It's A Matter of Choice

Quality Health Associates
of North Dakota

Peer Sharing

- What CRC Screening options are currently offered to your patients? How was it decided?
- When patients refuse CRC screening, are barriers to the tests discussed? Options offered?

There are many screening tests for CRC! Which is the best?

- Colonoscopy
- FIT
- Cologuard

Clinic Story

CRC Test Choice: Calling Patients and Offering Stool Test Kits Raise Colorectal Cancer Screening Use in South Dakota

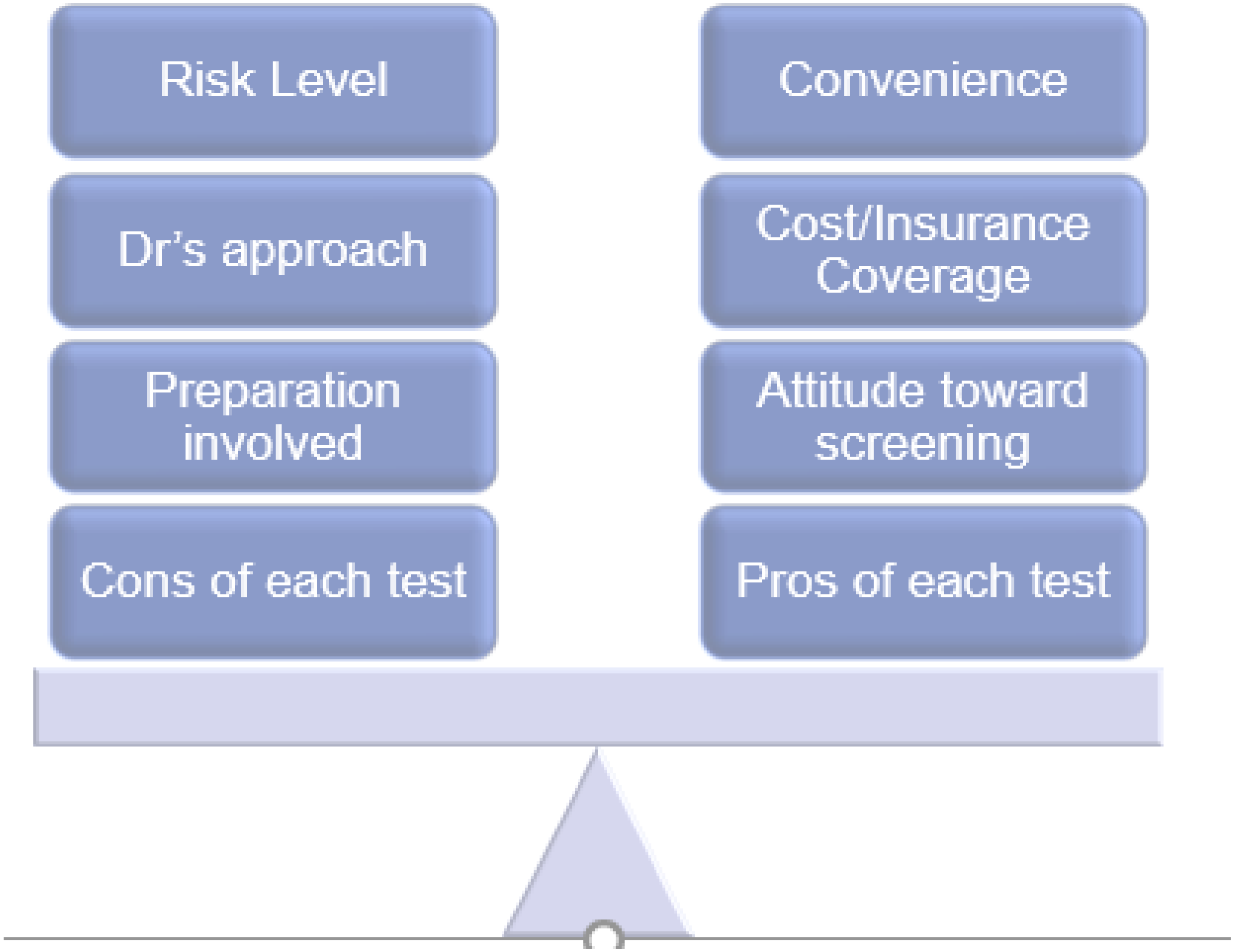
The Sanford Watertown Clinic tried but could not raise its colorectal cancer screening use. Patients said they didn't get screened because of the cost, they didn't like the preparation needed for a colonoscopy, they were afraid of a colonoscopy, or they couldn't take time off from work.

Care managers at the clinic made a list of patients who needed to be screened. They called these patients to talk about why they should be screened and the different tests available to them.

As a result, 21 patients scheduled a colonoscopy. The care managers mailed 100 stool test kits to patients not getting a colonoscopy; more than half of the tests were completed and returned. Three completed test kits had positive results, and all three people then had a colonoscopy. The clinic's screening use went up from 66% to almost 75% within a few months.

https://www.cdc.gov/cancer/crccp/success/test-choice.htm

Considerations



Scopes	Pros	Cons
Colonoscopy - 30-60 min,q-10yrs	• One of the most sensitive tests currently available • Doctor can view entire colon and rectum • Abnormal tissue, such as polyps, and tissue samples (biopsies) can be removed through the scope during exam	• May not detect all small polyps and cancers • Bowel prep required • Sedation almost always used – may take hours to wear off • Need a driver • Rare complications: bleeding from site of polyp or biopsy; tear in colon or rectum wall • Cramping/bloating may occur afterward
Virtual Colonoscopy - 10 min, q-5yrs	• No sedation	• May not detect all small polyps and cancers • Bowel prep required • Diet and medication adjustments b/4 test • Radiation exposure • Tissue samples can’t be taken during exam • Follow-up test needed if positive • Cramping/bloating afterward • May detect abnormalities in other abdominal organs and tests may be needed to determine cause
Flexible Sigmoidoscopy - q-5yrs or q-10 yrs with FIT annually	• One of the most sensitive tests currently available • Abnormal tissuecan be removed through the scope during exam • Bowel prep is less complicated. • Sedation not usually needed	• Same as colonoscopy • Can only view inside the rectum and lower 1/3 of colon • If a pre-cancerous polyp or cancer is found, will require a colonoscopy to look at the rest of the colon

Stool Tests	Pros	Cons
FIT (Immunochemical) - Annual	• Sample collection at home • No colon prep • Only one sample (1 BM) • No sedation • Overall diagnostic accuracy of 95% • Lowest cost ($75-$125)	• Fails to detect polyps • Additional tests needed if positive • Lowest risk of false-positive result
Stool DNA (Cologuard) - q 3yrs	• Sample collection at home • No colon prep • Requires collecting an entire BM (vs a sample) • No sedation • Cost of $500 (q3 yrs)	• Less sensitive than colonoscopy at detecting precancerous polyps • Additional tests needed if positive • False-positive result
High Sensitivity FOBT (Guaiac) - Annual	• Sample collection at home • No colon prep • Requires 3 bowel movements (3 samples) • No sedation	• Fails to detect polyps • Food/Medication restrictions for days before test • Additional tests needed if positive • Low risk of false-positive result

UNDERSTANDING COLORECTAL CANCER SCREENING

Colorectal Cancer Screening: Which test is right for you?

American Cancer Society

- **COLORECTAL CANCER IS THE SECOND-LEADING CAUSE OF DEATH FROM CANCER IN THE U.S. FOR MEN AND WOMEN COMBINED. The best way to prevent death from colorectal cancer is to stay current with screening.**
- **THERE ARE MANY SCREENING TESTS FOR COLORECTAL CANCER.** You and your health care provider have a decision to make about which screening test is right for you. The test you choose will depend on your preference and which tests are available to you. No matter which test you use, the most important thing is to get tested.
- **THE AMERICAN CANCER SOCIETY RECOMMENDS** that adults ages 45 and older with an average risk of colorectal cancer get screened regularly with a stool test or a visual test. Part of screening is having a follow-up colonoscopy for positive results on any screening test (besides colonoscopy).

Who is this decision aid for?

This decision aid is for adults who:

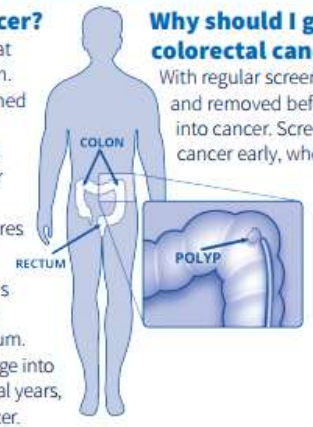
Are 45 years of age or older

Are at average risk for colorectal cancer

What is colorectal cancer?

Colorectal cancer is a cancer that starts in the colon or the rectum. These cancers can also be named colon cancer or rectal cancer, depending on where they start. Colon cancer and rectal cancer are often grouped together because they have many features in common.

Most colorectal cancers begin as a growth called a polyp on the inner lining of the colon or rectum. Some types of polyps can change into cancer over the course of several years, but not all polyps become cancer.



Why should I get screened for colorectal cancer?

With regular screening, most polyps can be found and removed before they have the chance to turn into cancer. Screening can also find colorectal cancer early, when it is smaller and easier to treat.

Colorectal cancer is the second-leading cause of cancer death in the U.S. when men and women are combined, yet it can be prevented or detected at an early stage.

How can I lower my risk of getting colorectal cancer?

There are things you can do to help lower your risk, such as staying at a healthy weight, being physically active, not smoking, limiting alcohol, and eating a diet high in vegetables and fruits.

ning tests are available?

g options may be available to creening tests below are effective ctal cancer. These tests fall into Stool tests are tests you can do at a stool sample and mailing it to a lab. Visual tests are tests that a doctor does to look inside your colon. Most health insurance plans, including Medicare, cover most of these screening tests. Talk with your provider about which screening tests might be right for you.

TESTS

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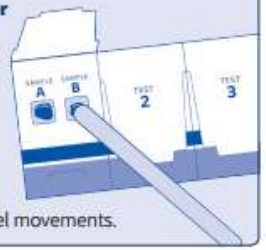

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VISUAL TESTS

Colonoscopy

HOW OFTEN: **Every 10 years**

- Your provider uses a tube with a tiny camera to look for and remove polyps and cancer in your colon and rectum.
- You take a prep (tablets and something to drink) before the test to empty the colon. It causes diarrhea (watery stool).
- You will be sedated and need a day off work. You will need someone to drive you.

CT Colonography(CTC)

HOW OFTEN: **Every 5 years**

- The test is also called virtual colonoscopy.
- Your provider uses an x-ray machine to look for polyps and cancer in your colon and rectum.
- You take a prep (tablets and something to drink) before the test to empty the colon. It causes diarrhea (watery stool).

Flexible Sigmoidoscopy (FS)

HOW OFTEN: **Every 5 years**

- Your provider uses a tube with a tiny camera to look for polyps and cancer in the lower part of your colon and rectum.
- You give yourself 1 or 2 pre-filled enemas before the test to empty and clean the colon.
- This test is not available in most places.

*Not all tests may be available. Talk with your health care provider about which tests are available to you.

n care provider

our next primary care will help you and your ening test is right for you.

Preventing colon cancer or finding it early doesn't have to be expensive. There are simple, affordable tests available. Get screened! Call your doctor today.

you in choosing a screening test. Answer the questions below to help ich test is right for you.

t:	NOT CONCERNED				VERY CONCERNED
our stool?	○	○	○	○	○
ear?	○	○	○	○	○
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cancer screening

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Questions for your health care provider

- Why do I need to get screened now?
- What tests do you recommend for me?
- How do I prepare for the test?
- Will the test be painful or uncomfortable?
- Is there any risk involved in the test?
- What happens if the screening test comes back positive?
- When should I stop screening?
- How and when will I get my results?

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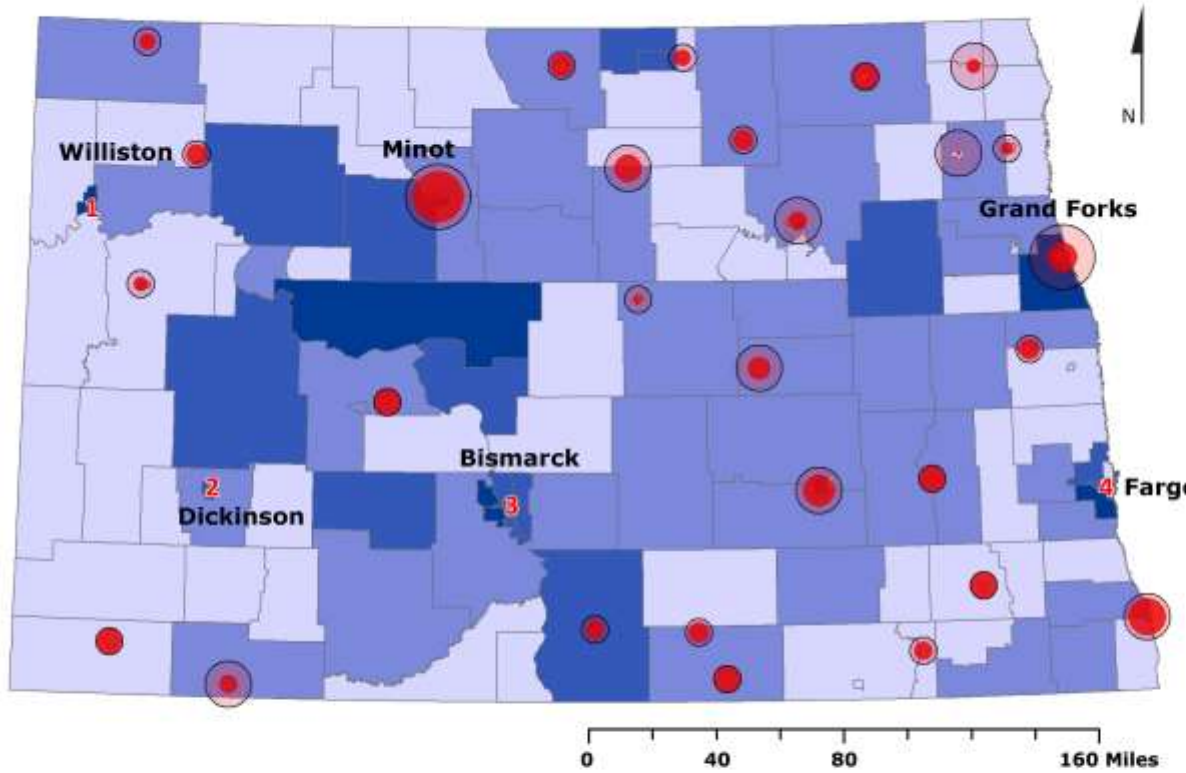
Population Age-Eligible for Colorectal Cancer Screening, by Census Tract, and Location of Facilities for Colonoscopy, North Dakota, 2016



Annual Maximum Colonoscopy Capacity by Facility, 2016

- 25–624
- 625–2,600
- 2,601–9,100

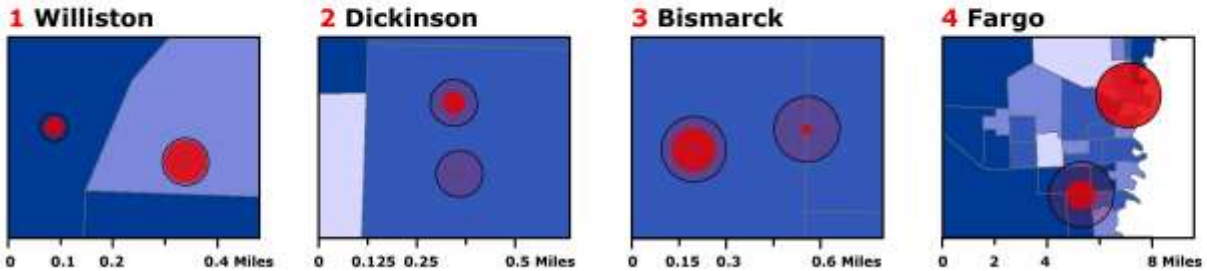
Proportion of Capacity Used by Facility, 2016

Least

Greatest (Approaching 100% Used)

Total Population Aged 50-74 by Census Tract, 2015

- 27–718
- 719–1,174
- 1,175–1,836
- 1,837–4,521



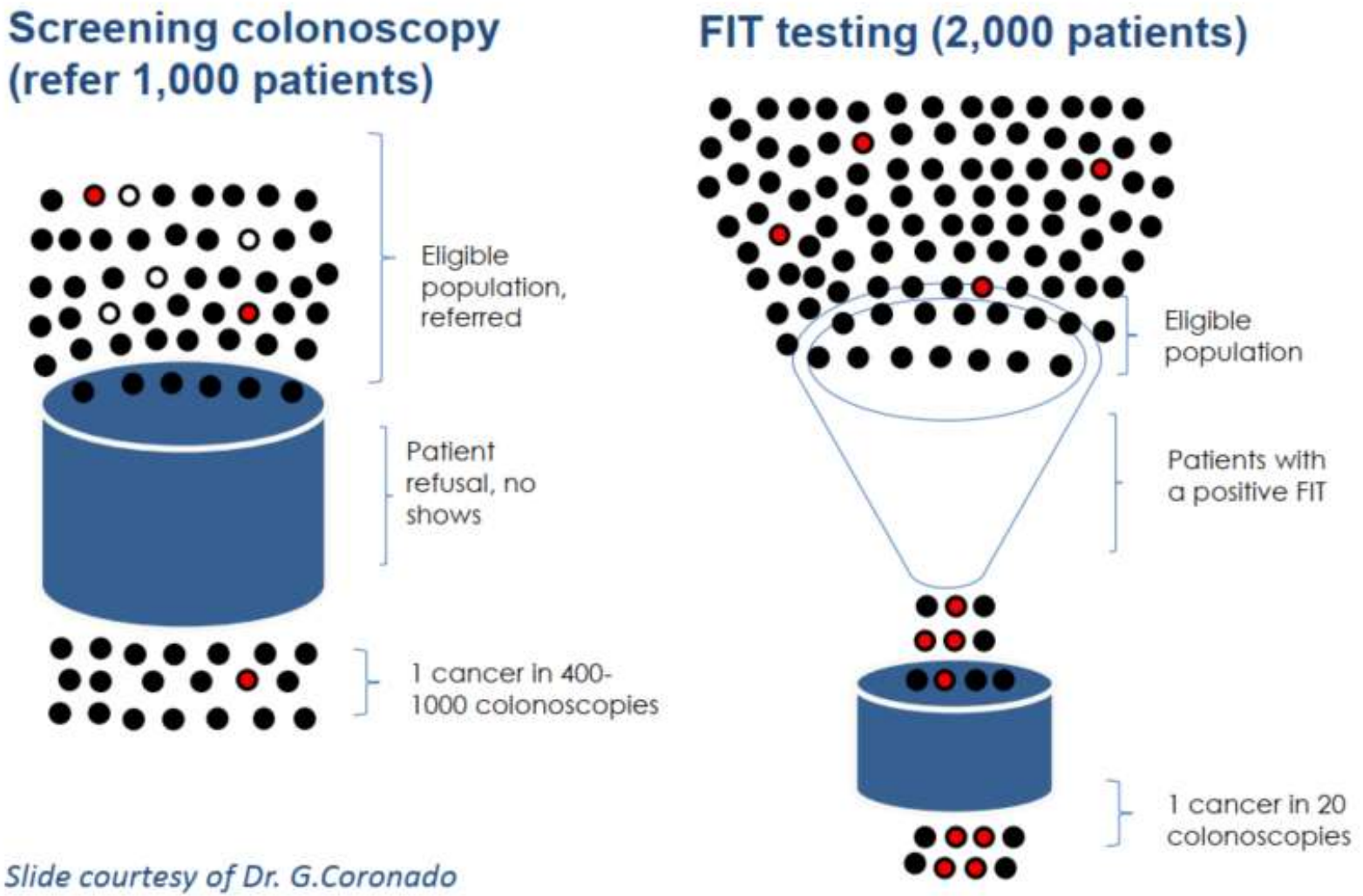
Source: 2011–2015 American Community Survey 5-year estimates (1)

Vu MH, Tran JL. Visualizing colonoscopy capacity for public health use. Prev Chronic Dis 2018;15:170421.

Making the Best Use of Scarce Resources:

Screening colonoscopy vs. FIT

- Represents 20 patients

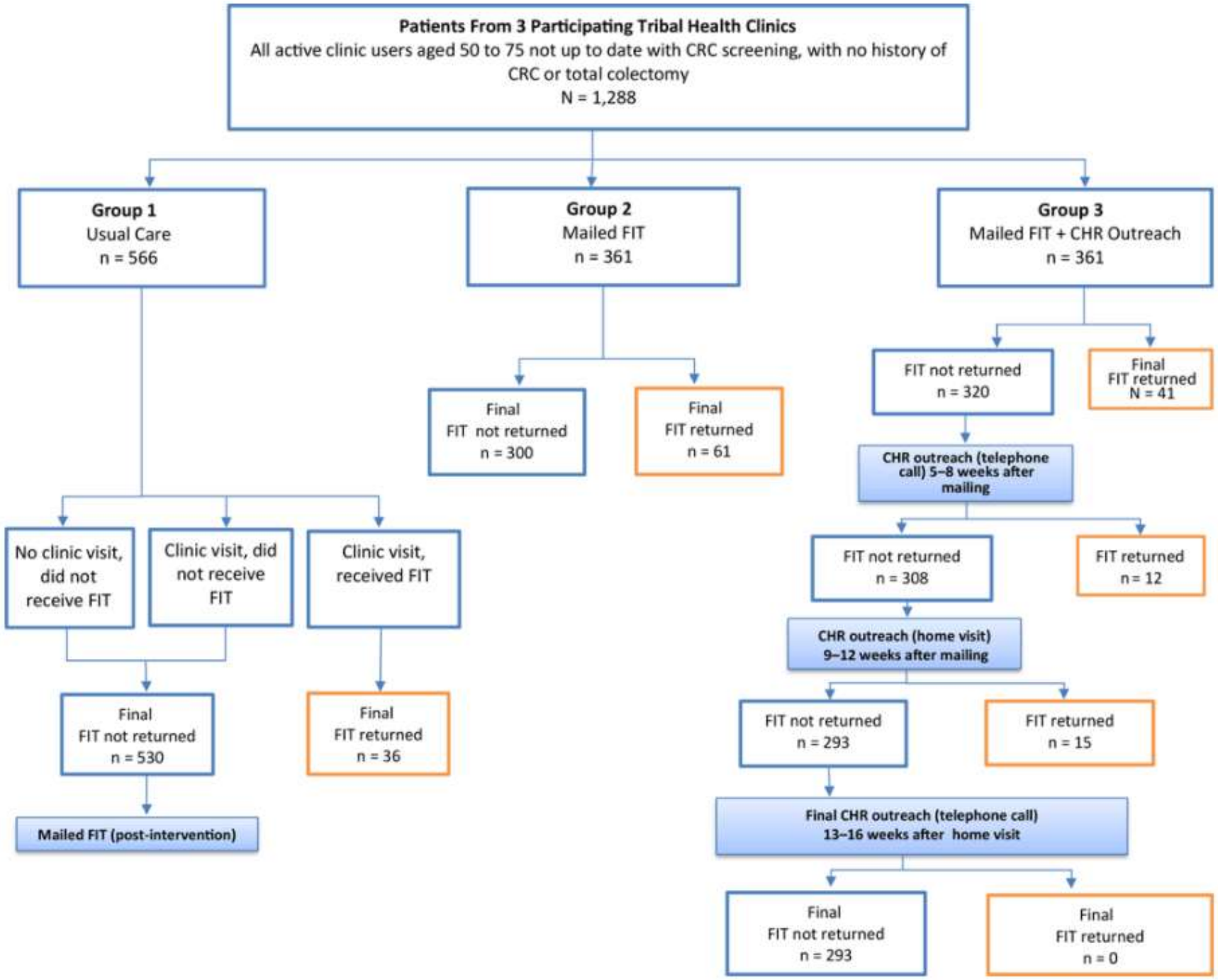


Slide courtesy of Dr. G.Coronado

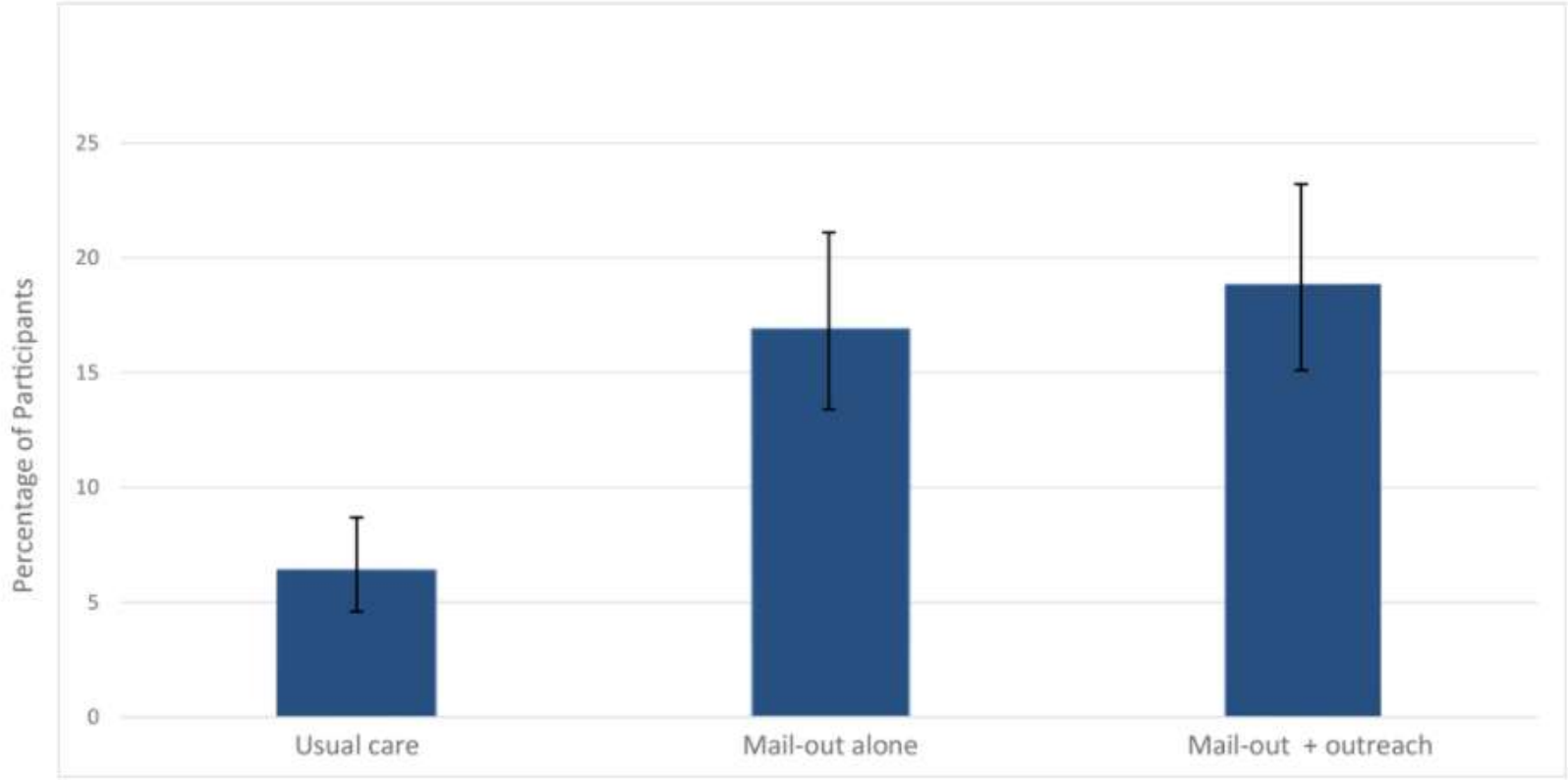
Stool tests appropriate only for average risk clients

All positive tests must be followed up with colonoscopy

Effectiveness of Interventions to Increase Colorectal Cancer Screening Among American Indians and Alaska Natives (July 16, 2020): https://www.cdc.gov/pcd/issues/2020/20_0049



Percentage of Participants Who Completed the FIT Test, By Intervention Group



Minute on FluFIT

- Goal: Increase colorectal cancer screening rates by offering home gFOBT or FIT to eligible patients during annual flu shot activities
- Core Functional Component: Standing orders allow non-physician clinic staff to offer flu shots and gFOBT/FIT together to any clinic patient 50-75 years of age seen during flu shot season
- Target Clinical Settings and populations: Community health centers, pharmacies, managed care organizations, healthcare settings
- ACS: FluFIT Implementation Guide: https://www.cancer.org/content/dam/cancer-org/cancer-control/en/reports/american-cancer-society-flufobt-program-implementation-guide-for-primary-care-practices.pdf

Announcement! Milestones Incentive

Copper: ($1000)

- Standing Rock SU
- Quentin Burdick MHCF

COPPER 	❒ Signed commitment letter ❒ Formed multidisciplinary innovation team ❒ Completed Clinic Readiness Assessment ❒ Completed introductory meeting ❒ Set goal for year 1 ❒ Submitted baseline data
BRONZE 	❒ Data submission is current ❒ Developed and submitted Action Plan and initiated two (2) evidence-based interventions ❒ Submitted current clinic policy for CRC Screening
SILVER 	❒ Team members participatee in scheduled coaching calls and rapid action collaborative ❒ Implemented at least two (2) evidence-based interventions specific to improving CRC screening rates ❒ Achieved 1st year goal for improving CRC screening rate ❒ Shared SCREEND performance with Clinic Board or Leadership
GOLD 	❒ Reviewed and updated Action Plan annually ❒ Submitted at least one success story or lesson learned related to the interventions selected ❒ Achieved 2nd year goal for improving CRC Screening rate ❒ Distributed clinician level data to medical staff
PLATINUM 	❒ Achieved 3rd year goal for improving CRC Screening rate ❒ Used EHR to fullest potential to sustain EBIs such as flagging for follow-up, tracking screening results, pulling reports, generating and sending reminders to both providers and patients

Resources for the Journey Ahead

Resources

- Effectiveness of Interventions to Increase Colorectal Cancer Screening Among American Indians and Alaska Natives
- ACS: FluFIT Implementation Guide
- Colorectal Cancer Screening: Which test is right for you? (Decision aid)
- ScreeND.org

Next Steps

- TA Calls
- Evaluation (required for CEUs): https://www.surveymonkey.com/r/ScreeND_Module_3_040821

Next collaborative call: 04/22/2021, 9:30 a.m. CT | Topic: Patient Navigation

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