Efficacy of FIT/FOBT for CRC Screening

June 2016

Durado Brooks, MD, MPH
Managing Director, Cancer Control Intervention
American Cancer Society
Colorectal Cancer

- 3\textsuperscript{rd} most common cancer and the 2\textsuperscript{nd} deadliest in the U.S.
  - Nearly 140,000 new cases expected this year
    - 4,000 in Massachusetts
  - Almost 50,000 deaths nationwide
    - 900 in Massachusetts
We are Making Progress!

- Among MA males the mortality rate has decreased from 23.1 per 100,000 in 2003 to 15.4 per 100,000 in 2014.
- Among MA females the mortality rate has decreased from 15.3 per 100,000 in 2003 to 10.4 per 100,000 in 2014.
Colorectal Cancer Mortality

- Decline due to:
  - Improvements in treatment
  - Screening → earlier detection
  - Screening → prevention

- Recent study estimates that screening has prevented more than 500,000 colorectal cancers in the US over the past three decades
CRC Screening: National Data

In 2012, 65.1% of US adults were up to date with screening.

- The percentages of blacks and whites up-to-date with screening were equivalent.
- Lower rates for Hispanics and Native Americans
- Lowest rates among the uninsured
MA Screening Data

- Statewide rate of 74.6%, but significant differences regionally

**Colorectal Cancer Screening Rate by Region**

- Western: 65%
- Central: 66.2%
- Southeastern: 73.7%
- Northeastern: 79.6%
- Boston: 67.4%
- Metro West: 76.5%

BRFSS, 2011-2013, MassCHIP
<table>
<thead>
<tr>
<th>Race</th>
<th>FOBT/FIT</th>
<th>Colonoscopy</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>16.7%</td>
<td>59.5%</td>
</tr>
<tr>
<td>Black (non-Hispanic)</td>
<td>15.2%</td>
<td>52.4%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>9.4%</td>
<td>46.3%</td>
</tr>
<tr>
<td>Asian/Pacific Islander</td>
<td>6.7%</td>
<td>57%</td>
</tr>
</tbody>
</table>

BRFSS, 2011-2013, MassCHIP
CRC mortality under 2 scenarios of screening uptake

80% screening rate by 2018 translates to 21,000 averted cancer deaths per year by 2030, and a total of 203,000 averted deaths from 2013 through 2030

Meester et al, Cancer 2015
80% Colorectal Cancer Screening Rate By 2018
Stool Tests

- Look for hidden blood in stool
- Two major types
Stool Tests: Guaiac

- Most common type in U.S.
- Solid evidence (3 RCT’s)
- 30 year f/u (NEJM Oct 2013)
- Need specimens from 3 bowel movements
- Non-specific
- Results influenced by foods and medications
- Better sensitivity with newer versions (Hemoccult Sensa)
- Older forms (Hemoccult II) not recommended!
Stool Tests: Immunochemical (FIT)

- 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-based FOBT
- Somewhat more costly than guaiac tests – but higher reimbursement may offset
Accuracy
Annals of Internal Medicine

Accuracy of Fecal Immunochemical Tests for Colorectal Cancer
Systematic Review and Meta-analysis

Jeffrey K. Lee, MD, MAS; Elizabeth G. Liles, MD, MCR; Stephen Bent, MD; Theodore R. Levin, MD; and Douglas A. Corley, MD, PhD

**Background:** Performance characteristics of fecal immunochemical tests (FITs) to screen for colorectal cancer (CRC) have been inconsistent.

**Purpose:** To synthesize data about the diagnostic accuracy of FITs for CRC and identify factors affecting its performance characteristics.

**Data Sources:** Online databases, including MEDLINE and EMBASE, and bibliographies of included studies from 1996 to 2013.

**Study Selection:** All studies evaluating the diagnostic accuracy of FITs for CRC in asymptomatic, average-risk adults.

**Data Extraction:** Two reviewers independently extracted data and critiqued study quality.

**Data Synthesis:** Nineteen eligible studies were included and meta-analyzed. The pooled sensitivity, specificity, positive likelihood ratio, and negative likelihood ratio of FITs for CRC were 0.79 (95% CI, 0.69 to 0.86), 0.94 (CI, 0.92 to 0.95), 13.10 (CI, 10.49 to 16.35), 0.23 (CI, 0.15 to 0.33), respectively, with an overall diagnostic accuracy of 95% (CI, 93% to 97%). There was substantial heterogeneity between studies in both the pooled sensitivity and specificity estimates. Stratifying by cutoff value for a positive test result or removal of discontinued FIT brands resulted in homogeneous sensitivity estimates. Sensitivity for CRC improved with lower assay cutoff values for a positive test result (for example, 0.89 [CI, 0.80 to 0.95] at a cutoff value less than 20 µg/g vs. 0.70 [CI, 0.55 to 0.81] at cutoff values of 20 to 50 µg/g) but with a corresponding decrease in specificity. A single-sample FIT had similar sensitivity and specificity as several samples, independent of FIT brand.

**Limitations:** Only English-language articles were included. Lack of data prevented complete subgroup analyses by FIT brand.

**Conclusion:** Fecal immunochemical tests are moderately sensitive, are highly specific, and have high overall diagnostic accuracy for detecting CRC. Diagnostic performance of FITs depends on the cutoff value for a positive test result.

**Primary Funding Source:** National Institute of Diabetes and Digestive and Kidney Diseases and National Cancer Institute.


For author affiliations, see end of text.
Figure 2. Pooled sensitivity and specificity for fecal immunochemical tests for the detection of colorectal cancer for all included studies.

<table>
<thead>
<tr>
<th>Author, Year (Reference)</th>
<th>Sensitivity (95% CI)</th>
<th>Specificity (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sohn et al, 2005 (14)</td>
<td>0.25 (0.05–0.57)</td>
<td>0.99 (0.98–0.99)</td>
</tr>
<tr>
<td>Levi et al, 2011 (15)</td>
<td>1.00 (0.54–1.00)</td>
<td>0.88 (0.86–0.90)</td>
</tr>
<tr>
<td>Allison et al, 1996 (31)</td>
<td>0.69 (0.50–0.84)</td>
<td>0.94 (0.94–0.95)</td>
</tr>
<tr>
<td>Allison et al, 2007 (32)</td>
<td>0.86 (0.57–0.98)</td>
<td>0.97 (0.96–0.97)</td>
</tr>
<tr>
<td>Levi et al, 2007 (33)</td>
<td>0.67 (0.09–0.99)</td>
<td>0.83 (0.73–0.91)</td>
</tr>
<tr>
<td>Cheng et al, 2002 (34)</td>
<td>0.88 (0.62–0.98)</td>
<td>0.91 (0.90–0.92)</td>
</tr>
<tr>
<td>Morikawa et al, 2005 (35)</td>
<td>0.66 (0.54–0.76)</td>
<td>0.95 (0.94–0.95)</td>
</tr>
<tr>
<td>Nakama et al, 1999 (36)</td>
<td>0.56 (0.31–0.78)</td>
<td>0.97 (0.96–0.97)</td>
</tr>
<tr>
<td>Nakama et al, 1996 (37)</td>
<td>0.83 (0.52–0.98)</td>
<td>0.96 (0.95–0.96)</td>
</tr>
<tr>
<td>Launoy et al, 2005 (38)</td>
<td>0.86 (0.67–0.96)</td>
<td>0.94 (0.94–0.95)</td>
</tr>
<tr>
<td>Itoh et al, 1996 (39)</td>
<td>0.87 (0.78–0.93)</td>
<td>0.95 (0.95–0.95)</td>
</tr>
<tr>
<td>Nakazato et al, 2006 (40)</td>
<td>0.53 (0.29–0.76)</td>
<td>0.87 (0.86–0.88)</td>
</tr>
<tr>
<td>Park et al, 2010 (41)</td>
<td>0.77 (0.46–0.95)</td>
<td>0.94 (0.92–0.95)</td>
</tr>
<tr>
<td>de Wijkerslooth et al, 2012 (42)</td>
<td>0.75 (0.35–0.97)</td>
<td>0.95 (0.93–0.96)</td>
</tr>
<tr>
<td>Parra-Blanco et al, 2010 (43)</td>
<td>1.00 (0.77–1.00)</td>
<td>0.93 (0.91–0.94)</td>
</tr>
<tr>
<td>Chiu et al, 2013 (44)</td>
<td>0.85 (0.55–0.98)</td>
<td>0.92 (0.91–0.92)</td>
</tr>
<tr>
<td>Chiang et al, 2011 (45)</td>
<td>0.96 (0.82–1.00)</td>
<td>0.87 (0.85–0.88)</td>
</tr>
<tr>
<td>Brenner and Tao, 2013 (46)</td>
<td>0.73 (0.45–0.92)</td>
<td>0.96 (0.95–0.96)</td>
</tr>
<tr>
<td>Brenner and Tao, 2013 (46)</td>
<td>0.60 (0.32–0.84)</td>
<td>0.95 (0.94–0.96)</td>
</tr>
<tr>
<td>Combined</td>
<td>0.79 (0.69–0.86)</td>
<td>0.94 (0.92–0.95)</td>
</tr>
</tbody>
</table>

$\hat{I}^2 = 68.45\%$ (95% CI, 53.48%–83.42%)  
Q = 57.05; P = 0.00

$\hat{I}^2 = 98.50\%$ (95% CI, 98.21%–98.79%)  
Q = 1200.46; P = 0.00
# Meta-analysis of FIT and Hemoccult Sensa

## Conclusion

Both have high sensitivity for cancer detection.

<table>
<thead>
<tr>
<th></th>
<th>FIT</th>
<th>Hemoccult Sensa</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sensitivity:</td>
<td>73-89%</td>
<td>64-80%</td>
</tr>
<tr>
<td>Specificity:</td>
<td>92-95%</td>
<td>87-90%</td>
</tr>
</tbody>
</table>

Table 1. Sensitivity and Specificity of the Multitarget Stool DNA Test and the Fecal Immunochemical Test (FIT) for the Most Advanced Findings on Colonoscopy.

<table>
<thead>
<tr>
<th>Most Advanced Finding</th>
<th>Colonoscopy (N = 9989)</th>
<th>Multitarget DNA Test (N = 9989)</th>
<th>FIT (N = 9989)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>no.</td>
<td>Positive Results</td>
<td>Sensitivity (95% CI)</td>
</tr>
<tr>
<td>Colorectal cancer</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Any</td>
<td>65</td>
<td>60</td>
<td>92.3 (83.0–97.5)</td>
</tr>
<tr>
<td>Stage I to III*</td>
<td>60</td>
<td>56</td>
<td>93.3 (83.8–98.2)</td>
</tr>
<tr>
<td>Colorectal cancer and high-grade dysplasia</td>
<td>104</td>
<td>87</td>
<td>83.7 (75.1–90.2)</td>
</tr>
<tr>
<td>Advanced precancerous lesions†</td>
<td>757</td>
<td>321</td>
<td>42.4 (38.9–46.0)</td>
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<tr>
<td>Nonadvanced adenoma</td>
<td>2893</td>
<td>498</td>
<td>17.2 (15.9–18.6)</td>
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<tr>
<td>All nonadvanced adenomas, non-neoplastic findings, and negative results on colonoscopy</td>
<td>9167</td>
<td>1231</td>
<td>86.6 (85.9–87.2)</td>
</tr>
<tr>
<td>Negative results on colonoscopy</td>
<td>4457</td>
<td>455</td>
<td>89.8 (88.9–90.7)</td>
</tr>
</tbody>
</table>

* These stages of colorectal cancer, as defined by the system recommended by the American Joint Committee on Cancer, are associated with an increased rate of cure.
† Advanced precancerous lesions include advanced adenomas and sessile serrated polyps measuring 1 cm or more.
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<tr>
<td></td>
<td>no.</td>
<td>no.</td>
<td>%</td>
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† Advanced precancerous lesions include advanced adenomas and sessile serrated polyps measuring 1 cm or more.
Efficacy
Long-Term Mortality after Screening for Colorectal Cancer

Aasma Shaukat, M.D., M.P.H., Steven J. Mongin, M.S., Mindy S. Geisser, M.S.,
Frank A. Lederle, M.D., John H. Bond, M.D., Jack S. Mandel, Ph.D., M.P.H.,
and Timothy R. Church, Ph.D.

ABSTRACT

BACKGROUND
In randomized trials, fecal occult-blood testing reduces mortality from colorectal cancer. However, the duration of the benefit is unknown, as are the effects specific to age and sex.

METHODS
In the Minnesota Colon Cancer Control Study, 46,551 participants, 50 to 80 years of age, were randomly assigned to usual care (control) or to annual or biennial screening with fecal occult-blood testing. Screening was performed from 1976 through 1982 and from 1986 through 1992. We used the National Death Index to obtain updated information on the vital status of participants and to determine causes of death through 2008.
Screen-detected colorectal cancers show improved cancer-specific survival when compared with cancers diagnosed via the 2-week suspected colorectal cancer referral guidelines

E. D. Courtney*, D. Chong*, R. Tighe†, J. R. Easterbrook‡, W. S. L. Stebbings* and J. Hernon*

*Department of Colorectal Surgery, Norfolk and Norwich University Hospital, Norwich, UK, †Department of Gastroenterology, Norfolk and Norwich University Hospital, Norwich, UK and ‡Department of Colorectal Surgery, Queen Elizabeth Hospital, King’s Lynn, UK
FOBT/FIT: Deaths Averted (USPSTF 2015)

Quality
# FOBT Quality Issues

Sensitivity of Take Home vs. In-Office FOBT (Hemoccult II)

<table>
<thead>
<tr>
<th>FOBT method (Hemoccult II)</th>
<th>Sensitivity</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>All Advanced Lesions</strong></td>
<td></td>
</tr>
<tr>
<td>3 card, take-home</td>
<td>23.9 %</td>
</tr>
<tr>
<td>Single sample, in-office</td>
<td>4.9 %</td>
</tr>
<tr>
<td><strong>Cancer</strong></td>
<td></td>
</tr>
<tr>
<td>3 card, take-home</td>
<td>43.9 %</td>
</tr>
<tr>
<td>Single sample, in-office</td>
<td>9.5 %</td>
</tr>
</tbody>
</table>

Collins et al, Annals of Int Med Jan 2005
Stool Testing Quality Issues

- In-office FOBT is essentially **worthless** as a screening tool for CRC and **should never be used**.
- CRC screening by FOBT should be performed with **high-sensitivity** FOBT - either FIT or a highly sensitive gFOBT (such as Hemoccult SENSA).
  - Older, less sensitive guaiac tests (such as Hemoccult II) should not be used for CRC screening.
- Annual testing
- All positive screening tests should be evaluated by colonoscopy
Clinicians Reference: FOBT

One page document designed to educate clinicians about important elements of colorectal cancer screening using fecal occult blood tests (FOBT).

Provides state-of-the-science information about guaiac and immunochemical FOBT, test performance and characteristics of high quality screening programs.

Available at www.cancer.org/colonmd
Preferences
PCPs and FOBT/FIT

- FOBT/FIT widely used, but:
  - Effectiveness questioned by many clinicians
  - Lack of knowledge re: performance of new vs. older forms of stool tests, other quality issues

- Colonoscopy viewed as the best screening test, but a high proportion of patients face barriers
  - Often recommended despite access or other challenges
  - Patient preferences rarely solicited
  - Focus on colonoscopy associated with low screening rates in a number of studies
Patient Preferences

- FOBT completed
- Colonoscopy completed

Participants, %

- FOBT Arm: 67%
- Colonoscopy Arm: 38%
- Choice Arm: 38%

P = .64
P < .001
P < .001
Figure 2. CRC Screening Participation For Usual Care, Colonoscopy Outreach, and FIT Outreach

CRC indicates colorectal cancer; FIT, fecal immunochemical test.
Many Patients Prefer Stool Tests

- Diverse sample of 323 adults given detailed side-by-side description of FOBT and colonoscopy (DeBourcy et al. 2007)
  - 53% preferred FOBT
  - Almost half felt very strongly about their preference

- 212 patients at 4 health centers rated different screening options with different attributes (Hawley et al. 2008)
  - 37% preferred colonoscopy
  - 31% preferred FOBT

- Nationally representative sample of 2068 VA patients given brief descriptions of each screening mode (Powell et al. 2009)
  - 37% preferred colonoscopy
  - 29% preferred FOBT
Implementing FOBT/FIT in Practice
Steps from the Clinician’s Guide
“Action Plan” Toolkit Version

- Eight page guide introduces clinicians and staff to concepts and tools provided in the full Toolkit
- Contains links to the full Toolkit, tools and resources
- Not colorectal-specific; practical, action-oriented assistance that can be used in the office to improve screening rates for multiple cancer sites (colorectal, breast and cervical)

Available at
http://nccrt.org/about/provider-education/crc-clinician-guide/
Staff Involvement

- Key Point.....the clinicians cannot do it all!
- Time that patients spend with non-clinician staff is underutilized
- Standing orders can empower nurses, intake staff, etc. to distribute educational materials, schedule appointments, etc.
- Involve staff in meetings to discuss progress in achieving office goals for improving the delivery of preventive services
**Make a Recommendation**
The primary reason patients say they are not screened is because a doctor did not advise it. A recommendation from you is vital.

**Develop a Screening Policy**
Create a standardized course of action. Engage your team in creating, supporting, and following the policy.

**Communication**

**Measure Practice Progress**
Establish a baseline screening rate, and set an ambitious practice goal. Seeing screening rates improve can be rewarding for your team.

**Be Persistent With Reminders**
Track test results, and follow up with providers and patients. You may need to remind patients several times before they follow through.
#1: Make a Recommendation

**Goal = Recommendation to each eligible patient**

- Requires an opportunistic/global approach
  - Don’t limit efforts to “check-ups” or well visits
- Requires a system that doesn’t depend on the doctor alone
- Requires consistent messaging from clinicians and staff, taking into account patient knowledge and concerns
Table 2. Patient rated importance of screening information and proportion that received information from physician (n = 415)

<table>
<thead>
<tr>
<th>Type of information</th>
<th>Patients who rated information &quot;very important&quot;</th>
<th>Patients receiving information (of those who rated information &quot;very important&quot;)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Screening purpose</td>
<td>368/415 (88.7%)</td>
<td>214/368 (58.2%)</td>
</tr>
<tr>
<td>Test accuracy</td>
<td>354/415 (85.3%)</td>
<td>26/354 (7.3%)</td>
</tr>
<tr>
<td>Testing alternatives</td>
<td>346/415 (83.4%)</td>
<td>101/346 (29.2%)</td>
</tr>
<tr>
<td>Testing pros/cons</td>
<td>356/415 (85.8%)</td>
<td>14/356 (3.9%)</td>
</tr>
<tr>
<td>Testing process</td>
<td>323/415 (77.8%)</td>
<td>323/323 (100.0%)</td>
</tr>
</tbody>
</table>

Cancer Epidemiol Biomarkers Prev. 2011
Recommendation discussions must be sensitive to and address:

- Fear of cancer diagnosis
  - Perception that cancer is a “death sentence”
- Lack of understanding of need for asymptomatic screening
- Misconceptions about cancer causes and risks
- Embarrassment
- Concern over discomfort
- Cultural issues
- Patient preferences
Risk Assessment

- Making appropriate screening recommendation requires accurate assessment of each patient’s risk status

- Individual Risk Levels
  - Average
  - Increased
  - High
Sample Screening Algorithm

Assess Risk: Person & Family

Average Risk = no family hx of CRC or adenomatus polyp

- < 50 yrs: Do Not Screen
- ≥ 50 yrs: Screen*

If + Diagnosis by Colonoscopy

Screen* Options:
- FOBT at home qyr
- Flex sig q5yr
- FOBT + Flex sig
- DCBE q5-10 yrs
- Colonoscopy q10 yrs

Increased or High Risk = + family or personal hx of CRC or adenomatus polyp, IBD or HNPC related cancer

- Personal History:
  - Adenoma: Surveillance Colonoscopy
  - CRC: Childhood Screening
  - IBD**: Childhood Screening

- Family History:
  - Germline Syndrome
  - Adenoma or Cancer

** IBD refers to inflammatory bowel disease for eight years

Screen 10 yrs before youngest relative or age 40
#2: Develop a 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!
<table>
<thead>
<tr>
<th>Risk Category</th>
<th>Age to Begin Screening</th>
<th>Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Average risk</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No risk factors</td>
<td>&lt; Age 50</td>
<td>No screening needed</td>
</tr>
<tr>
<td>No symptoms</td>
<td>≥ Age 50</td>
<td>Screen with any one of the following options:</td>
</tr>
<tr>
<td></td>
<td></td>
<td><em>Tests That Find Polyps and Cancer</em></td>
</tr>
<tr>
<td></td>
<td></td>
<td>FS q 5 yrs*</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CS q 10 yrs</td>
</tr>
<tr>
<td></td>
<td></td>
<td>DCBE q 5 yrs*</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CTC q 5 yrs*</td>
</tr>
<tr>
<td></td>
<td></td>
<td>OR</td>
</tr>
<tr>
<td></td>
<td></td>
<td><em>Tests That Primarily Find Cancer</em></td>
</tr>
<tr>
<td></td>
<td></td>
<td>gFOBT q 1 yr*</td>
</tr>
<tr>
<td></td>
<td></td>
<td>FIT q 1 yr*</td>
</tr>
<tr>
<td></td>
<td></td>
<td>sDNA***</td>
</tr>
<tr>
<td><strong>Increased risk</strong></td>
<td>Age 40 or 10 years</td>
<td>Colonoscopy*</td>
</tr>
<tr>
<td>CRC or adenomatous polyp in a first-degree relative</td>
<td>younger than the earliest diagnosis in the family, whichever comes first</td>
<td></td>
</tr>
<tr>
<td><strong>Highest risk</strong></td>
<td>Any age</td>
<td>Needs specialty evaluation and colonoscopy</td>
</tr>
<tr>
<td>Personal history for &gt; 8 years of Crohn’s disease or ulcerative colitis or a hereditary syndrome (HNPCC or, FAP, AFAP)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Office Screening Policy

Factors to Consider in Your Office Policy

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

- Standing orders allowing nursing staff or medical assistants to discuss CRC screening options, provide FOBT/FIT kits and instructions, and submit referrals for screening colonoscopy have been demonstrated to increase CRC screening rates.

- Staff training on risk assessment, components of the screening discussion… is essential for a successful program.

- Check State practice regulations.
#3: Be Persistent with Reminders

**Essential #3:**

Determine how your practice will notify patient and physician when screening and follow up is due.

**Essential #3:**

Ensure that your system tracks test results and uses reminder prompts for patients and providers.
Electronic Medical Record (EMR)

Tremendous potential

- Registry functions
- Population management
tools/resources

However, the potential is often not met.
#4: Measure Practice Progress

**Essential #4:**

*Discuss how your screening system is working during regular staff meetings and make adjustments as needed.*

**Essential #4:**

*Have staff conduct a screening audit or contact a local company can perform such a service.*
Tracking Practice Progress

- Determine your baseline
- Set realistic goals
- Chart audits or other tracking measures (i.e. EHR reports)
- Provide staff-specific feedback on performance
- Seek patient feedback
- Identify strengths and weaknesses, barriers, opportunities to improve efficiency
- Track progress and periodically reassess goals
Take home

- The goal of an 80% screening rate in MA is very much achievable – we’re so close!

- There are many resources available to help providers increase their capacity to offer patients the option of a take home stool test and increase overall colorectal cancer screening.