

Colorectal Cancer Screening

- ▶ *An Integrated Care Pathway of the Collaborative Care Network*

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First, a Friendly Reminder. . .

This Integrated Care Pathway was developed by and for members of the AAMC CCN.

These materials will refer to some resources available **only** to CCN members and their patients.

Not a CCN member?

We invite you to join the CCN! Membership is free. Contact Renee Kilroy at rkilroy@aaahs.org

Learning Objectives

- This CME material will help you to:
 - Understand the array of colorectal cancer (CRC) screening methods and their pros and cons
 - Guide individual patients in choosing the best screening method for them
 - Use CCN tools, processes, and people to engage your patients in CRC screening

Intended Audience and Scope

- Intended Audience for this Pathway
 - Primary care clinicians
- Scope of Pathway
 - Average-risk and high-risk individuals who have not been previously diagnosed with CRC and who do not have symptoms of CRC
 - Most commonly used, effective, and patient-friendly CRC screening methods will be reviewed
 - Colonoscopy, FIT, FIT-DNA
 - **Not these:** flexible sigmoidoscopy, CT colonography, barium enema, guaiac cards, digital rectal exam

A word about: *Screening* of Asymptomatic Individuals Versus *Diagnostic Workup*

Screening is for individuals **without** symptoms

Diagnostic workup (synonymous with **diagnostic colonoscopy**) is the standard of care for individuals with symptoms consistent with or suggestive of CRC, for example: bleeding, obstructive symptoms, changes in BM patterns, abdominal or rectal pain, incidental findings on imaging, OR for those who have a **positive screening test**, for example: FIT or FIT-DNA

CRC Screening

Primary care clinicians historically have been frustrated by patients who persistently decline screening colonoscopy.

Yet, for average-risk patients, a different approach might work better. . .

CRC Screening Facts

- Only 66% of people in the US who are eligible for CRC screening receive it, **yet screening can prevent 60% of CRC deaths.**
- A growing body of evidence demonstrates that **offering average-risk patients different test options substantially increases adherence to screening recommendations.**
- Clinicians can improve screening rates by **emphasizing to patients that *CRC screening can help save lives.*** That approach works better than insisting exclusively on specific screening tests, e.g. colonoscopy alone.

In these materials, we will describe

- The population that is eligible for CRC screening
- Average- and high-risk populations
- Recommended CRC screening strategies for high-risk individuals
- CRC screening choices for average-risk individuals
- Tools, processes and people in the CCN who can help you and your patients improve CRC screening rates

Who Should get CRC screening?

United States Preventive Services Task Force is the authority regarding how primary care clinicians should provide preventive care to the general population. Their recommendations are observed by public and private insurance companies as well as organizations that establish standards of care.

USPSTF Grade A* Recommendation:

Screen all adults age 50-75

Medicare, CareFirst, Aetna, etc. focus on this age group in their CRC screening quality metrics.

*Grade A Recommendation means:

“Do this; there’s good evidence it helps people.”

What About Older People?

USPSTF Grade C* Recommendation:

Offer CRC screening to those age 76-85, but keep in mind:

Those most likely to benefit are those who have never been screened before AND are HEALTHY.

DON'T screen patients who have co-morbidities that make it unlikely they could tolerate treatment for CRC, or if they have limited life expectancy.

*Grade C Recommendation means:

“FIRST consider individual circumstances and patient values, then decide whether to proceed.”

USPSTF Recommendations are for the general, average-risk population

- But what about patients at higher risk for CRC?
 - High risk individuals typically need CRC screening earlier and more often.
 - *Colonoscopy is by far the high-risk person's BEST choice of screening method* (more on choices later)

Individuals at Higher Risk for Developing CRC:

- Personal history of adenomatous polyps
- Family history of adenomatous polyps and/or CRC
- Individuals with certain genetic syndromes
- Those with inflammatory bowel disease
- African Americans
- Those with type 2 diabetes

Let's Consider These One At a Time

Personal History of Adenomatous Polyps

Tubular, tubulovillous, villous, serrated, sessile, and sessile-serrated polyps are all a concern.

Depending on several factors, including the number of polyps found, the degree of dysplasia described by the pathologist, and whether the patient's bowel prep was adequate, the colonoscopist will recommend repeat colonoscopy in 1, 3, or 5 years.

Note: Hyperplastic polyps are completely benign; their presence does not increase the risk of CRC.

Family History of Adenomatous Polyps and/or CRC

First-degree relatives: most significant, especially if >1 relative, yet there is emerging evidence that second-degree relatives also confer risk.

Generally speaking, start CRC screening 10 years before the youngest first degree relative was diagnosed, or age 40, whichever comes first. **Colonoscopy is preferred**, because the likelihood that your patient already has polyps is higher than for an average risk person, and those polyps need to come out before they progress to cancer.

Individuals with Certain Genetic Syndromes Require Frequent Colonoscopy

It's rare that these patients are NOT already in a high-surveillance screening program, but just so you know, the most common syndromes are:

- Lynch Syndrome
- Familial Adenomatous Polyposis Syndrome
- Peutz-Jeghers Syndrome
- Juvenile Polyposis Syndrome

Patients With Inflammatory Bowel Disease

Here we're talking about Ulcerative Colitis and Crohn's Disease. These patients are likely already being followed by a gastroenterologist, but just so you know:

These individuals need a colonoscopy to screen for CRC every 1-2 years beginning 8 years after initial diagnosis.

African Americans and Patients with Type 2 Diabetes

These populations are at somewhat higher risk of developing CRC.

Whereas their screening intervals are the same as average-risk patients, we should make them aware of their increased risk and counsel them to choose colonoscopy.

African Americans

- African Americans have both a higher incidence of CRC and higher mortality from CRC
- USPSTF references this, but stops short of recommending screening them before age 50
- Other organizations recommend screening starting at age 45 for this population
- Often, insurance companies will pay for screening this population starting at age 45, but to be safe, have your patient check first
- Recommend colonoscopy first, but offer FIT or FIT-DNA if they refuse colonoscopy

Patients With Type 2 Diabetes

As with African Americans, the incidence of and mortality from CRC is higher in type 2 diabetics than in the general population.

Use this information to guide your patients toward colonoscopy, but offer FIT or FIT-DNA if they refuse.

Now Let's Talk About Screening Methods

- Colonoscopy
- FIT
- FIT-DNA

Colonoscopy

Think of colonoscopy as a **cancer prevention** screening tool, as opposed to a cancer detection screening tool.

Although colonoscopies can miss colon polyps and cancers, that is rare. And the removal of pre-cancerous polyps is not possible with other screening methods.

Colonoscopy

Refer your patient to a reliable colonoscopist with experience, expertise and a low rate of complications (e.g. perforations).

“Reliable” also means the colonoscopist shares procedure and pathology reports with you and the patient, and assists in timely call-backs for appropriate screening intervals.

Great Example

Dear Ms. Patient,

The pathology from your recent colonoscopy shows your polyp was an adenoma. Adenomas are benign polyps. They are NOT cancer, yet a small percentage of adenomas can develop into cancer over time. Because your polyp has been removed, we have prevented any chance of your polyp from developing into cancer. However, a colonoscopy should be repeated in 5 years to determine if any NEW polyps have formed. Please keep a copy of this letter for your records. I will also forward a copy to your primary care provider.

Usually we contact patients when our computer tells us a follow-up colonoscopy is to be done. However, computer glitches can occur. As a failsafe mechanism, we recommend you put a reminder in your personal calendar as well.

Sincerely,

Dr. Gastroenterologist

Cc: Ms. Patient's primary care clinician

Colonoscopy Reports

- The procedure report will comment on the prep adequacy and findings, as well as any specimens taken.
- The pathology report will classify polyps as adenomatous or non-adenomatous.
- The colonoscopist takes all of this information into consideration when determining the next screening interval.

Preparing Your Patient for Colonoscopy

- Typically, an otherwise healthy patient doesn't need a visit prior with the colonoscopist prior to the procedure.
- You may need to help your patient make adjustments in medication prior to the procedure, e.g. anticoagulants, antiplatelet agents, insulin.
- Coach your patient to follow the prep directions closely so that a repeat colonoscopy attempt is not needed due to retained stool.
- The actual procedure takes 20-30 minutes, and the patient is sedated.
- Afterward, the patient is driven home by a responsible adult.
- The patient goes home with the procedure report in hand, and the report is simultaneously faxed or sent electronically to the referring primary care clinician.

Colonoscopy Screening Intervals

- For average-risk patients, the interval for colonoscopy may be ten years, particularly if
 - Bowel prep was adequate and there was good visualization throughout the colon
 - No polyps were found
 - The patient remains average risk (for example, no first degree relative gets diagnosed with CRC in meantime)

Options for Average-Risk Patients Who Just Plain Refuse Colonoscopy

- For the reasons already cited, you want to offer colonoscopy first.
- But some people refuse.
- Rather than give up, ask them to consider FIT or FIT-DNA. These are **cancer detection (as opposed to cancer prevention) screening tests** with good sensitivity and specificity.
- Both of these are stool tests that can be done at home.

Let's start with FIT

- The first thing to know about FIT is that is it NOT the same as the old guaiac cards

You may be wondering. . .

Can I/should I offer 3 guaiac cards for the patient to take home?

You could do that, but we don't recommend it. FIT is easier, costs about the same, and demonstrates better sensitivity and sensitivity than the guaiac method.

Why is FIT better than guaiac testing?

- Guaiac-based tests for occult blood in stool suffer from drawbacks:
 - Can't distinguish human blood from animal blood (in diet)
 - Can't distinguish upper GI from lower GI blood source
 - Are thrown off by fruits and vegetables in the diet as well as drugs, vitamins, and other substances that can cause false positive and false negative results.

Why is FIT Different and Better?

- FIT uses antihuman hemoglobin antibodies to detect the globin portion of un-degraded human hemoglobin in stool.
- Hemoglobin from the upper GI tract is mostly degraded by bacterial and digestive enzymes before reaching the lower intestine; hemoglobin from lower GI bleeding undergoes less degradation and remains immunochemically reactive. Thus FIT is more specific for lower GI bleeding.
- FIT does NOT react to animal hemoglobin, peroxidase compounds, drugs, vitamins, or other substances in food that can produce false results.
- FIT does NOT require any dietary or drug restrictions.
- FIT requires just one stool specimen from one bowel movement

FIT Options For Your Practice

- You can purchase FIT kits from a supplier and have patients mail you the specimen, which your staff then tests and gives you the result. Your supplier or the CCN can train your staff. Use CPT code 82274. Average reimbursement is about \$20
- You can also order FIT from commercial labs through your EMR. Both LabCorp and Quest will give you the kits and envelopes. The specimen is mailed by the patient back to them. They run the test and send you the result via your EMR.

What FIT kits look like

- Some examples
- All include patient instructions and mailing envelopes

(c)



LabCorp's Version of FIT



Quest's Version of FIT (used by AAMC)

REPLY FORM
Please return this form with the InSure[®] Test Card

21344384

PHYSICIAN REQUISITION
To be completed by physician or office staff

☐ @ 1726XX (Fecal Immunochemical Test (FIT)) ☐ (F) 1126XX (Fecal Immunochemical Test (Medicare Screen))

☐ Bill My Account

Diagnosis Code **REQUIRED** _____ Client # (Quest Acct #) **REQUIRED** _____


Physician Name (PLEASE PRINT) _____ NP# _____

Physician Signature (REQUIRED FOR NJ, NY, PA, MA MEDICAID) _____ Phone Number _____

Patient ID # (if applicable) _____

Medicare Limited Coverage Tests
@ Medicare limited coverage diagnosis
(F) Has prescribed frequency rules for coverage.

If you have any questions or need help using InSure[®], please call Enterix at 1-800-531-3881

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Removable Labels

Patient Name _____ SAMPLE DATE _____
21344384
Patient Name _____ SAMPLE DATE _____
21344384

Please read all instructions carefully for the correct use of these labels.

Brush Kit
Fecal Immunochemical Test

CAUTION
Not For Internal Use
Keep Out Of Reach Of Children

Contents
2 x Brushes
2 x Waste Bags


InSure FIT[™]
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BALTIMORE MD 21227-9965

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What to do with FIT Results

- **Negative:** repeat FIT in a year (or offer colonoscopy in a year. Who knows? Your patient may be more receptive then!)
- **Positive:** DIAGNOSTIC colonoscopy is needed NOW. Do not delay. Recall that FIT is a cancer detection screening tool. Recent studies suggest that patients with true positive FIT results often have advanced disease. Please catch them and refer for colonoscopy. You may well save a life.

FIT-DNA (Cologuard)

- FIT-DNA combines FIT with DNA markers for colorectal neoplasia
- Currently one lab in the US does this: Exact Sciences Laboratories
- The company furnishes you with order forms that you complete and fax to them; they send the kit to the patient and the patient sends them the specimens. Results are mailed or faxed to you, or transmitted to your EMR.

Cologuard Kit: Comes in a box with its own toilet seat insert



FIT-DNA (Cologuard) Results

- **Negative:** repeat FIT-DNA in 3 years (or offer colonoscopy in 3 years)
- **Positive:** as with FIT, a diagnostic colonoscopy is required, right away.

FIT versus FIT-DNA

	FIT	FIT-DNA (Cologuard)
Cost	\$9 - \$40	Up to \$650
Insurance Coverage	Universal	Varies (patients should check with their insurance companies)
Screening Intervals	1 year	3 years
Sensitivity (CRC)	73-88% (rationale for yearly testing)	92%
Specificity (CRC)	91-95%	84% (see important comment next slide)
Dietary restrictions	none	none
Collection method *	Smear	Smear and entire bowel movement

FIT-DNA Consideration

False positives with Cologuard are a concern.

There are no empirical data on the appropriate longitudinal follow-up for an abnormal FIT-DNA test result that is then followed by a negative colonoscopy. Afterward, there is potential for overly intense surveillance owing to clinician and patient concerns about the implications of the genetic component of the test.

Be prepared to discuss this with your patient.

Population-based CRC Screening Strategies for Your Practice

- CRC screening is the right thing to do, and your practice's performance affects your revenue (quality measures payments)
- How the CCN can help
 - Patient registries
 - Patient Panel Managers
 - Outreach methods that work

Patient Registries and Other Methods to Identify Patients Needing CRC Screening

- Patient rosters provided by insurance companies
- EMR registries
- CCN-provided data

One or more of these lists can be used by the CCN Patient Panel Managers to help your practice

Patient Panel Managers

These are highly trained medical assistants who “scrub” the lists and improve your screening score by :

1. Removing from your quality measure “denominator” those patients who have died, moved away, or otherwise left your practice
2. Gathering and recording missing data points for your current patients who have had screening.
3. Working with you to discuss what you want to do with your remaining patients who are in need of screening

Next Step: Triage and Outreach

Work with your Patient Panel Manager (PPM) to determine which of those remaining patients are average-risk or high-risk for CRC screening.

-For those at high risk, determine how you would like them to be referred for colonoscopy. The PPM will follow your directions. We have given them scripts to use on the phone or by letter. Feel free to modify the scripts to make them sound more like you.

Triage and Outreach, cont'd

- For those patients at average risk, we have provided the PPMs with scripts to first offer colonoscopy. For patients that refuse colonoscopy, the script then offers FIT or FIT-DNA. Feel free to modify the scripts to make them sound more like you.
- The PPMs will show you all scripts they use.
- The PPMs can familiarize your practice staff with workflows for both FIT and FIT-DNA

Patient-Facing Materials

The CCN has also developed a one-page, patient-friendly piece that provides an overview of the three CRC screening methods. In the piece, patients are first directed to ascertain whether they are at high or average risk for CRC. They are then guided to the appropriate choice.

This patient engagement piece is available to you through the PPMs. You may use it any way you wish.

What This Material Was Designed to Help You Achieve

- Understand the array of colorectal cancer (CRC) screening methods and their pros and cons
- Guide individual patients in choosing the best screening method for them
- Use CCN tools, processes, and people to engage your patients in CRC screening

CCN Gastroenterology Practices

- **Digestive Disorders**

- Endoscopy suite and main practice site in Annapolis, satellite offices in Gambrills and Chester
- Main number: 410 224 4887
- CRNP speaks Spanish
- Par with most insurance carriers, including Priority Partners

- **Woodholme Gastroenterology Associates**

- Baltimore-based, with a large practice and endoscopy suite in Glen Burnie
- Main number: 410 863 4899
- Par with essentially all insurance carriers

How Did We Do?

Please move on to the test module so that we can gather your feedback and you can get CME credit.

Thank you!