Colorectal Cancer Screening – Overview

Revised January 2, 2015

Colorectal Cancer Screening

Colorectal cancer is preventable. Routine screening can reduce deaths through the early diagnosis and removal of pre-cancerous polyps. Screening saves lives, but only if people get tested. However, one in three (36 percent) Oregonians ages 50-75 are not being screened as recommended[1], and only one in five Latinos are getting screened (21 percent), the lowest among all racial/ethnic groups in Oregon.[2]

Oregon state data from 2010 show that colorectal cancer was the fourth most common cancer and the second leading cause of cancer deaths. Compared to national data from 2010, Oregon's colorectal cancer incidence was below the national rate and the mortality was slightly above the national rate.[3] In 2011, 53 percent of all colorectal cancers were diagnosed at late stage.[4]

Screening Recommendations

Colorectal cancer screening carries the U.S. Preventive Services Task Force (USPSTF) highest grade for a screening service when performed "beginning at age 50 years and continuing until age 75 years."[5]

The USPSTF recommends against routine screening for adults age 76 and older, although there may be considerations that support screening for individual patients.

Types of Screening

The USPSTF recommends screening for colorectal cancer for average risk adults using fecal occult blood testing (FOBT), sigmoidoscopy, or colonoscopy.

- A fecal occult blood stool test (FOBT) is a take home test that checks for blood in the stool that is not visibly apparent.
- A sigmoidoscopy is an invasive medical examination of the large intestine from the rectum through the last part of the colon.
- A colonoscopy is an invasive medical examination of the large bowel and the distal part of the small bowel with a fiber optic camera on a flexible tube that is passed through the anus.

Barriers to Screening

In 2010, focus groups conducted by the Oregon Health Authority found these common themes:

- Cost (perceived or actual) is a major barrier.
- Lack of provider recommendation.
- Lack of information about the need for screening in the absence of symptoms and details about screening procedures, options and costs created uncertainty, confusion and inaction.

Additionally, embarrassment, the invasive nature of a colonoscopy, and the preparation are likely barriers to screening and even to thinking or talking about the topic.[6]

2015 Measure Specifications

In 2013, CCOs were not ready to report on hybrid measures so the HEDIS® measure was adapted to measure an annual rate of colorectal cancer screening for members.

The Metrics & Scoring Committee have adopted the HEDIS® 2013 hybrid measure specifications for the second measurement year, CY 2014, and the HEDIS® 2015 hybrid measure specifications for the third measurement year, CY 2015. Moving to the full hybrid methodology will allow for a more robust measure of colorectal cancer screening, including re-instating the look back period.

CCOs must conduct chart review and submit data to OHA. OHA will provide CCOs with sampling frames and additional guidance on hybrid measurement for each measurement year. Guidance will be posted online at http://www.oregon.gov/oha/Pages/CCO-Baseline-Data.aspx

Note that medical record of colorectal cancer or total colectomy was added as a required exclusion in 2014; these were not excluded in the 2013 specifications.

CCO incentive measure specifications for 2014 and 2015 are posted online at:
http://www.oregon.gov/oha/analytics/Pages/CCO-Baseline-Data.aspx

Tips for Improvement

Four essentials actions for improved screening rates that can be incorporated into health systems and clinical practice are:

(1) **Choose a Fecal Immunochemical Test (FIT)**: The medical literature has demonstrated that when offered a single-sample FIT test, patients were over 15 percent more likely to complete testing, compared to a 3-sample fecal occult blood test (FOBT).[7]

(2) **Implement systematic approaches:** Health plans can develop systems that make it easier for patients to be screened, such as creating standing orders for colorectal cancer screening with annual FOBT kits. Evidence-based system approaches to increase screening include:[8]

- Explore non-visit-based outreach strategies to increase screening rates, such as mailing FOBT kits directly to patients, especially in settings with an EHR system to facilitate the ready identification of patients who are eligible and overdue for screening. Studies have shown this strategy can improve screening rates in white, middle-class insured populations as well as populations with higher levels of poverty, limited English proficiency, and racial and ethnic diversity.[9]

- Consider implementing a FluFIT program. It has been demonstrated in the medical literature that offering and providing take home fecal occult blood tests (FOBTs or FITs) at the time of annual flu shot increases colorectal cancer screening rates. The program can support the health facility in meeting HRSA performance measures and Patient-Centered Medical Home Standards.[10]

- Increase screening through supportive clinic environments, such as including information about CRC screening status in patient records and using electronic health records or registries to identify patients who are not up to date on their screening.

(3) **Implement effective communication systems within the plan, providers and clinic environment to**:

- Incorporate cancer screening into patient data and tracking systems.
- Identify and facilitate screening for patients due for screening and rescreening.
- Identify and facilitate services for patients who are at increased and high risk for colorectal cancer.
- Notify patients (via in-visit and non-visit approaches) about the need for screening.
- Notify patients when they are due for screening.
- Ensure test results and follow-up for any abnormal results.
- Monitor health plan population screening rates.
- Help patients to get insurance coverage. Most Medicaid programs cover screening in full.
- Identify community resources for covering the costs of screening and follow-up such as Project Access or the Cervical, Breast, and Colon Health Programs.

(4) **Support patient choice**: The medical literature has demonstrated that when offered more than one screening option, the rate of screening completion is increased. Health care providers should explain and offer all recommended test options and match the patient with the test they are most likely to complete. The best test is the one that gets done.[11]

Messaging

OHA research has found that people are most likely to get screened if they are encouraged by someone they know and trust, particularly by doctors and people who have already been screened.[12]

- The most powerful messages emphasize that colorectal cancer can be prevented, is highly treatable, is the number two cancer killer, the ease of the procedure (particularly with fecal testing), that it affects both men and women, and often lacks symptoms.
- Provide information about different test options, including key facts and things to consider and costs.
- Personal testimony from someone who has been screened and/or has experienced colorectal cancer is a major motivator for getting screened.

Use OHA's *The Cancer You Can Prevent* campaign materials and messages to encourage providers and individuals who have been screened to talk with others' about getting screened. (www.thecanceryoucanprevent.org).

Resources

Available online at www.transformationcenter.org and www.thecanceryoucanprevent.org/.

Data

- Oregon State Cancer Registry incidence and mortality data http://public.health.oregon/gov/DiseasesConditions/ChronicDisease/Cancer/oscar/Pages/pubs.aspx
- Oregon State Cancer Registry, Colorectal Cancer 2010 https://public.health.oregon.gov/DiseasesConditions/ChronicDisease/Cancer/oscar/Documents/ar2010/ar2010_colorectal.pdf
- Oregon State Cancer Registry, Colorectal Cancer Incidence and Mortality by County (2001-2010) https://public.health.oregon.gov/DiseasesConditions/ChronicDisease/Cancer/oscar/Documents/ar2010/ar2010_table3c.pdf

Background Reading

- CDC Vital Signs, Colorectal Cancer Test Save Lives, November 2013 http://www.cdc.gov/VitalSigns/pdf/2013-11-vitalsigns.pdf
- Colorectal Cancer Screening Test Use – United States, 2012. Morbidity and Mortality Weekly Report, Nov. 8, 2013/62 (44); 881-888. http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6244a4.htm?s_cid=mm6244a4_w
- AHRQ Health Care Innovations Exchange: integrated system nearly doubles colorectal cancer screening rate through distribution of in-home kit and follow up with non-responders. http://www.innovations.ahrq.gov/popup.aspx?id=2900&type=1&name=print
- Intervention to Increase Recommendation and Delivery of Screening for Breast, Cervical, and Colorectal Cancer by Healthcare Providers: nine updated systematic reviews for the Guide to Community Preventive Services, 2012. http://www.thecommunityguide.org/cancer/screening/ClientProviderOriented2012_EvidenceReview.pdf

Toolkits

- The Community Guide to Preventive Options for Increasing Colorectal Cancer Screening Rates in North Carolina Community Health Centers http://ncspeed.org/sites/default/files/CRC_Toolkit.pdf
- Acumentra Health's Colorectal Cancer Screening Toolkit http://www.acumentra.org/resources/colorectal-cancer-screening-toolkit/

- How to Increase Preventive Screening Rates in Practice: An Action Plan for Implementing a Primary Care Clinician's Evidence-Based Toolbox and Guide http://www.cancer.org/acs/groups/content/@editorial/documents/document/acspc-029276.pdf

- How to Increase Colorectal Cancer Screening Rates in Practice: *A Primary Care Clinician's Evidence-Based Toolbox and Guide (2008).* http://www.cancer.org/acs/groups/content/documents/document/acspc-024588.pdf

- Community Health Worker eTraining: "Colorectal Cancer - Delivering a Life-Saving Message" in English and Spanish, from the American Cancer Society. http://volunteerlearning.cancer.org (you must create an account and login, then go to Home/Find Courses / Community Health Initiatives / Community Health Worker Trainings)

[1] Oregon Behavioral Risk Factor Surveillance System (BRFSS) 2012.

[2] Oregon Behavioral Risk Factor Surveillance System (BRFSS) Race Oversample 2010-2011. http://public.health.oregon/gov/DiseasesConditions/ChronicDisease/DataReports/Pages/AdultData.aspx

[3] Colorectal Cancer, Oregon 2010, Oregon State Cancer Registry. http://public.health.oregon.gov/DiseasesConditions/ChronicDisease/Cancer/oscar/Pages/pubs.aspx

[4] Colorectal Cancer, Oregon 2011, Oregon State Cancer Registry. http://public.health.oregon.gov/DiseasesConditions/ChronicDisease/Cancer/oscar/Pages/pubs.aspx

[5] U.S. Preventive Services Task Force (USPSTF) recommendations on screening for colorectal cancer, 2008. http://www.uspreventiveservicestaskforce.org/uspstf/uspscolo.htm

[6] Colorectal Cancer Focus Groups 2010, Oregon Colorectal Cancer Program, Oregon Health Authority.

[7] Comparing participation rates between immunochemical and guaiac faecal occult blood tests: a systematic review and meta-analysis. Preventive Medicine Volume 55, Issue 2, August 2012. http://www.sciencedirect.com/science/article/pii/S0091743512001727

[8] The Community Guide to Preventive Services http://www.thecommunityguide.org/cancer/screening

[9] Program to Improve Colorectal Cancer Screening in a Low-income, Racially Diverse Population: A Randomized Controlled Trial. Ann Fam Med September / October 2012. http://annfammed.org/10/5/412.full#abstract-1

[10] FluFOBT Implementation Guide for Primary Care Practices, 2013 American Cancer Society, Inc. and National Colorectal Cancer Roundtable 2013.
http://www.cancer.org/acs/groups/content/@editorial/documents/document/acspc-040286.pdf

[11] Colorectal Cancer Focus Groups 2010, Oregon Colorectal Cancer Program, Oregon Health Authority.

[12] Colorectal Cancer Focus Groups 2010, Oregon Colorectal Cancer Program, Oregon Health Authority.