2021.

All Non-colonoscopic Screening is a Two-step Process

Abnormal (e.g., positive) screening result → **Diagnostic colonoscopy to detect polyps and CRC**

Increased Risk of Death with Abnormal Stool Test Results



United Kingdom
All FOBTs; 2000-2016
N=134,192

If abnormal result:

CRC mortality:
HR: 7.79
(95%CI=6.13-9.89)

Non-CRC mortality:
HR: 1.58
(95%CI=1.45-1.73)

Libby et al. Gut. 2018.

CRC Incidence Increases 10-12 Months After Abnormal FIT

Table 3. Time to Colonoscopy Among Patients Receiving a Positive FIT Result

Time to Colonoscopy[a]	Any Colorectal Cancer		
	No. of Cases/ Total No.	Rate per 1000 Patients (95% CI)	Adjusted OR (95% CI)[c]
Comparison Group, 1-30 d			
1-30 d	871/28 567	30 (28-32)	1 [Reference]
2 mo	685/24 644	28 (26-30)	0.90 (0.81-0.99)
3 mo	265/8666	31 (27-34)	0.93 (0.80-1.07)
4-6 mo	165/5251	31 (27-36)	0.95 (0.80-1.13)
7-9 mo	58/1335	43 (32-54)	1.27 (0.96-1.67)
10-12 mo	37/748	49 (34-65)	1.44 (1.02-2.02)
>12 mo	174/2304	76 (65-86)	2.19 (1.84-2.60)

Kaiser Permanente Northern and Southern California
2010-2014

N= 70,124 patients with abnormal FIT

Compared to abnormal-FIT individuals who underwent colonoscopy at 1-30 days, individuals who waited 10 to 12 months were more likely to have CRC at time of diagnostic colonoscopy.
(OR 1.44, 95%CI: 1.02 – 2.02)

@drfolamay

Corley et al. JAMA. 2017.

Recent Systematic Review Supports Colonoscopy within 9 months

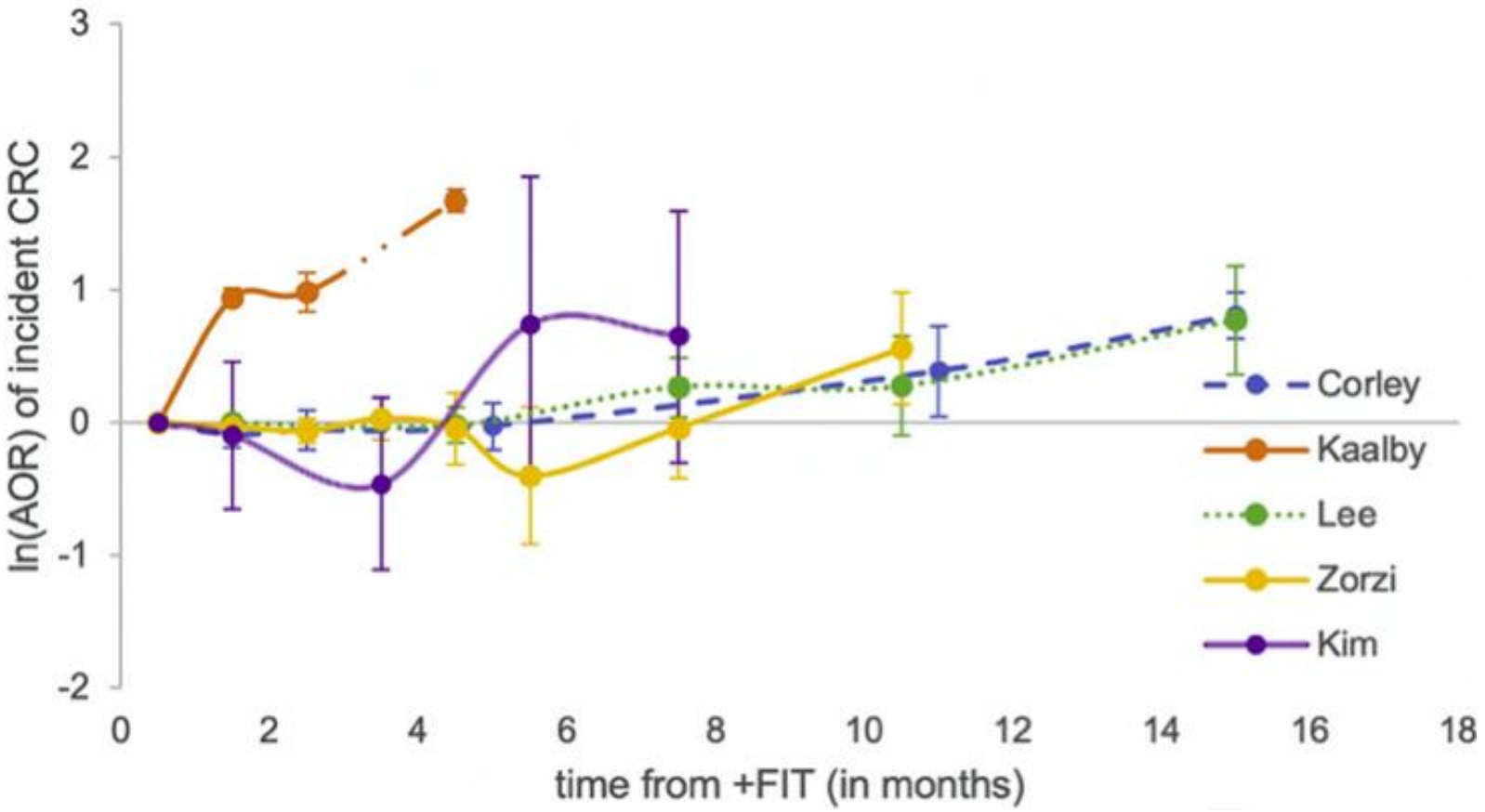
Systematic Review

Relationship between time to colonoscopy after abnormal fecal screening and CRC-related outcomes.

N=8 studies

FIT: 5 studies

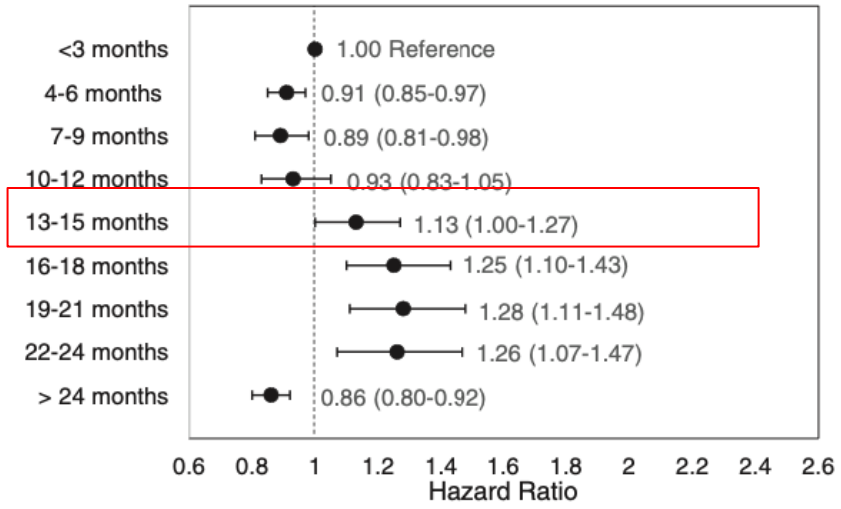
FOBT: 3 studies



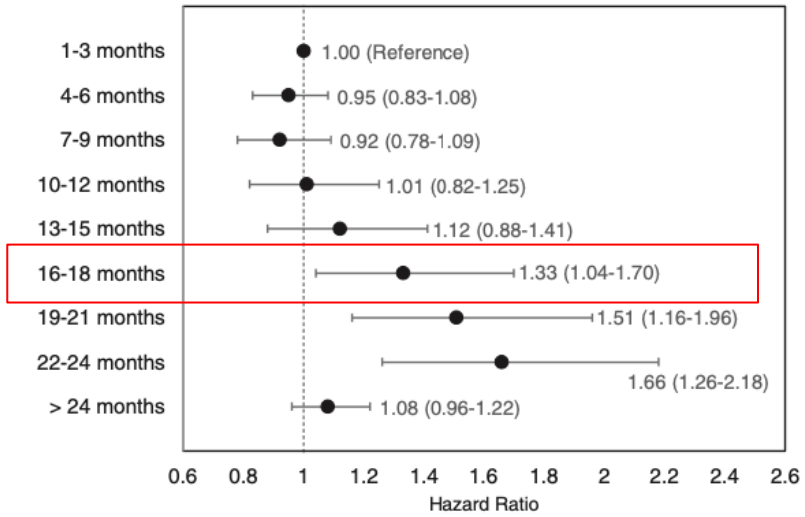
Forbes et al. CGH. 2020.

Time to Colonoscopy Associated with Incident CRC, Late-stage CRC, Fatal CRC

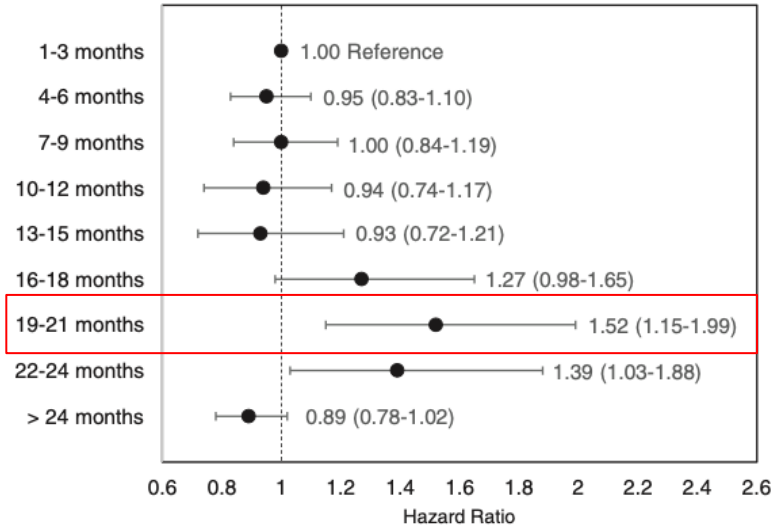
Incident CRC



Late-Stage CRC



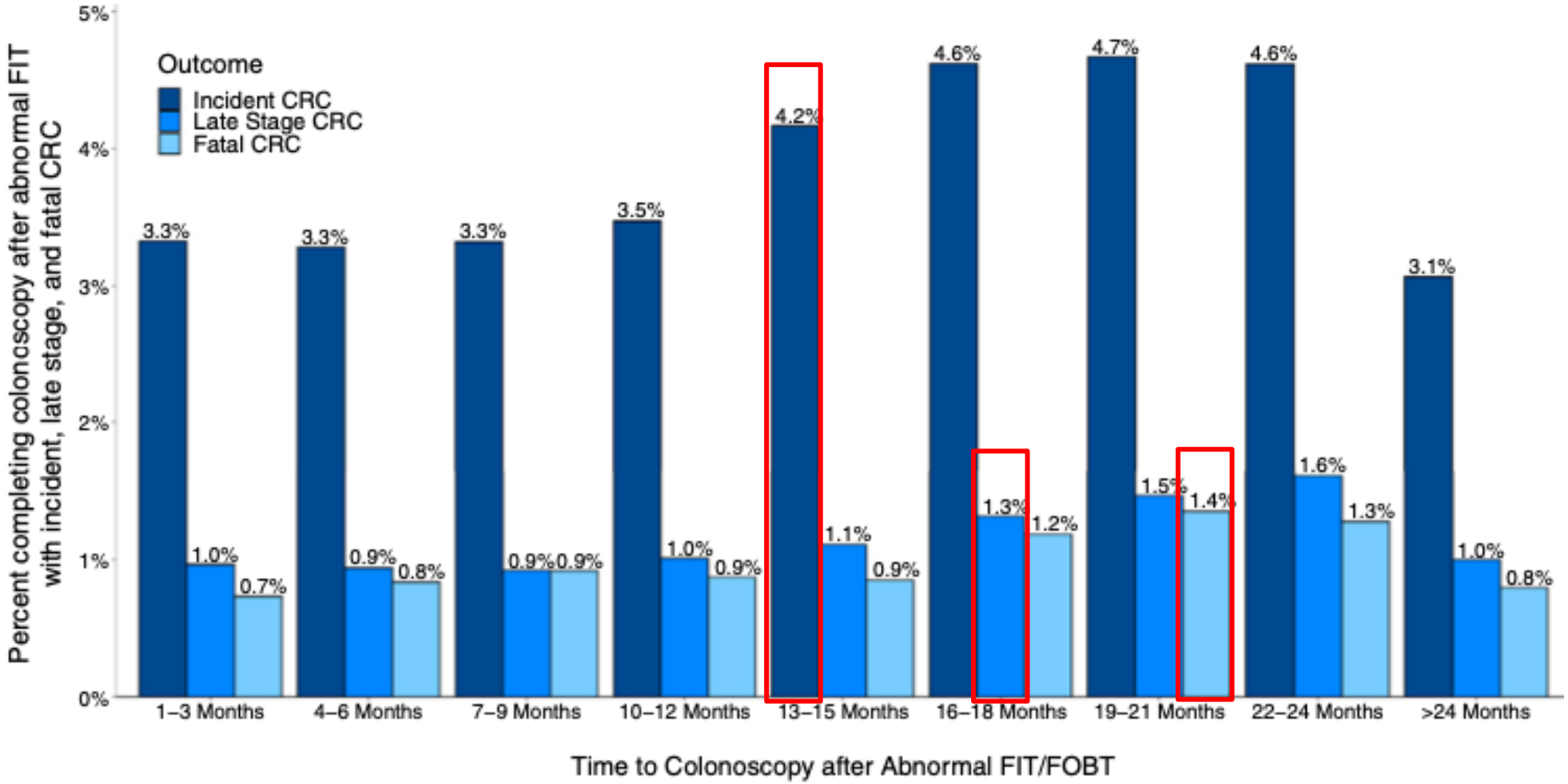
Fatal CRC



VA Cohort
Abnormal FIT/FOBT 1999-2010

San Miguel et al. Gastro. 2020.

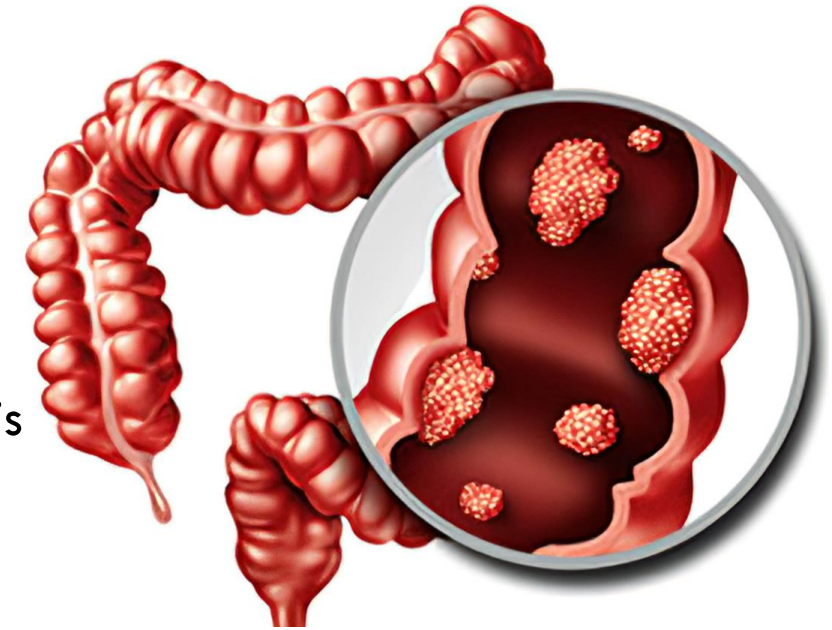
Colonoscopy Should be Performed Well Within One Year of Abnormal FIT/FOBT



San Miguel et al. Gastro. 2020.

Summary

- Non-colonoscopic CRC screening is beneficial but requires follow-up when results are abnormal ("two-step process").
- Time to follow-up is also a priority; colonoscopy should occur as early as possible but well within 1 year of an abnormal stool-based screening result.
- Lack of timely follow-up after abnormal stool-based screening is associated with poor clinical outcomes:
  - Increased CRC incidence,
  - Advanced CRC stage at presentation,
  - Increased CRC-related mortality, and
  - Increased overall mortality



Thank You!

UCLA Jonsson Comprehensive Cancer Center

UCLA FIELDING SCHOOL OF PUBLIC HEALTH

UCLA Health

VA U.S. Department of Veterans Affairs

drfolamay

hhttps://www.uclahealth.org/gastro/may-lab




FIGHT™
COLORECTAL CANCER

Molly McDonnell
Director of Advocacy
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FIGHT COLORECTAL CANCER

Catalyst State-by-State Advocacy Program

Fight CRC's Catalyst Program aims to accelerate progress toward turning aspirational colorectal cancer screening goals into reality by increasing access and reducing barriers to colorectal cancer screening. Specifically,

- Ensure coverage for insured populations to include 45-49-year olds, as is now recommended through American Cancer Society & USPSTF draft guidelines.
- Remove patient cost-sharing for follow-up colonoscopies following a positive non-invasive CRC screening test for insured populations.

FUNDING

Fight CRC provides grant funding of up to $50,000 to state coalitions and provides a facilitator to carry out a robust action planning process

ASSISTANCE

Fight CRC provides funding and technical assistance to support grassroots activities and coalition-building at the state level

MODEL FOR CHANGE

Grantees will serve as a model and offer lessons learned for other communities looking to organize coalitions to advance policies and advocate around the issue of CRC screening.

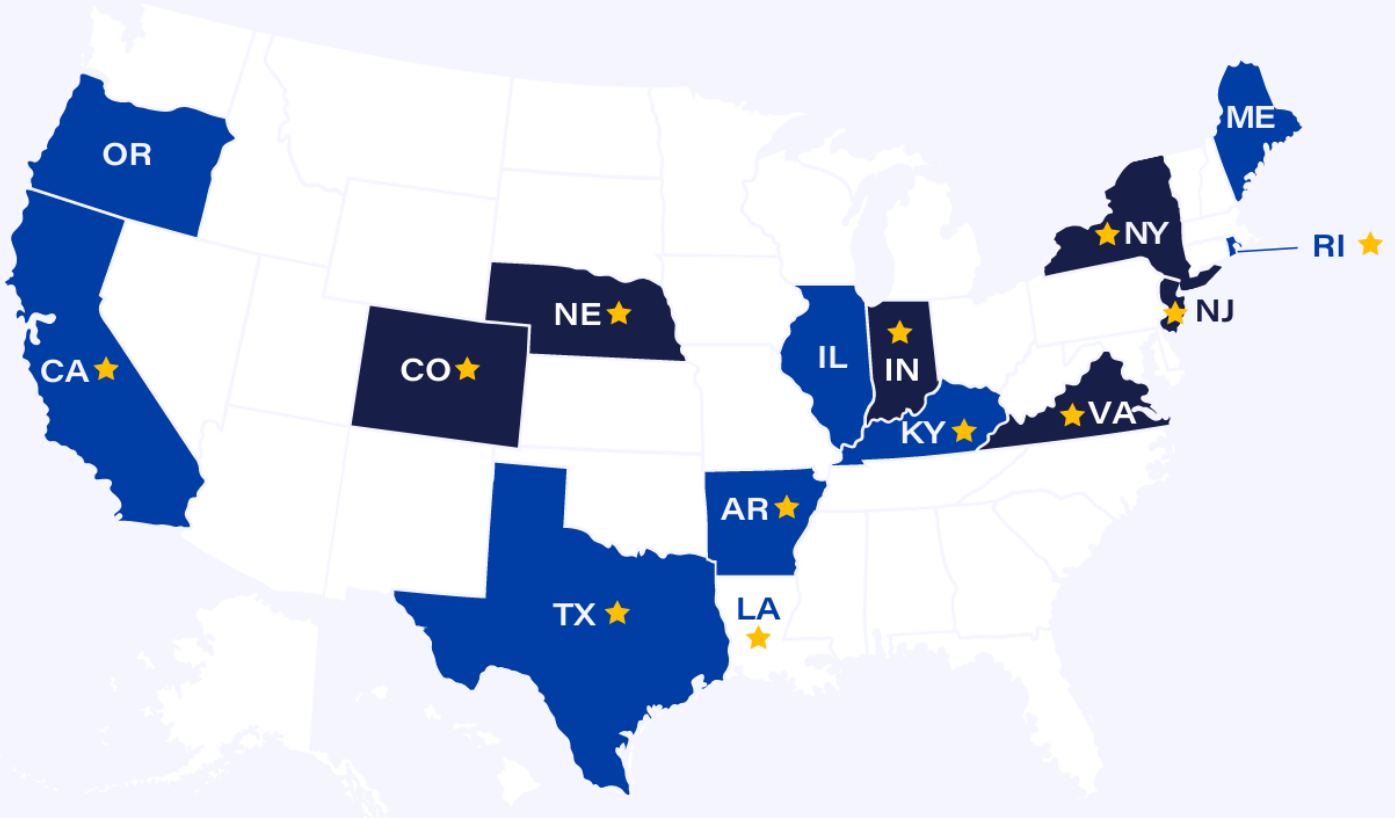
STATES

Our grantees include **Arkansas**, **California**, **Colorado, Kentucky, Louisiana, Nebraska, Rhode Island, and Texas**.

CATALYST PROGRAM YEAR IN REVIEW

FIGHT COLORECTAL CANCER

State Policy Landscape



Legislation passed

Legislation pending

Catalyst Grantee State

FIGHTCRC.ORG

Catalyst Resources:
Arkansas Center for Health Innovation

[1-8] Visit https://achi.net/library/colorectal-cancer-disease-in-arkansas/ for these references. | *1999 and 2000 data are suppressed. | **U.S. Preventive Services Task Force. | ***Arkansans ages 50 to 75 enrolled in commericial, traditional Medicaid or Arkansas Works, or Medicare coverage.

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Developed in partnership with and funding by: FIGHT COLORECTAL CANCER

FIGHT COLORECTAL CANCER

Federal Efforts on Follow-Up Colonoscopy

- **CMS Engagement**
- **Medicare Physician Fee Schedule Comment Letter**
- **Letter to Tri-Agencies**
- **Meeting with Tri-Agencies**

aga American Gastroenterological Association

Cancer Action Network℠ American Cancer Society®

FIGHT™ COLORECTAL CANCER

Healthefficient

Greater insight. Better care.

Abnormal Stool Tests: NCCRT Best Practices Brief

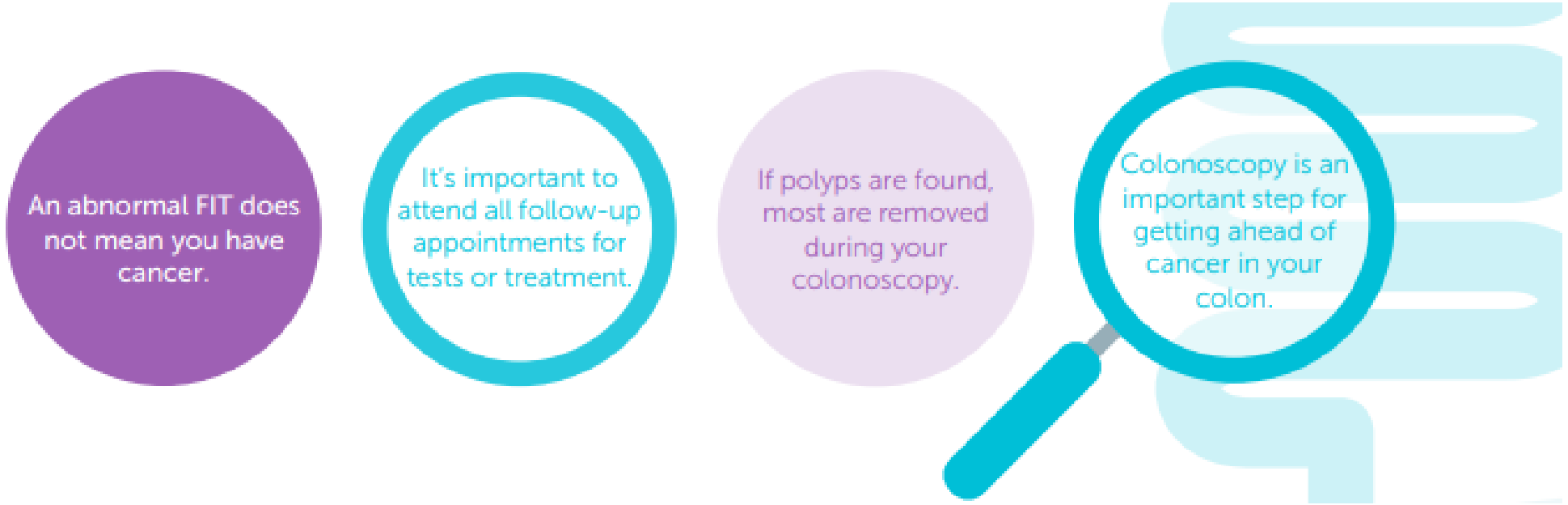
Michelle Tropper, MPH

November 16, 2021

Importance of Follow-up of Abnormal Results

- Stool tests only save lives if they are followed up appropriately when abnormal.
- Colonoscopy within 1 year of an abnormal result rarely exceeds 50%.
- Practices need to develop workflows and implement steps to close the loop on the screening process and verify that the test was completed as ordered.

Clearly Communicate Results and Next Steps to Patients



Source: http://www.bccancer.bc.ca/screening/Documents/Abnormal-FIT-Brochure.pdf

The USPSTF clearly states in its colorectal cancer screening guidelines that *"Follow-up of positive screening test results requires colonoscopy regardless of the screening test used."*

Best Practices for Follow-up of Abnormal Results

Use registries to track patients with abnormal FIT results

Standardized and scripted approach to follow-up

- ✓ Delivering results to patients
- ✓ Scheduling Follow-up tests within one month of receiving abnormal test results

Utilize patient navigators

Identify a clinical champion

Ensure quality screening for a stool-based screening program

- ✓ Stool samples collected at home
- ✓ Verify date of collection with patient

- ✓ Use trained, experienced personnel to develop and report test kits
- ✓ Send test kits to a central laboratory for processing, when possible
- ✓ Monitor test positivity rates

Best Practices for Follow-up of Abnormal Results (continued)

Mailed FIT test outreach

- ✓ Track return rates and follow-up
- ✓ Use closed loop system to track lab orders and diagnostic imaging/referrals ordered

Coordinate follow-up after colonoscopy

Delaying colonoscopy after an abnormal stool test can have major consequences, including increased risk for cancer diagnosis, late-stage cancer at diagnosis, and death from colorectal cancer. – Dr. Samir Gupta, VA San Diego Healthcare System

Establish a medical neighborhood

- ✓ Understand insurance complexities
- ✓ Use consistent language to describe the entire screening process; use “follow-up colonoscopy”, rather than “diagnostic colonoscopy”

Q&A

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Healthefficient

Greater insight. Better care.

ZUFALL HEALTH

Colon Cancer Screening Program

Rina Ramirez, MD, CMO and
Kathleen Felezzola, BSN,
Director of Nursing

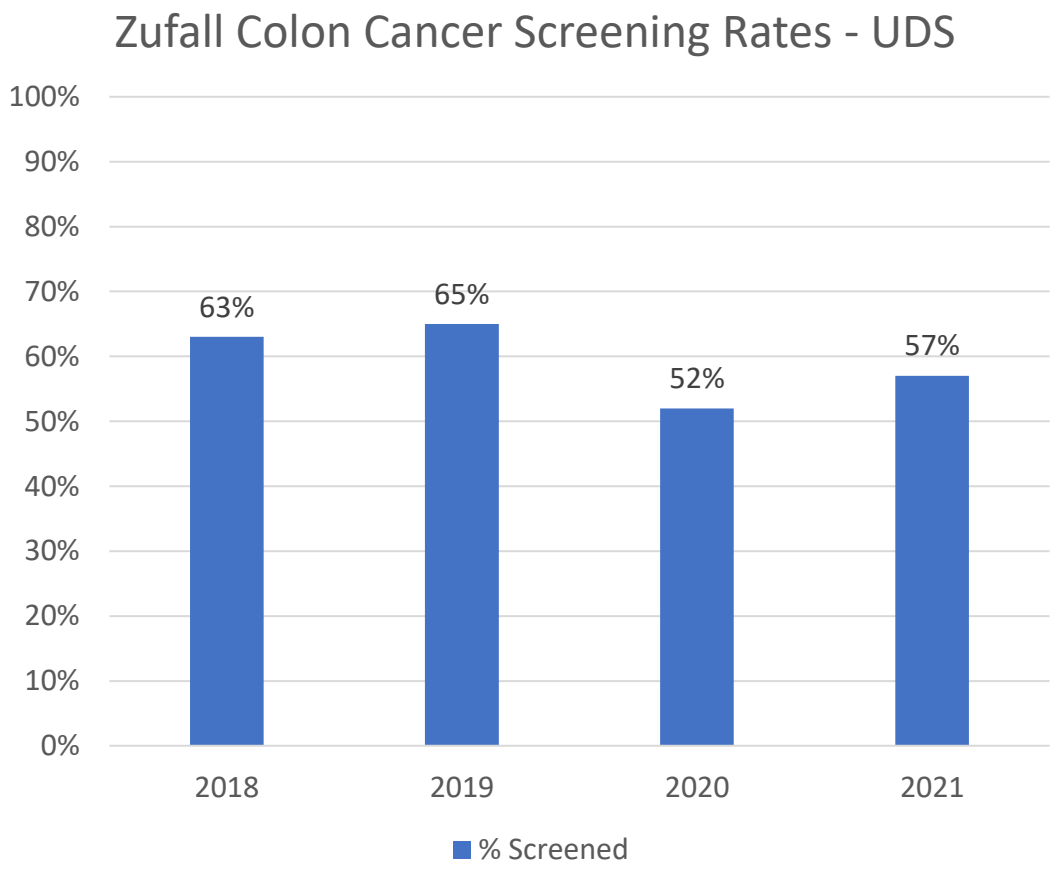
Zufall Health Center – A Federally Qualified Health Center since 2004

- Established in 1990 as a volunteer clinic
  - Nine offices in seven counties
  - Fully Licensed Medical and Dental vans
  - Wellness Center
- Serving the underserved population, homeless, farmworkers, residents of public housing and veterans
- HRSA Health Center Quality Leader
- Partnering with ScreenNJ since 2017 and NJCEED since 2009
- In 2020, saw 40,000 patients, 143,000 visits (excluding Covid), if include, 177,000 total visits
  - 90% under 150% poverty; 53% uninsured; 65% Latino; 59% need interpretation services

Colon Cancer Screening Rates

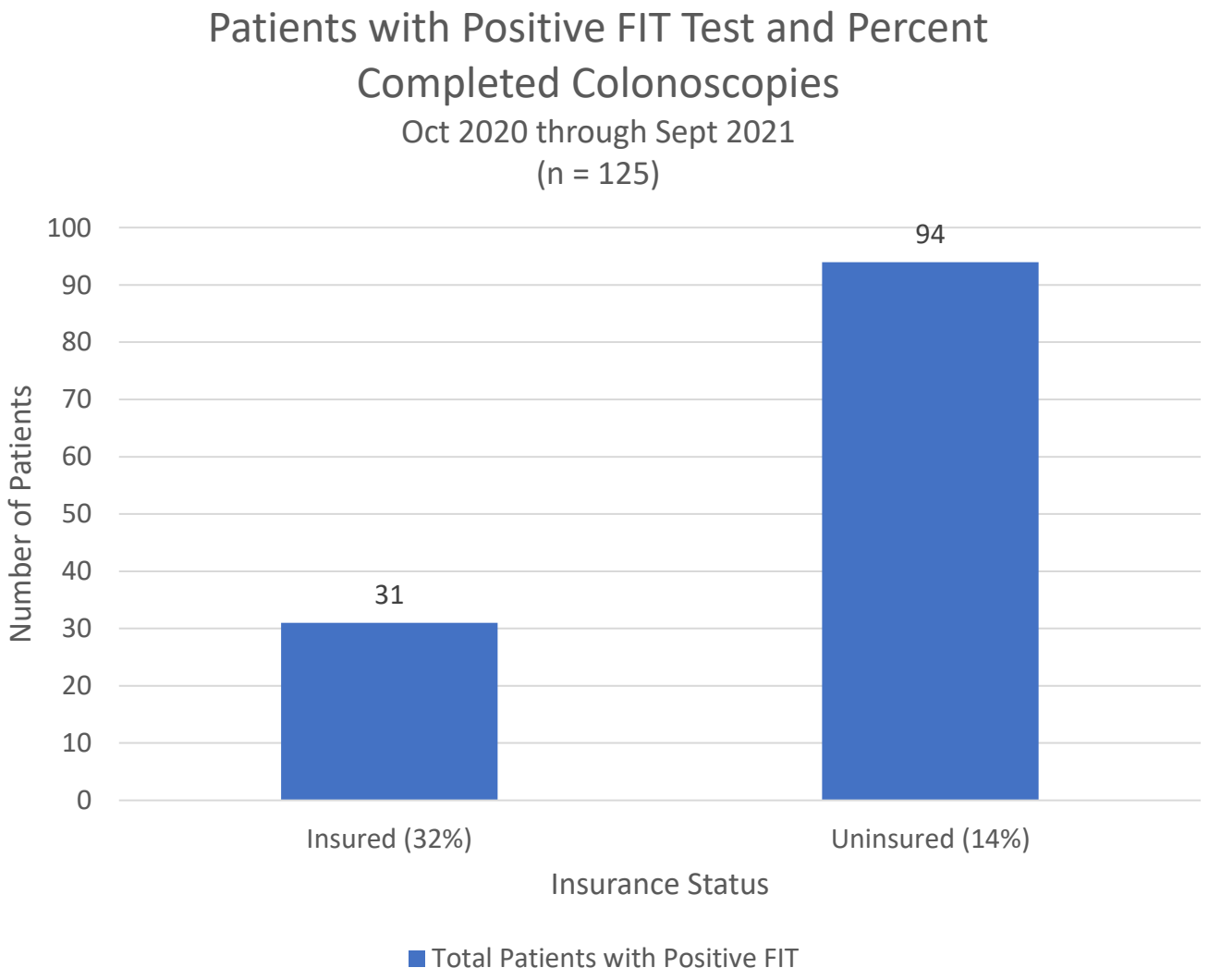
between 6,500 – 7,000 eligible patients

Year	% Colonoscopy	% FIT Returned	% Positive FIT
2018	16%	61%	4%
2019	21%	65%	6%
2020	18%	61%	4%
2021 (to 9/30)	19%	66%	6%

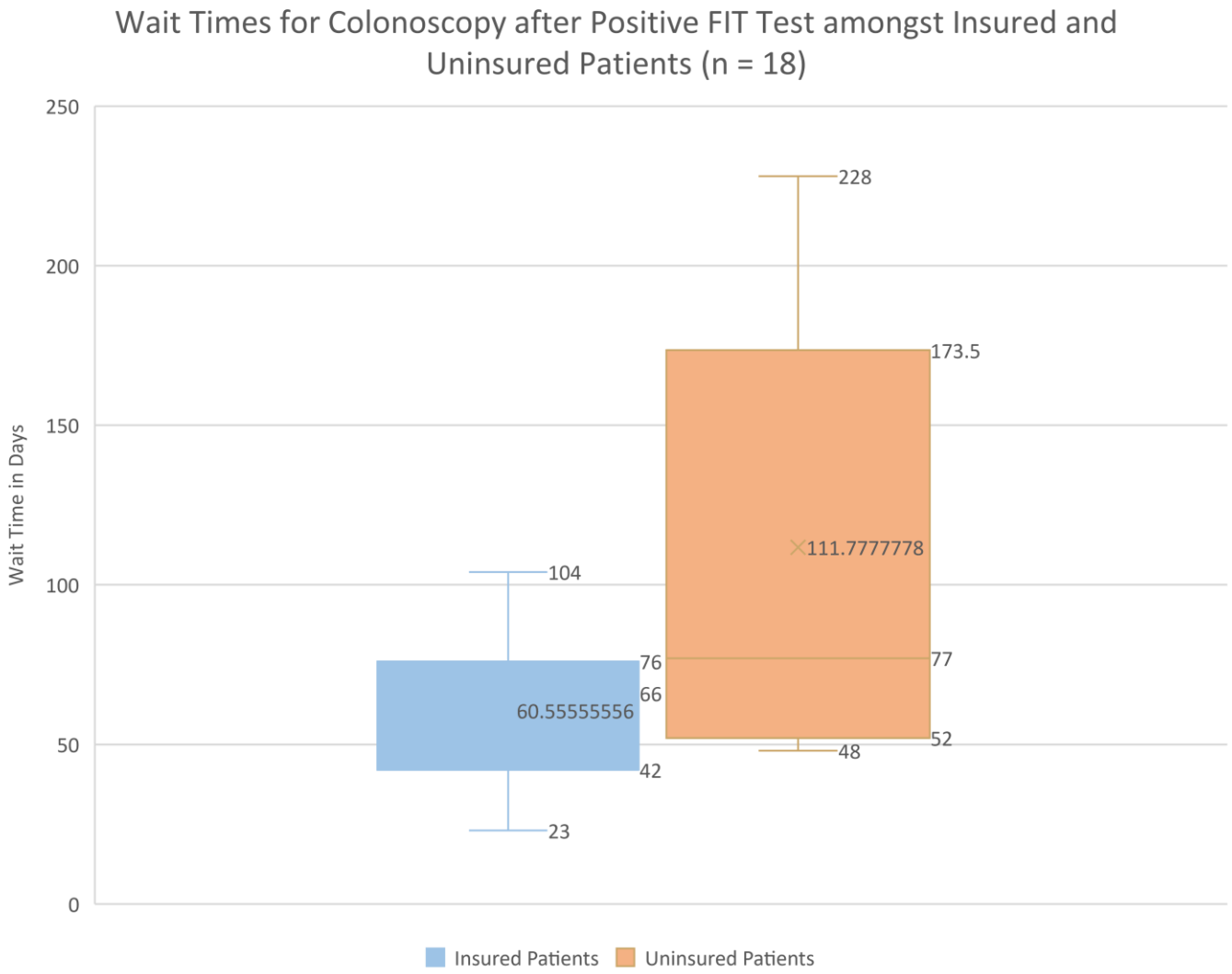


- We continue to strive to reach 80%
- Focusing to increase our 2021 rates to pre-pandemic levels
- Concern: status of positive FIT Tests

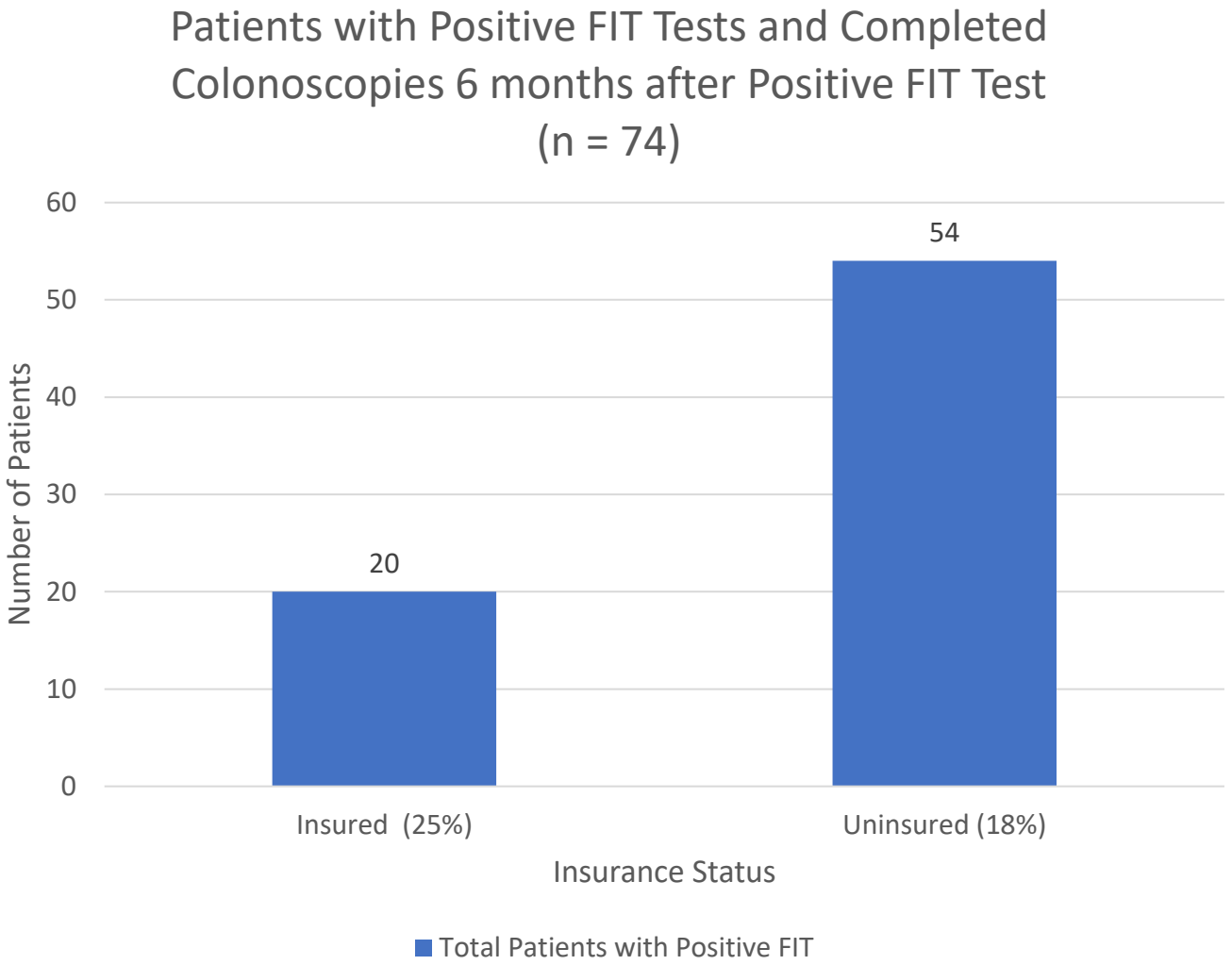
Positive FIT Test and Colonoscopy Completion (Oct 2020-Sept 2021)



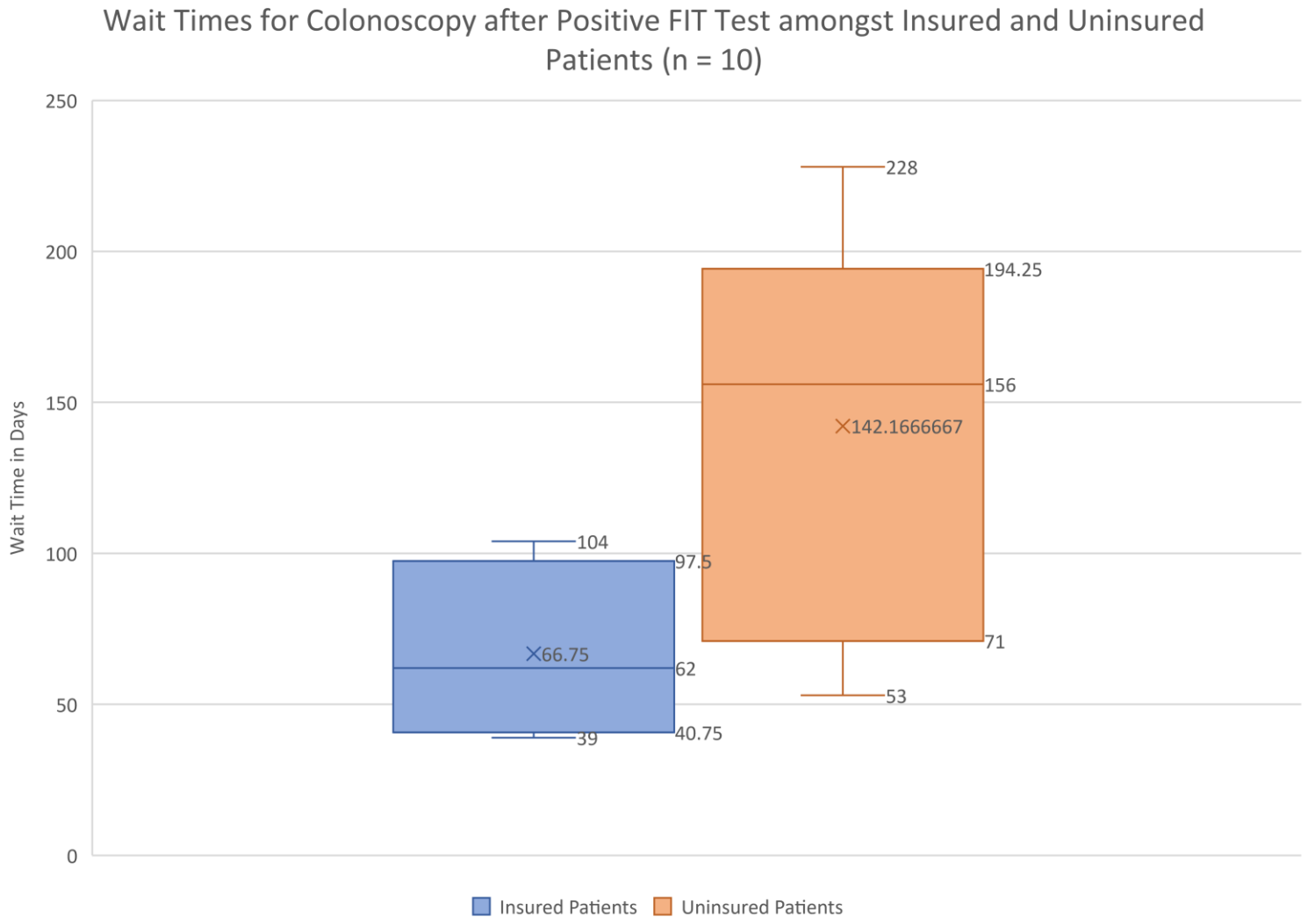
The Impact of Insurance Status on Colonoscopy Wait Times (Oct 2020-Sept 2021)



Positive FIT Test and Colonoscopy Completion 6 Months After Positive FIT Result (Oct 2020-May 2021)



Impact of Insurance Status on Colonoscopy Wait Times (6 months after Positive FIT)



- Navigator/Trainer
- Navigators at each site
- Identified GI specialists who will provide needed care to our patients who may have financial barriers to care
- All Zufall team members including Providers and MA's who see the patients each and every day and can provide education and reinforce the importance of this screening to support this program

WHO WILL MAKE THIS HAPPEN?

COLORECTAL CANCER SCREENING

Activity

- Provide FIT-FOBT tests to all eligible patients across all centers
- Conduct Patient Navigation to encourage return of tests
- Process the returned kits in-house or prepare them for LabCorp
- Provide negative results and remind of yearly testing
- Refer and navigate patients with positive result to colonoscopy services

Expected Outcomes

- CRC screening rates increase across Zufall's sites
- Let's get to 80%!!!!

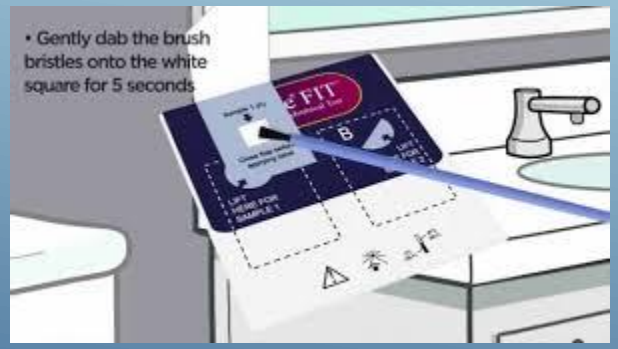
FIT TEST DISTRIBUTION

Activity

- FIT tests are distributed, and returns are tracked in Zufall's EMR by staff
- Timeline is as follows:
  - FIT kits are given at any visit
  - Navigator follows up at 3 days, 7 days and 14 days
  - Navigator confirms lab results or follow up to request lab results 5 days after FIT return/delivery to lab
  - Gift card given to patient when FIT is returned

Outcome

- FIT kits are distributed to our target patient population
- 3500 or more kits will be returned by our target population and processed



Review standing orders!

Activity

- Navigators reach out to positive patients with follow-up reminders and assistance with further diagnostic testing, via phone and patient portal
- Zufall provides patients with funding to eliminate the GI visit Copay
- Zufall provides Financially indigent patients requiring colonoscopies with subsidies to alleviate financial burdens associated with copays

Outcome

- Patients with positive FIT tests have access to Colonoscopies

FOLLOW UP

BARRIERS TO FOLLOW UP CARE/COLONOSCOPY

Barrier	Potential Intervention
Financial • **Both insured and uninsured patients will delay or decline to have follow up colonoscopy screening due to out-of-pocket expense**	• Partner with Providers/Organizations to provide follow up care who will accept Charity Care/Medicaid rates or provide services to those who don't qualify for Charity Care/Medicaid with no or limited out of pocket expense to patient • Provide financial assistance to patients who do not qualify for Charity Care/Medicaid or who don't have access to Partner provider/organization
Knowledge Deficit • **Patient does not acknowledge need for follow up colonoscopy after educational interaction with Navigator**	• Provide clear education prior to FIT test about necessary follow up for positive FIT test • Schedule in person or Telemedicine visit with trusted provider to discuss results and necessary follow up • Provide clear patient education materials

BARRIERS TO FOLLOW UP CARE/COLONOSCOPY

Barrier	Potential Intervention
Language Barrier • **Patients are not comfortable seeking care from a provider if they are unable to communicate in their language**	• Navigators assist to make appointments; • When possible, navigators arrange for translator to assist at appointments • Navigators follow up with patients after appointments, discuss any questions, pre-procedure questions.
Transportation • **Limited funding and limited access to Public Transportation/Uber in rural areas**	• Schedule transportation through public transportation or ride sharing
Pre-Procedural Prep • **Unable to afford** • **Limited literacy affects ability to be compliant**	• Provide Prep through 340B program • Follow up by navigator to remind of appointments, prep regimen, ensure understanding, translate as necessary, check in on day of prep to encourage compliance

Thank You!

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- Kathleen Felezzola, BSN
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Questions & Answers