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Saving Lives: How New York State is Increasing Colorectal Cancer Screening Rates

March 17, 2016

Featured Speakers

- Daniel Napolitano, MD, AAHIVMS, Deputy Chief Medical Officer, Director of Primary Care, Community Healthcare Network

- Heather Dacus, DO, MPH, Director, Bureau of Cancer Prevention and Control, New York State Department of Health
Today’s Presentation

- Define the need for improving Colorectal Cancer (CRC) screening rates in New York State
- Describe the role of multiple sectors in improving CRC screening rates
- Identify innovative approaches to improving CRC screening rates

Colorectal Cancer (CRC)

- Third most common cancer
- Second leading cause of cancer death
- Screening can:
  - Find colorectal cancer early; best chance for cure
  - Find and remove polyps to prevent cancer
- Evidence-based interventions increase screening rates
- A team approach is needed
CRC in New York State

Make New York the Healthiest State

2012-2017
New York State Comprehensive Cancer Control Plan

“80% by 2018”

A national initiative to achieve an 80% CRC screening rate among men and women ages 50 to 75 years by 2018.
The 80% by 2018 Pledge

Potential Impact

- Within less than 20 years, nationally, could avert
  - 280,000 new colorectal cancer cases
  - 200,000 colorectal cancer deaths
- In NYS - 1 million men and women aged 50-75 need to be screened

Public Health Impact of Achieving 80% Colorectal Cancer Screening Rates in the United States by 2018
% of NYS adults aged 50-75 years up-to-date with screening per most recent screening guidelines, 2001-2013, NYS BRFSS Brief

Screening Rates - Statewide

% NYS adults aged 50-75 who have up-to-date CRC screening as of 2013-2014

NYSDOH Expanded BRFSS data, September 2014
Screening Rates - New York City

% reporting colonoscopy in past 10 years by neighborhood, from the New York City Community Health Survey 2014

Data from NYC EpiQuery

Opportunities for Success

- New Yorkers have access to affordable health care
- Screening tests are covered health insurance benefits
- An evidence-base exists for what works
- Tools and resources are available
- Partners all over the state are already working to increase colorectal cancer screening rates
Opportunities for Success

Healthcare access among never screened adults aged 50-75 years, 2012 BRFSS

NYS Behavioral Risk Factor Surveillance System (BRFSS) 2012

Recommended Screening Tests

U.S. Preventive Services Task Force (USPSTF) & American Cancer Society (ACS)

- Colonoscopy
- High Sensitivity Fecal Occult Blood Testing (FOBT)
  - Guaiac
  - Immunochemical
- Flexible Sigmoidoscopy (FSIG)
  - Recent studies support efficacy
  - Availability extremely limited in U.S.
Screening Comparison

- No evidence that one screening method is the “best”
- Years of life saved through an annual high-quality stool blood screening program COMPARABLE to a high-quality colonoscopy-based screening program when positive stool tests are followed by colonoscopy

## Comparable Mortality Benefit

### Outcomes for the Recommendable Set of Efficient Screening Strategies

<table>
<thead>
<tr>
<th>Test, Age Begin- Age- Stop, Interval</th>
<th>Outcomes per 1000 Persons</th>
<th>Efficiency Ratio</th>
<th>Incidence Reduct %</th>
<th>Mortality Reduct %</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>COL</td>
<td>Non-COL Tests</td>
<td>LYG</td>
<td></td>
</tr>
<tr>
<td><strong>MISCAN</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>COL, 50-75, 10</td>
<td>4136</td>
<td>0</td>
<td>230</td>
<td>29.6</td>
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<tr>
<td>Hemoccult SENSA, 50-75, 1</td>
<td>3350</td>
<td>9541</td>
<td>230</td>
<td>30.9</td>
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<tr>
<td>Fit, 50-75, 1</td>
<td>2949</td>
<td>11773</td>
<td>227</td>
<td>25.9</td>
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<tr>
<td>Hemoccult II, 50-75, 1</td>
<td>1982</td>
<td>16232</td>
<td>194</td>
<td>14.3</td>
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<tr>
<td>FSIG, 50-75, 5</td>
<td>1911</td>
<td>4139</td>
<td>203</td>
<td>9.7</td>
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<tr>
<td>FSIG + SENSA, 50-75, 5, 3</td>
<td>2870</td>
<td>5822</td>
<td>230</td>
<td>16.3</td>
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<tr>
<td><strong>SimCRC</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>COL, 50-75, 10</td>
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<tr>
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<td>259</td>
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<tr>
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<td>11830</td>
<td>256</td>
<td>19.7</td>
</tr>
<tr>
<td>Hemoccult II, 50-75, 1</td>
<td>1456</td>
<td>16239</td>
<td>218</td>
<td>9.6</td>
</tr>
<tr>
<td>FSIG, 50-75, 5</td>
<td>995</td>
<td>4483</td>
<td>199</td>
<td>8.4</td>
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<tr>
<td>FSIG + SENSA, 50-75, 5, 3</td>
<td>1655</td>
<td>11623</td>
<td>257</td>
<td>7.0</td>
</tr>
</tbody>
</table>
Patient Preferences

Many patients will forego testing if offered only colonoscopy

<table>
<thead>
<tr>
<th>RECOMMENDED TEST</th>
<th>COMPLETED SCREENING</th>
</tr>
</thead>
<tbody>
<tr>
<td>COLONOSCOPY</td>
<td>38%</td>
</tr>
<tr>
<td>FOBT</td>
<td>67%</td>
</tr>
<tr>
<td>COLONOSCOPY + FOBT</td>
<td>69%</td>
</tr>
</tbody>
</table>
Screening Tests: FIT

Fecal Immunochemical Tests (FIT) may be superior to older guaiac-based testing

- Specific for human blood and for lower GI bleeding
- Results not influenced by foods or medications
- Some types require only 1 or 2 stool specimens
- Higher sensitivity than older forms of guaiac FOBTs
- Costs a little more than guaiac tests (but higher reimbursement)

Physician Perceived Screening Barriers

<table>
<thead>
<tr>
<th>Perceived barriers by Arizona PCPs to ordering CRC screening tests</th>
<th>#1</th>
<th>#2</th>
<th>#3</th>
<th>Totals (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient reluctance to undergo screening</td>
<td>501</td>
<td>229</td>
<td>83</td>
<td>813 (83)</td>
</tr>
<tr>
<td>Patient fear of procedure or results</td>
<td>183</td>
<td>279</td>
<td>180</td>
<td>642 (65)</td>
</tr>
<tr>
<td>Patient lacks insurance coverage</td>
<td>188</td>
<td>147</td>
<td>173</td>
<td>508 (52)</td>
</tr>
<tr>
<td>Time constraints</td>
<td>42</td>
<td>55</td>
<td>107</td>
<td>204 (21)</td>
</tr>
<tr>
<td>Logistical problems for the patient</td>
<td>20</td>
<td>55</td>
<td>118</td>
<td>193 (20)</td>
</tr>
<tr>
<td>Lack reimbursement for ordering/performing proc.</td>
<td>38</td>
<td>45</td>
<td>53</td>
<td>136 (14)</td>
</tr>
<tr>
<td>Decreased availability of screening tests</td>
<td>36</td>
<td>22</td>
<td>51</td>
<td>109 (11)</td>
</tr>
<tr>
<td>Other</td>
<td>27</td>
<td>7</td>
<td>17</td>
<td>51 (5)</td>
</tr>
<tr>
<td>Your familiarity with current guidelines</td>
<td>4</td>
<td>1</td>
<td>4</td>
<td>9 (1)</td>
</tr>
</tbody>
</table>
Patient Barriers to Screening

Commonly cited patient reason for not getting screened:

“My doctor never talked to me about it!”

Information and Education

<table>
<thead>
<tr>
<th>Type of information</th>
<th>Patients rating info “very important”</th>
<th>Patients receiving information (among those rating it “very important”)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Screening purpose</td>
<td>368 (88.7%)</td>
<td>214 (58.2%)</td>
</tr>
<tr>
<td>Test accuracy</td>
<td>354 (85.3%)</td>
<td>26 (7.3%)</td>
</tr>
<tr>
<td>Testing alternatives</td>
<td>346 (83.4%)</td>
<td>101 (29.2%)</td>
</tr>
<tr>
<td>Testing pros/cons</td>
<td>356 (85.8%)</td>
<td>14 (3.9%)</td>
</tr>
<tr>
<td>Testing process</td>
<td>323 (77.8%)</td>
<td>323 (100%)</td>
</tr>
</tbody>
</table>
Develop a Clear Screening Policy

An office policy states the intent of the practice

- Tangible, maintains consistency
- Prerequisite for reliable, reproducible practice
- Algorithms can improve understanding and adherence to policy
- Beware: one size does not fit all practices!
- Beware: one size does not fit all patients!

Screening Policy Should Include

1. Individual Risk Level ("risk stratification")
2. Medical resources (e.g., location of endoscopy facilities)
3. Insurance (deductible? copay? resources for uninsured?)
   - Impact of Affordable Care Act (ACA) on preventive services
4. State and federal program policies/processes
5. Patient preferences/options
Evidence Based Interventions

<table>
<thead>
<tr>
<th>Patient oriented screening intervention strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient reminders</td>
</tr>
<tr>
<td>Small media</td>
</tr>
<tr>
<td>One-on-one education</td>
</tr>
<tr>
<td>Reducing structural barriers</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Provider oriented screening intervention strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider assessment &amp; feedback</td>
</tr>
<tr>
<td>Provider reminder &amp; recall systems</td>
</tr>
</tbody>
</table>

- Key Point: the clinicians cannot do it all!
- Time that patients spend with non-physician staff is underutilized
- Involve staff in meetings to discuss progress in achieving office goals for improving the delivery of preventive services

Entire Staff Should Be Involved
Stakeholders

- Local health departments
- Health systems
- Community organizations
- Academic institutions
- Employers
- Other stakeholders

Additional Barriers to Screening

- Fear
- Cost
- No symptoms
- Embarrassment
- No family history of colon cancer
- No personal connection to cancer
Messages that Address Barriers

- Colon cancer can be prevented
- Early detection saves lives
- Colon cancer may not cause symptoms
- There are testing options and **the best test is the one that gets done**
- Most health plans cover lifesaving preventive tests
- If you are uninsured, there are programs that can help with free or affordable testing

National Colorectal Cancer Roundtable Materials
Communities/CBOs/LHDs

- Partner to make 80% by 2018 a community-wide goal
- Leverage local leaders to communicate about the importance of screening
- Designate spokespeople that resonate with target populations
- Commit to educating your community on colon cancer testing options, reimbursement and local resources

Employers

- Adopt 80% by 2018 as a corporate commitment/company-wide goal
- Educate your employees about colon cancer and testing options
- Create a cancer testing-friendly work culture
- Engage your insurance provider to reduce any financial barriers
- Adopt a paid time off policy
Additional Resources

- New online trainings
- Two versions:
  - Primary care
  - Endoscopists
- Developed by nationally recognized experts
- Available via CDC

Community Health Centers Tool

*Steps for Increasing Colorectal Cancer Screening Rates: A Manual for Community Health Centers*

Available from the National Colorectal Cancer Roundtable
TOGETHER WE CAN DO IT

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