

COLORECTAL SCREENING: OFFERING STOOL TESTS TO PATIENTS

OCT 20, 2020 | 11:00 AM CST

CO-HOSTED BY



Despite COVID-19, colorectal cancer screening remains a public health priority. When there are barriers to colonoscopy, screening can be safely offered through at-home stool-based tests.

COLONCANCERCOALITION.ORG/WEBINAR

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We will be starting soon.

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WELCOME

AGENDA

Colorectal Cancer Screening Recommendations
During the Pandemic

Case Studies

Generating Screening Awareness in a Pandemic
and Beyond

Q & A

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HOUSEKEEPING

Webinar is being recorded.

Use the Chat function to submit questions for the Q&A.

If you want to tweet along use #BlueForCRC or #MNCRC.

Stool Tests

Recommendations During the Pandemic, Matt Flory

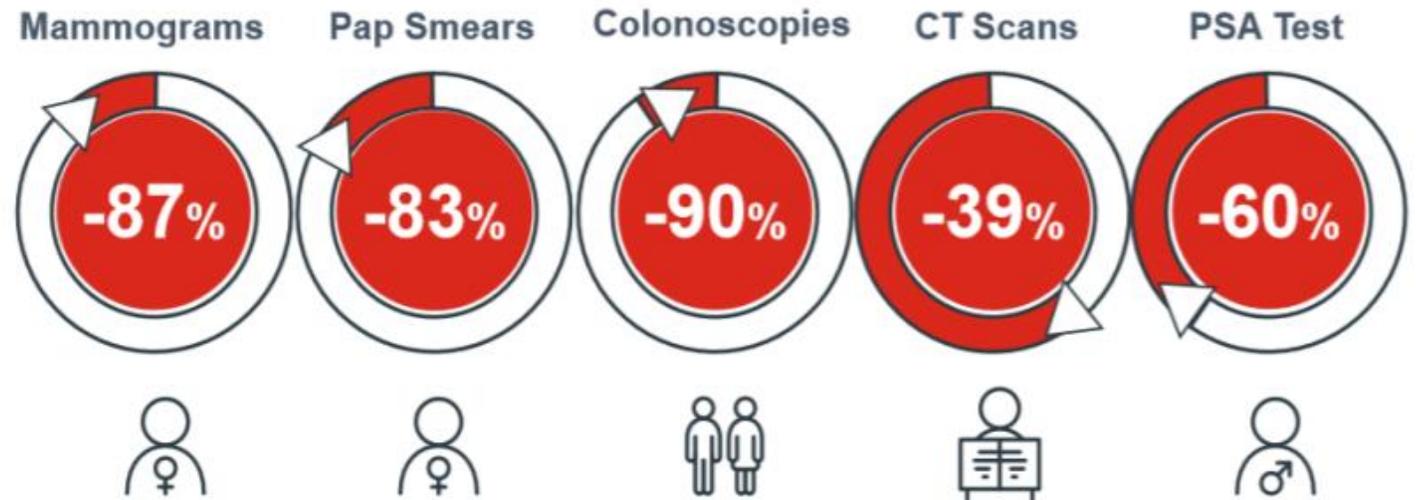


SCREENING RATES DURING COVID-19 PANDEMIC

- ▶ The COVID-19 pandemic has led to unprecedented drops in breast, colorectal, and cervical cancer screenings
 - ▶ Decreases of **83 - 90%** compared to three-year averages
- ▶ The resulting backlog of cancer screenings will pose significant challenges for health systems as they adopt new processes and protocols necessary to safely restart screening.

Diagnostics used to screen and monitor cancer have dropped dramatically due to postponement of non-essential visits

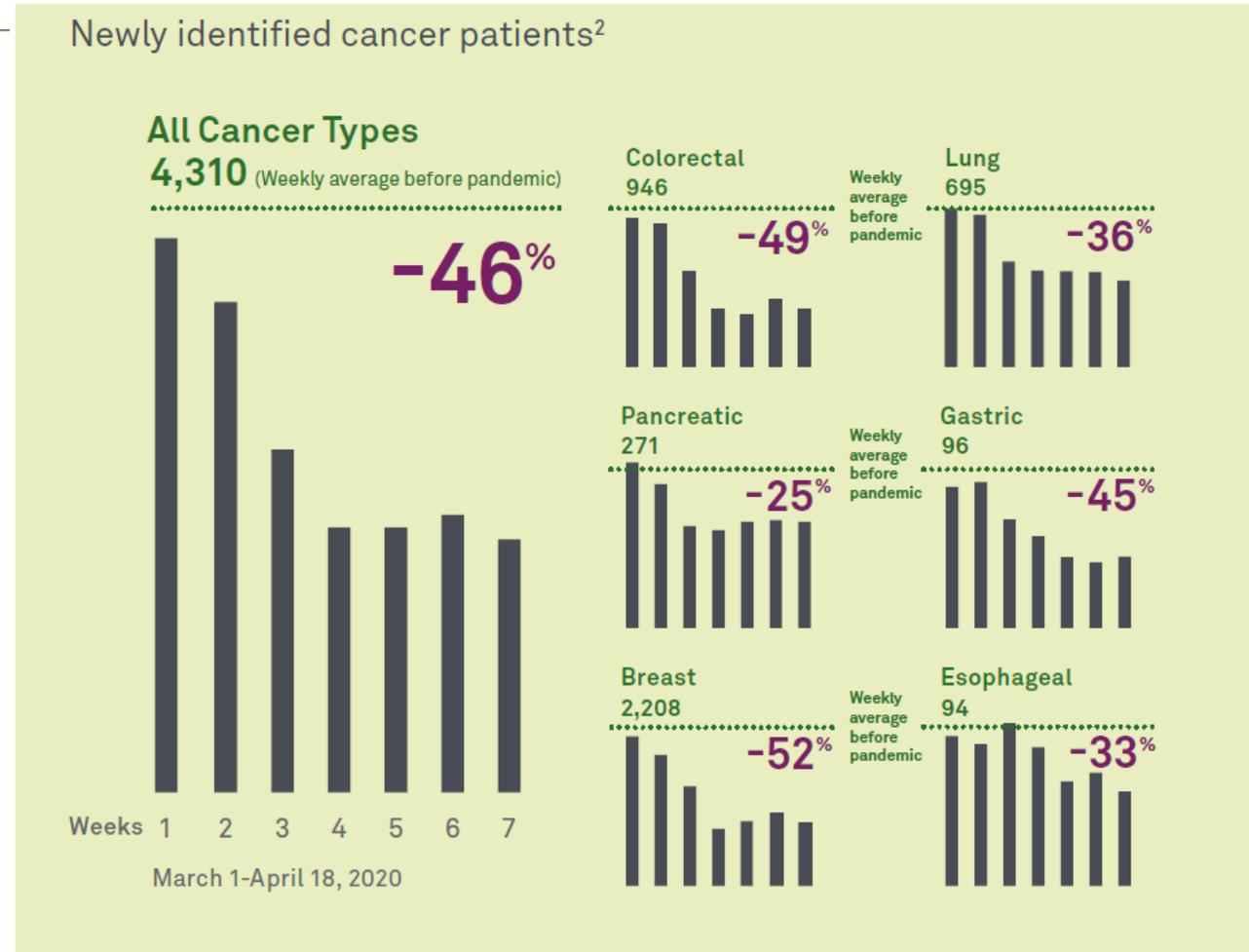
Exhibit 14: Reduction in Diagnostic Testing Procedures, Week Ending April 10 Compared to February 2020



Source: IQVIA Real World Claims, April 17, 2020

Changes in the Number of US Patients With Newly Identified Cancer Before and During the Coronavirus Disease 2019 (COVID-19) Pandemic

Harvey W. Kaufman, MD; Zhen Chen, MS; Justin Niles, MA; Yuri Fesko, MD



<https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2768946>

ESTIMATES OF DELAYED/MISSED CANCER DIAGNOSES

Over 22 million screening tests for five common tumors may be disrupted, risking delayed or missed diagnoses for 80,000 patients

Exhibit 15: Modeled Impact of Reduced Screening Tests Three Months Ending June 5, 2020



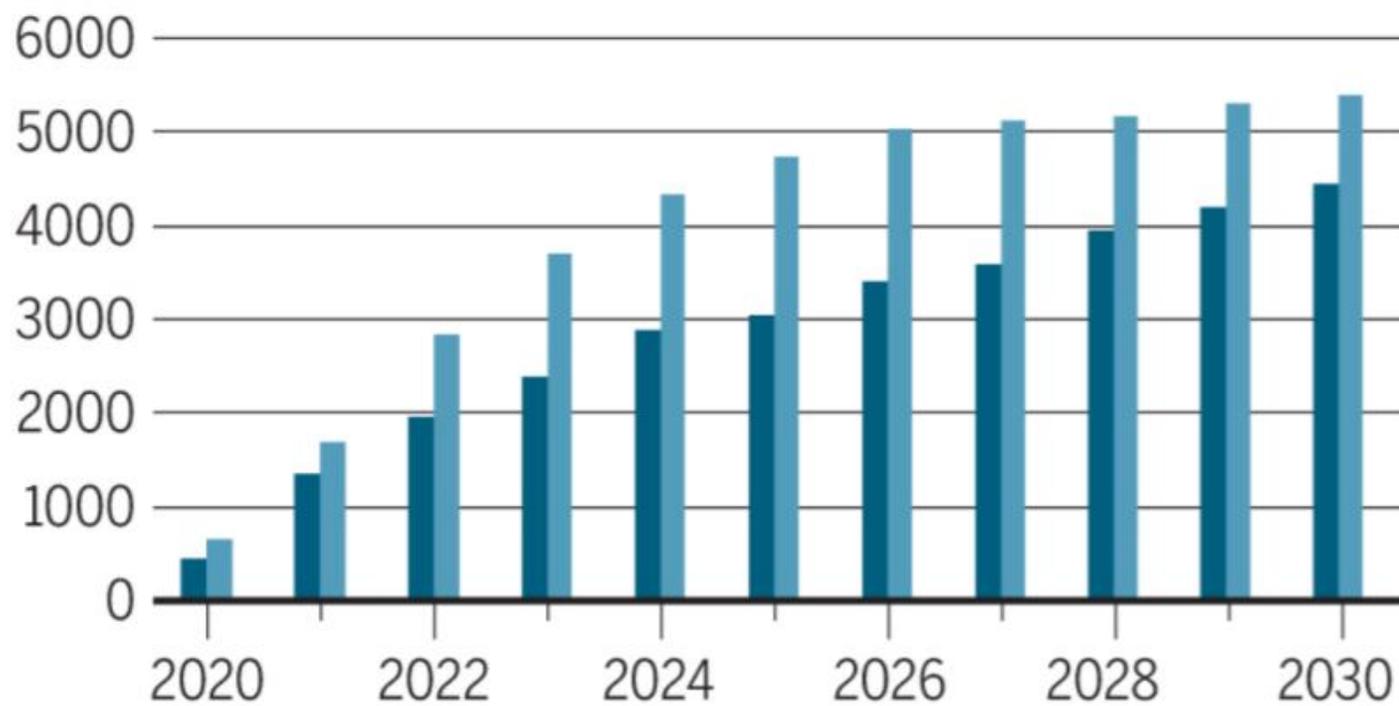
Source: IQVIA Institute, Apr 2020

18,800 delayed CRC diagnoses

Modeling the effect of COVID-19 on Cancer Screening and Treatment

Modeled cumulative excess deaths from colorectal and breast cancers, 2020 to 2030*

● Colorectal ● Breast



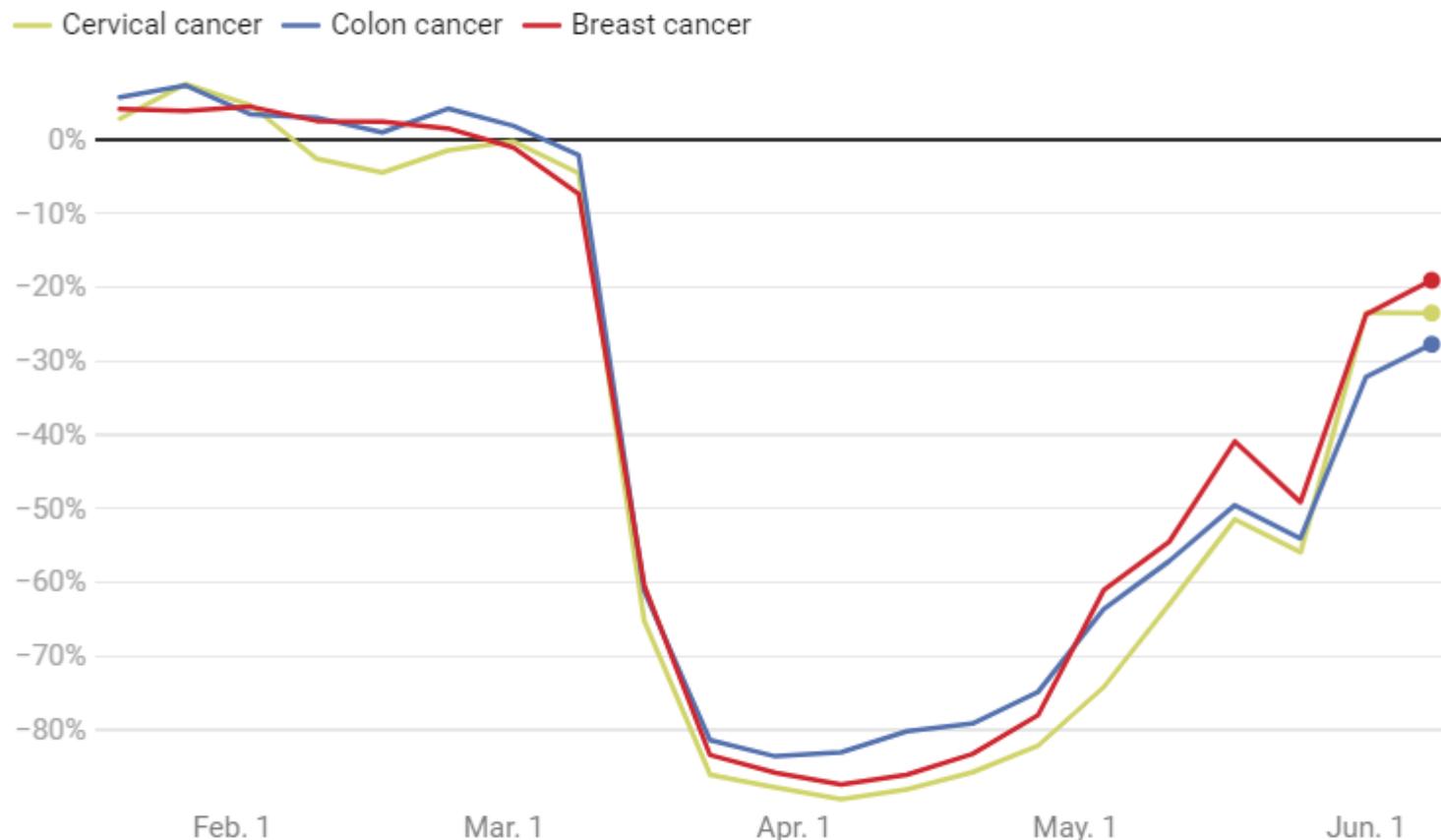
Resuming Colorectal Cancer Screenings



- ▶ The preceding estimates were based on the assumption of a return to normal screening and treatment levels by early June.
- ▶ As of June 1, weekly screening volumes remained significantly lower than pre-COVID-19 levels in many parts of the country

Percentage change in cancer screenings during COVID-19

The lines show how the volume of cancer screenings this year compares to the weekly average in the three years prior to the pandemic.



Data are pooled from 60 health care organizations representing 306 hospitals that span 28 states and cover 9.8 million patients.

Chart: Emily Barone for TIME • Source: [Epic Health Research Network](#) • [Get the data](#) • Created with [Datawrapper](#)

RESUMING CANCER SCREENING: CHALLENGES

- ▶ Unprecedented backlog of cancer screenings requiring health systems to adopt new processes and protocols to identify, prioritize and track those needing screening and follow up.
- ▶ New cleaning and social distancing protocols have led to lower capacity for tests and procedures compared with pre-pandemic levels in many settings.
- ▶ Varied local policies and capacity due to fluctuating COVID-19 infection rates
- ▶ Patient fear, reluctance, and confusion
- ▶ Complexities of shift to telehealth and other changes to healthcare system
- ▶ Potential decreased primary care capacity
- ▶ Staggering loss of employment and employer sponsored health insurance.
- ▶ Exacerbation of long-standing inequities.

RESUMING CANCER SCREENING: PATIENT PRIORITIZATION

Due to backlog must prioritize based on patient circumstances:

- ▶ Symptomatic patients.
- ▶ Patients who had an abnormal screening exam before the shutdown, and were scheduled for diagnostic evaluation.
- ▶ Patients who had undergone evaluation prior to the shutdown and were scheduled for biopsies or procedures.
- ▶ High-risk patients for whom regular screening or further diagnostic evaluation is a higher priority due to the higher probability of disease.
- ▶ Patients who are asymptomatic, but behind in adherence.
- ▶ New patients just arriving at the age to begin screening.



RESUMING CANCER SCREENING: WHAT TO TELL PATIENTS

Facilities have new precautions in place to keep patients and staff safe:

- ▶ Most facilities check everyone for symptoms of COVID 19 before entering the facility and many check temperatures on all entering staff and visitors.
- ▶ EVERYONE in the facility—including patients—should be wearing a mask.
- ▶ The facility staff should do everything possible to keep people — including staff — at least six feet apart.
- ▶ Waiting rooms should not be crowded. This may mean fewer available appointments or patients waiting in their car until they are called into the office.
- ▶ Some endoscopy centers require pre-procedure COVID-19 testing prior to colonoscopy



National Colorectal Cancer Roundtable

The screenshot shows a web browser window with the URL nccrt.org/about/. The page features a blue header with a navigation menu and a search bar. The main content area is titled "Our Mission" and includes a paragraph about the organization's history, a bulleted list of coalition members, a paragraph about its mission, and a paragraph about its ultimate goal. There are two buttons at the bottom: "How We Work" and "Download our Bylaws".

About NCCRT - National Colorec... | NCCRT_CRC-Screening-and-COV... | PowerPoint Presentation

[nccrt.org/about/](#)

The National Colorectal Cancer Roundtable supports our members and partners as our nation responds to the COVID-19 pandemic. Please click [here](#) to learn more about what cancer patients, their families, and caregivers need to know about COVID-19.

 NATIONAL Colorectal Cancer ROUNDTABLE

ABOUT ▾ WHAT WE DO ▾ WHAT'S NEW ▾ RESOURCE CENTER GET INVOLVED

Our Mission

The National Colorectal Cancer Roundtable, established by the American Cancer Society (ACS) and the Centers for Disease Control and Prevention (CDC) in 1997, is a national coalition of:

- Public Organizations
- Private Organizations
- Voluntary Organizations, and
- Invited Individuals

Dedicated to reducing the incidence of and mortality from colorectal cancer in the U.S., through coordinated leadership, strategic planning, and advocacy.

The ultimate goal of the NCCRT is to increase the use of proven colorectal cancer screening tests among the entire population for whom screening is appropriate.

[How We Work](#) [Download our Bylaws](#)



Have a question? Please review our [frequently asked questions](#) or [contact us](#).

NCCRT Community Reacts

- Co-hosted expert panel on stool testing amidst the pandemic
 - May 5 w/ Colorectal Cancer Alliance
- Published CRC screening and COVID-19 Playbook
 - June 30
- Webinar with Playbook lead authors
 - July 23

REIGNITING COLORECTAL CANCER
SCREENING AS COMMUNITIES FACE AND
RESPOND TO THE COVID-19 PANDEMIC



Introduction

Since 1997, the members of the National Colorectal Cancer Roundtable (NCCRT) have united to increase the use of evidence-based colorectal cancer screening tests among the entire population for whom screening is appropriate. As part of this mission, the NCCRT along with its 150 member organizations launched the **80% in Every Community** initiative, which aims to ensure that colorectal cancer screening rates reach or exceed 80% in communities and organizations across the nation. From 2012 to 2018, due to improved screening rates, **9.3 million more individuals** were up to date with screening.

Yet, many communities lag behind, and the COVID-19 pandemic has challenged efforts to address inadequate screening and inequities in colorectal cancer outcomes, hindering the progress toward our **80% in Every Community** goals. In the early stages of the COVID-19 pandemic, leading agencies, such as the [Centers for Medicare & Medicaid Services \(CMS\)](#) and the [American Cancer Society](#), made recommendations to delay all non-urgent procedures. Colonoscopies to detect colorectal cancer have been delayed or cancelled and patient fears about contracting COVID-19 have led to further [reductions in screening](#). This drop has raised concern that COVID-19-related screening delays will lead to missed and advanced stage colorectal cancer diagnoses and to [excess deaths from colorectal cancer](#). Moreover, this burden will likely not be evenly distributed as screening disparities may be exacerbated in communities and populations that are disadvantaged by both old and new challenges in the COVID-19 era.

The colorectal cancer fighting community stands prepared and well-positioned to respond to and overcome the difficult task ahead. This document provides an action-oriented playbook for how NCCRT members, 80% pledged partners, and colorectal cancer screening advocates across the nation can work together to reignite our screening efforts appropriately, safely, and equally for all communities.

Overarching Messages to Guide Our Response to Delays in Screening:

1. **There are several safe and effective tests to screen for colorectal cancer, including stool tests (fecal immunochemical test [FIT], guaiac fecal occult blood test [FOBT], multi-target stool DNA [mt-sDNA]), and tests which provide a structural exam of the colon and rectum including colonoscopy, sigmoidoscopy, and CT colonography (also called virtual colonoscopy).**
2. **Screening disparities are already evident and, without deliberate focus, are likely to increase as a result of the COVID-19 pandemic.** Efforts to promote screening in populations with low screening prevalence must be at the forefront of our focus and accelerated immediately.
3. **For those at the highest risk, access to colonoscopy should be prioritized.** While multiple screening options are now available to those at average risk, people at above average risk or high risk for colorectal cancer due to family history or a positive initial screening test should be given priority to complete colonoscopy.
4. **Overcoming the screening barriers and delays resulting from the pandemic is urgently needed and will demand that organizations work creatively to find new solutions. Close collaboration between every partner in the health care system and critical policy changes will help us accomplish this critical preventive health goal.**



It is critical to ensure that patients with signs or symptoms of gastrointestinal illness, including colorectal cancer, undergo colonoscopy as soon as possible. Many people with symptoms that might be due to colorectal polyps or cancer - such as blood in bowel movements, change in bowel habits, abdominal pain, weight loss or unexplained anemia - have avoided medical care due to fears of infection with the SARS-CoV-2 virus. Colonoscopy is being safely provided throughout the country and diagnostic colonoscopies for patients with symptoms need not and should not be delayed.

Overarching Messages to Guide Our Response to Delays in Screening:

-  **1. There are several safe and effective tests to screen for colorectal cancer**, including stool tests (fecal immunochemical test [FIT], guaiac fecal occult blood test [FOBT], multi-target stool DNA [mt-sDNA]), and tests which provide a structural exam of the colon and rectum including colonoscopy, sigmoidoscopy, and CT colonography (also called virtual colonoscopy).
- 2. Screening disparities are already evident and, without deliberate focus, are likely to increase as a result of the COVID-19 pandemic.** Efforts to promote screening in populations with low screening prevalence must be at the forefront of our focus and accelerated immediately.
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- 4. Overcoming the screening barriers and delays resulting from the pandemic is urgently needed and will demand that organizations work creatively to find new solutions. Close collaboration between every partner in the health care system and critical policy changes will help us accomplish this critical preventive health goal.**

Stool Tests are ACS and USPSTF recommended

SCREENING GUIDELINES FOR **AVERAGE RISK** ADULTS (ACS & USPSTF)

Recommendations	ACS, 2018	USPSTF, 2016
Age to start screening S-strong Q-Qualified	Age 45y Starting at 45y (Q) Screening at aged 50y and older - (S)	Aged 50y (A)
Choice of test	High-sensitivity stool-based test or a structural exam.	Different methods can accurately detect early stage CRC and adenomatous polyps.
Acceptable Test options	<ul style="list-style-type: none"> • FIT annually • HSgFOBT annually • mt-sDNA every 3y • Colonoscopy every 10y • CTC every 5y • FS every 5y <p>All positive non-colonoscopy tests should be followed up with colonoscopy.</p>	<ul style="list-style-type: none"> • HSgFOBT annually • FIT annually • sDNA every 1 or 3y • Colonoscopy every 10y • CTC every 5y • FS every 5y • FS every 10y plus FIT every year
Age to stop screening	Continue to 75y as long as health is good and life expectancy 10+y (Q) 76-85y individual decision making (Q) >85y discouraged from screening (Q)	76-85 y individual decision making (C)

Stool Tests Are Effective

IssueBrief_FOBT_CliniciansRef-09: x +

Not secure | nccrt.org/wp-content/uploads/dlm_uploads/IssueBrief_FOBT_CliniciansRef-09282019.pdf

IssueBrief_FOBT_CliniciansRef-09282019.pdf 2 / 4

and needed follow up occurs at recommended intervals over a lifetime.

Colorectal Cancer Deaths Averted¹ per 1,000 Screened

Screening Method	Colorectal Cancer Deaths Averted (per 1,000 Screened)
FIT 1y	22 (20-23)
gFOBT 1y	22 (20-23)
SIG 10y + FIT 1y	23 (22-24)
COL 10y	24 (22-24)

Colorectal Cancer Deaths Averted

IMPLEMENTING HIGH QUALITY STOOL-BASED SCREENING PROGRAMS

Use stool tests only for **average risk patients** (no personal or family history of CRC, adenomas, or genetic syndromes). High risk patients should have colonoscopy screening.

Use only high-sensitivity fecal immunochemical (FIT), guaiac-based FOBTs (such as Hemoccult II Sensa), or FIT-DNA tests. Hemoccult II and generic guaiac-based tests are far less sensitive and should not be used for CRC screening.

Stool samples obtained by digital rectal exam (DRE)

All patients should be aware that stool tests are a

NCCRT Playbook

Aligning Statement 3

Lead Author: Steven Itzkowitz, MD, FACP, FACG, AGAF

During a time when availability of elective screening colonoscopy may be limited by the COVID-19 pandemic, colorectal cancer screening can be safely offered through at-home stool-based tests.

Issue Summary

- There are several safe, effective, and guideline-endorsed tests to screen for colorectal cancer
- Stool-based tests are convenient for patients, especially in areas of high COVID prevalence.
- The vast majority of insurances cover these tests.
- The tests can reach those living in rural or hard-to-reach locations (mailed programs)
- A positive (abnormal) test must be referred promptly for colonoscopy because a delay of six months or longer after an abnormal FIT result is associated with higher rates of advanced adenomas and late-stage colorectal cancer.

Stool-Based CRC Screening Tests



Fecal Immunochemical Test (FIT; ELISA)



Multi-Target Stool DNA (FIT-DNA) (Hgb; 10 DNA markers)



Fecal Occult Blood Test (FOBT; Guaiac)

Learn More: The [NCCRT's Clinicians Reference](#) provides guidance on high-quality stool testing.

NCCRT Clinician's Reference



Guidelines from the American Cancer Society, the US Preventive Services Task Force, and others recommend Fecal Immunochemical Tests (FIT), High-Sensitivity Fecal Occult Blood Tests (HS-gFOBT) and FIT-DNA testing as options for colorectal cancer (CRC) screening in men and women at average risk for developing colorectal cancer.

This document provides state-of-the-science information about these tests.



Clinician's Reference
STOOL-BASED TESTS FOR
COLORECTAL CANCER
SCREENING



The number of colorectal cancer cases is dropping thanks to screening. We are helping save lives. We can save more.

Three types of stool tests are available – FIT, guaiac-based FOBT, and FIT-DNA

Fecal Immunochemical Tests (FITs) look for hidden blood in the stool and are specific for human blood while older guaiac-based tests (gFOBTs) are not. Unlike gFOBT, FIT results are not impacted by food or medication. There is evidence that patient adherence with FIT may be higher than with gFOBT possibly because no dietary and medication restrictions are required before collecting samples, or because some brands of FIT require collection of only 1 or 2 specimens for a completed test. It is important to note that not all FITs are equally effective. As of July 2016, there are 26 FDA-cleared FITs available for purchase in the US, however most do not have published data on their performance for detection of cancer. To assist with choosing a FIT for use in your setting, the table below includes FITs that have published data on sensitivity and specificity for cancer.

FIT BRAND NAME	MANUFACTURER	SENSITIVITY FOR CANCER ^{1,2}	SPECIFICITY FOR CANCER ^{1,2}	NUMBER OF STOOL SAMPLES
Automated (non-CLIA waived) FITs				
OC Auto-FIT ³	Polymedco	65%-92.3% ^{1,4}	87.2%-95.5% ^{1,4}	1
CLIA-waived FITs				
OC-Light iFOB Test (also called OC Light 5 FIT)	Polymedco	78.6%-97.0% ^{1,4}	88.0%-92.8% ^{1,4}	1
QuickVue iFOB	Quidel	91.9% ⁵	74.9% ⁵	1
Hemosure One-Step iFOB Test	Hemosure, Inc.	54.5% ⁶	90.5% ⁶	1 or 2
InSure FIT	Clinical Genomics	75.0% ⁶	96.6% ⁶	2
Hemoccult-ICT	Beckman Coulter	23.2%-81.8% ³	95.8%-96.9% ³	2 or 3

¹Used with OC-Sensor DIANA and OC-Auto Micro 80 automated analyzers.

²Detection limits for cancer vary across FIT brand and by study such that direct comparison between FIT brands is not possible.

³Cited studies should be interpreted in the full context of the published literature given variation in study size and quality.

Guaiac-based FOBTs (gFOBTs) have been the most common form of stool tests used in the US prior to FIT becoming widely available. Modern high-sensitivity tests have much higher cancer and adenoma detection rates than older tests, resulting in fewer missed cancers. Hemoccult II SENSAs is the only test in this category for which published performance data is available. Screening guidelines now specify that only high-sensitivity forms of guaiac-based tests should be used for colorectal cancer screening. **Hemoccult II and similar older guaiac-based tests should not be used for colorectal cancer screening.**

gFOBT BRAND NAME	MANUFACTURER	SENSITIVITY FOR CANCER	SPECIFICITY FOR CANCER	NUMBER OF STOOL SAMPLES
Hemoccult II SENSAs	Beckman Coulter	61.5%-79.4% ⁸	86.7%-96.4% ⁸	3

FIT-DNA is a stool test that looks for increased levels of altered DNA biomarkers that are released into the stool as cells from colorectal cancer and adenomas degenerate. Cologuard is the only stool DNA test currently marketed in the US and combines testing for these DNA biomarkers with a high-quality FIT (a "FIT-DNA" test).

FIT-DNA BRAND NAME	MANUFACTURER	SENSITIVITY FOR CANCER	SPECIFICITY FOR CANCER	NUMBER OF STOOL SAMPLES
Cologuard	Exact Sciences	92.3% ⁷	89.8% ⁷	1

Deep Dive Topic: Stool-Based Programs

- Must be considered a “program”, not simply a test.
- Systems should be in place for: ordering and distributing the test; making sure it gets done; obtaining results; acting on both positive and negative results.
- Both FIT and mt-sDNA tests must be ordered by a clinician, most commonly the patient’s primary care clinicians, although the tests can be ordered through urgent care centers, retail clinics, or independent telehealth providers.

A positive stool-based test:

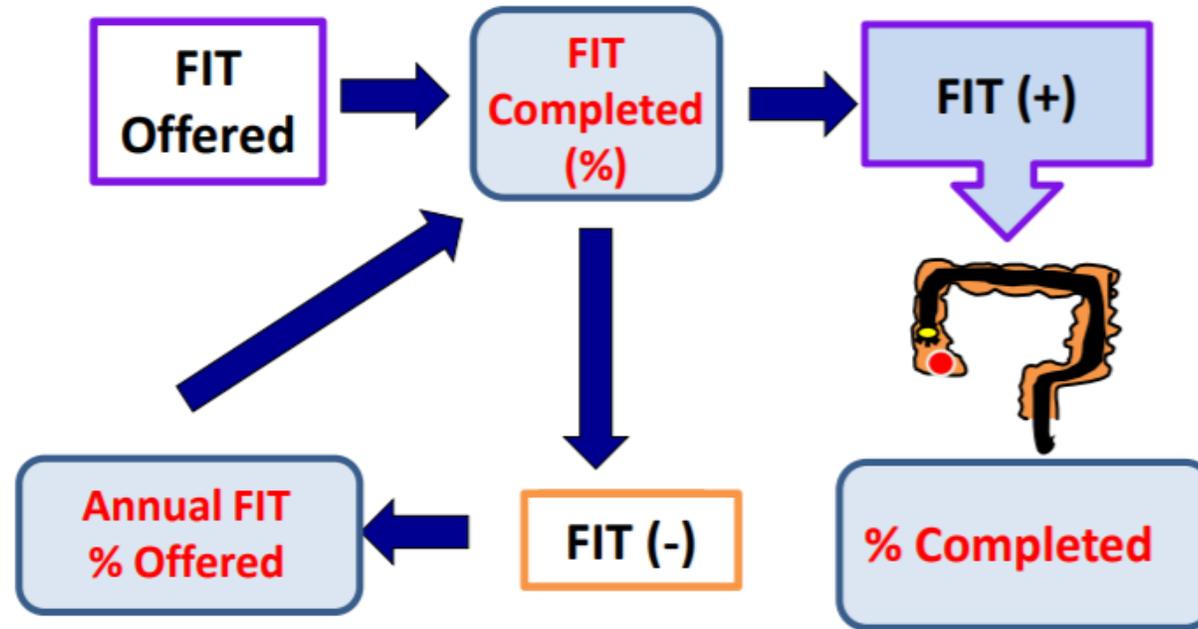
- Prompt referral to colonoscopy (e.g. delay >6 months after positive FIT = worse outcomes)
- Requires close communication between primary care and GI practices.
- A positive test without colonoscopy is an “incomplete” screening round.

A negative stool-based test must be repeated:

- FIT, or hsFOBT -- Q1Y
- Multi-target sDNA -- Q3Y

FIT:

Many Steps for Programmatic Adherence



Quality Metrics (red)

NCCRT Recommendations

1. Discuss with your patients (within your community) that stool-based tests are important and effective options for CRC screening.
2. Stool tests are safe, even in areas of high COVID prevalence.
3. Understand how FOBT, FIT, and multi-target stool DNA testing are being conducted in your environment.
4. Develop tracking and reminder systems.
5. Establish and maintain close communication between primary care and colonoscopy practices.

Stool DNA

FIT-DNA is a stool test that looks for increased levels of altered DNA biomarkers that are released into the stool as cells from colorectal cancer and adenomas degenerate. Cologuard is the only stool DNA test currently marketed in the US and combines testing for these DNA biomarkers with a high-quality FIT (a “FIT-DNA” test).

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The NEW ENGLAND JOURNAL of MEDICINE

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Multitarget Stool DNA Testing for Colorectal-Cancer Screening

Thomas F. Imperiale, M.D., David F. Ransohoff, M.D., Steven H. Itzkowitz, M.D., Theodore R. Levin, M.D., Philip Lavin, Ph.D., Graham P. Lidgard, Ph.D., David A. Ahlquist, M.D., and Barry M. Berger, M.D.

ABSTRACT

BACKGROUND

An accurate, noninvasive test could improve the effectiveness of colorectal-cancer screening.

METHODS

We compared a noninvasive, multitarget stool DNA test with a fecal immunochemical test (FIT) in persons at average risk for colorectal cancer. The DNA test includes quantitative molecular assays for *KRAS* mutations, aberrant *NDRG4* and *BMP3* methylation, and β -actin, plus a hemoglobin immunoassay. Results were generated with the use of a logistic-regression algorithm, with values of 183 or more considered to be positive. FIT values of more than 100 ng of hemoglobin per milliliter of buffer were considered to be positive. Tests were processed independently of colonoscopic findings.

RESULTS

Of the 9989 participants who could be evaluated, 65 (0.7%) had colorectal cancer and 757 (7.6%) had advanced precancerous lesions (advanced adenomas or sessile

From the Department of Medicine, Indiana University School of Medicine, the Regenstrief Institute, the Simon Cancer Center, and the Center for Innovation at Roudebush Veterans Affairs Medical Center — all in Indianapolis (T.F.I.); the Departments of Medicine and Epidemiology and the Lineberger Comprehensive Cancer Center, University of North Carolina at Chapel Hill, Chapel Hill (D.F.R.); the Dr. Henry D. Janowitz Division of Gastroenterology, Department of Medicine, Icahn School of Medicine at Mount Sinai, New York (S.H.I.); Kaiser Permanente Medical Center, Walnut Creek, CA (T.R.L.); Boston Biostatistics Research Foundation, Framingham MA (P.L.); Exact Sciences, Madison, WI (G.P.L., B.M.B.); and the Division of Gastroenterology and Hepatology, Mayo Clinic, Rochester, MN

Stool DNA: Higher Sensitivity

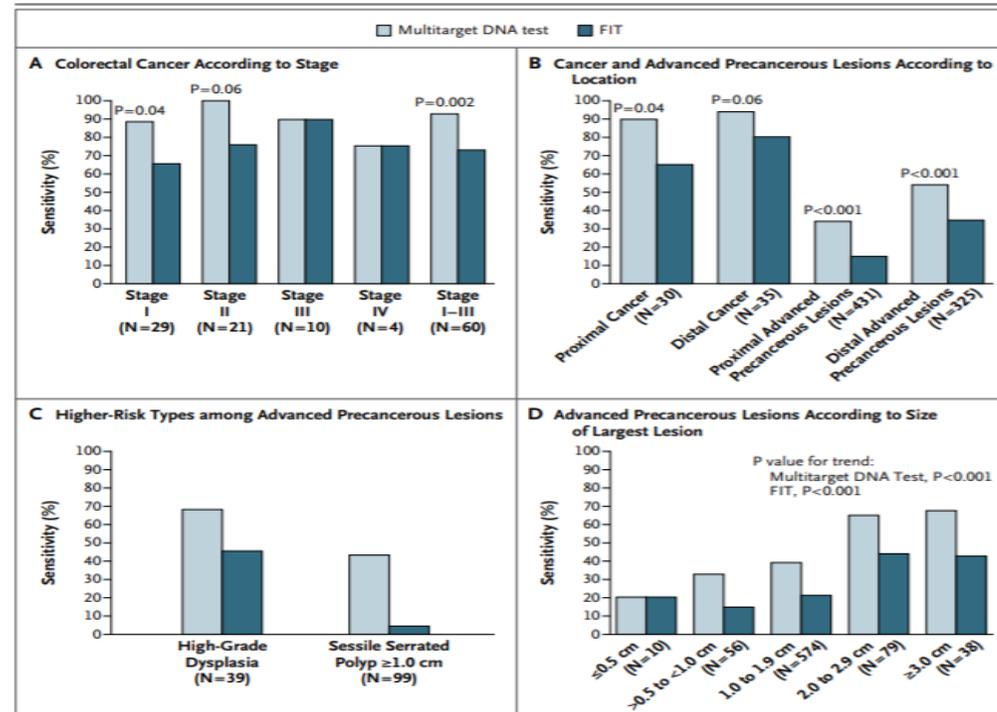


Figure 2. Sensitivity of the Multitarget Stool DNA Test and the Commercial Fecal Immunochemical Test (FIT), According to Subgroup.

Shown are the sensitivities of the DNA test and FIT for the detection of colorectal cancer according to tumor stage (Panel A), for the detection of colorectal cancer and advanced precancerous lesions according to the location in the colon (Panel B), and for the detection of higher-risk subtypes among participants with advanced precancerous lesions (Panel C) and according to lesion size (Panel D). The numbers in parentheses are the number of participants in each category. In Panel A, the stage of 1 of 65 colorectal cancers was not available. In Panel B, the location of 1 of 757 advanced precancerous lesions was not available.

Stool DNA Follow-up Rates

Colorectal cancer screening completion: An examination of differences by screening modality

Lila J. Finney Rutten^{a,b,*}, Debra J. Jacobson^{a,c}, Gregory D. Jenkins^{a,c}, Chun Fan^{a,c}, Emily Weiser^d, Philip Parks^d, Mary Doroshenko^d, Paul J. Limburg^{d,e}, Jennifer L. St. Sauver^{a,c}

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^b Division of Health Care Policy and Research, Department of Health Sciences Research, Mayo Clinic, Rochester, MN, United States
^c Division of Biomedical Statistics and Informatics, Department of Health Sciences Research, Mayo Clinic, Rochester, MN, United States
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ARTICLE INFO

Keywords:
Colorectal cancer
Cancer screening
Cancer early detection

ABSTRACT

Average-risk colorectal cancer (CRC) screening is broadly recommended, using one of several endorsed test options. However, CRC screening participation rates remain below national goals. To gain further insights regarding recent, population-based patterns in overall and test-specific CRC screening participation, we conducted a retrospective study of adults, ages 50–75 years, utilizing comprehensive data resources from the Rochester Epidemiology Project (REP).

Among residents of Olmsted County, MN eligible and due for CRC screening, we identified 5818 residents across three annual cohorts who completed screening between 1/1/2016 and 12/31/2018. We summarized CRC screening rates as incidence per 1000 population and used Poisson regression to test for overall and mode-specific CRC trends. We also analyzed rates of follow-up colonoscopy within 6-months after a positive stool-based screening result.

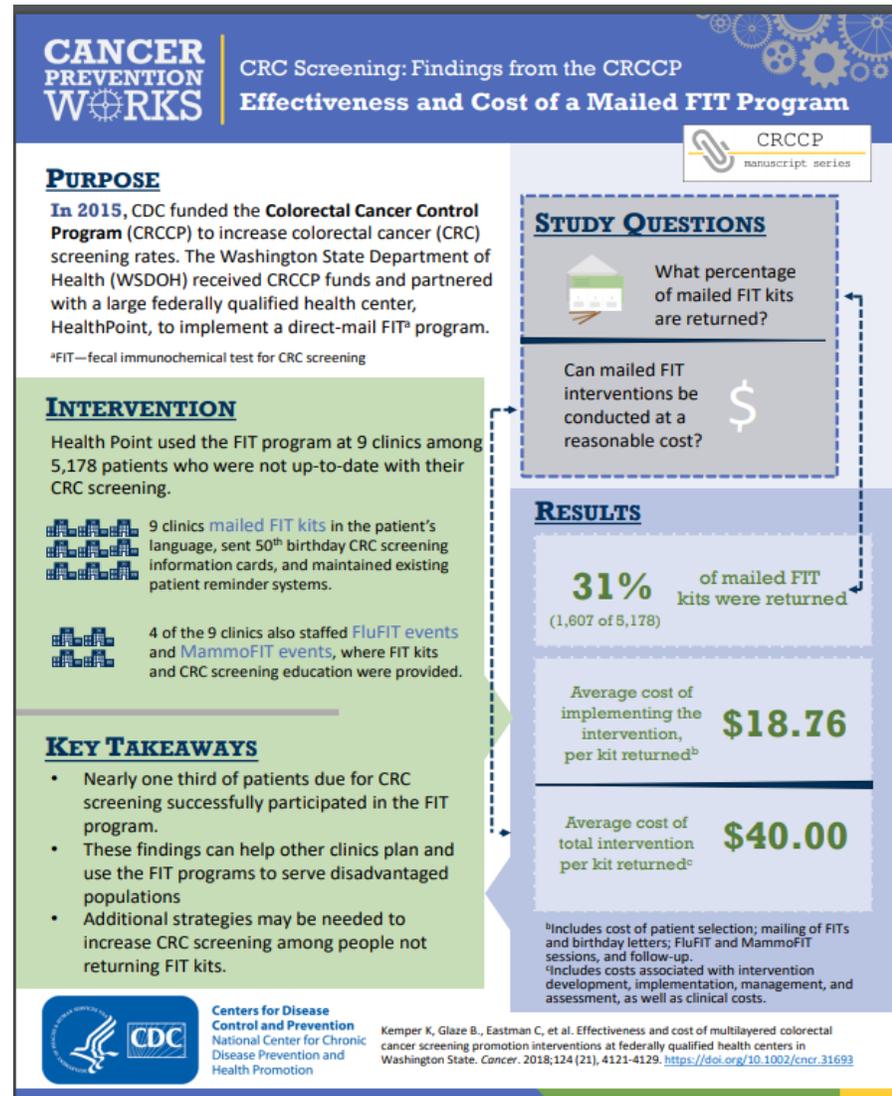
While no significant differences over time were observed in overall CRC screening incidence rates among those due for screening, we observed a statistically significant increase in mt-sDNA test and statistically significant decreases in screening colonoscopy and FIT/FOBT test completion rates; differences in screening overall and by modality were observed by age, sex, and race/ethnicity. The diagnostic colonoscopy follow-up rate within six months after a positive stool-based test was significantly higher following mt-sDNA (84.9%) compared to FIT/FOBT (42.6%).

In this retrospective, population-based study, overall CRC screening incidence rates remained stable from 2016 to 2018, while test-specific rates for mt-sDNA significantly increased and decreased for colonoscopy and FIT/FOBT. Adherence with follow-up colonoscopy after a positive stool-based test was significantly higher among patients who underwent mt-sDNA screening compared to FIT/FOBT.

Case Studies



Health Point Case Study



Health Point Case Study

INTERVENTION

Health Point used the FIT program at 9 clinics among 5,178 patients who were not up-to-date with their CRC screening.



9 clinics mailed FIT kits in the patient's language, sent 50th birthday CRC screening information cards, and maintained existing patient reminder systems.



4 of the 9 clinics also staffed FluFIT events and MammoFIT events, where FIT kits and CRC screening education were provided.

RESULTS

31% of mailed FIT kits were returned
(1,607 of 5,178)

Average cost of implementing the intervention, per kit returned^b **\$18.76**

Average cost of total intervention per kit returned^c **\$40.00**

Kaiser Implementation Guide

The screenshot shows a web browser window with the URL `research.kpchr.org/Research/Our-People/Gloria-D-Coronado/mailedfit/Maile-FIT-Implementation-Guide`. The page header includes the Kaiser Permanente logo and navigation links for Home, About, Research, News, and Contact. The breadcrumb trail reads: Research > Our People > Gloria D. Coronado > mailedfit > Maile FIT - Implementation Guide. The main heading is "Implementation Guide".

The page content includes two paragraphs of text, a "Download the Implementation Guide" button, and two sections with bulleted lists:

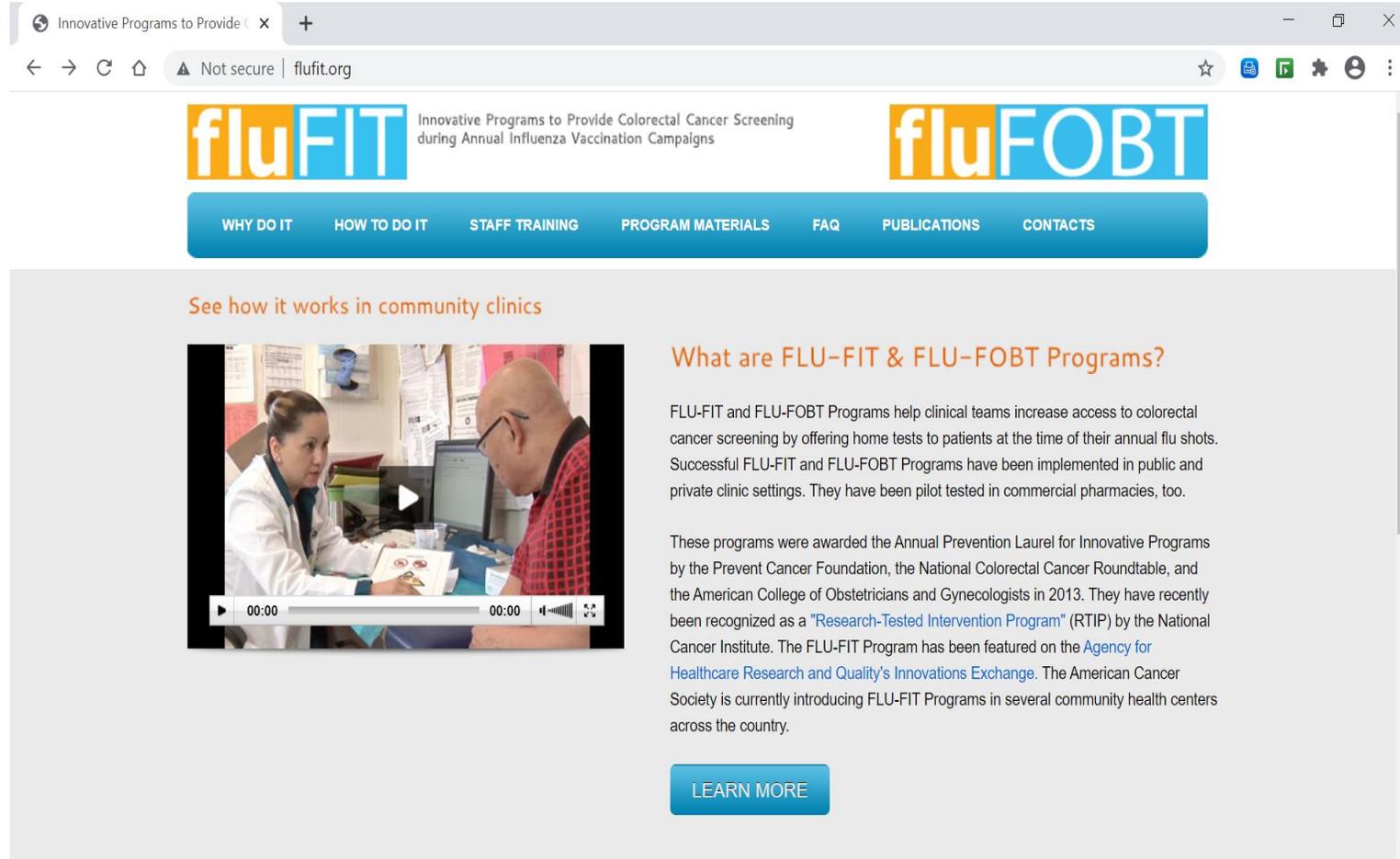
- Mailed FIT Program Implementation Guide: Guide for Clinics**
 - Why CRC Screening Programs Are Important
 - Fecal Immunochemical Testing vs. Colonoscopy
 - Advantages of Direct-Mail FIT Programs
 - Overview of STOP-CRC Program
- Prerequisites: Clinic Capacity and Technical Resources**
 - Technical Resources

On the right side, there is a vertical navigation menu with the following items:

- Mailed FIT
- Why Do It?
- Research Projects
- Program Materials
- Mailed FIT News
- Workflows
- Implementation Guide
- Videos
- MailedFit Publications

At the bottom of the page, the word "Contact" is partially visible.

FluFIT



The screenshot shows a web browser window with the URL flufit.org. The page features a navigation bar with the following links: WHY DO IT, HOW TO DO IT, STAFF TRAINING, PROGRAM MATERIALS, FAQ, PUBLICATIONS, and CONTACTS. Below the navigation bar, there is a section titled "See how it works in community clinics" which includes a video player. The video player shows a healthcare professional interacting with a patient. To the right of the video player, there is a section titled "What are FLU-FIT & FLU-FOBT Programs?" with two paragraphs of text and a "LEARN MORE" button.

Innovative Programs to Provide Colorectal Cancer Screening during Annual Influenza Vaccination Campaigns

fluFIT **fluFOBT**

WHY DO IT HOW TO DO IT STAFF TRAINING PROGRAM MATERIALS FAQ PUBLICATIONS CONTACTS

See how it works in community clinics

What are FLU-FIT & FLU-FOBT Programs?

FLU-FIT and FLU-FOBT Programs help clinical teams increase access to colorectal cancer screening by offering home tests to patients at the time of their annual flu shots. Successful FLU-FIT and FLU-FOBT Programs have been implemented in public and private clinic settings. They have been pilot tested in commercial pharmacies, too.

These programs were awarded the Annual Prevention Laurel for Innovative Programs by the Prevent Cancer Foundation, the National Colorectal Cancer Roundtable, and the American College of Obstetricians and Gynecologists in 2013. They have recently been recognized as a "Research-Tested Intervention Program" (RTIP) by the National Cancer Institute. The FLU-FIT Program has been featured on the [Agency for Healthcare Research and Quality's Innovations Exchange](#). The American Cancer Society is currently introducing FLU-FIT Programs in several community health centers across the country.

LEARN MORE

Actual Case Examples

How are Medical Groups Approaching Colorectal Cancer Screening during the Pandemic?



HealthPartners Care Group FIT during COVID

- Sending FITs to approximately 7,500 patients by the end of 2020
- Patient population
 - No contraindications in EMR to receiving FIT
 - No active orders for colonoscopy
 - No previous outreach about FIT
 - Black and Indigenous patients included at age 45
- Centralized the outreach during the pandemic
 - Had been work of clinic teams
 - Looking at centralizing ongoing work from the lab
- New messaging about COVID
- New patient education material about FIT test



HealthPartners Care Group Colonoscopy during COVID

- Sending letters and MyChart messages to patients with colonoscopy reminders
- Patient population
 - Started with “high risk” patients
 - Expanding to “average risk”
 - Includes breast cancer screening messages for those overdue/coming due for mammogram
- New messaging about being safe while visiting clinic during COVID
- Centralized outreach during the pandemic
- Seeing about a 15% conversion of letter send to colonoscopy completion



HealthPartners Plan FIT during COVID

- Sent FITs to approximately 20,000 members in 2020
 - Patient population
 - “Unattributed” patients
 - Never screened or not up to date on CRC Screening
 - Medicare population
 - Never screened or not up to date on CRC Screening
- Overall return rate is 14.5%
 - Medicare population return rate is 23.9%
- Got kits out earlier in the year due to pandemic.
- Offered support to care delivery groups to manage FIT program
- New messaging about COVID not included in outreach until October/November reminders



Colorectal Cancer (CRC) Screening COVID-19 Implications

10/20/2020

American Cancer Society & Colon Cancer Coalition

CRC Screening Recommendations

Allina Health has endorsed both stool-based testing and colonoscopy for CRC screening, in alignment with the United States Preventative Services Task Force (USPSTF).

The 2016 USPSTF recommendations concluded that “there are numerous screening tests to detect colorectal cancer and found no head-to-head studies demonstrating that any of these screening strategies are more effective than others, although they have varying levels of evidence supporting their effectiveness, as well as different strengths and limitations.”



CRC Screening – COVID-19 Public Health Emergency (PHE)

Advantages of stool-based testing strategies for CRC screening early on in the pandemic environment included:

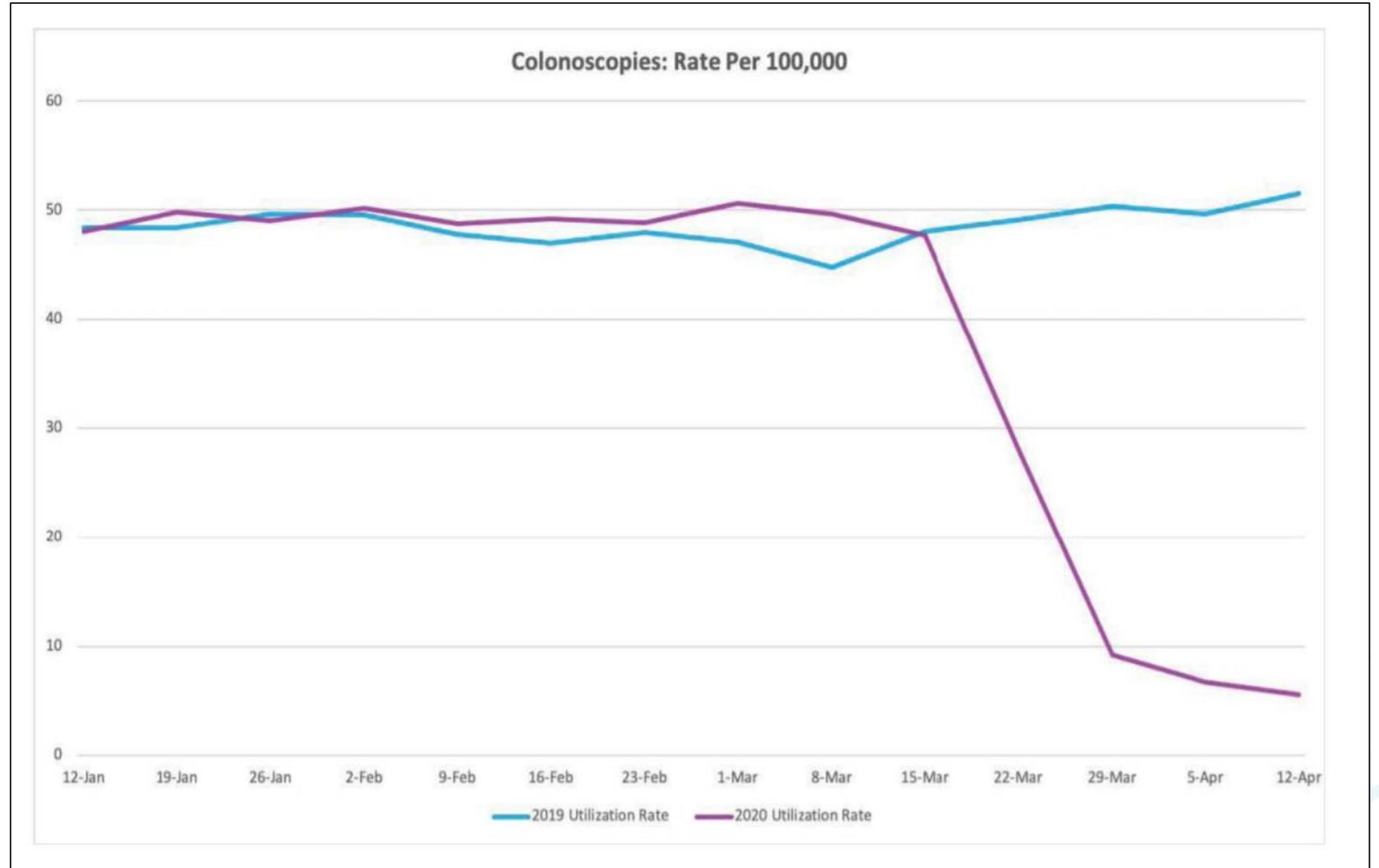
- Physical Distancing & Convenience: Stool-based testing can be completed in the convenience of your own home, including mailing of kits.
- Patient Preference: Reports from patients that they are not comfortable having a colonoscopy during the PHE, but were open to stool-based testing methods.
- Capacity: Ensures high-risk patients needing colonoscopy have adequate access.
- COVID-19 testing: Testing was initially limited and stool-based testing strategies do not require COVID-19 testing prior.
- Personal Protective Equipment (PPE): Providers and staff participating in screening colonoscopy require consumable PPE, diminishing supplies. Limited PPE is used with stool-based approaches.
- Procedural staff: Staff from procedural areas, including endoscopy suites, may be called upon to staff intensive care units or backfill for other procedural staff who are moved to intensive care units.

Interventions (06/2020)

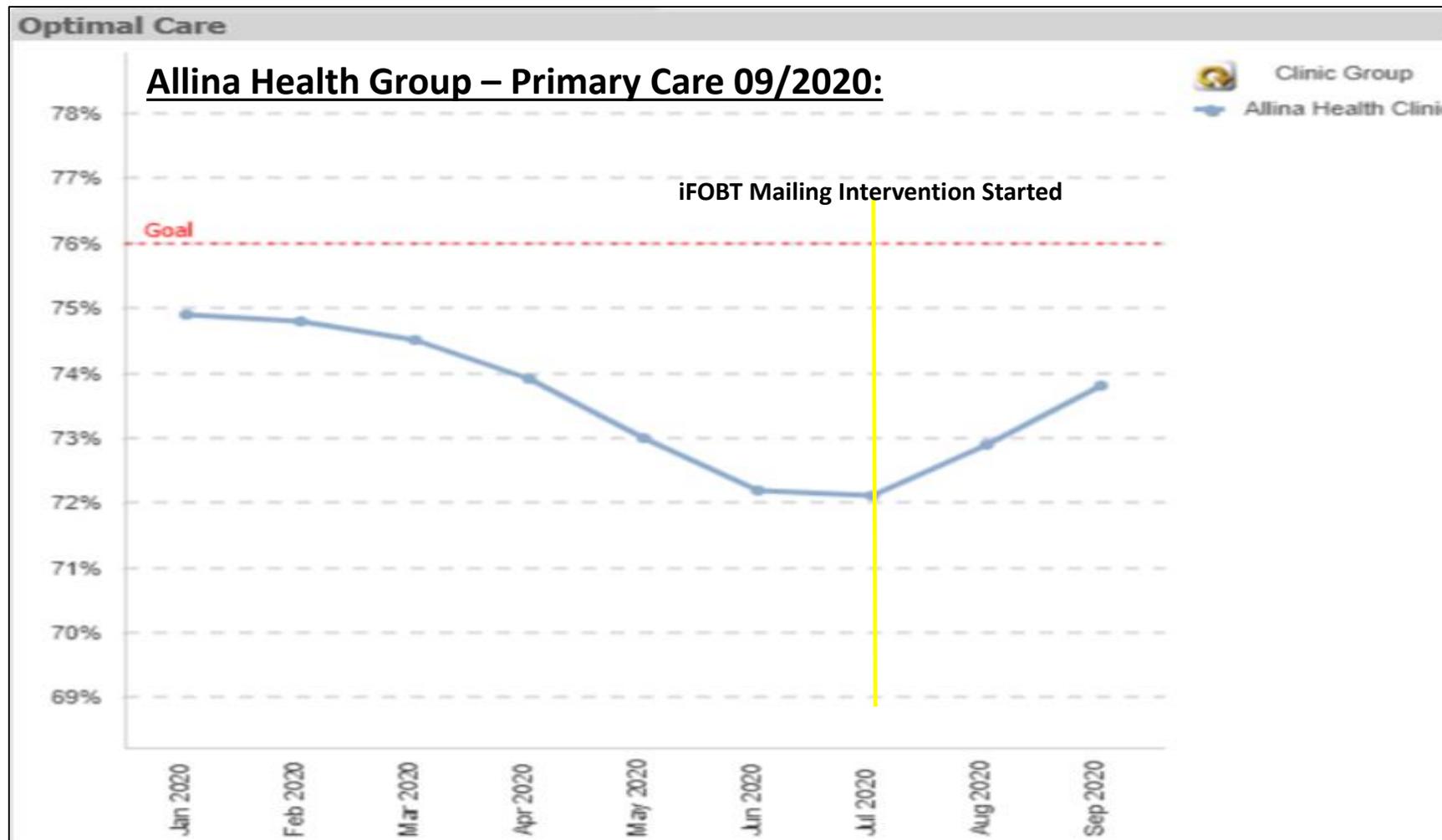
- 1.) Offer stool-based testing as primary CRC screening method to average-risk patients using the “CRC Screening Risk Assessment Algorithm” during clinic and virtual visits. High-risk patients should continue to have a shared decision making conversation with their PCP related to appropriate screening method based on risk.
- 2.) Expand annual iFOBT mailing initiative beyond the never been screened population to include patients overdue for stool-based testing. Appropriate exclusions were applied.



NCCRT 07/23/2020 Presentation Data:



Results



5,145 patients have been screened through our focus on iFOBT testing and mailing since July. (A 2% increase in this method of screening, while colonoscopy and FIT-DNA volumes remain constant).

Next Steps

- 1.) Complete the iFOBT Mailing by end of October 2020
- 2.) Continue MyChart (Patient Portal) reminder letters to patients with an active MyAllina account that have not returned their kit
- 3.) Finalize Program Results
 - Kits sent and resulted
 - Positive rates
 - F/U after positive rates
 - Health Equity breakdown of those not returned
- 4.) Consider additional health equity outreach reminder/recall strategy, if disparities emerge in the program results



2020 80% in Every Community Conference & NCCRT Annual Meeting



Date & Time:
Monday, Nov. 16, 1:00 to 4:45 PM ET
Tuesday, Nov. 17, 1:00 to 4:30 PM ET
Location: Virtual

Each year the NCCRT membership, a collaboration of over 150 medical, advocacy, government, and corporate organizations, convenes to work together on our shared goal to increase colorectal cancer screening awareness and utilization, thereby reducing deaths from this highly preventable and curable disease. This year the event will be held virtually and will include the 80% in Every Community Conference and the annual meeting of the membership with select conference sessions open to the public.

The 2020 80% in Every Community Conference and NCCRT Annual Meeting will feature presentations by nationally known experts, thought leaders, and decision makers on colorectal cancer screening policy and delivery, with opportunities to network and learn from each other. Task group sessions will be held in the weeks prior to the meeting, dates to be determined.

Registration:

NCCRT Members will receive an email with a personalized link to register starting October 8, 2020. Please register through this email and NOT through the 80% Pledge Partners link below to ensure you will have access to the full NCCRT Member portion of the meeting.

80% Pledge Partners and others: [Register now for the 80% in Every Community Conference](#). This registration link is open to the public. Please share with your partners and colleagues!

Please direct questions about registration to nccrt@cancer.org.

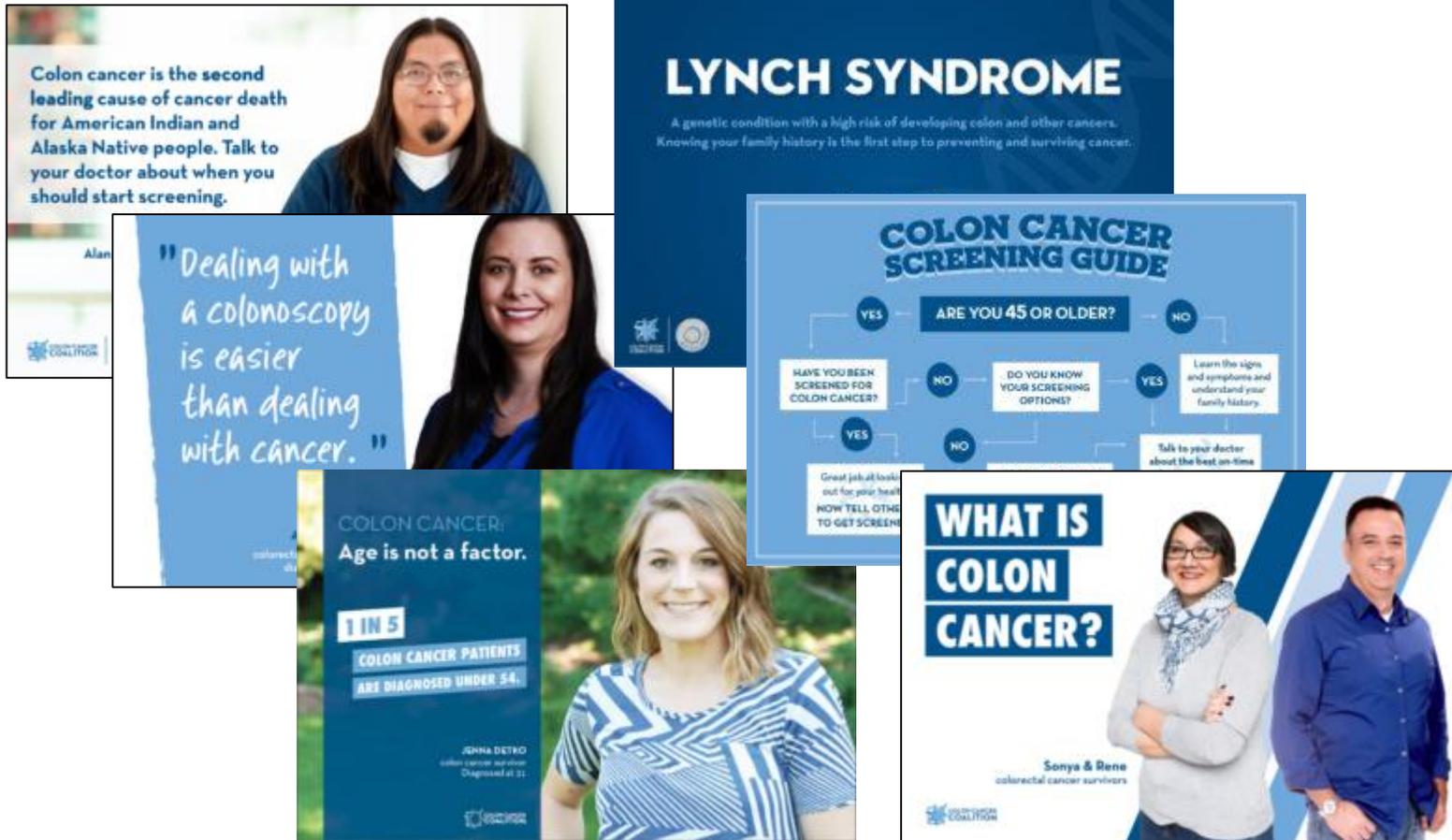
Generating Screening Awareness

...in a Pandemic and Beyond, Erin Peterson



Materials

Awareness materials for health fairs, waiting rooms, and patient education.



Tri-fold brochures available for download in 5 languages.

Request for materials: <http://coloncancercoalition.org/get-educated/free-materials/>

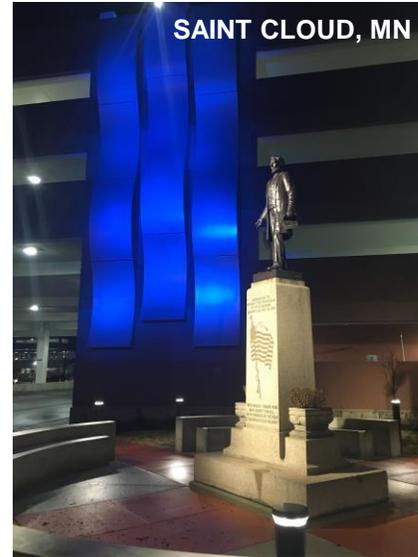
#BlueForCRC / #MNCRC



BOSTON, MA



MINNEAPOLIS, MN



SAINT CLOUD, MN



HOUSTON, TX



OKLAHOMA CITY, OK



DALLAS, TX

Q & A



COLORECTAL SCREENING: OFFERING STOOL TESTS TO PATIENTS

OCT 20, 2020 | 11:00 AM CST

CO-HOSTED BY



Despite COVID-19, colorectal cancer screening remains a public health priority. When there are barriers to colonoscopy, screening can be safely offered through at-home stool-based tests.

[COLONCANCERCOALITION.ORG/WEBINAR](https://coloncancercoalition.org/webinar)

THANK YOU

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A recording of this webinar will be available.