

EVIDENCE-BASED STRATEGIES TO INCREASE COLORECTAL CANCER ADHERENCE

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What works to increase CRCs?

- Mailed stool test kits
- Mailed and Phone reminders
- Patient navigation
- Promotion of multiple screening options
- Shared decision making

- Unfortunately, CRCs adherence is still sub-optimal

CRCS Options & Confusion

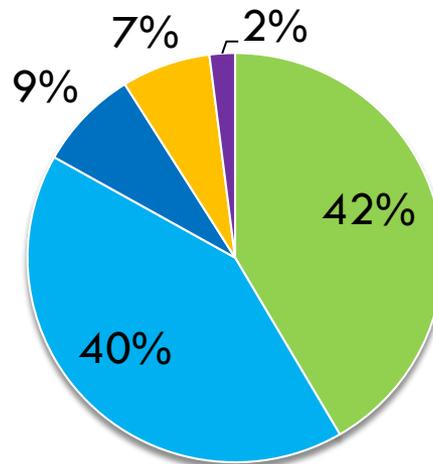
- Adults may be confused by multiplicity of options
 - ▣ 49% of adults agreed it was hard to know which recommendation to follow
 - ▣ Confused people are 1.8 times more likely to be non-adherent to CRCS than people who are not confused (Jones et al. CEBP, 2010)

Interventions: Patient Preferences & Barriers

- Few interventions take patient modality preferences into account
 - ▣ 31-39% prefer stool test/FIT
 - ▣ 37-49% prefer colonoscopy
- Previously tested decision aid tools and educational materials have not been integrated into clinical practice
- No interventions have systematically addressed test-specific patient-reported barriers
 - ▣ Non-adherent adults have significantly higher barriers than adherent adults and they are test-specific (Jones et al., AJPM, 2010)

Opportunities

“In terms of making decisions about your healthcare with your doctor, which ONE of the following best describes how you would like to make these decisions?”

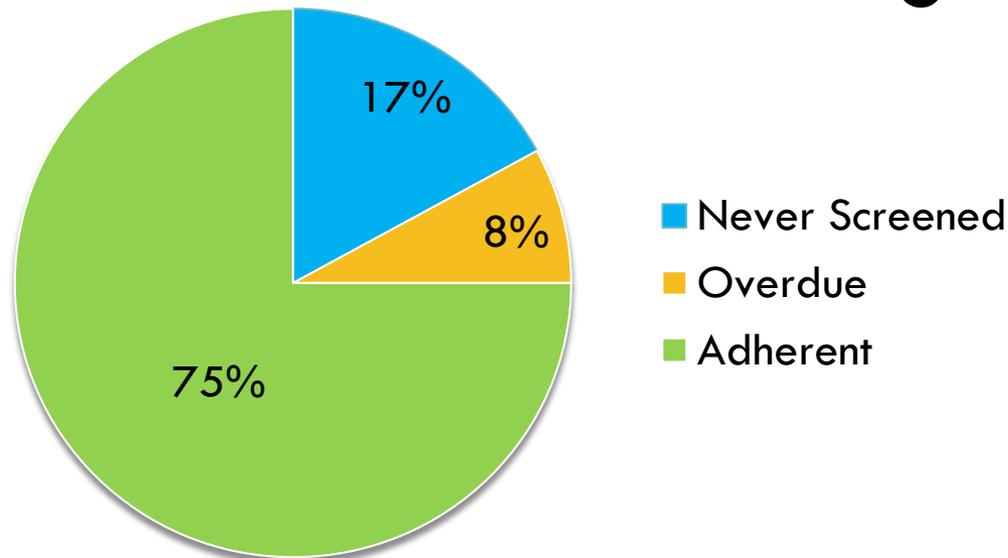


~91%

- My doctor and I share responsibility for deciding what is best
- I make final decision after seriously considering my doctor's opinion
- My doctor makes the final decision but considers my opinion
- I make the final decision about what I will receive
- Leave all decisions to my doctor

Challenges

Overall Colorectal Screening Status*



- **56%** reported a healthcare provider didn't discuss options for CRCs
- **Colonoscopy offered as primary test by public health programs**
 - **>50%** of CDC-funded CRC Control Program grantees
 - **67%** of non-funded state public health departments

*Derived from responses to 4 questions about specific CRCs tests and time since last test

Challenges & Opportunities

Top 5 Test-Specific Barriers

“It would be difficult for me to have a [FOBT/Colonoscopy] because...(strongly agree, somewhat agree, neither somewhat disagree, strongly disagree)”

FOBT

Because...	Mean (SE)
1. My healthcare provider has never suggested I get this test	2.81 (0.043)
2. I did not know if I should have this test	2.59 (0.039)
3. My health insurance does not cover this test	2.34 (0.033)
4. I do not need this test because I feel fine	2.33 (0.035)
5. I do not want to handle my stool	2.27 (0.038)

COLONOSCOPY

Because...	Mean (SE)
1. I do not want to do the preparation and take laxatives	2.94 (0.041)
2. I do not want a tube inserted into my rectum	2.31 (0.038)
3. I am worried that the test is uncomfortable or painful	2.24 (0.037)
4. I do not want to have anesthesia or be “put under”	2.17 (0.035)
5. This test costs too much	2.14 (0.036)

WISDM Community: Decision Aid & Web Site

What Everyone Should Know About Colorectal Cancer Screening

Colorectal Cancer Screening Shared Decision Making: Your Story, Your Choice



"Do I have to get screened?"

- Screening for colorectal cancer is recommended for women and men 50-75 years of age.
- You can always choose not to get screened.
- This booklet will help you understand your choices for colorectal cancer screening (described on the next pages) and what it means for your health.

"I don't know what my options are."

- You are not alone. Many medical decisions are confusing; finding the right information can be difficult.
- This booklet will help you understand your options, and the advantages and disadvantages (pros and cons) for each option.

"I don't know what to do."

- Life experiences shape the decisions we make every day.
- No one has the same experiences or makes decisions in the same way.
- Deciding which screening option to choose can be confusing, especially when there is no evidence to prove one method is best.
- Shared decision making can help you make the decision that is best for you.



Need more information to help make a decision?

Visit our web site: www.ScreenToPrevent.com or call the colorectal cancer screening community line at: (763) 684-7129 or (651) 438-1699.

Recipe for Shared Decision Making

Ingredients

Main Ingredient: **YOU**

A member of your healthcare team (doctor, nurse, etc.)

Friends, family or other important people in your life

Directions

- 1 Know your options
- 2 Take time to learn and understand the facts
- 3 Understand the pros and cons
- 4 Have a conversation with a member of your healthcare team and / or family and friends
- 5 Decide what matters most to you
- 6 When you are ready, make a decision that is right for you

Talking to Your Healthcare Provider

Colorectal cancer screening is covered by Medicare and Medicaid. You may also be eligible for Medicare (1-800-Medicare) for you.

Here are some insurance provider questions:

- What colorectal cancer screening options does my insurance plan cover?
- What is not covered or only partially covered under my insurance plan?
- Does it matter where I get screened?

Talking to Important People in Your Life



You don't have to make a screening decision alone. Talk to your healthcare provider and with other important people in your life. Their experience matters, and so do yours.

Getting screened is an important health decision. Before making a decision, you should:

- Know your options
- Take time to learn and understand the facts
- Understand the pros and cons of each screening option
- Have a conversation with a member of your healthcare team and/or family and friends
- Decide what matters most to you
- When you are ready, make a decision that is right for you

WISDM: Clinical Components

Pre-Visit

- Identify patients due for screening
- Pre-visit letters & insert (DA or flyer)

Clinic Visit

- Identify patients due for screening (BPA)
- Provider talking points (options)
- Referral to SDM if decisional conflict

SDM Visit

- Either during clinic visit or scheduled
- Phone or in person

Follow-Up

- Reminder letter, follow-up phone calls
- BPA re-fires at recommended intervals

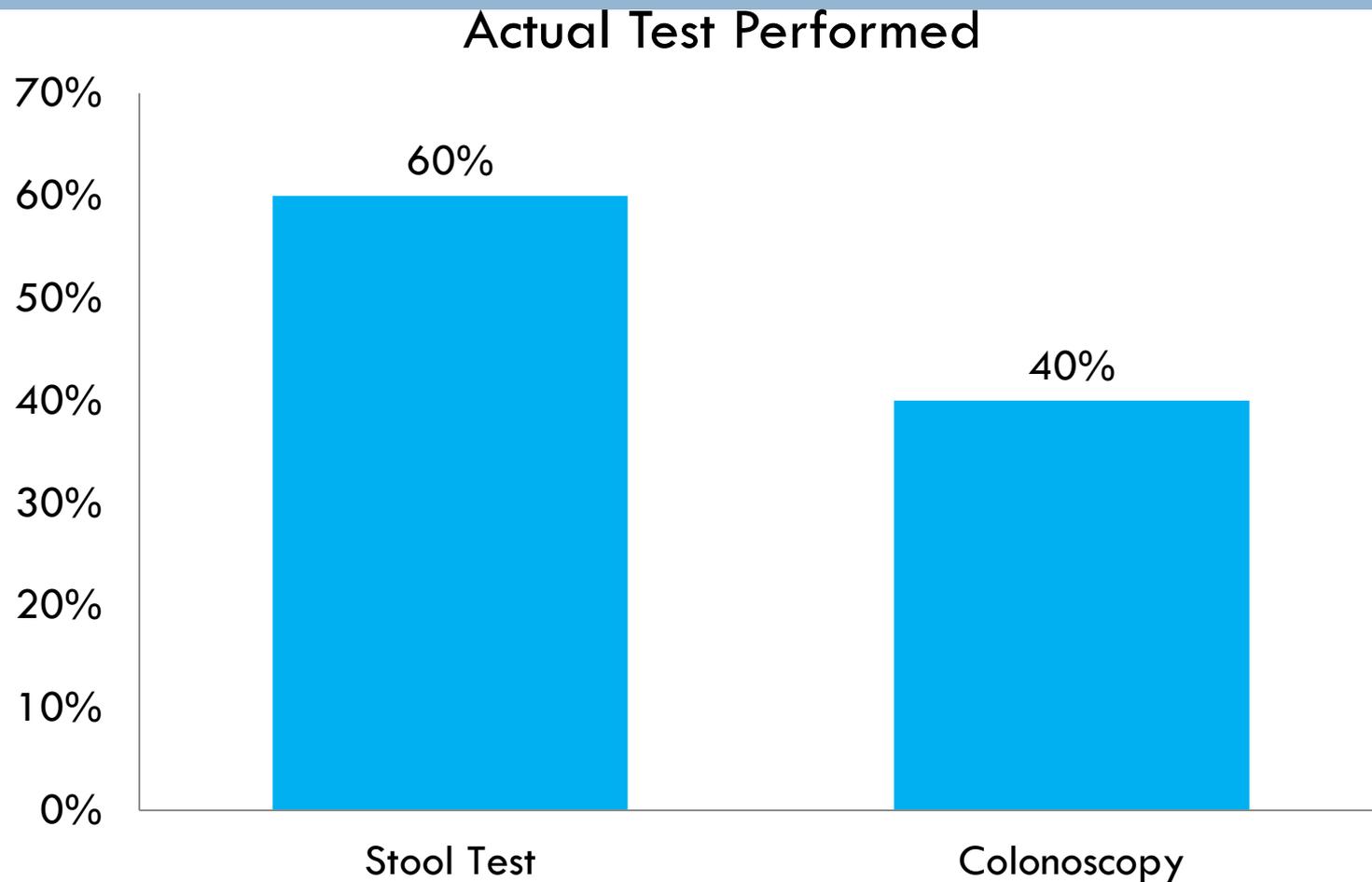
Odds of CRCS adherence by intervention condition – Intention to treat analyses (N=1,537)

	Adjusted OR (95% CI)	
	Intervention	Comparison
	Baseline (n=687)	Baseline (n=681)
	Year 1 (n=581)	Year 1 (n=585)
	Year 2 (n=580)	Year 2 (n=599)
Baseline		
Stool test	0.693 (0.368-1.531)	1.00 (reference)
Colonoscopy	0.955 (0.742-1.23)	1.00 (reference)
Overall CRCS	0.894 (0.690-1.16)	1.00 (reference)
Year 1		
Stool test ^a	1.98 (1.01-3.88)	1.00 (reference)
Colonoscopy ^a	0.782 (0.486-1.26)	1.00 (reference)
Overall CRCS ^a	0.813 (0.495-1.34)	1.00 (reference)
Year 2		
Stool test ^a	1.36 (0.741-2.54)	1.00 (reference)
Colonoscopy ^a	1.11 (0.693-1.64)	1.00 (reference)
Overall CRCS ^a	1.23 (0.785-1.91)	1.00 (reference)

^a Adjusted for respective baseline test adherence measure and model-specific confounders

Clinic SDM-related Results

- 64% became CRCS adherent after SDM visit





Click the play button to see a short video on colorectal cancer screening and why it is important for you.



Acknowledgments

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