

CDC *Vital Signs* Town Hall Teleconference

Colorectal Cancer Screening Saves Lives
November 12, 2013
2:00–3:00 pm EST

Coordinator: Thank you for standing by. At this time all participants are in a listen only mode. During the question and answer session you may press Star 1. Today's conference is being recorded. If you have any objections, you may disconnect at this time. Now turning the meeting over to your host for today's conference to Dr. Dan Baden.

Dr. Dan Baden: Hello everyone. I'm Dr. Dan Baden, Associate Director for External Partner Outreach and Connectivity in CDC's Office for State, Tribal, Local and Territorial Support. Welcome and I'm glad you could join us today.

Today we'll be discussing the latest *Vital Signs* report on colorectal cancer screening. Before we get started I want to go over some housekeeping details. You can still go online and download today's PowerPoint presentation so you can follow along with presenters.

The web address is www.cdc.gov/stltpublichealth. That's S-T-L-T public health. There's a link directly to the *Vital Signs* Town Hall website under highlighted products and resources on the lower right side of the page.

On this Town Hall web page you can also view biographies for each of the presenters. This is where we'll be adding the audio recording and transcript from today's teleconference as well. They should be available next week. But back to our topic.

Colorectal cancer is an important public health topic because it's the second leading cancer killer of men and women in the US. Testing saves lives. Unfortunately, not enough people are getting tested.

About one in three adults between the ages of 50 and 75 are not getting tested as recommended. Studies are showing that people who are able to pick the test they prefer are more likely to get the test done.

A couple ways that health departments and community organizations can help are to develop record systems that will keep track of patients and notify those who need to be tested. And also working with Medicaid programs, primary care associations, Medicare quality improvement organizations to help people getting tested make sure they get additional tests and treatment as needed.

On today's call we're going to hear from two colleagues. First we're going to hear from Commander Djenaba Joseph, the Medical Director of the Colorectal Cancer Control Program in the National Center for Chronic Disease Prevention and Health Promotion here at CDC.

She'll provide a summary of this month's *Vital Signs* report. Dr. Joseph will then hand the call over to Ms. Felisha Dickey, the Program Director of the Florida Colorectal Cancer Control Program at the Florida Department of Health.

Ms. Dickey will share how Florida has increased their partnership and grown their colorectal cancer control program. There'll be time for questions after our presentations today. And you can get into queue to ask a question at any time during the teleconference. Just press Star 1 and record your name when prompted.

And now I'll turn the call over to Dr. Joseph.

Dr. Djenaba Joseph: Thank you. So today -- as Dr. Baden mentioned -- I'll be talking about the MMWR with this year's *Vital Signs* on colorectal cancer screening. So - and this is slide 5 I'm looking at.

Colorectal cancer is the second most common cause of cancer death among cancers that affect both men and women. There is strong evidence that colorectal cancer screening reduces both the incidence and mortality from this disease.

The United States Preventative Services Task Force actually recommends three tests to screen for colorectal cancer. There are two types of stool blood tests. There's the guaiac-based fecal blood test -- which is commonly referred to as FOBT. And it's the fecal immunochemical test or FIT -- which you can do every year.

There's colonoscopy -- which can be done every ten years. And then there's flexible sigmoidoscopy -- which can be done every five years and should be done with FOBT or a FIT every three years.

The thing to remember about these tests that as it stands right now, not one of these tests has proven to be better than the other tests in terms of mortality reduction from colorectal cancer. We're lacking in some strong randomized trials for some of these tests. There are some head to head trials of comparing colonoscopy to FOBT that are in progress, but we don't have results from those tests or trials yet.

Slide 6. So what we do is we look at BRFSS data from 2012. We looked at adults age 50 to 75 years. Those are the ages where people are recommended to be screened for colorectal cancer. And we looked at the percentage of the population that was up to date with colorectal cancer screening.

So that would mean they had an FOBT or a FIT within one year and/or a colonoscopy within ten years and/or a sigmoidoscopy within five years with FOBT FIT within three years - which is a mouthful. So I'll just refer to that as "up-to-date."

Then we looked at the proportion that was screened, but not up to date. And they've been screened at some point in the past, but hadn't been screened within the recommended time frame. And then we looked at the proportion of the population that never had been screen at all.

And then we looked at use of the tests by test. So looking people who had used colonoscopy versus people who had used FOBT. We did not look specifically at people who had used sigmoidoscopy because the proportion of the population that uses that test is very small so it was difficult to do any detailed analysis on that particular piece of the population.

So going to our results on slide 7 -- when you look at screening status -- and that's up to date or never screened -- by age, insurance status, and income. So you can see that people with Medicare -- and that would be the 65 to 75 age group -- much higher proportion are up-to-date. Much smaller proportion of never been screened.

When you look at insured and uninsured, certainly having insurance makes it easier to get screened therefore a proportion of that population much higher in terms of being up to date. When you look at the uninsured, 55% have never been screened at all.

And certainly when you look at annual household income, those with lower incomes are less than \$15,000 per year -- the proportion that is up-to-date is

fairly low. And then there's that increase right up to greater than \$75,000 per year.

When you look at the never screened, those numbers are actually incorrect. You should see sort of the inverse. So the never screened is highest amongst those at the lowest income and then it steadily goes down as you go up in income.

Slide 8. So when you look at screening status by race and ethnicity - so the good news is that when you look back at previous years of data there's pretty wide disparity between whites and pretty much every other racial ethnic group. So that has actually narrowed between whites and blacks.

What's not so good is that we have several others that are lagging behind. So Asian Pacific Islanders, American Indian, and Alaskan Natives - much lower percentage of their population is being up-to-date. And certainly, when you look at Hispanics versus non-Hispanics, the proportion of Hispanics that is up-to-date is very low in comparison.

So when you look at by test type - so looking at colonoscopy and FOBT you tend to see the same patterns mostly because most people in this country have a colonoscopy so that tends to drive the percentage that is up-to-date. So again, when you look at Medicare population, much higher proportion of people aged 65 to 75 are up-to-date with colonoscopy and FOBT for that matter. And then when you look at younger age groups who aren't eligible for Medicare yet tend to have much lower screening rates.

Certainly having a provider makes a difference. So for having a provider and having insurance are kind of the two keys for being up-to-date with screening. If you don't have either, they're just going to be - tend to be very low.

So certainly, again, having a provider - much higher proportion of being up-to-date with either colonoscopy or FOBT. So what is interesting is when you look at income -- so as your income goes up, the proportion that have had a colonoscopy within the last ten years tend to go straight up with it. But the proportion that have had an FOBT or FIT test within the last year tends to stay fairly flat. And that's just a reflection of that test isn't used very much in this country.

And looking at slide 10. When we look at test type by race and ethnicity -- so again, you're starting to see equivalence between whites and blacks in terms of colonoscopy use. All other racial ethnic groups are lagging behind in terms of being up-to-date with colonoscopy. The groups that use FOBT the most actually tend to be blacks and Asian Pacific Islanders. And we're not quite sure why that is.

Looking at slide 11. So this is just looking at blacks and whites in terms of their colonoscopy within ten years and FOBT within one year. And when you look, actually they're either fairly equivalent. When you look for colonoscopy - when you look at FOBT, a higher proportion of blacks tend to use FOBT. And that may help explain how they sort of caught up in terms of their proportions that are up-to-date with screening.

So and then lastly we looked at colorectal cancer test used by state. The proportion by state that was up-to-date ranged from a low of 55.7% to a high of 76.3% for colonoscopy. Similar range, lower, 53.4%, high of 73.7%.

FOBT use just tends to be lower across the board. We have one, sort of, outlier -- that's California with a rate of 20.2%. That's because they have Kaiser Permanente in Northern California. They use FIT as their main colorectal cancer screening test. They seem to be driving that rate for the whole state.

Then when you look at all states altogether again, sigmoidoscopy use with FOBT is very low -- less than 3% in every single state. And then when you look at colonoscopy though, the percentage of the population that use colonoscopy within ten years was greater than 53% in every single state.

So what did we conclude from this? When you look at the literature many providers believe that colonoscopy is actually the best test. So that's why they tend to offer it to their patients and that's why you see a lot of people getting a lot of colonoscopy's done.

We also know from research that patients have very particular preferences for the colorectal cancer screening test. Some people want a colonoscopy and some people are saying no way, I'm not having that done and they want a FOBT.

But if you don't make any effort to match the patient with the test they'll actually do, the average screening might suffer. So people offer them something they just have no intention of following through on, and clearly, are not going to get good screening rates.

So our suggestion was colorectal cancer screening rates could increase if we recommended a screening test or offered. So instead of just offering colonoscopy or just offering FOBT, try to offer both tests or all three tests if you have access to all three tests and try to match the person that you're offering it to with the test that they actually prefer.

And we also know that from looking at this, how the insurance certainly does not equate with screening. Certainly among those who aren't insured, therefore are less likely to be screened. But when you look at people who have

never been screened at all, 76% of them actually have insurance. So having insurance certainly isn't a guarantee that you're going to get screened.

You need to have a provider or someone who's going to, sort of, prompt you to get it done and help you get it done. This leads us to our last point -- which is that organized screening systems are needed -- which is where instead of what we have now is what we refer to as an opportunistic system.

So you go to your doctor for some other reason. Your ankle is sprained or your headache and while you're there they just happen to remember you're in the right age range and that you're due for a screening so they offer it to you.

That's a little haphazard and tends to work very well. So what we're looking for is health systems where a doctor's office can actually identify their eligible population. So they know who they have enrolled that is age 50 to 75. They know who is due for a screening. They can send reminders to those patients. Hey, you're due for a screening. We need you to come in.

Or you can have systems within the office where it doesn't rely completely on the provider remembering to offer it. So you can have your nurses talk about screening. Or you can have your medical assistants do it. Or you can have chart reminders and postcards and electronic medical record reminders and all sorts of ways of going about it. You also need to quality control that - especially with FOBT. You can't just give them a kit and let them walk out the door.

You need to have some way to keep track of those people you gave those kits to. You need to hunt them down and make sure they do it. And if it's positive you need to make sure they get a colonoscopy. So that's what we mean when we say organized screening systems are needed.

So that was slide 13. I'm on slide 14. So thank you for having me this afternoon and I will pass it on to Felisha.

Felisha Dickey: Thank you Dr. Joseph. Good afternoon. It is indeed a privilege for me to have this opportunity to share with you some of the activities that have taken place through the Florida Colorectal Cancer Control Program.

We are one of the Centers for Disease Controls' funded programs with the goal of increasing the colorectal cancer screening rate in Florida to 80% by 2014. The current screening rate in the state is approximately 61% for those up-to-date screening as defined by Dr. Joseph earlier.

Slide 16. The Florida Department of Health Colorectal Cancer Control Program -- Florida Screen for Life -- facilitates screening provision through three lead county health departments -- Miami Dade, Manatee, and Alachua -- where a community navigator works with designated primary care providers to identify eligible patients, provide navigation services to program participants, and also engages in promotional activities through various partnerships and systems within their regions.

Screening services are provided in partnership with three largest cancer centers in the state, Moffitt Cancer Center in Tampa, Shan Hospital in Gainesville, and Jackson Memorial Hospital in Miami.

Slide 17. Now we'll briefly talk about screening services as they are provided in the three regions.

Slide 18. In the greater Tampa region screening colonoscopies are provided to individuals who are at risk and some with increased risk defined as having a primary relative diagnosed with colorectal cancer after the age of 60. The

screening provider, H. Lee Moffitt Cancer Center, will serve any patient who is a Florida resident.

Slide 19. In the greater Gainesville region, screening colonoscopies are also provided to individuals who are at average risk and some with increased risk as previously defined. The screening provider, Shan Hospital, will only serve patients who reside within the facilities 11 county catchment area as treatment for patients seen through the program are either facilitated or paid for by our screening partners.

During March, 2013 the community navigator in Gainesville accompanied Shan staff and the University of Florida Mobile Clinic pictured here to four surrounding rural areas in Alachua County and made over 350 contacts with members of those communities to increase colorectal cancer screening awareness and to refer patients to the program for screening services. The group was able to enroll 45 patients.

Slide 20. In the greater Miami region colorectal cancer screening is conducted using a one sample fecal immunochemical test -- also known as FIT. The screening provider, Jackson Memorial Hospital, will only serve patients - average risk individuals who qualify to receive services from the Jackson Health System. This region provides the largest number of screenings for our program.

The provider also conducts diagnostic colonoscopies for program participants that have a positive FIT result. Since the onset of screening service provision in March of 2010 through the end of June, 2013, 344 colonoscopies and over 1,500 FITs have been completed.

Slide 21. The greater Miami region currently has four clinic sites providing FITs on behalf of the program. This slide depicts the clinic flow for one of the

sites, Doris Ison Health Center. As patients present to the clinic for a routine visit, the provider completes a pre-eligibility checklist.

The checklist is sent to the navigator for approval. This model also consists of a designated liaison within the clinic for the program who schedules approved patients for a colorectal cancer screening visit specifically. During the visit the liaison provides detailed instruction regarding completion of the FIT and reviews the contents of the test kit with the patient.

We believe this to be one of the primary reasons for the 98% compliance rate we have consistently seen in this region.

Slide 22. In the first year of the grant, the Florida Colorectal Cancer Control Program collected baseline information to inform program planning for reaching various populations with the colorectal cancer screening message.

This poster presentation, exploring barriers to screening -- especially among the Haitian Creole population in Miami Dade County was presented at the National Dialogue for Action this year. Results of a Barrier Survey indicated that individuals who have never been screened believed both that colorectal cancer is preventable and that screening reduces risk for colorectal cancer.

Additionally 71% of those never screened stated they that they never received a physician recommendation for colorectal cancer screening. Thus the program strategy focused on provider education and awareness with an emphasis on including FIT as a viable option when discussing screening with patients.

Therefore, provider education highlighted alternative, approved screening choices to increase screening compliance among patients, a FIT toolkit, and

provider education workshop. Consumer education messaging included promoting choices.

Slide 23. The program has presented to various programs within the department to amplify the colorectal cancer screening message which included a minority health liaison -- which are located at the local department of health in each of the 67 counties in the state and work within their communities to develop initiatives focused on minority health issues state wide.

The Healthy Community, Healthy People coordinators focused on reducing death and disability due to chronic diseases by working with state and community partners to create environmental and policy changes for healthy lifestyles.

Additionally presentations were made to the medical directors at the local Departments of Health and the Community Health Worker Coalition. Within the Bureau of Communications there is a liaison to the Bureau of Chronic Disease Provision who develops media strategies and communication pieces such as the article indicated here.

Slide 24. The program champions the message of the importance of giving patients a choice of screening method as the most effective way to increase screening adherence in practice. Partnerships have grown greatly since the inception of the program.

Slide 25. In 2010 -- during the first year of the grant -- program partners primarily consisted of local county health departments, then referred to at county health departments through staff working with the Healthy Communities, Healthy People Program. Other cancer programs located with the Bureau of Chronic Disease at the Department of Health, the American

Cancer Society, and the Federally Qualified Health Centers in Broward County.

Slide 26. As denoted by this graphic, the program partnerships have doubled from 2010 to 2013. We have engaged in a number of effective strategies with labs, multiple Federally Qualified Health Centers, tribes, faith based organizations, non-profit organizations, health foundation, and various programs internal to the department.

Slide 27. Federally qualified health centers are critical partners for increasing colorectal cancer screening rates. The program has partnered with two entities who work with providers in this system. Focusing on Florida's Federally Qualified Health Centers, the Florida Association of Community Health Centers played a vital role in educating federal, state, and local policy makers about issues related to healthcare and the role of the health centers.

The primary mission of the association is to improve access to quality health services by bringing together agencies, legislators, and key persons of able to affect healthcare services. The Florida Medical Quality Assurance Incorporated (FMQAI) is dedicated to improving quality care delivery and healthy outcomes through data, education, and assistance.

By collaborating with physician practices, health plans, home health agencies, nursing homes, rehabilitation facilities, and hospitals FMQAI seeks to encourage the Medicare beneficiaries receive the right care in the right setting every time.

County health departments -- medical and directors -- and county and state labs were previously discussed. The Cancer Control and Research Advisory Council monitors cancer trends and disparities and also evaluates and

promotes effective interventions to help in cancer prevention, screening, and treatment.

Specifically, the Council is working with the Colorectal Cancer Control Program on a policy initiative to address the inequity of the state Medicaid reimbursement rate for the fecal immunochemical test compared to the Medicare reimbursement rate.

Florida's current Medicaid reimbursement rate is \$2 versus the Medicare reimbursement rate of \$22.38.

Slide 28. The program has partnered annually with the American Cancer Society Florida Division to provide continuing medical education workshops during awareness month since the first year of the grant. During March 2013, six workshops were held throughout the state and a total of 634 providers attended.

These trainings include two continuing education credit hours of prevention of medical errors -- a required training -- as well as one hour of the latest on colorectal cancer screening. Dinner is also provided by the American Cancer Society. The workshops focus on four essentials highlighting the American Cancer Society's toolkit and guide and titled, "How to Increase Preventive Screening Rates in Practice: An action plan for implementing a primary care clinician, evidence based toolbox and guide."

And also provide information related to risk factors, screening guidelines, quality issues, failure to screen, and risk management. The program funded the extension of community grant for consumer awareness through four organizations with the American Cancer Society.

During May through June 2013, more than 38,000 individuals were reached through education sessions, media, and health fairs held by community health workers. Screening referrals were also provided and more than 600 reminder calls were made for colorectal cancer screening.

Other collaborations included small media mail out to non-compliant members of Blue Cross/Blue Shield. These were 44,000 men who received a letter and a -- all jokes aside -- DVD featuring Steve Harvey. Webinars, conference exhibits, and a provider survey on colorectal cancer screening practices was conducted in partnership with the Florida Medical Quality Assurance Incorporated.

Slide 29. The Department of Health Cancer Program, Colorectal Cancer, Comprehensive Cancer, Breast and Cervical Cancer, and the Policy Environment and Systems Change Programs collaboratively have supported various initiatives through the Southeast American Indian Council.

We have supported needs assessment work in the development of the group as a part of the Comprehensive Cancer Control Collaborative framework. Staff has attended the Annual Seminole Health Fair and provided lunch and learns to tribal communities.

The Cancer Program also funded a Cancer Education Program provided by the Southeast American Indian Council -- where over 2,800 tribal members in others received cancer prevention education at tribal gatherings and pow wows. The program supported the development and production of a colorectal cancer educational video presentation and brochure that featured a memorial tribute to tribal Micco (Muscogee Indian for "chief") Bearheart who died recently to colorectal cancer.

These materials are used by 15 community health worker volunteers within the tribal communities.

Slide 30. Recently the program partnered with the Health Foundation of South Florida and the American Cancer Society to fund a colorectal cancer screening project with Federally Qualified Health Centers in South Florida.

The American Cancer Society facilitated the provision of an educational workshop -- which all invitees were required to attend in order to apply to receive funding for the purpose of purchasing FIT tests which were funded by the Health Foundation of South Florida and/or to support administrative costs for patient reminders to increase adherence. Three centers were funded.

Two of the three participating clinics experienced notable increases in screening compliance. Borinquen reported an increase from 20.7% for the clinic screening rate to 61.8% compliance for the project participants. Community Health of South Florida reported an increase from 34.7% for the clinic screening baseline rate to 45% for program participants.

The third clinic, Jefferson Reeves, provided a screening rate for participants in the program of 54.6%.

Slide 31. Efforts with employers and insurers have included staff making cold calls to large employers within their region to speak with wellness coordinators initiating discussions regarding the importance of colorectal cancer screening among employees as a factor of improved work productivity, increased efficiency, and positive return on investment.

These contexts have resorted in a number of presentations for employees, development of an employee campaign specifically regarding colorectal cancer screening -- which included the provision of incentives for employees

who provided documentation signed by their healthcare provider indicating that screening options were discussed, a stool test was received, or a doctor appointment was scheduled.

Employer leakages also led to several insurer group connections. The Tampa Community Navigator has joined multiple employer health events to provide educational presentations on the importance of colorectal cancer screening to employees.

In terms of networks, the Community Navigator has attended multiple meetings of wellness professionals along with fostering of partnerships with members that resulted in additional presentations and engagement in discussions with wellness professionals about strategies and methods that will encourage employees to make healthy choices.

Slide 32. The program has engaged in concentrated efforts of several evidence based methods involving provider practices since provider recommendation tops the list as the number one reason for screening compliance. In 2010 the Get the FIT Facts Provider Awareness Campaign was launched -- especially highlighting the superior performance attributes of FIT in comparison to the traditional guaiac fecal occult blood test.

Slide 33. The purpose of the campaign was to increase the use and recommendation of the fecal immunochemical test by providers in their practices. Multiple avenues have been used to distribute the toolkit to providers.

Through the Florida Association of Community Health Centers Annual Meeting, the program interacted with physicians and other clinic staff to share key messaging from the kit and also a co-branded letter was mailed with

copies of the toolkit to each of the more than 250 clinics that are members of the association.

The American Cancer Society Provider Workshops - each participant was provided a copy of the toolkit in addition to a sample of a FIT test. The Florida's Free for Life Community Navigators continued to provide presentations at provider offices academically detailing the components of the American Cancer Society Action Plan and also distributing copies of the toolkit.

The program exhibits at profession organizational meetings as well, such as the Florida Academy of Family Physicians and the Florida Academy of Physician Assistants. We have found the presence of our staff at these meetings to interact with professionals as the kits are distributed to be highly effective.

Community navigators also conducted joint office visits in partnership with Lapcorp representatives, where representatives were focusing the messaging on the discontinuation of processing of the lab, of the guaiac fecal occult blood test, and only processing FIT test going forward.

Slide 34. There's a tremendous opportunity for collaborative partnerships to move forward the message of the importance of colorectal cancer screening and the effective systems change to foster increase adherence among Floridians. This concludes my presentation. Thank you again for the opportunity to share our experiences.

Dr. Dan Baden: All right thank you very much for those excellent presentations. I'd like to remind everyone that you can get in queue to ask a question by pressing Star 1. Say your name when prompted and you'll be announced into the conference by the operator when it's your turn to ask a question.