ACS Webinar Series for Cancer Coalitions

Promoting Non-Invasive CRC Screening

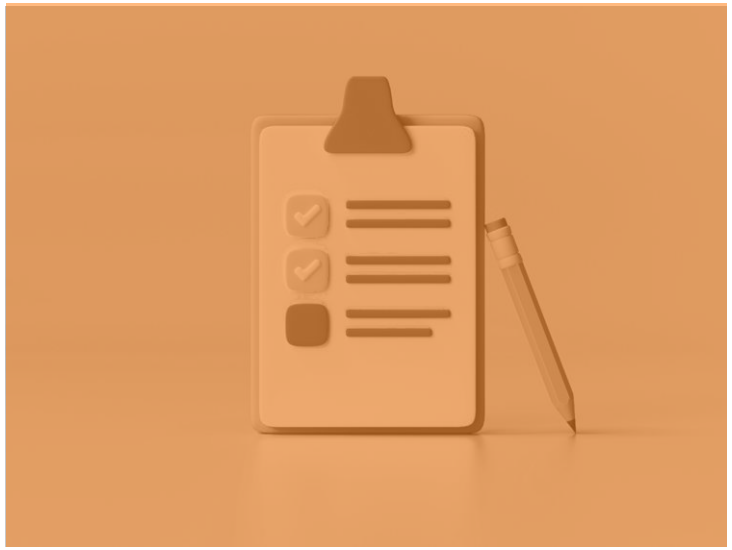
August 14, 2024

Brought to you by the ACS Comprehensive Cancer Control Initiatives Team. ACS is proud to be a training & technical assistance provider for grantee coalitions within the CDC National Comprehensive Cancer Control Program.

CDC Funding Acknowledgement

Today's webinar is supported by the **Centers for Disease Control and Prevention** of the U.S. Department of Health and Human Services (HHS) as part of a financial assistance award totaling $750,000 with 100 percent funded by CDC/HHS. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by CDC/HHS, or the U.S. Government.

Housekeeping Slide

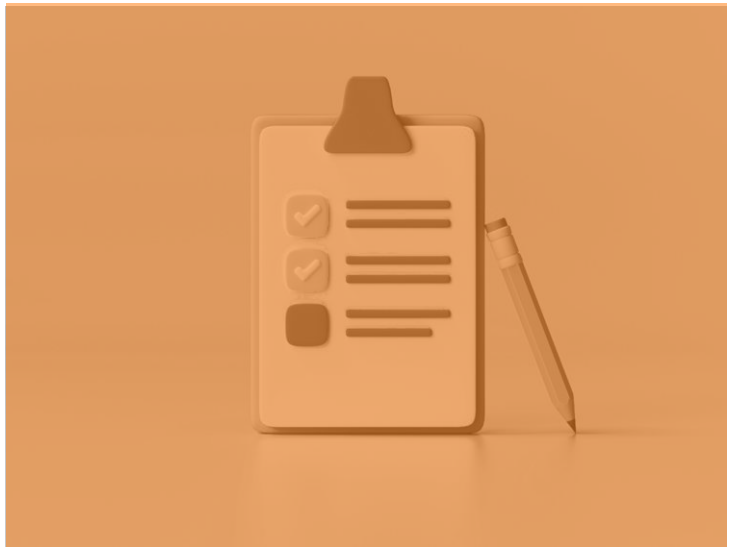


1. Today's seminar will be recorded. The link to view the recording will be shared with all who have registered.
2. If you have any issues during today's seminar or have any questions for our presenters, please use the chat.
3. To ensure that there are no disruptions during the presentation, all participants have been muted by the host.
4. We will have a Q&A portion at the end – so please put your questions in the chat.

Learning Objectives

- Describe the benefits of promoting stool-based testing for CRC screening.
- Explain the different types of stool-based testing for CRC screening.
- Promote and educate partners on how to implement a high-quality CRC screening program, including promotion of stool-based screening and follow-up colonoscopy.

Time for a quick poll!



1. Brief pre-survey

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American Cancer Society

NATIONAL COLORECTAL CANCER ROUNDTABLE

Promoting Non-Invasive CRC Screening

PRESENTER

Aubree Thelen, MPH

ACS NCCRT Program Manager who provides support for the Roundtable's events, communications and programmatic work.

American Cancer Society

ACS NCCRT Resources & Overview

- Aubree Thelen MPH -

Non-Invasive Colorectal Cancer Screening:

Practical Resources from the ACS NCCRT for Coalitions

Aubree Thelen, MPH

August 14, 2024

ACS NCCRT Snapshot

History: Established by the ACS, in partnership with the CDC, in 1997, to serve as an umbrella organization to engage all types of stakeholders who are committed to save more lives from CRC

Mission: Reduce incidence of and mortality from CRC

Membership: Collaborative partnership of 200+ member organizations, including nationally known experts, thought leaders, and decision makers

Operations: Work is conducted year-round by Strategic Priority Teams and in Special Topic Meetings

Convening: Each year the **ACS NCCRT Annual Meeting** addresses important topics and sets the agenda for the following year

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2024 ACS NCCRT Priority Areas

1. **Mobilize** national and community-level efforts that will lead to health equity in CRC outcomes.
2. **Support** on-time screening as soon as eligible and continued participation per screening recommendations.
3. **Promote** timely colonoscopy follow up to positive (abnormal) non-colonoscopy tests.

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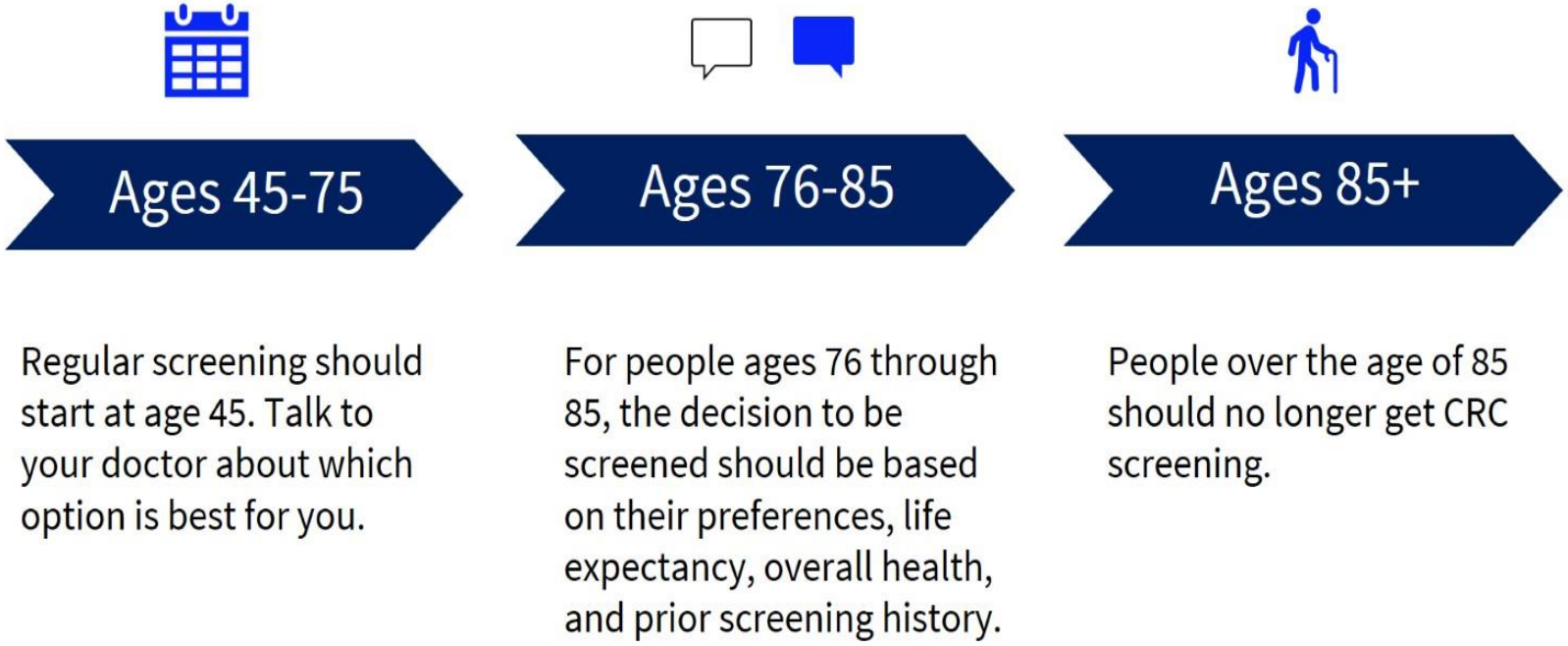
CRC Screening Recommendations for Average-Risk Individuals

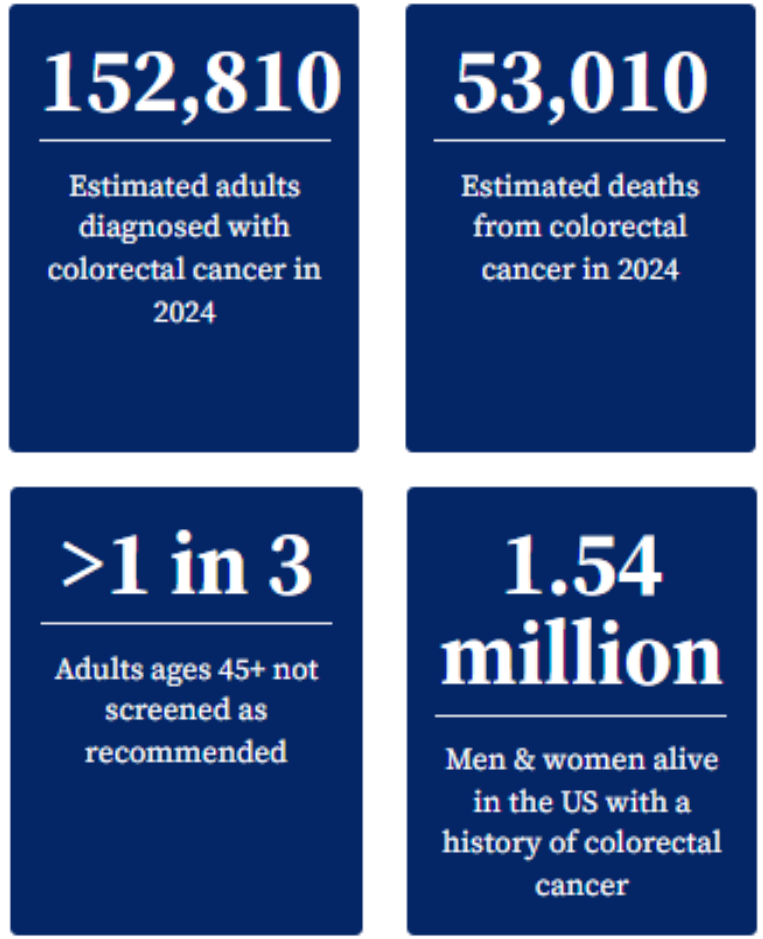


USPSTF/ACS Approved Screening Tests for CRC:

Stool-Based Tests	Direct Visualization Tests
High-Sensitivity gFOBT	Colonoscopy
FIT	CT Colonography
sDNA-FIT/MT-sDNA	Flexible Sigmoidoscopy (+/- FIT)

Colorectal Cancer By the Numbers

- **Colorectal cancer is the second leading cause of cancer death in men and women combined**
- Early age onset CRC is on the rise. **Diagnoses of people under 55 years of age doubled from 11% (1 in 10) in 1995 to 20% (1 in 5) in 2019.**
- In the US, screening is lowest among:
  - **Ages 45-49 (20%)** and ages 50-54 (50%)
  - Asian Americans (50%), American Indians or Native Alaskans (52%), and Hispanics (52%)
  - Individuals with less than a high school education (48%)
  - Individuals with a lower income (<100% FPL) (47%)
  - **The uninsured (21%)**
  - **Recent (<10 years) immigrants (29%)**



Comparing Guideline-Approved Tests

Stool-based tests

About stool-based tests

- Can be done at home
- Low cost
- No bowel prep or sedation
- Need to be done more often than visual tests
- Will need a colonoscopy if test is abnormal
- Can miss many polyps and some cancers

Stool-based test options

- Guaiac-based fecal occult blood test (gFOBT) **every year** or
- Fecal immunochemical Test (FIT) **every year** or
- Multi-targeted stool DNA test (MT-sDNA) **every 3 years**

Visual-exam tests

About visual-exam tests

- Done in doctor's office or health facility
- Bowel prep needed
- Only a colonoscopy can remove and test polyps
- Any test other than a colonoscopy will require a colonoscopy if the test is abnormal.

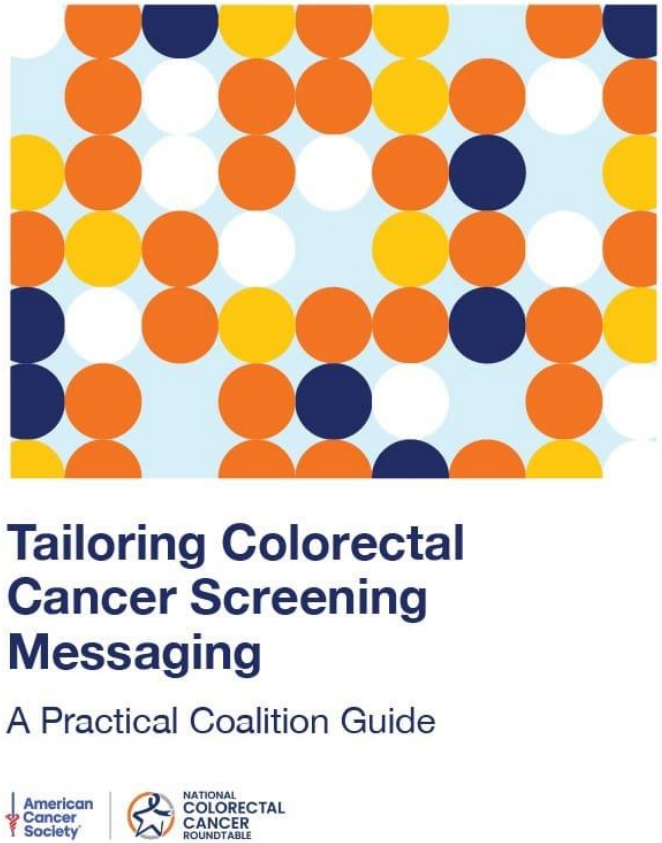
Visual exam test options

- Colonoscopy **every 10 years** or
- CT colonography (virtual colonoscopy) **every 5 years** or
- Flexible sigmoidoscopy **every 5 years**

The most important message is to get screened, no matter which test is chosen.

ACS NCCRT Resources

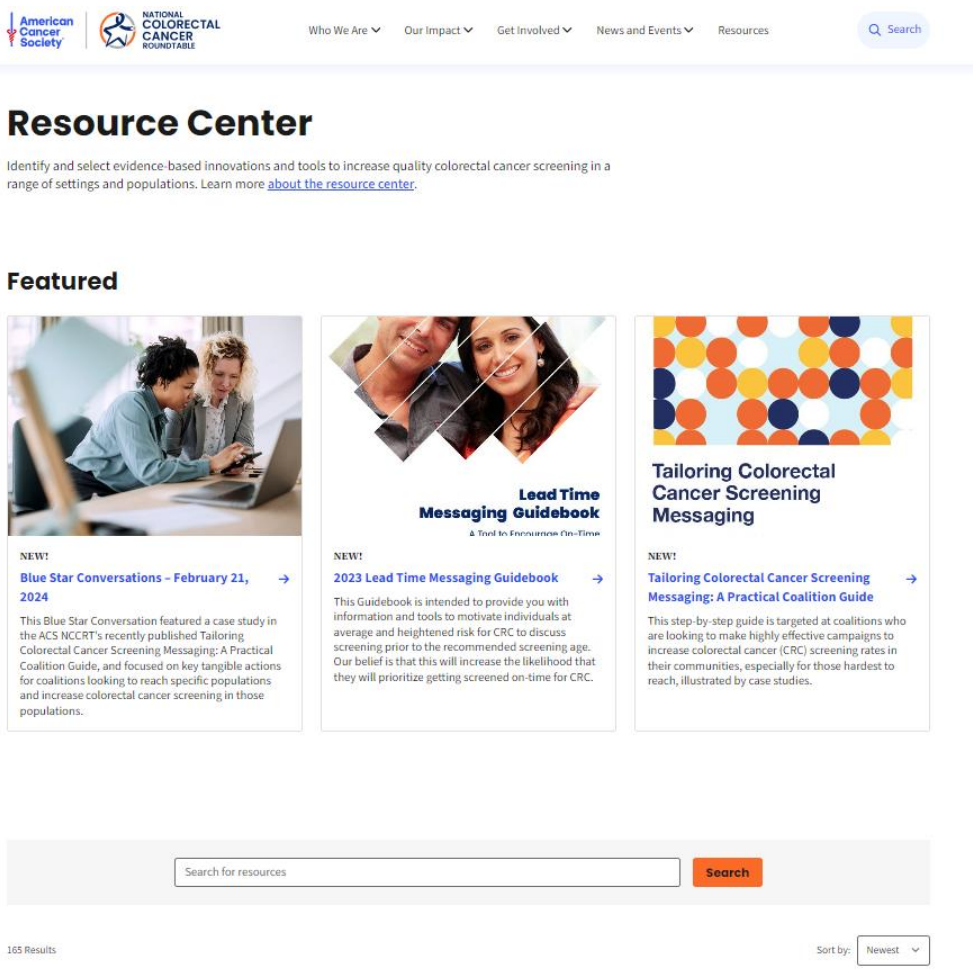
- Clinician's Reference: Stool-Based Tests for CRC Screening, designed to introduce (or reintroduce) clinicians to the value of stool-based testing for colorectal cancer - SOON TO BE UPDATED
- Case Studies in Steps for Increasing Colorectal Cancer Screening Rates: A Manual for Primary Care Practices, which outline multiple ways people engaged their health systems, clinics and partners to increase their CRC screening rates.
- Dos and Don'ts one pager - RECENTLY UPDATED
- Colonoscopy Needs Calculator, to help assess need and referral load to partners
- Tailoring Colorectal Cancer Screening Messaging: A Practical Coalition Guide, which addresses how coalitions specifically can message to hard-to-reach communities
- Mailed Fit Implementation Guide from NACDD



ACS NCCRT Resource Center

The **ACS NCCRT Resource Center** contains evidence-based resources and tools to help you increase quality colorectal cancer screening in a range of settings and populations.

Visit nccrt.org/resource-center to learn more



Learn More!

- Follow us on LinkedIn and X
  - linkedin.com/company/nccrt/
  - @NCCRTnews
  - Use #80inEveryCommunity
- Sign up for the newsletter
- Apply for NCCRT membership
- Visit: nccrt.org/get-involved

Questions? Contact nccrt@cancer.org

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Promoting Non-Invasive CRC Screening

PRESENTER

Frank Colangelo, MD, MS-HQS, FACP

Practices as an internist and serves as Vice President and Chief Quality Officer for Premier Medical Associates, a member of the Allegheny Health Network.

American Cancer Society®

A Clinician's Perspective on Promoting Stool-Based Screening

- Frank Colangelo, MD, MS-HQS, FACP -

Promoting Non-Invasive CRC Screening: A PCP's Perspective

Frank Colangelo MD, MS-HQS, FACP

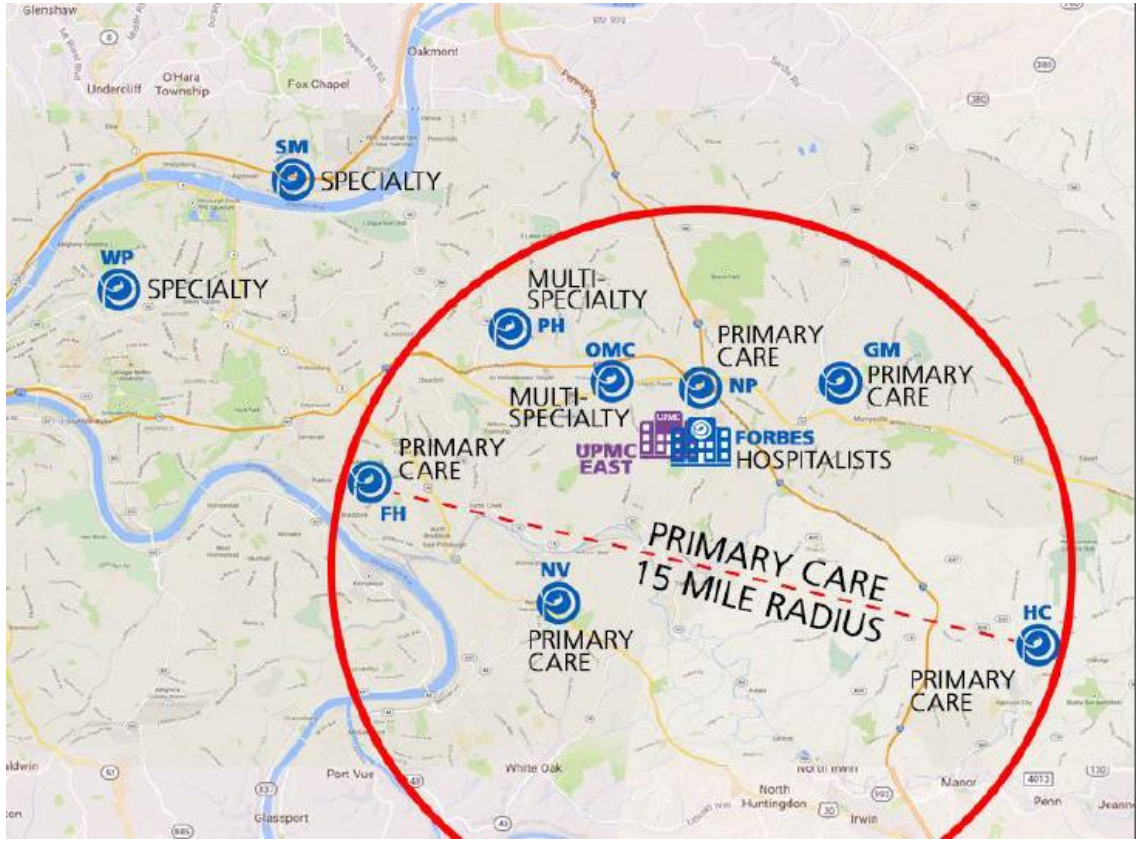
August 14, 2024


UPMC

Practice Overview

Allegheny Health Network

Premier Medical Associates



Why Should Providers Offer Choice?

Screening Modalities

Stool-Based Strategies

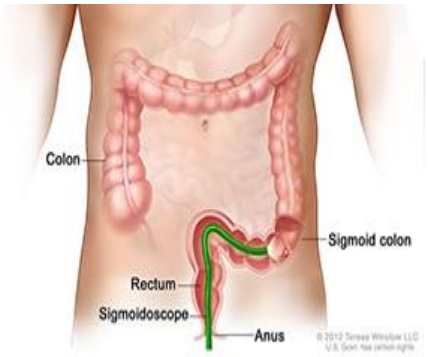
High Sensitivity FOBT

Fecal Immunochemical Test (FIT)

mt-sDNA

Direct Visualization Techniques

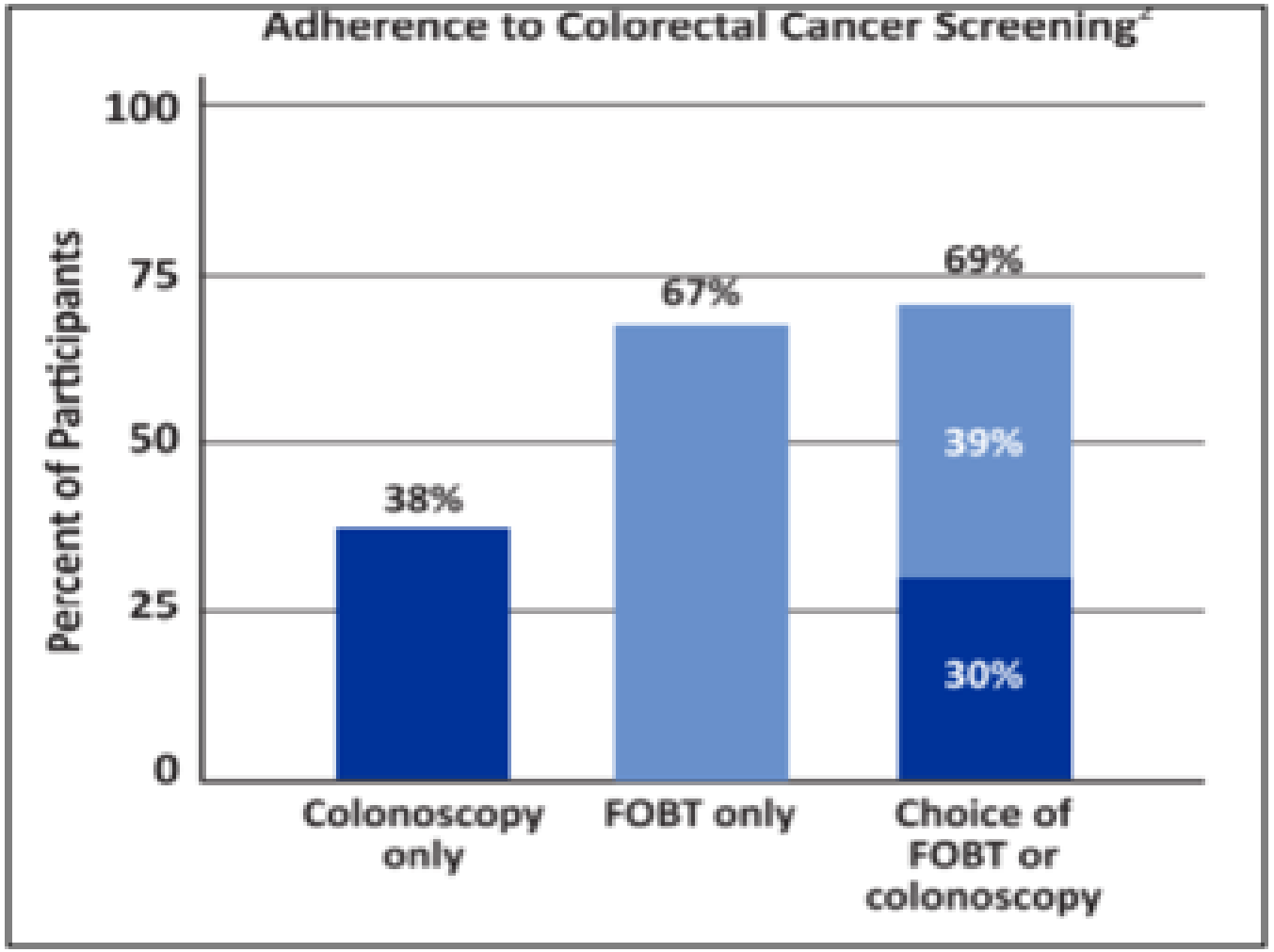
CT Colonography



Flexible Sigmoidoscopy

Colonoscopy

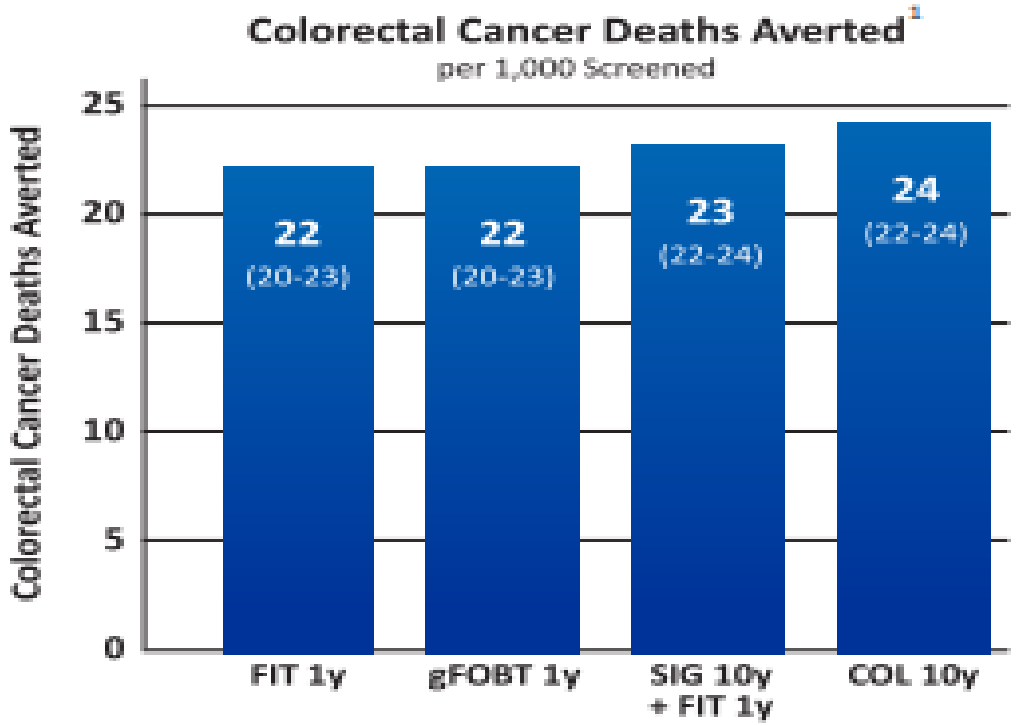
Offering Choice of Screening Modality



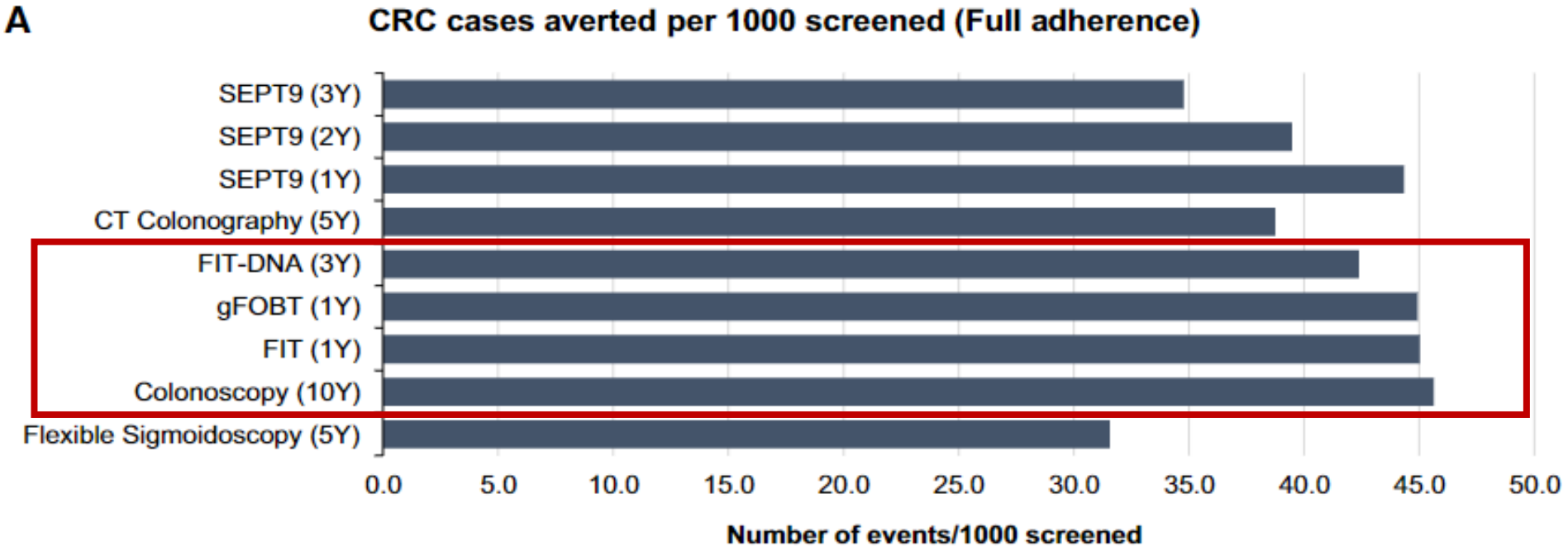
Inadomi, et.al. (2012). *Archives of internal medicine*, *172*(7), 575-582.

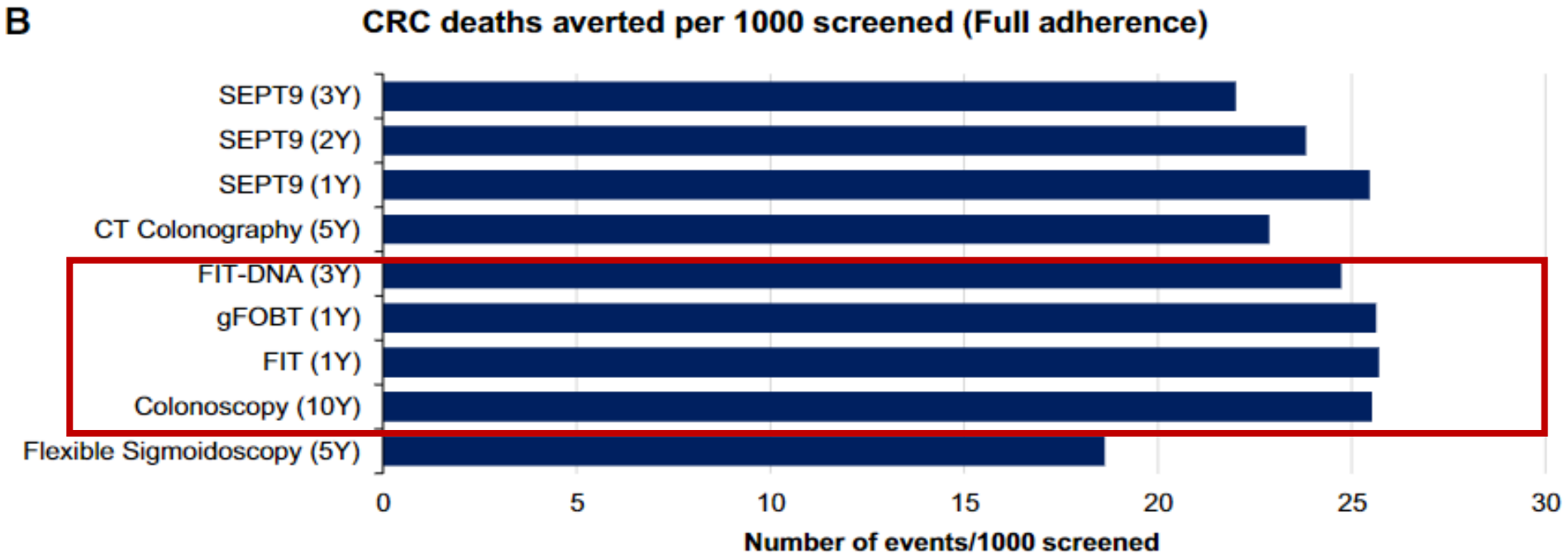
The following factors make stool tests a good option for colorectal cancer screening

- Colorectal cancer screening with guaiac-based FOBT has been shown to decrease both incidence and mortality in randomized controlled trials.
- Modeling studies suggest that lives saved through a high quality stool-based screening program are nearly the same as with a high quality colonoscopy-based screening program when strict adherence to screening and needed follow up occurs at recommended intervals over a lifetime.



https://nccrt.org/resource/fobt-clinicians-reference-resource/





D'Andrea, E., Ahnen, D. J., Sussman, D. A., & Najafzadeh, M. (2020). Quantifying the impact of adherence to screening strategies on colorectal cancer incidence and mortality. *Cancer medicine*, *9*(2), 824-836.

An Observation

Health systems with > 80% CRC Screening rates incorporate the use of at least one at home, stool-based test to reach those rates.

Fecal Immunochemical Test (FIT)
Done Annually
CRC Sensitivity 74%
Advanced Adenoma Sensitivity 22%
Specificity 97%

Mt-sDNA Test
Done every 3 years
CRC sensitivity 94%
Advanced Adenoma Sensitivity 43%
Specificity 86%

Knudsen, A. B.,et.al. (2021). *Jama*, *325*(19).

Imperiale, T. F.,et.al.. (2014).*NEJM*,*370*(14)

Potentially a Two Step Process

Fecal Immunochemical Test (FIT)

Stool DNA-FIT

If stool-based test is abnormal…

A diagnostic colonoscopy must be performed to complete the screening process

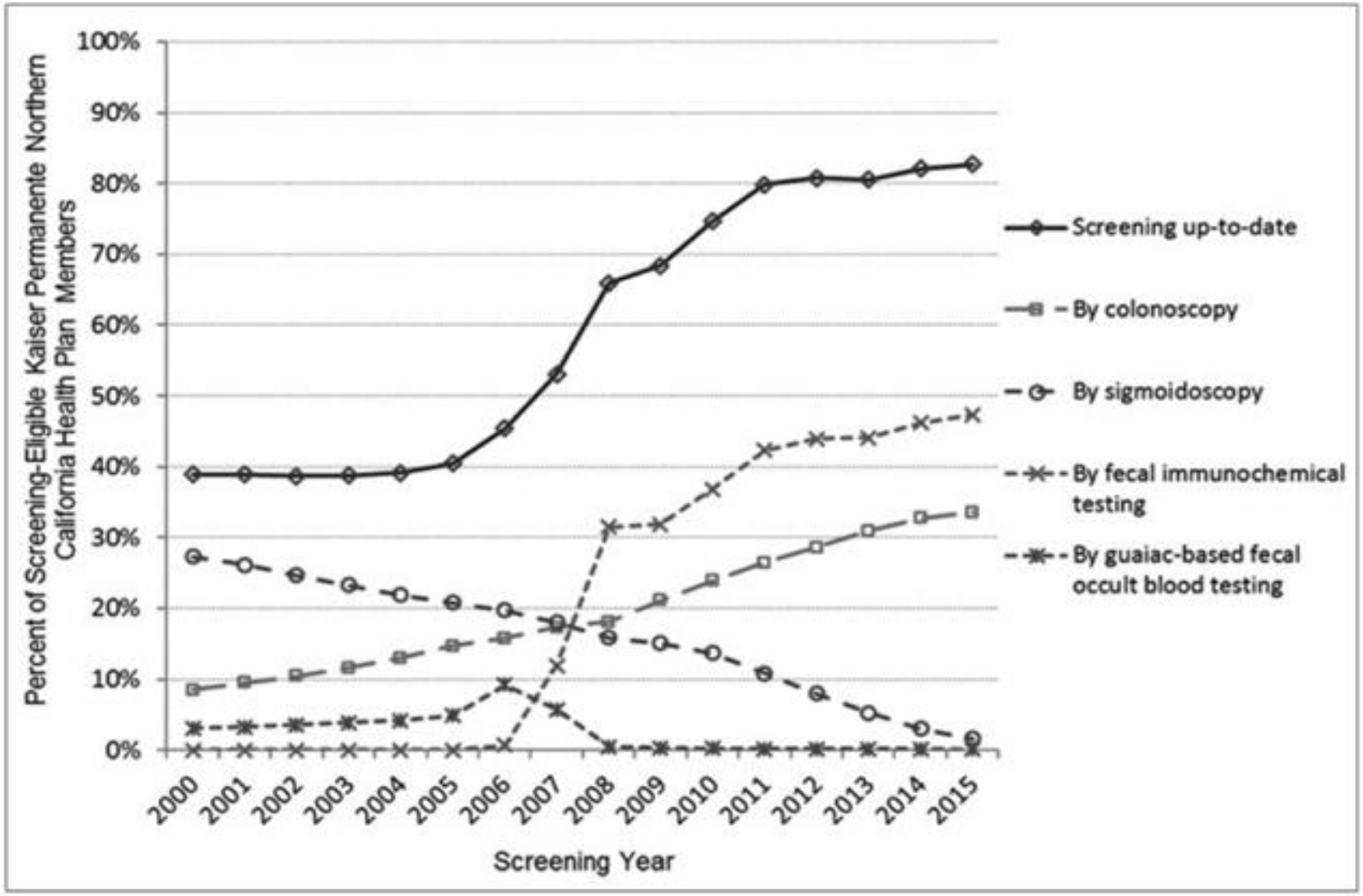
Success Stories

Kaiser No. Cal Experience

Effects of Organized Colorectal Cancer Screening on Cancer Incidence and Mortality in a Large Community-Based Population

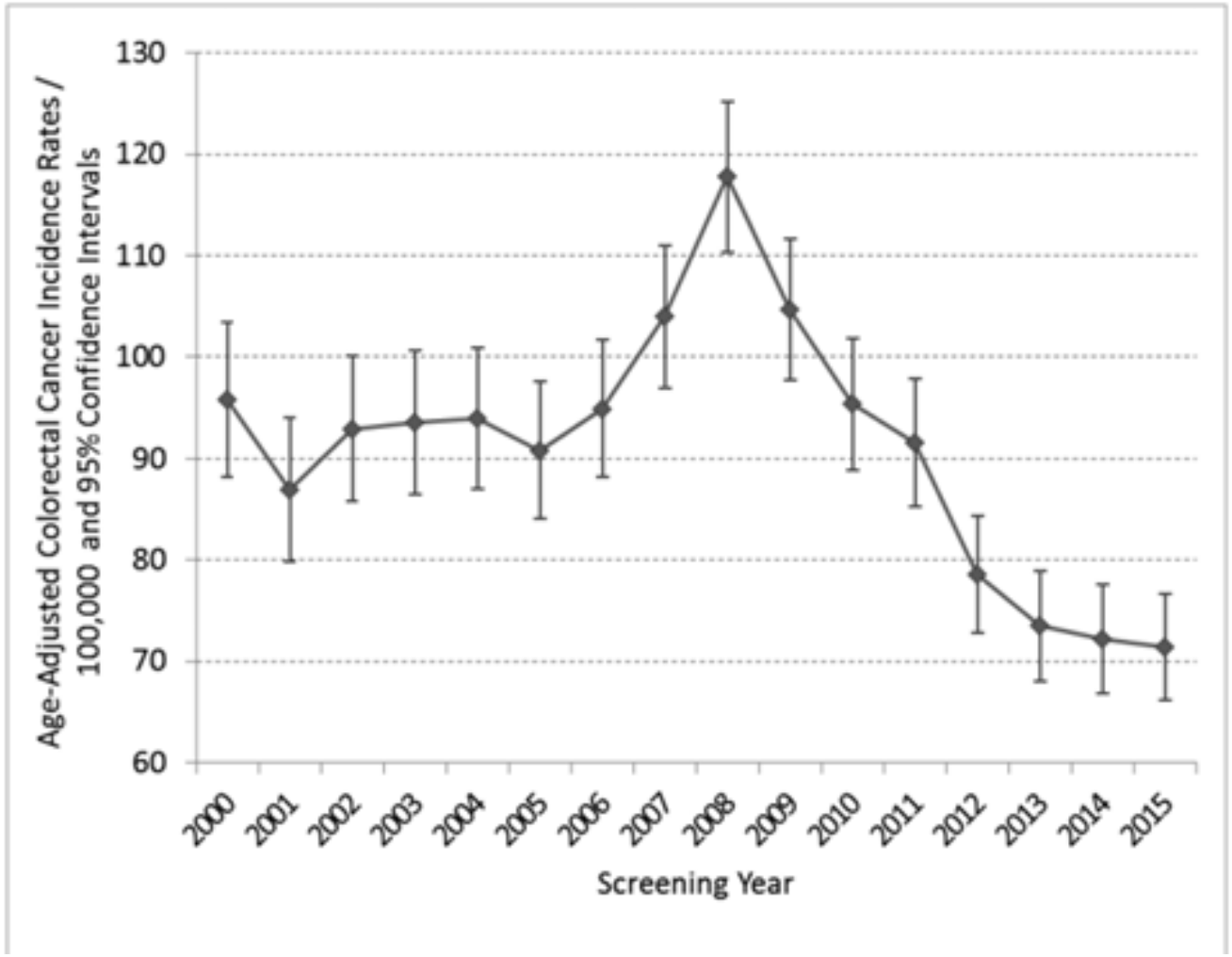
Theodore R. Levin,[1,2,*] **Douglas A. Corley**,[2,*] Christopher D. Jensen,[2] Joanne E. Schottinger,[3] Virginia P. Quinn,[3] Ann G. Zauber,[4] Jeffrey K. Lee,[2] Wei K. Zhao,[2] Natalia Udaltsova,[2] Nirupa R. Ghai,[3] Alexander T. Lee,[3] Charles P. Quesenberry,[2] Bruce H. Fireman,[2] and Chyke A. Doubeni[5]

Gastroenterology, *155*(5), 1383-1391.



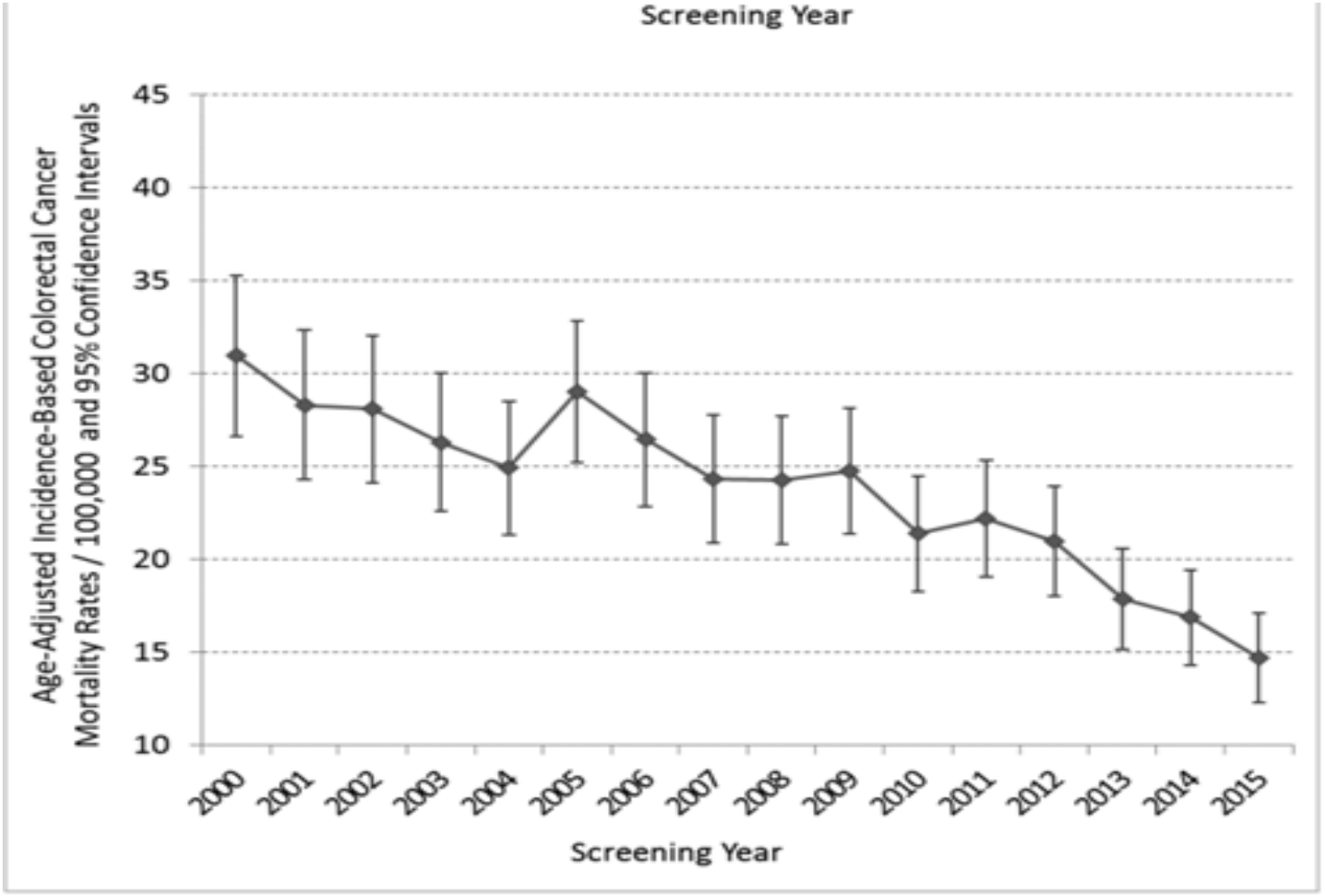
Gastroenterology, *155*(5), 1383-1391

KPNC CRC screening rates over time



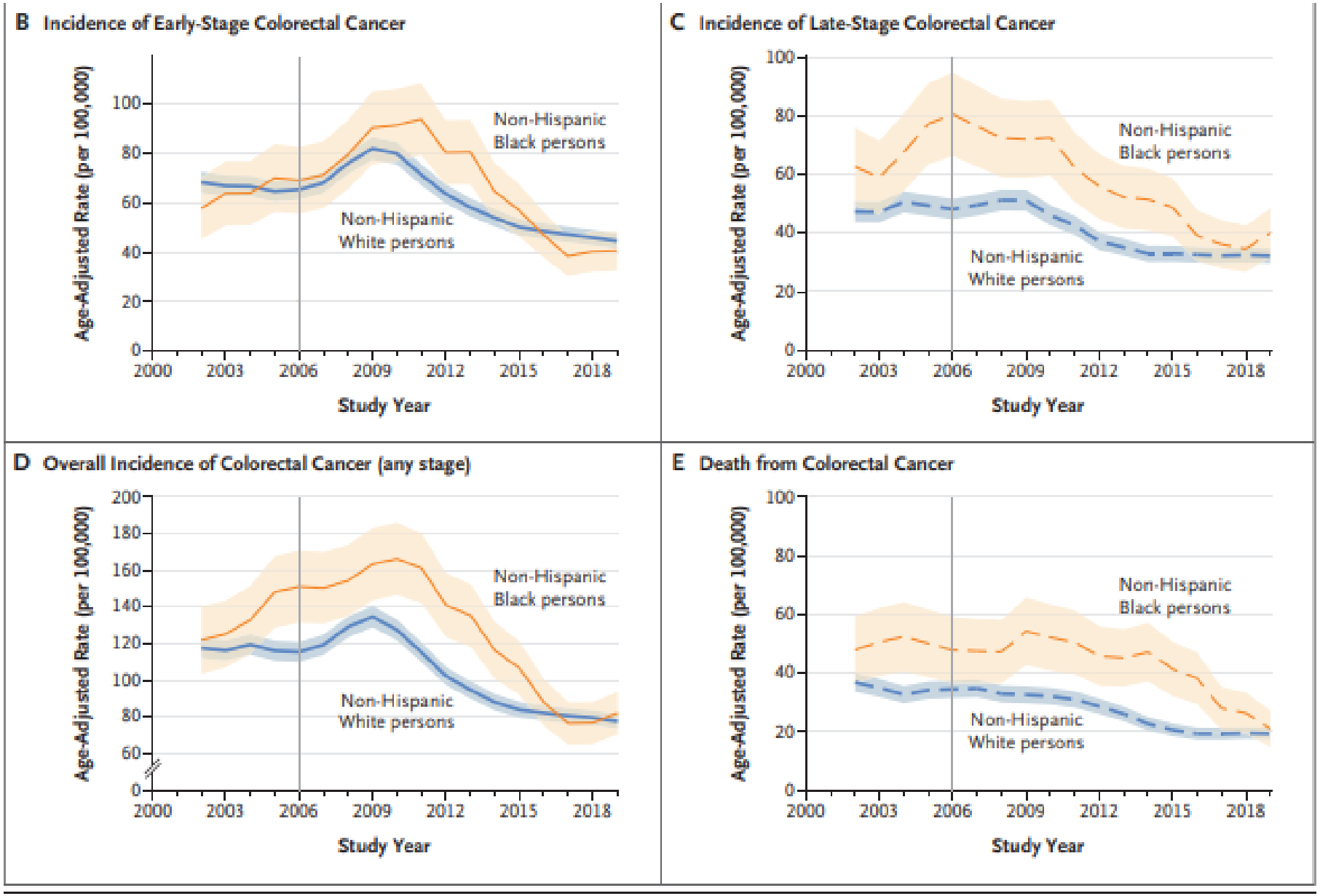
An initial increase in incidence as early-staged CRCs found

Gastroenterology, *155*(5), 1383-1391

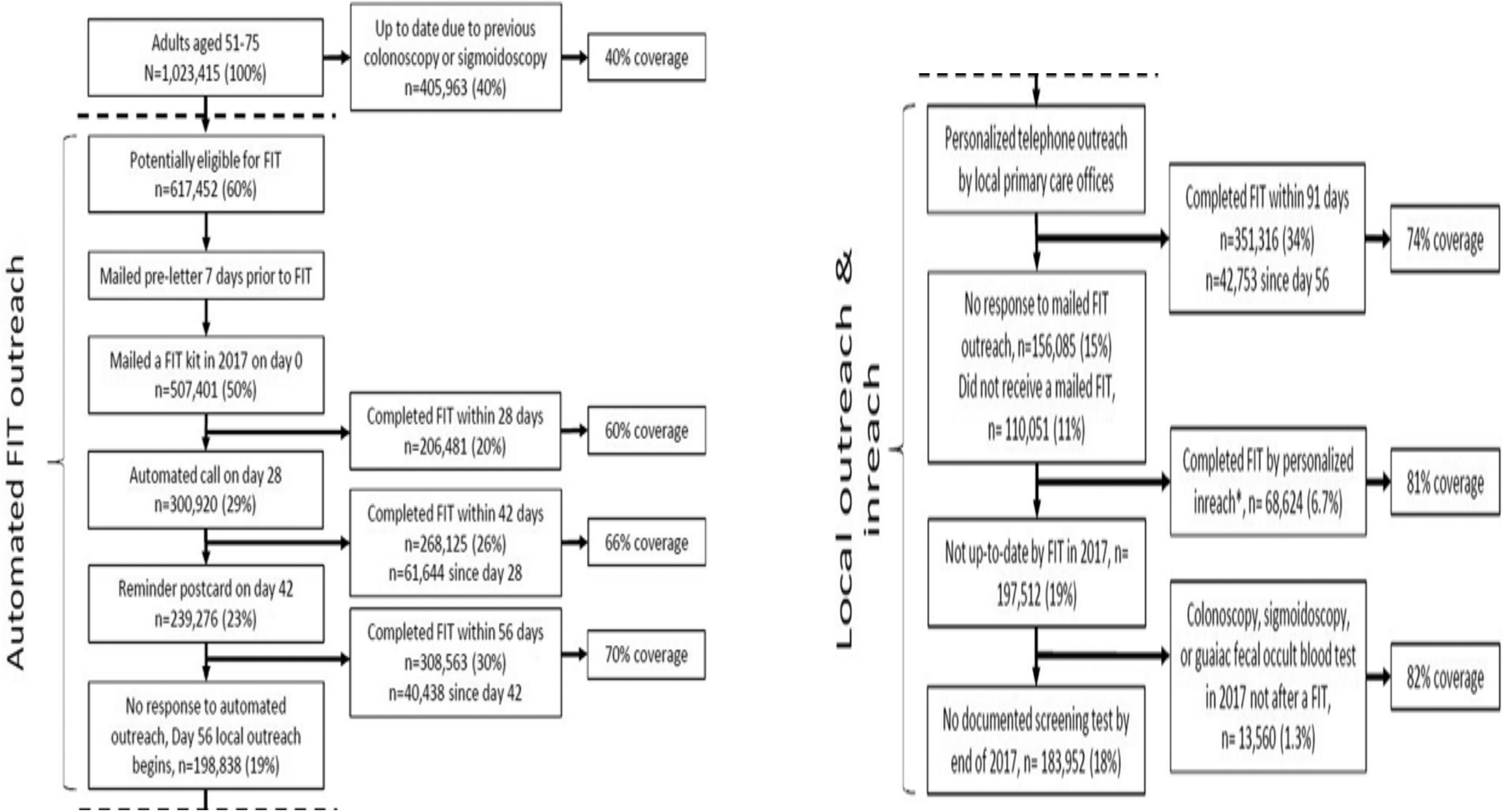


An eventual significant drop in mortalities demonstrated

Gastroenterology, *155*(5), 1383-1391



Doubeni, C. A., *New England Journal of Medicine*, *386*(8), 796-798.



Clinical Gastroenterology and Hepatology, *20*(1), 145-152.

Equitable Implementation of Mailed Stool Test–Based Colorectal Cancer Screening and Patient Navigation in a Safety Net Health System

Rebekah E. Scott, BA[1], Patrick Chang, MS[2], Nicole Kluz, MPH[1], Eda Baykal-Caglar, PhD[2,4], Deepak Agrawal, MD, MPH, MBA[1], and Michael Pignone, MD, MPH[1,2,3]

[1]Department of Internal Medicine, Dell Medical School, The University of Texas at Austin, Austin, TX, USA; [2]Department of Population Health, Dell Medical School, The University of Texas at Austin, Austin, USA; [3]Livestrong Cancer Institutes, Dell Medical School, The University of Texas at Austin, Austin, USA; [4]CommUnityCare Health Centers, Austin, TX, USA.

Scott, R. E., et.al.(2023). *Journal of General Internal Medicine*, *38*(7), 1631-1637.

Equitable Success Story

- Large FQHC
- Bilingual materials and navigators
- Mailed FIT campaign increased screening rates by 19.9%
- Latinx, Spanish speaking and uninsured patients were more likely to complete FIT testing
- 72.5% of + FIT patients did a colonoscopy within 90 days
- Spanish speakers more likely to complete

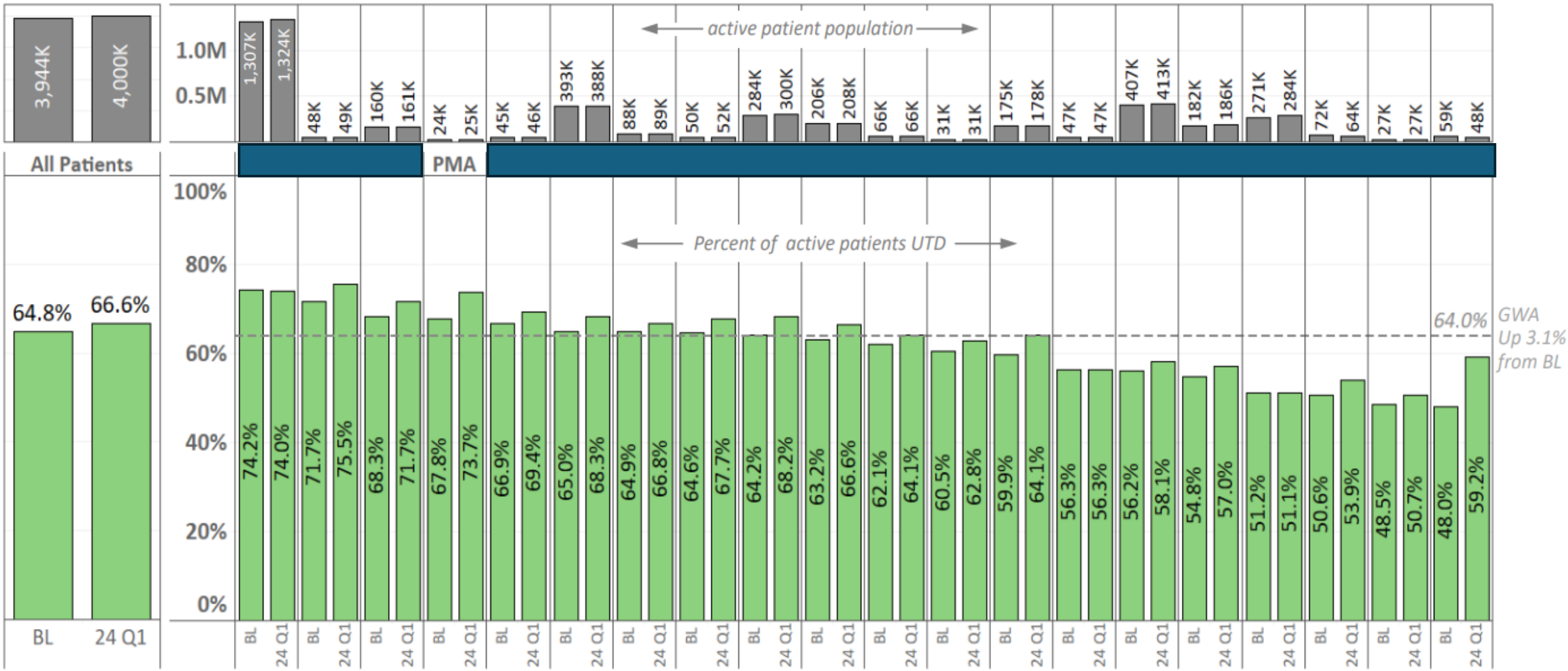
A Personal Example

- Since January 2013
- Started at 57.5% screening rate
- Offered choice in screening
- Leveraged transparent provider reporting
- Reached 80%+ screening rate by Oct. 2016


Colorectal Cancer Screening Benchmark (2021 Q4)
734,046
All Participants
36%
64%
Patient Count
100K
50K
0K
FB WN RN VB TU DE KU UA SY OM IY OL LM WK CG AR JA DG
Percent of Patients Eligible for Screening
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
17% 19% 20% 20% 24% 31% 34% 35% 37% 38% 38% 39% 40% 41% 45% 46% 46% 46%
83% 81% 80% 80% 76% 69% 66% 65% 63% 62% 62% 61% 60% 59% 55% 54% 54% 54%
CPX Goal: 80%
CRC Screening
Not Screened
Screened
Age
Multiple values
Ethnicity
All
Gender
All
Financial Class
All
Race
All

Percent of Patients with CRC Screening UTD

- Q1 2024 UTD rate for the collaborative's 4 million patients is 66.6% and ranges from 50.7% to 75.5%
- Group weighted average (GWA) increased from 60.9% at BL (Q2 2023) to 64.0% in Q1 2024.



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PRESENTER

Annie Thibault, MS, BS

Director of the Colorectal Cancer Prevention Network.

American Cancer Society®

Working with Partners to Promote Stool-Based Screening

- Annie Thibault, MS, BS -

CCPN a safety-net CRC screening program for average risk patient using stool-based testing (FIT, FIT/DNA), how the program relies on partnerships.

Annie Thibault MS
Executive Director (Institute Chair)
Colorectal Cancer Prevention Network
College of Arts and Sciences
University of South Carolina

Components to achieve screening sustainability

What are the gaps?

(Need of FIT kits, colonoscopy, pathology, surgery, etc.)

How many patients will require screening ?

(Let the data guide your asks to potential partners.)

How many patients will need furtherment of care (surgery, oncology, radiation)?

What's the cost benefit of partners participation? (What's in it for them)

Which partners need to be involved in the process?

How should you inform your partners of your screening outcomes, to get their continued commitment?

A sustainable screening program requires:

1-Focus on the entire healthcare process from the time of referral to the cancer treatment.
2-Remove barriers and assist the patient throughout the screening and treatment journey.

What does this mean?

1-Review your internal processes based on your outcomes data.
2- Identify current and missing partnerships (healthcare organizations, pharmaceutical, community groups, etc)
3 - Develop and maintain strong partnerships with external providers and institutions.

Start small and build using data to reach success!

Organizational Plan: Things to Consider

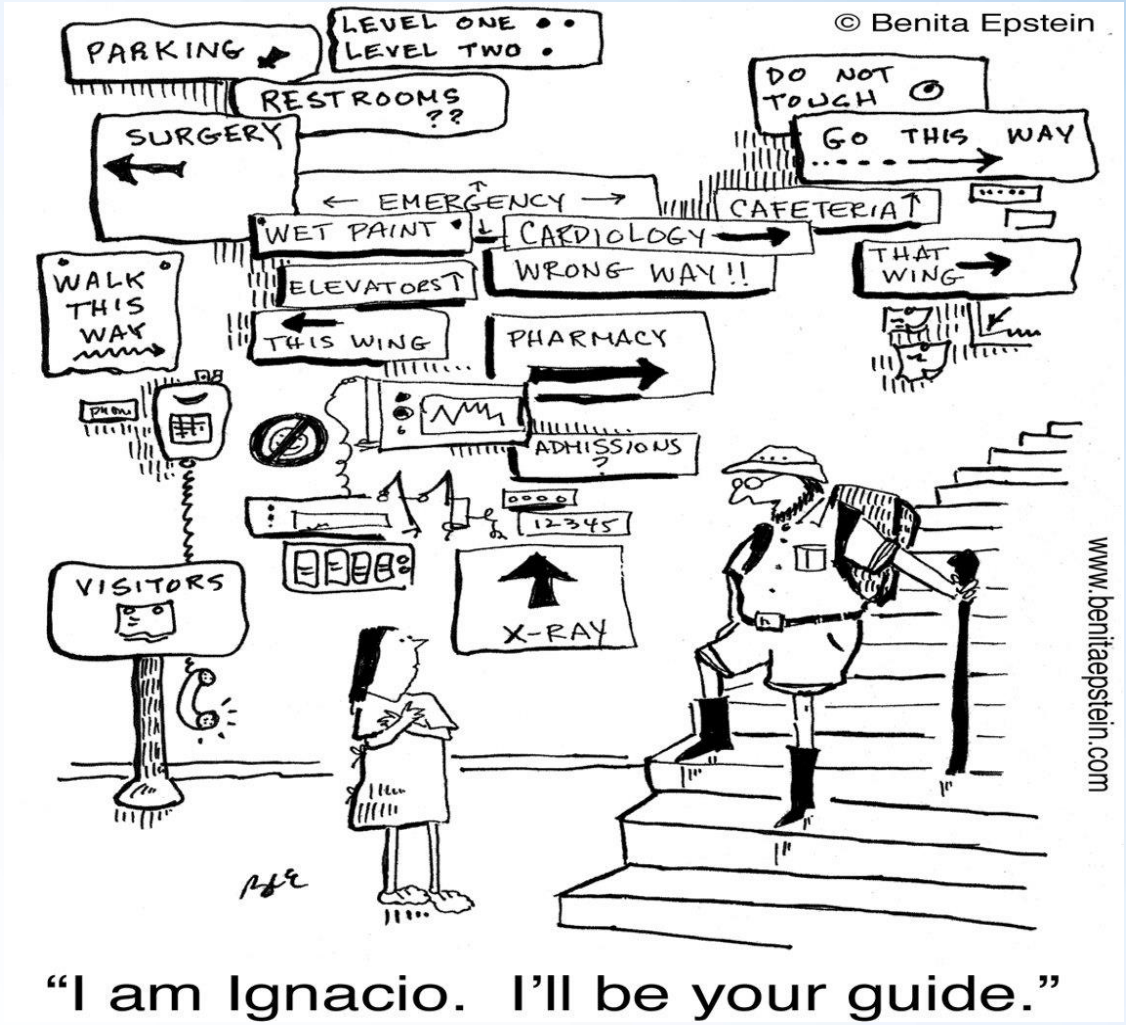
1-What do we need to ensure sustainability of screenings and follow-up care for uninsured patients?
2-Which organizations need to be at the table to help you achieve your goals?
3- Define ask based upon the data. Incorporate data as part of the ask. Ask for small achievable goals to build success in the partnership and build upon the success.
4-Motivate your new partners to get involved in your project by highlighting the benefits.

5- Define success

Two components that can lead to successful programs:

1-Using patient navigation to reduce patient barriers.

2-Creating a medical neighborhood of healthcare partners to remove the cost of screening and follow-up.

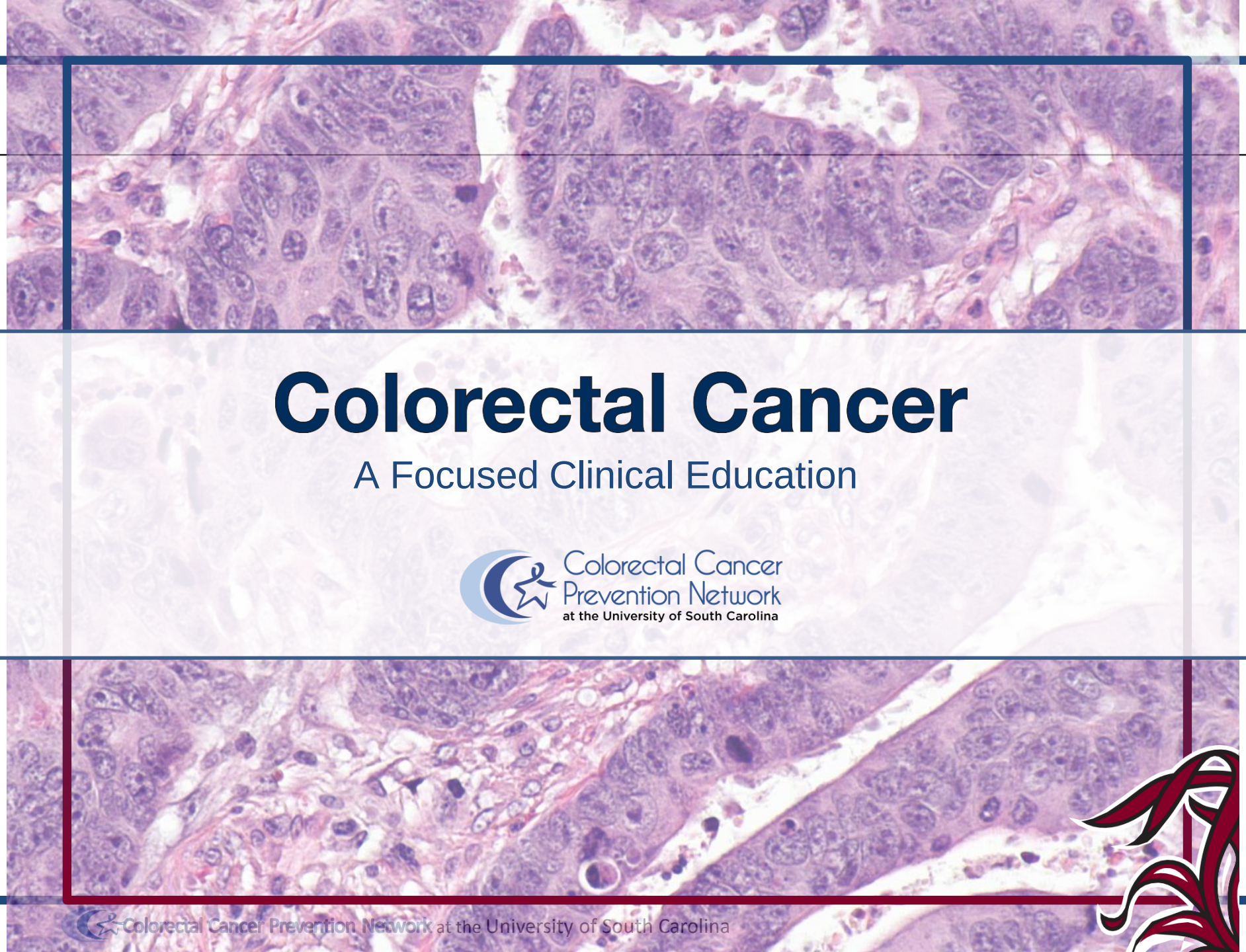


CCPN's considerations before launching a 2-step stool-based screening program

- Cost vs Effectiveness vs compliance
- Limitations of test
- Testing Appropriateness
- Tests requiring Follow-up
- One test does NOT fit All

How will we ensure compliance to follow-up colonoscopy if stool-based test come back positive?

Consider what you can do to assist your healthcare providers in their endeavor



Colorectal Cancer

A Focused Clinical Education

Colorectal Cancer Prevention Network
at the University of South Carolina

Measure compliance

FY 23 FIT+ Follow-up (7/1/2022-6/30/2023)		
Total FIT Positive	96	
Follow-up Colonscopy Completed	65	67.71%
Medical IE	1	1%
Insured	4	4%
Unable to Contact	4	4%
No longer with clinic	0	0%
Declined	6	6%
Ineligible for CCPN	2	2%
NO Show	6	6%
Unable to obtain Referral	0	0%
Unwilling to travel for services/no caregiver	2	2%
No results provided to patient by clinic	0	0%
Unable to obtain medical clearance	3	3%
Follow-up Colonoscopy Not Completed	28	29.17%

FY 22 FIT+ Follow-up (7/1/2021-6/30/2022)		
Total FIT Positive	96	
Follow-up Colonscopy Completed	61	63.54%
Medical IE	1	1%
Insured	3	3%
Unable to Contact	7	7%
No longer with clinic	2	2%
Declined	5	5%
Ineligible for CCPN	5	5%
NO Show	4	4%
Unable to obtain Referral	1	1%
Unwilling to travel for services/no caregiver	1	1%
No results provided to patient by clinic	4	4%
Unable to obtain medical clearance	2	2%
Follow-up Colonoscopy Not Completed	35	36.46%

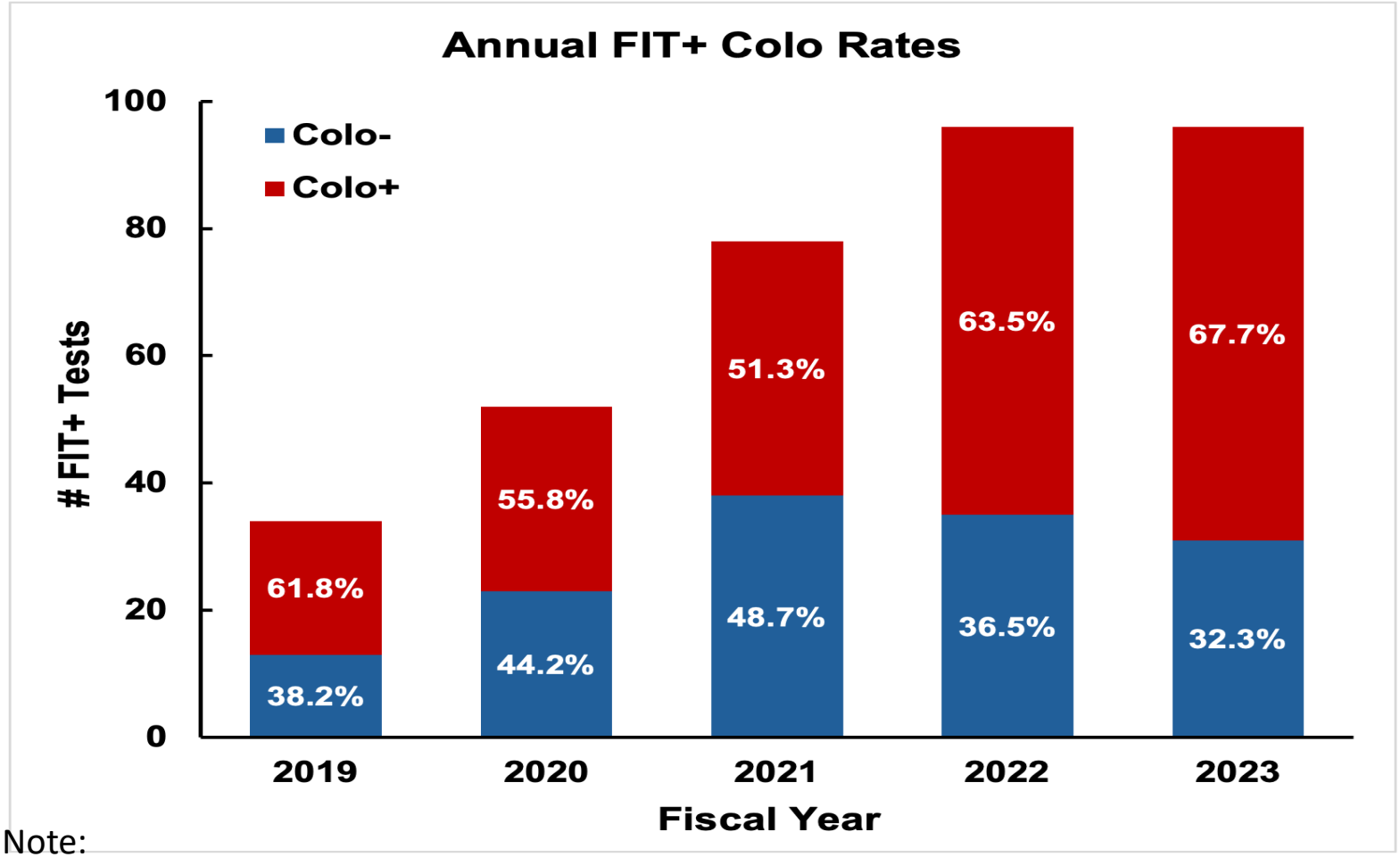
FY 21 FIT+ Follow-up (7/1/2020-6/30/2021)		
Total FIT Positive	78	
Follow-up Colonscopy Completed	40	51.28%
Medical IE	8	10%
Insured	3	4%
Unable to Contact	5	6%
No longer with clinic	1	1%
Declined	6	8%
Ineligible for CCPN	3	4%
NO Show	4	5%
Unable to obtain Referral	3	4%
Unwilling to travel for services/no caregiver	2	3%
No results provided to patient by clinic	2	3%
Unable to obtain medical clearance	1	1%
Follow-up Colonoscopy Not Completed	38	48.72%

FY20 FIT+ Follow-up (7/1/2019-6/30/2020)		
Total FIT Positive	52	
Follow-up Colonscopy Completed	29	55.77%
Medical IE	1	2%
Insured	4	8%
Unable to Contact	1	2%
No longer with clinic	4	8%
Declined	3	6%
Ineligible for CCPN	3	6%
NO Show	4	8%
Unable to obtain Referral	1	2%
Unwilling to travel for services	1	2%
No results provided to patient by clinic	1	2%
Unable to obtain medical clearance	0	0%
Follow-up Colonoscopy Not Completed	23	44.23%

FY 19 FIT+ Follow-up (7/1/2018-6/30/2019)		
Total FIT Positive	34	
Follow-up Colonscopy Completed	21	61.76%
Medical IE		
Insured	3	9%
Unable to Contact		
No longer with clinic		
Declined	8	24%
Ineligible for CCPN		
NO Show		
Unable to obtain Referral		
Unwilling to travel for services	1	3%
No results provided to patient by clinic	1	3%
Unable to obtain medical clearance		
Follow-up Colonoscopy Not Completed	13	38.24%

How can we improve compliance to colonoscopy?

The importance of following up on FIT+



Note:
Colo + means colonoscopy after a positive stool-based test result completed
Colo - means colonoscopy after positive stool-based test result not completed

CCPN Lessons learned

When starting a stool-based program consider what partner do we need at the table (PCP, gastroenterologists, anesthetists, pathologist, surgeons, oncologists, community organizations)

Compliance to 2-steps screening can be multi-factorial, at the patient and provider level. (How will you track compliance, and how will you address barriers to follow-up screening.)

3. Data collection and continuous quality improvement can help identify factors that influence poor compliance.

4. By engaging with external clinical partners make a realistic ask, if you want buy-in and highlight the benefits to them.

Annie Thibault, MSc
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Visit us:

CRCFacts.com

@CCPNatUSC

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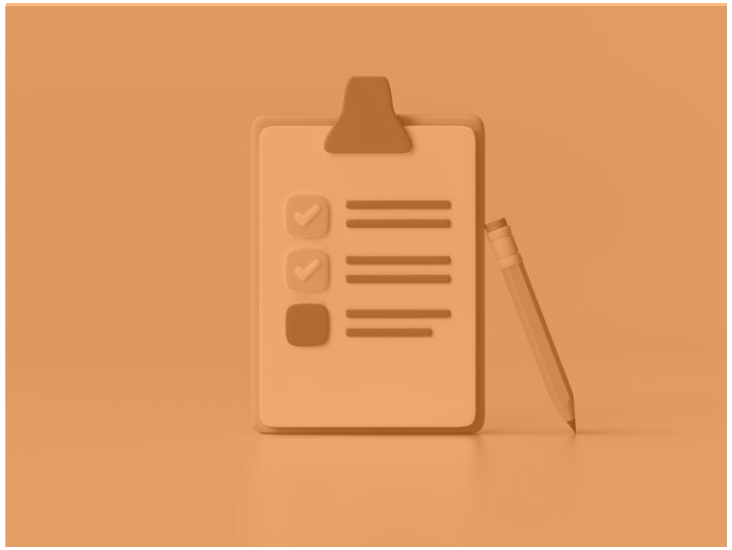
American Cancer Society

NATIONAL COLORECTAL CANCER ROUNDTABLE

Promoting Non-Invasive CRC Screening

Q&A

Time for our last poll!

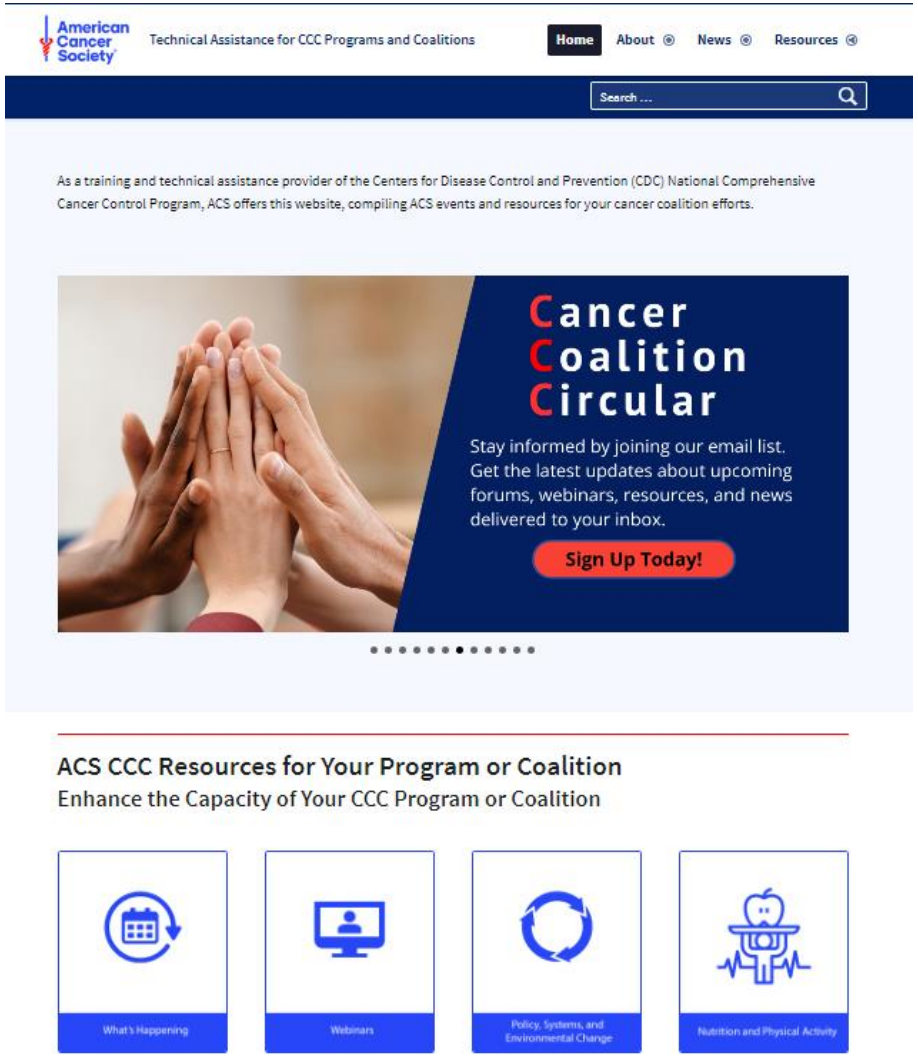


1. Brief post-survey

View the series recordings!

ACS CCC brings you this series through a cooperative agreement with the CDC National Comprehensive Cancer Control Program. Our goal is to provide quality trainings and technical assistance to NCCCP's 66 grantee coalitions across the country.

Your One-Stop-Shop for Coalition Resources from Across ACS



[acs4ccc.org](acs4ccc.org)

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linkedin.com/in/nationalnavigation-roundtable

@NNRTnews

Visit: navigationroundtable.org

www.thecommunityguide.org

"Enhancing Colorectal Cancer Screening Through Effective Patient Navigation: Integrating CPSTF Recommendations for Economic Impact"

September 11, 2024 from 1:00 pm – 2:30pm ET

Register HERE

ACS NNRT is pleased to facilitate a webinar with national thought leaders from the Professional Oncology Navigation Task Force and the Centers for Disease Control and Prevention's Community Guide Program and Division of Cancer Prevention and Control.

Speakers will discuss The Community Guide –

- How to explore CPSTF findings
- Effectiveness in Increasing Screening Rates
- Cost-Effectiveness and Return on Investment
- Comprehensive Support and Culturally Appropriate Services
- Learning from others to apply in improve your program

We will also address ACS NNRT Sustainability for Patient Navigation as well as ways that Comprehensive Cancer Control coalitions might promote patient navigation centered screening strategies through their collaborative efforts across the country.

The American Cancer Society National Navigation Roundtable (ACS NNRT) was established in 2017. The ACS NNRT is a national coalition of 80 member organizations to advance navigation efforts that eliminate barriers to quality care, reduce disparities, and foster ongoing health equity across the cancer continuum. The American Cancer Society provides organizational leadership and expert staff support to the ACS NNRT.

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Thank You

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