YOU are the Key to Preventing Cancer!

South Dakota Society of Medical Assistants

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American Cancer Society

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American Cancer Society®

- Screening Saves Lives
  - Colon Cancer
  - Human Papillomavirus – HPV
- ACS Programs
- Get Involved!
- Q & A

Why Colon Cancer?

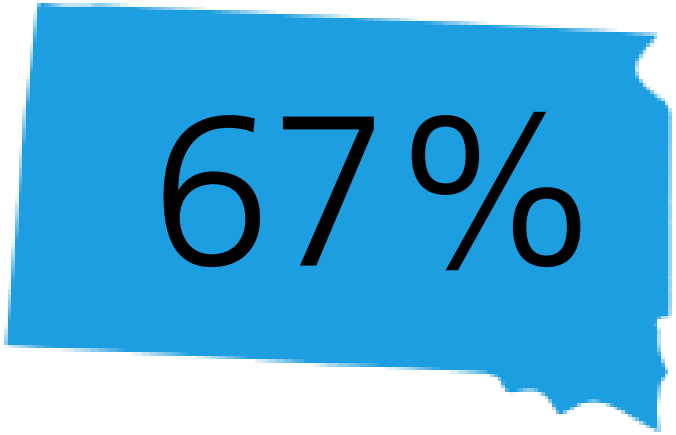
- **Colon cancer is the 2nd most common cause of cancer death** when men and women are combined.

- **Testing can catch colon cancer early**, when treatment is more likely to succeed.

- **Some tests can find polyps before they become cancer.** Most people who have polyps removed never get cancer.

Screening Goal:

Increase colorectal cancer screening to **80%!**



Why Test?

There are two aims of testing:

1. Prevention

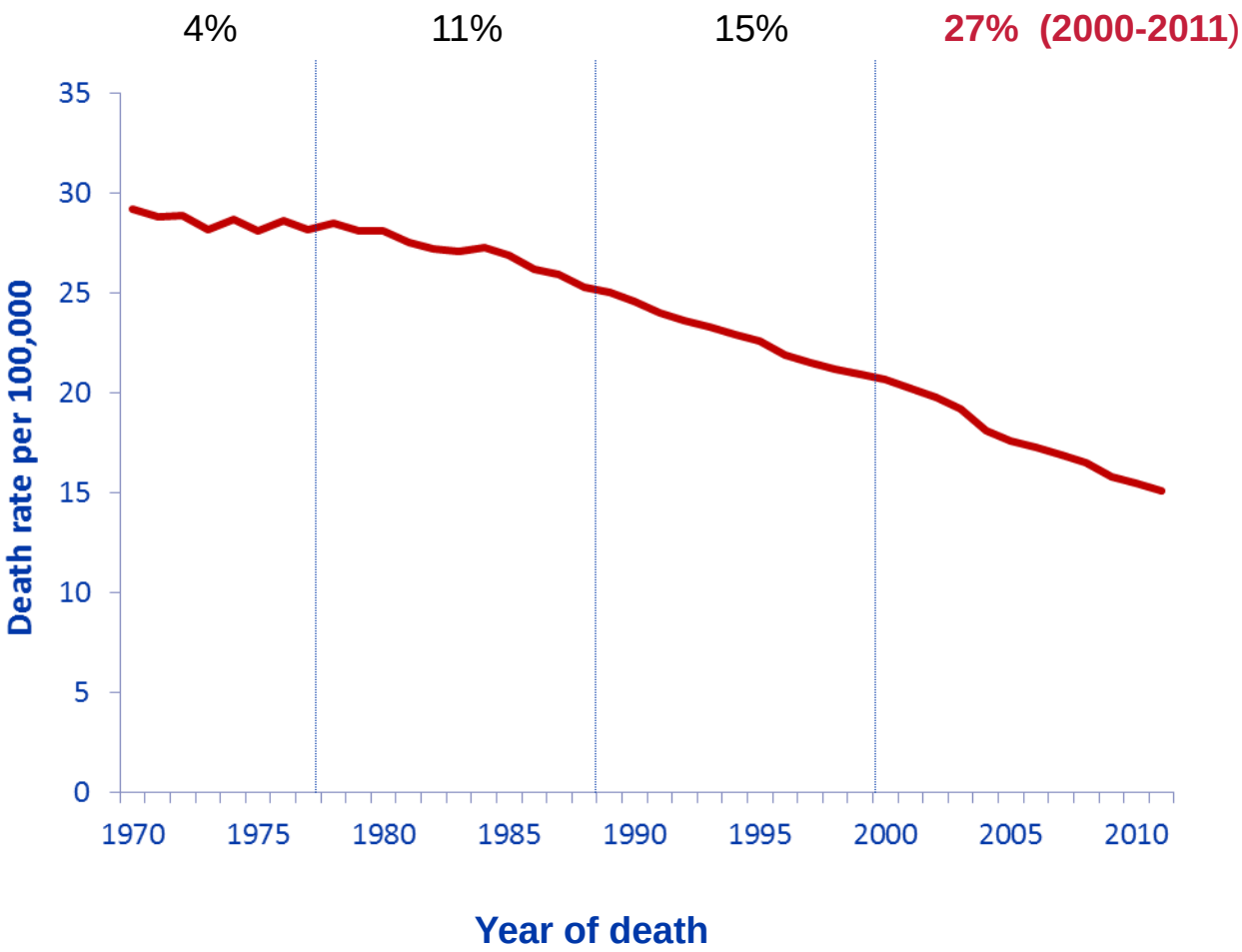
Find and remove polyps to prevent cancer

2. Early Detection

Find cancer in the early stages, when best chance for a cure

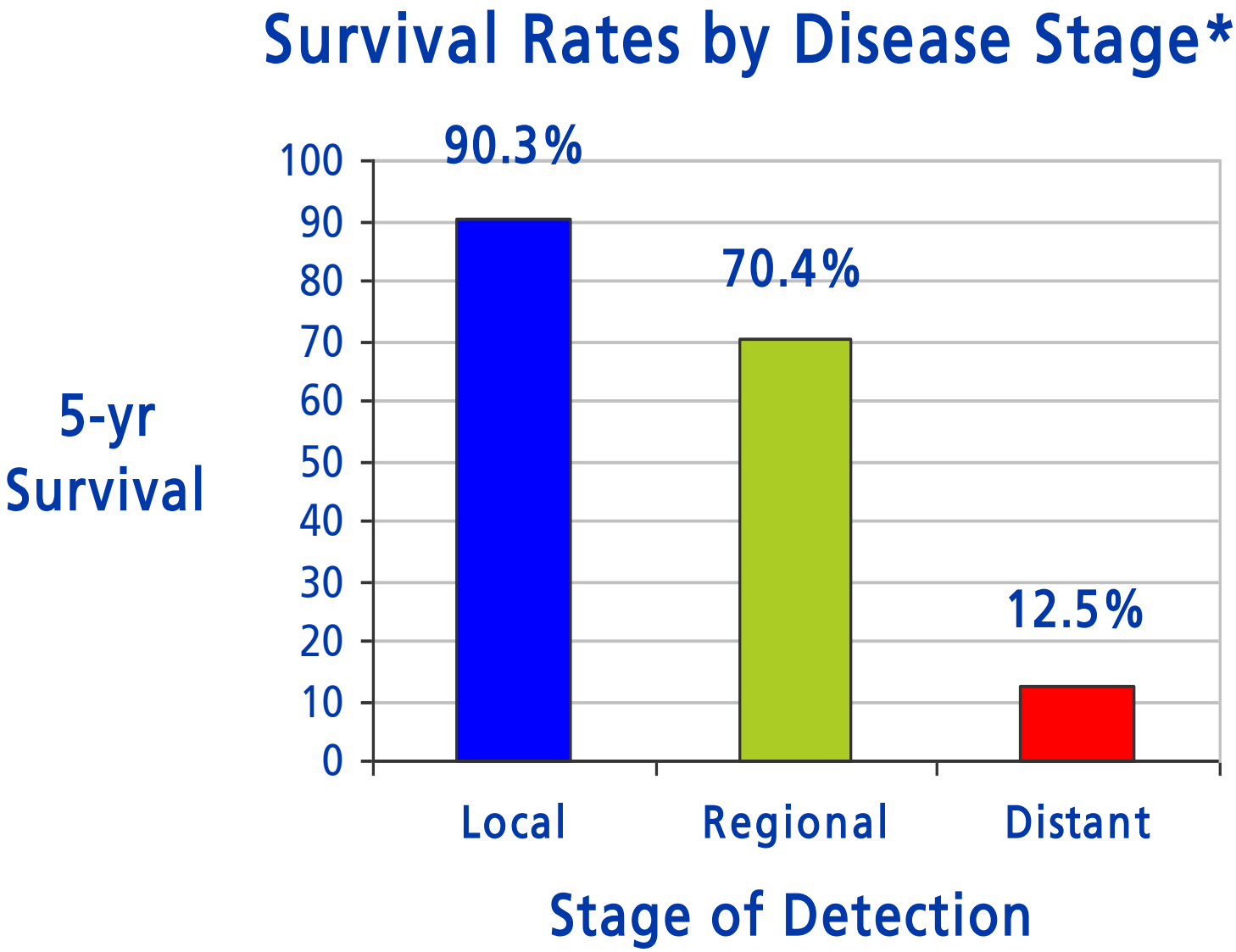
Overall CRC death rate decline

CRC mortality decline per decade:

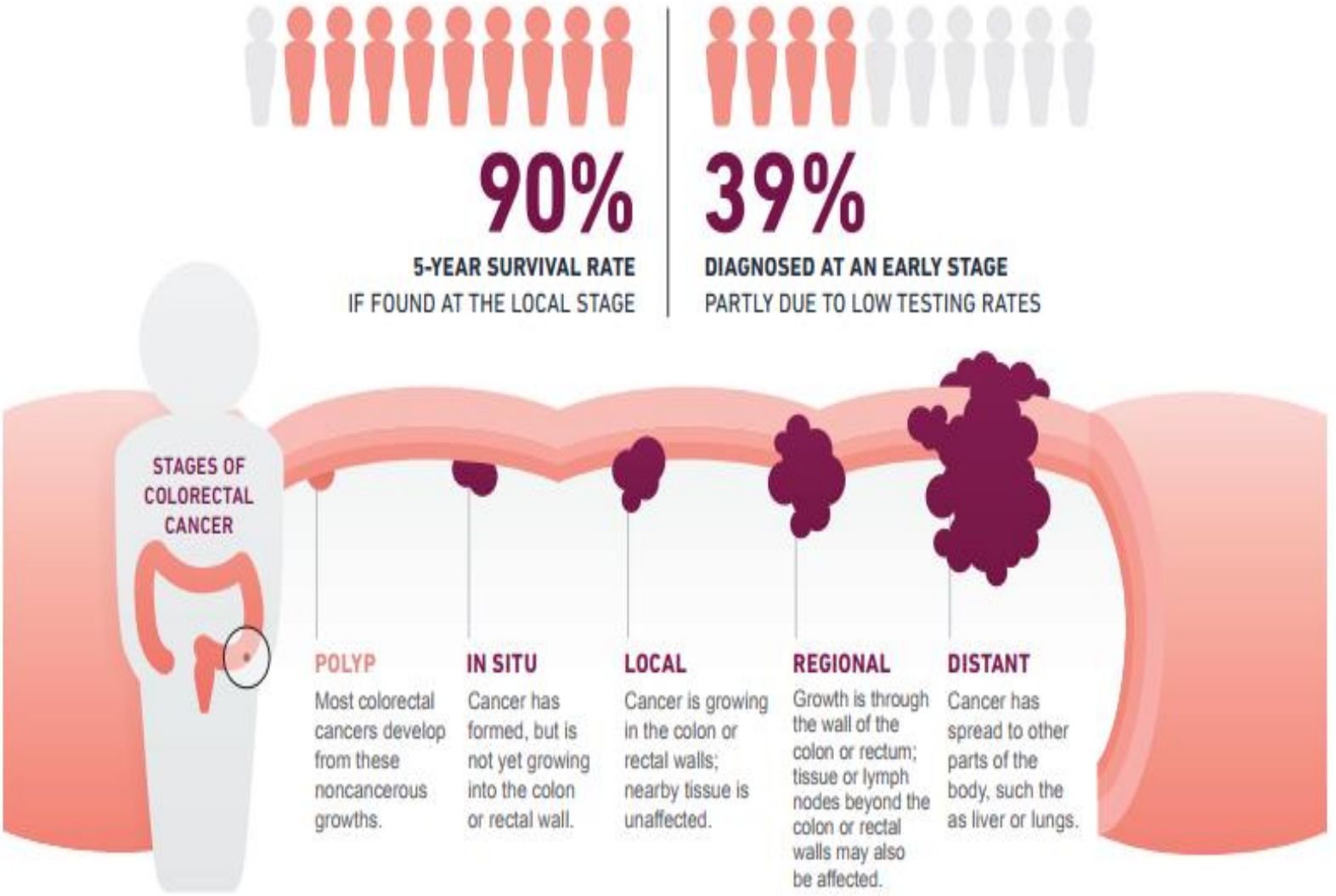


Siegel et al, CEBP 2015

Benefits of Early Detection



Catching It Early



Decrease in Incidence

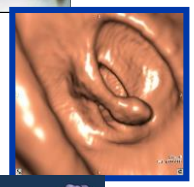
- Decline due to:
  - **Screening** → polyp removal → prevention
- Recent study estimates that screening has prevented approximately **550,000** cases of colorectal cancer in the US over the past three decades

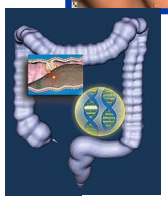
ACS CRC Screening Guidelines

Options for Average risk adults age 50 and older:

Direct Visualization Tests

- **Colonoscopy** every 10 years, or
- **Flexible sigmoidoscopy** (FSIG) every 5 years, or
- **Double contrast barium enema** (DCBE) every 5 years, or
- **CT colonography** (CTC) every 5 years





Stool Based Tests

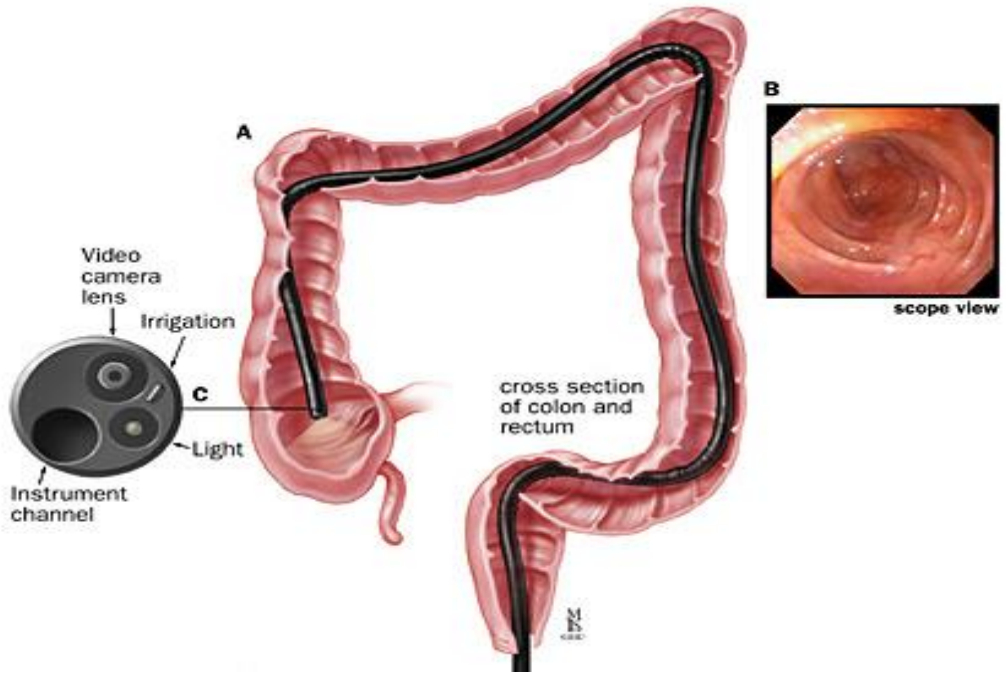
- **Guaiac-based fecal occult blood test** (gFOBT) with high
- test sensitivity for cancer, or
- **Fecal immunochemical test** (FIT) with high test sensitivity
- for cancer, or
- **Stool DNA test** (sDNA), with high sensitivity for cancer

Most Commonly Used Screening Tests

- Colonoscopy
- High Sensitivity Fecal Occult Blood Testing
  - High Sensitivity Guaiac Tests
  - Fecal Immunochemical Tests

Colonoscopy

- Allows direct visualization of entire colon lumen
- Screening, diagnostic and therapeutic
- 10 yr interval
- The most common screening test in US (nearly 90%)



Colonoscopy Limitations

Frequently referred to as "best test" or "gold standard", but evidence shows:

- Colonoscopy misses ~ 10% of significant lesions in expert settings
- More costly on a one-time basis
- Higher potential for patient injury than other tests
- Wide variation in quality (when data are captured and available)

Colonoscopy Limitations

- Greater patient requirements for successful completion
  - Requires a bowel prep and facility visit, and often a pre-procedure specialty office visit
- Access
  - Limited by insurance status, local resources
- Patient preference
  - Many individuals don't want an invasive test or a test that requires a bowel prep

What about stool tests?

Types of Stool Tests*

A) Tests that detect blood (Fecal Occult Blood Tests)

- Two types (but multiple brands, variable performance)
  - Guaiac-based FOBT
  - Immunochemical (FIT)

B) Tests that detect aberrant DNA

- One test (Cologuard) available in U.S.
  - Combines DNA mutation test with FIT
  - Recently added to USPSTF screening guideline (June 2016)

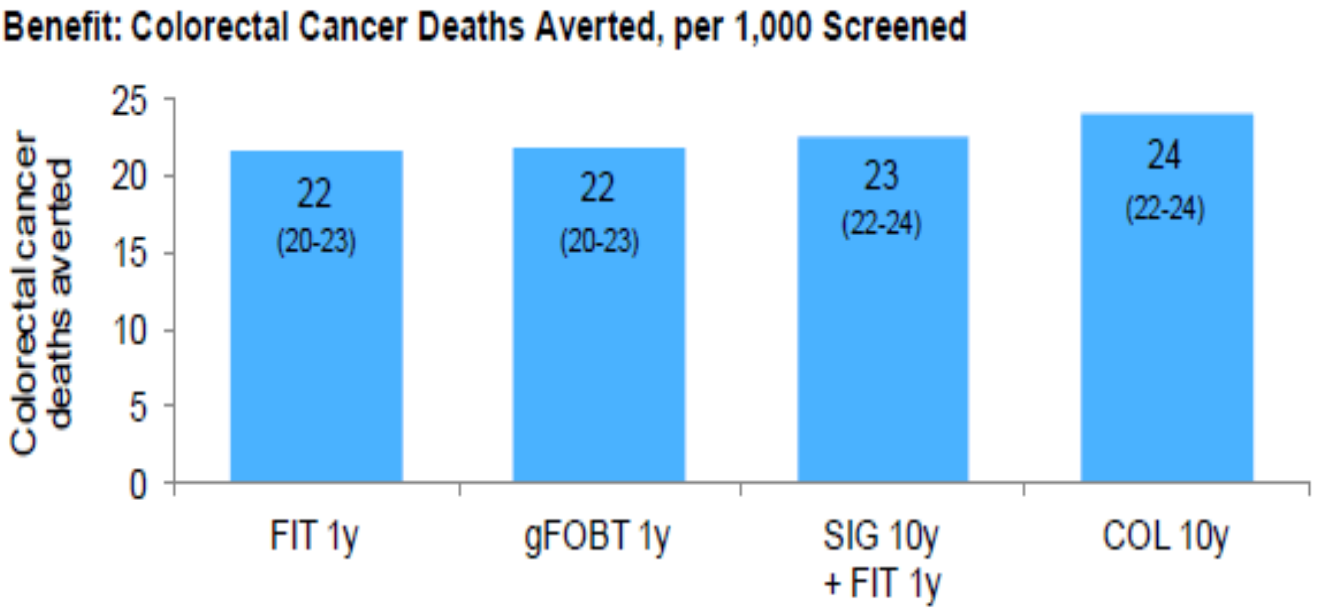
Stool tests are only appropriate for **average risk patients*

Fecal Immunochemical Tests (FIT)

- Detect blood by immunoassay
- An antibody specifically recognizes the globin component of human hemoglobin
- High specificity for human blood and for lower GI bleeding
- Some types require only 1 or 2 stool specimens
- Sensitivity for cancer much higher than that of guaiac FOBT in most studies (~70% vs ~20%)

FOBT/FIT Efficacy (USPSTF 2015)

- Modeling studies suggest years of life saved through a high-quality stool-based screening program are similar to outcomes with a high-quality colonoscopy screening program

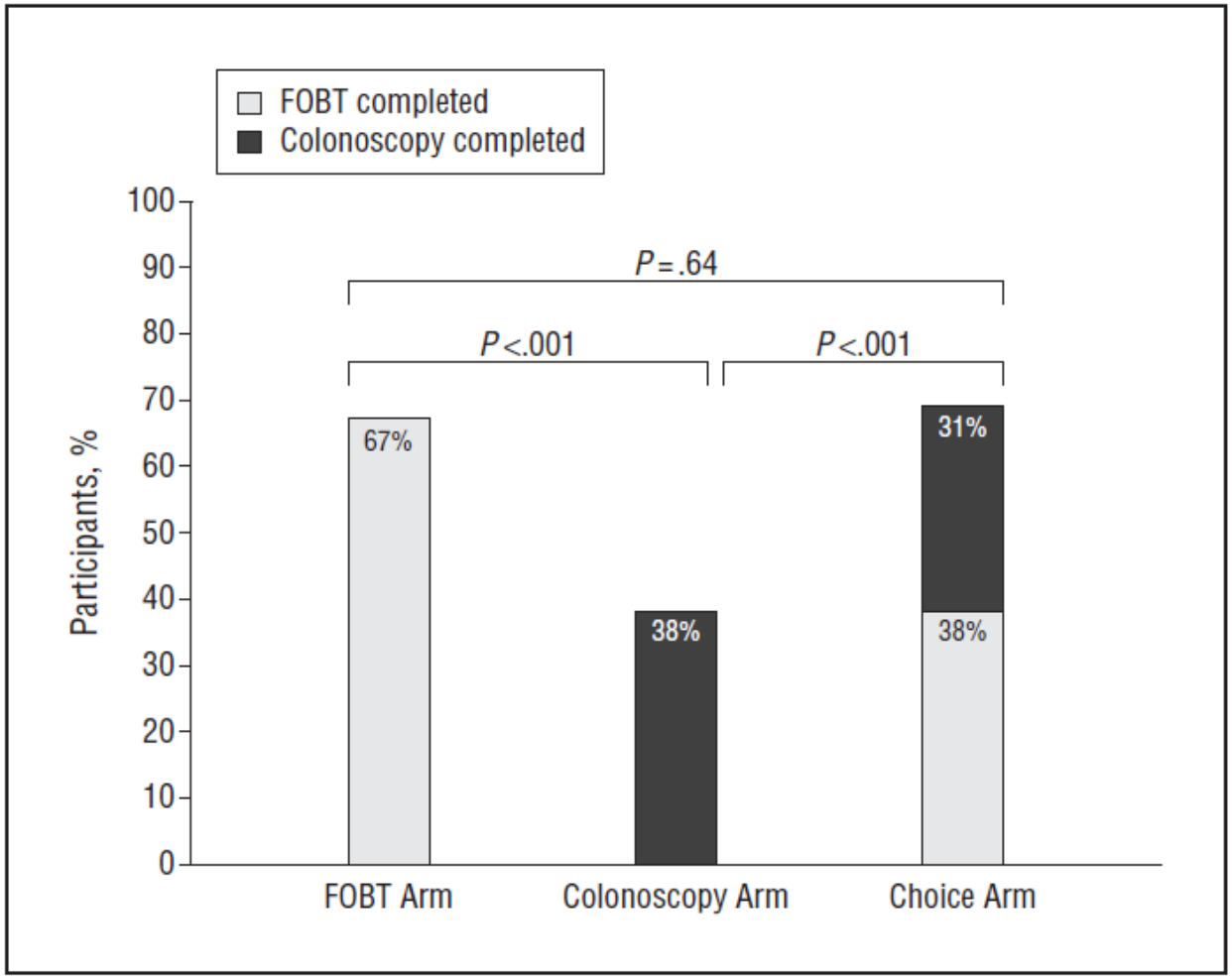


http://www.uspreventiveservicestaskforce.org/Page/Document/draft-recommendation-statement38/colorectal-cancer-screening2

Advantages of stool tests

- Less expensive
- No bowel preparation.
- Done in privacy at home.
- No need for time off work or assistance getting home after the procedure.
- Non-invasive – no risk of pain, bleeding, perforation
- Limits need for colonoscopies – required only if stool blood testing is abnormal.

Patient Preferences



Inadomi, Arch Intern Med 2012

Many patients prefer stool tests

- Diverse sample of 323 adults given detailed side-by-side description of FOBT and colonoscopy (DeBourcy et al. 2007)
  - 53% preferred FOBT
  - Almost half felt very strongly about their preference
- 212 patients at 4 health centers rated different screening options with different attributes (Hawley et al. 2008)
  - 37% preferred colonoscopy
  - 31% preferred FOBT
- Nationally representative sample of 2068 VA patients given brief descriptions of each screening mode (Powell et al. 2009)
  - 37% preferred colonoscopy
  - 29% preferred FOBT

FOBT/FIT Quality Issues

In-office FOBT
essentially *worthless* as a screening tool for CRC and should NEVER be used.

Missed 19 of 21 cancers
in largest study

Stool Test Quality Issues

- Stool tests are appropriate only for *average risk* (no family history, no history of adenomas,…)
- Use only high sensitivity guaiac or FIT
  - Hemoccult II and other less sensitive guaiac tests should not be used for screening
  - All FIT are not created equal
- All positive tests must be followed up with colonoscopy
  - Follow up often lacking (in many practices up to 1 in 3 patients does not receive appropriate follow up)
  - Prior to choosing FIT screening patients should be aware of potential cost-sharing for colonoscopy after abnormal FIT

High Quality Stool Testing

Clinician's Reference: Stool-Based Tests For Colorectal Cancer Screening

This newly revised resource is designed to introduce (or reintroduce) clinicians to the value of stool-based testing for colorectal cancer. It explains the different types of stool-based tests available—Fecal Immunochemical Tests (FIT), High-Sensitivity Fecal Occult Blood Tests (HS-gFOBT) and FIT-DNA testing—and provides guidance on implementing high quality stool-based screening programs. The resource now includes information on sensitivity and specificity for many of the most commonly used tests.

Available at http://nccrt.org/resource/fobt-clinicians-reference-resource/

Patient Questions

- I'm over 50 and am perfectly healthy. Why do I need to worry about colon cancer?
- I understand that there is more than one type of test for colon cancer and I really don't want to do the colonoscopy prep. Are there other test options?
- Is there a particular stool test that you would recommend?
- Will my insurance cover this?
- I don't have insurance and have a limited income. Is there are more affordable test available than a colonoscopy?

Top-rated Messages: Market Research Results

Message #1	*There are several screening options available, including simple take-home options. Talk to your doctor about getting screened.*

Why does this message work?

Ties to emotional driver of empowerment

- Consumers have a need to be informed, knowledgeable, prepared and responsible about their health.
- This message allows consumers to feel control regardless of barriers they may face (e.g. affordability, fear, etc.).

Alleviates a diverse set of barriers

- Diminishes fear associated with standard procedures and prep.
- Too easy for even procrastinators to put off.
- Suggests a more affordable option.

Appeals more than other "options" messages

- The phrase "at home" was very important to the success of this message. Other "options" messages that did not specify the test could be done at home did not resonate as well with consumers.

Message #2	Colon cancer is the second-leading cause of cancer death in the U.S. when men and women are combined, yet it can be prevented or detected at an early stage.

Why does this message work?

Ties to emotional driver of empowerment

- Educates people about their ability to take control of their own health through prevention and early detection.
- Detecting issues early means that there is an opportunity to fix problems and prevent future issues.
- Appeals to the desire to stay in good health as long as possible.

Challenges assumptions

- Challenges the assumption that colorectal cancer "can't happen to them," particularly for those who don't believe they are at risk unless they have symptoms or a family history.

Appeals more than other "empowerment" messages

- Describes the problem while simultaneously giving the consumer a way to address it.

Message #3	Preventing colon cancer or finding it early doesn't have to be expensive. There are simple, affordable tests available. Get screened! Call your doctor today.

Why does this message work?

Ties to emotional driver of empowerment

- Consumers have a need to be informed, knowledgeable, prepared and responsible about their health.
- Encourages consumers to take control of their health, while addressing concerns about affordability.

Alleviates major barrier

- Hits the affordability issue head on.
- Alleviates the stress of financial hardships that often comes with health care.

Appeal of "options" message continues

- Couples "options" messages with key information about why those options might work for them.

Communications Guides on CRC Screening

nccrt.org/tools/80-percent-by-2018

Barriers to Screening
2014 Market Research

Affordability	• Unscreened have lower income than screened counterparts • More likely to be uninsured • Newly insured don't know it's covered
Lack of symptoms	• Symptoms drive doctor visits • Misconception about disease
No family history	• Perception that heredity is only risk factor • Reduced sense of urgency
More pressing health issues	• Focus on acute illnesses and issues of more concern • Not a top priority • No personal connection to cancer
Negative perceptions about the test	• Connotation of test being unpleasant, invasive, embarrassing • Fear of test-prep compounds negativity
No regular primary care to reinforce message	• Utilize medical neighborhood • Avoids doctors/no routine physicals or wellness visits • Think they're healthy already
Doctor does not recommend it	• #1 reason among African Americans • #3 reason among Hispanics

The Dos and Don'ts of **Colorectal Cancer Screening**

Do's

- ✔ **Do** make a recommendation! Be clear that screening is important. Ask patients about their needs and preferences. The best test is the one that gets done.
- ✔ **Do** use the American Cancer Society and/or the USPSTF recommendations for colorectal cancer screening in average-risk adults, starting at age 50.*
- ✔ **Do** assess your patient's family history, medical history, and age.
- ✔ **Do** be persistent with reminders.
- ✔ **Do** develop standard office operating procedures and policies for colorectal cancer screening, including the use of EHR prompts and patient navigation.

Don'ts

- ✘ **Do not** use digital rectal exams (DREs) for colorectal cancer screening. In 1 large study, DREs missed 19 of 21 cancers.
- ✘ **Do not** repeat a positive stool test. Always refer the patient for a colonoscopy.
- ✘ **Do not** use stool tests on those with a higher risk. A colonoscopy must be performed.
- ✘ **Do not** forget to use non-clinical staff to help make sure screening gets done. They can hand out educational materials and schedule follow-up appointments.
- ✘ **Do not** forget to coordinate care across the continuum.

** If a patient at any age is symptomatic, please evaluate and refer them as needed for a colonoscopy.*

For more tools and resources, please visit nccrt.org or contact

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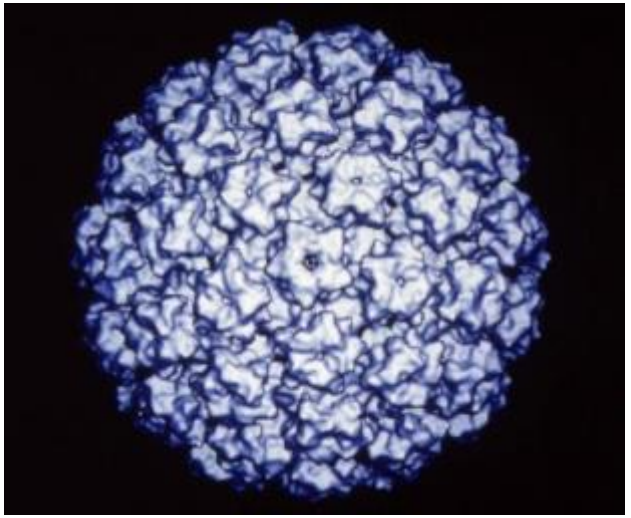
What is HPV?

Human Papilloma Virus

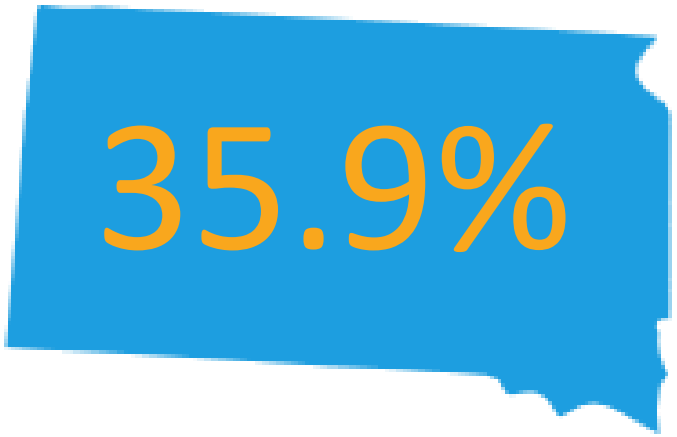
- >100 types
- Some cause cancer
- VERY common



HPV VACs

HPV Vaccination Goal:

Increase **HPV Vaccination** rates for preteens to 80%!



HPV Vaccination Guidelines

- Boys and girls
- At age 11 or 12 = ON TIME
- Can start at age 9
- Can vaccinate LATE at ages 13 to 26
- **Individuals ages 22 to 26 who were not previously vaccinated should be informed that vaccination at older ages is less effective in lowering cancer risk**
- 2 doses*

HPV VACs

HPV Vaccination…

- ✓ **IS CANCER PREVENTION**
- ✓ **IS SAFE AND EFFECTIVE**
- ✓ **IS FOR BOYS AND GIRLS**
- ✓ **WORKS BEST AT AGE 11-12**

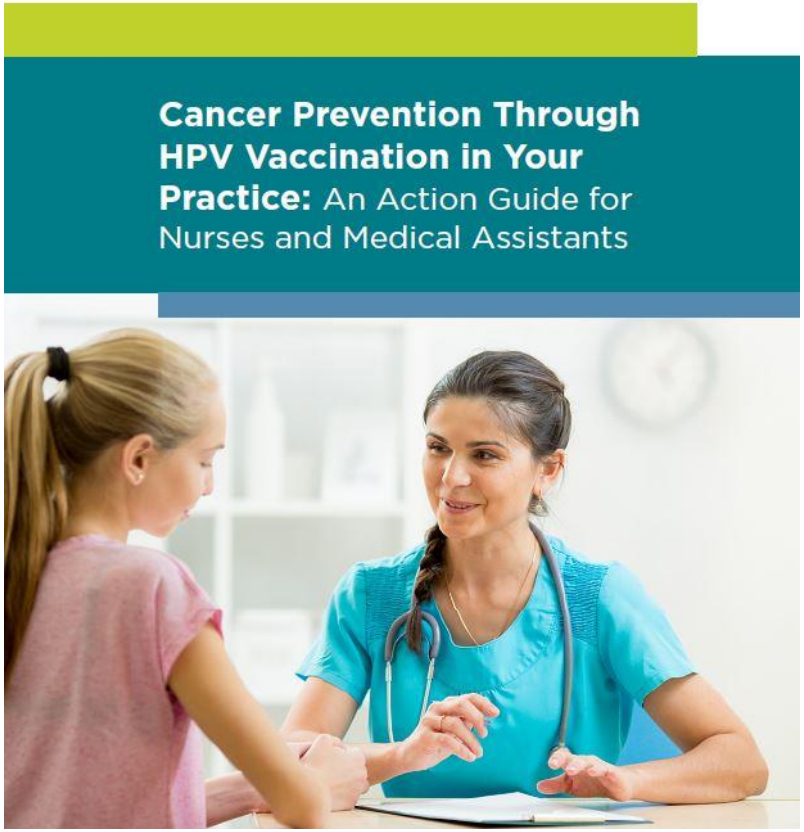
HPV VACs

HPV Vaccination Truths

1. HPV vaccination is cancer prevention.
2. HPV vaccination is the new normal.
3. The HPV vaccine series is most effective for cancer prevention when given at age 11 and 12.
4. HPV vaccine is safe and effective.
5. Clear, consistent, effective recommendations from clinicians is the key to increasing HPV vaccination.
6. There are disparities in vaccine uptake in rural areas of the U.S. Additionally, there is a ~50 percentage point difference between states with highest and lowest rates for HPV measures.
7. To increase rates on a state level, HPV vaccination efforts should be collaborative and involve partnerships between key cancer and immunization stakeholders.

HPV VACs

National HPV Vaccination Roundtable



http://hpvroundtable.org/wp-content/uploads/2018/02/RNMA-Action-Guide-WEB.pdf

American Cancer Society Programs

The American Cancer Society has been providing free programs and services to cancer patients across South Dakota for over 30 years.

- **Transportation:** 1,027 free rides were provided to cancer patients receiving treatment across South Dakota.
- **Lodging:** 2,542 free nights of lodging were provided to 216 cancer patients (and their caregivers) from South Dakota to receive their cancer treatment.
- **Information and Resources:** 1,330 people from South Dakota contacted ACS in 2017 and received information, used a free program or received a referral to another resource.
- **Emotional Support:** 491 women across the state have utilized ACS support program of Reach to Recovery to get support with the physical side effects related to cancer and connect with other survivors.

Get Involved

- Volunteer www.cancer.org
- Join SD Cancer Coalition www.cancersd.com
- Be an advocate www.acscan.org

Cancer Action Network℠
American Cancer Society®

Thank you

- Questions?

- Contact information:

Stacey.Burnette@cancer.org

www.cancer.org

www.cancersd.com