80% in Every Community

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National Goal:
80% Colon Cancer Screening Rate in Every Community
80% in Every Community: Potential Impact

80% screening rate yields:
- 43,000 averted cases and 21,000 averted cancer deaths/yr
- 277,000 cases averted and 203,000 total averted deaths from 2013 through 2030

Meester et al., Cancer 2015
When we launched this our 80% by 2018 campaign, we never imagined it would capture the attention of the nation like it has.
More Organizations Are Taking the Pledge

1,600+ and counting!
Niagara Falls Went Blue!
The 80% by 2018 campaign has even been included in the Cancer Moonshot initiative.
Through hard work and determination, we have made unprecedented progress since this initiative was launched in 2014.
What We’ll Discuss Today

• Indicators of progress
• Key takeaways … and how to apply them
• New tools and resources
• Where to next?
• Progress toward our goal
We’re tracking all major measures – BRFSS, NHIS, HEDIS, UDS – and there are strengths and limitations of each.

Absolute percentages vary between measures due to technical factors. We are tracking directional trends.
NHIS Data

After plateauing for several years, screening increased from 59% to 63% from 2013 to 2015.
The increase in screening rate between 2013 and 2015 as measured by NHIS translates to an additional 3.7 million adults screened by 2015.
If screening remains at the 2015 level, an estimated **39,700 additional cases and 37,200 deaths** will be prevented through 2030.
HEDIS Measures

<table>
<thead>
<tr>
<th>Year</th>
<th>Commercial HMO</th>
<th>Commercial PPO</th>
<th>Medicare HMO</th>
<th>Medicare PPO</th>
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<tbody>
<tr>
<td>2012</td>
<td>63% 63% 64% 63% 66%</td>
<td>56% 57% 58% 57% 58%</td>
<td>62% 64% 67% 67% 68%</td>
<td>58% 61% 63% 67% 71%</td>
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<td>2013</td>
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<td>2016</td>
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#NCCRT2017
Percentage of U.S. Adults Age 50-75 years Up-to-Date with CRC Screening (BRFSS 2016)
Amazing Screening Rates Among 65+ (BRFSS 2016)

Source: BRFSS 2016
Colorectal Cancer Screening Rate

ALL FQHCs (UDS)

FQHC Screening Rates Going Up

More than 300,000 additional FQHC patients screened!
>100 Organizations Nationwide Have Achieved or Exceeded 80%!

- 47 Medicare plans
- 28 Community health centers
- 25+ Medical practices and health systems
- 7 Commercial health plans
• Where is progress lagging?
Persistent Racial/Ethnic Screening Gaps

Colorectal Cancer Screening Among Adults Aged 50-75 Years, by Race/Ethnicity, NHIS, US, 2000-2015
Sub-Optimal Rates Among <65 (BRFSS 2016)

50 to 64 yrs: 61.8%
65 to 75 yrs: 78.4%

Source: BRFSS 2016
Who’s Not Screened?

Among adults aged 50 to 75 years, one quarter have never been screened.

- Screened: 67.3%
- Screened, not up-to-date: 7.1%
- Never screened: 25.6%

Among the never screened:
- 85% are insured
- 82.3% are 50 to 64 years

Source: CDC BRFSS 2016
CRC screening test use in Oklahoma has not increased since 2012.

• In 2016, 58.8% of age-eligible residents had a current CRC screening test.

• 453,000 residents were not currently screened.

• Hispanic/Latinos and African Americans lagged behind whites when it came to having a current screening test.

• Screening occurred more frequently in women and people aged 65 to 75, who were likely insured by Medicare.
Who’s Not Screened in Oklahoma?

CRC screening test use, by race/ethnicity:
- Whites (60.0%)
- African Americans (58.0%)
- Hispanic/Latinos (48.9%)

CRC screening test use, by sex:
- 2012 – 60.7%
- 2014 – 61.0%
- 2016 – 61.1%
- 2012 – 56.8%
- 2014 – 54.6%
- 2016 – 56.3%

CRC screening test use, by age:
- 50 to 64 Years (52.3%)
- 65 to 75 Years (71.5%)

Men and women aged 65 to 75 years were eligible for Medicare insurance.
What are the most important lessons emerging from the first four years of this campaign?
80% demands daily work, constant nurturing, and leadership by many people and organizations.
Hard Work and Innovation

• Hundreds of people have served on task forces, produced tools, given talks, spread the word, and arranged public events.
• Countless CRC workgroups at FQHCs, hospitals, employers, and health plans have been critical to success.
Hard Work and Innovation

• Innovation is happening all the time at the local level – everything from Poop on Demand to FluFIT to Surgery on Sunday.
We All Have a Role to Play
The work is happening one **state** at a time …
... one coalition at a time ...
... one hospital

at a time ...
... one health center at a time ...
... and one **patient** at a time.
5 Keys to Real Change

1. It’s all about evidence-based interventions.
2. Screening options must be promoted.
3. Primary care, primary care, primary care
4. Champions matter!
5. We have to share knowledge about what works.
1. It’s All About Evidence-based Interventions

• There is no magic solution.
• Systems are having success by implementing what we’ve long promoted:
  • Patient reminders
  • Provider reminders
  • Provider feedback
  • Navigation
  • A team-based approach to care
Example: Federally Qualified Health Center

- C. L. Brumback Primary Care Clinics (Florida)
- Project efforts included:
  - Patient navigator
  - Care Team education and training
  - Morning huddle and monthly QI meetings focus on colorectal cancer screening
  - Standing FIT orders
  - Poop-on-demand
  - Open access colonoscopy with county public hospital
  - Clinical protocols for colonoscopy referral
  - Optimized EHR documentation and data collection
  - Data transparency – screening rates, by provider
CL Brumback CRC Screening Rates

*CRC Grant received in November 2014
Example: Hospital Systems Success

• Advocate Illinois Masonic Hospital used evidence-based strategies to increase screening rates
  • 50- to 65-year-olds:
    • 2014 screening rate: 25%
    • 2016 mid-year screening rate: 60%
  • 65 and older:
    • 2014 screening rate: 17%
    • 2016 mid-year screening rate: 70%
    • 2016 year end rates approaching 80%
2. Screening Options Must Be Promoted

- USPSTF guidelines now essentially identical to ACS guidelines, recommending multiple screening strategies
- No system reaches 80% with colonoscopy alone.
2. Screening Options Must Be Promoted

- Many primary care clinicians continue to think that FIT is a second rate choice.
- Some patients can’t or won’t have a colonoscopy – but are willing to complete stool testing.
- Stool tests are often the only option for low resource settings.
- When practice settings “discover” the value of FIT, screening rates go up.
2. Options: Stool Tests are Effective

2. Options: Partners are Embracing FIT

• Many patients prefer home stool testing.

<table>
<thead>
<tr>
<th>Colonoscopy recommended:</th>
<th>38% completed colonoscopy</th>
</tr>
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<tbody>
<tr>
<td>FOBT recommended:</td>
<td>67% completed FOBT</td>
</tr>
<tr>
<td>Colonoscopy or FOBT:</td>
<td>69% completed a test</td>
</tr>
</tbody>
</table>

• Use of FIT and/or offering screening test choices appeared again and again in the partner survey as an essential element to moving the needle on screening.

Adherence to Colorectal Cancer Screening: A Randomized Clinical Trial of Competing Strategies
3. Primary Care Matters

The data show over and over again that the strongest predictor of whether someone is up-to-date with screening or not is whether or not their primary care clinician recommended it.
3. What Must a Primary Care Practice Do to Improve Screening Rates?

- Have strong leadership and champions.
- Have the capacity to measure and report screening rates in real time:
  - By practice
  - By clinician
  - By patient
- Have a system to contact patients who are out of date with screening and invite them to participate.
3. What Must a Primary Care Practice Do to Improve Screening Rates?

• Identify a screening policy
  - Financial/insurance considerations
  - Availability of colonoscopy

• Develop a reliable network of colonoscopists
  - Reliance on FOBT/FIT substantially reduces the number of colonoscopies

• Provide patient navigation
  - Ideally, navigation for colonoscopy should be provided by colonoscopy providers
3. Primary Care Must Focus on Initiating Screening for Avg Risk starting at age 50

• Colorectal cancer mortality rates have increased in adults under 55 since the mid-2000s after falling for decades.

• The rise was confined to white individuals.
Less than half (49.1%) of 50- to 54-year-olds are up-to-date on screening
3. Primary Care Must Focus on Initiating Screening Before Age 50 for Increased Risk

- Identification and appropriate early screening of those at increased risk might prevent nearly half of early onset cases.
3. Strategies for Reaching Primary Care Providers

1. Partner with the influencers – state and national professional organizations.
2. Work with network leaders to develop ways to reach PCPs within those systems.
3. Focus more on HEDIS rates and work with payers.
4. Champions are Key

• The secret to success is to surround yourself with good people.
• Support from leaders and champions is a strong indicator of achievement.
4. Champions are Important

Show me a system or practice or hospital that signed a pledge but where you can’t identify a true champion – the person who OWNS the issue and is the go-to person – and I’ll show you a system that isn’t likely to make much progress.
5. We Must Share What We Know

- We’re constantly learning and sharing what we know.
- In our 80% by 2018 partner survey, our partners have identified needs that we’re working hard to address:
  - How to better use EHRs
  - How to secure follow up colonoscopy for the uninsured
  - How to work with health plans
  - How to work with hospitals
  - How to implement effective state and regional coalitions
80% in Every Community Tools and Resources
Resource Center on NCCRT.org

All the tools you need are all in one place.
Where do we go from here?
Here’s What We Know

1. This is the most successful public health campaign of its type in history.
2. We’re moving the needle nationally.
3. We’re moving the needle in FQHCs.
4. We won’t know exactly how this turns out until 2020.
5. The first wave of indicators is exciting!
No matter the result, our work did not end in 2018.
Where should we focus our efforts?
Solutions are Local

- Community by Community,
- City by City,
- System by System
- Audience by Audience.
1. Reach PCPs beyond FQHCs

- Most unscreened patients are cared for in private practices.
- PCPs in private practice settings may be difficult to reach.
  - Most PCPs – whether they’re independent or working for a health system – haven’t heard of 80% in Every Community.
  - We have to find ways to educate and engage them.
1. Insured Individuals Ages 50-64

- Much lower screening rates overall than the 65+ group
- Rising CRC rates and lowest screening rates in those age 50-55
- Vast majority of the unscreened have insurance (85%)
2. Younger Individuals

• We need to encourage providers to:
  - start screening on time at age 50
    o Only 49.1% of 50-55 yr olds are up to date
  - Solicit, document and act on family history and risk factors long before a patient reaches 50;
  - Respond to symptoms at any age.
3. Reach Out to Key Populations with Low Screening Rates

• Screening rates among African American, Hispanic, American Indian and Alaska Natives, and Asian American groups are low.

• We don’t have all the answers here. Get the right people at the table to find an approach that works.
  - Cultural appropriate messages and messengers
  - Improve access to screening and to follow up colonoscopy
  - Innovation and research remain critical.
Our goal is big …

… but so is the potential impact.
Reaching 80% will prevent hundreds of thousands of cases and deaths.
Colorectal cancer doesn’t need to be the second leading cause of cancer death in the US among men and women combined.
Thank You