Housekeeping Items

- Welcome to L.A. Care Provider Continuing Education (PCE) Program's Live Webinar!
- The Live Webinar is being recorded.
- Webinar participants are muted upon entry and exit of webinar.
- ***Webinar attendance will be noted via log in and call in with assigned unique Attendee ID #. Please log in through a computer (instead of cell phone) to Join Webinar / Join Event and choose the Call In option to call in by telephone with the event call in number, event access code and assigned unique attendee ID number. If your name does not appear on our WebEx Final Attendance and Activity Report (only as Caller User #) and no submission of online survey, no CME or CE certificate will be provided.***
- Questions will be managed through the Chat feature and will be answered at the end of the presentation. ***Please keep questions brief and send to All Panelists. One of our Learning and Development Team members and/or webinar host***, will read the questions via Chat when it's time for Q & A session (last 30 minutes of live webinar).
- Please send a message to the Host via Chat if you cannot hear the presenter or see the presentation slides.

L.A. Care PCE Program Friendly Reminders

- ***Partial credits are not allowed at L.A. Care's CME/CE activities for those who log in late (more than 15 minutes late) and/or log off early.***

- PowerPoint Presentation is allotted 60 minutes and last 30 minutes for Q&A session, total of 90-minute webinar, 1.50 CME credits for L.A. Care Providers and other Physicians, 1.50 CE credits for NPs, RNs, LCSWs, LMFTs, LPCCs, LEPs, and other healthcare professionals. Certificate of Attendance will be provided to webinar attendees without credentials.

- **Friendly Reminder,** a survey will pop up on your web browser after the webinar ends. Please do not close your web browser and wait a few seconds, and please complete the survey. ***Please note:*** ***the online survey may appear in another window or tab after the webinar ends.***

- Within two (2) weeks after webinar and upon completion of the online survey, you will receive the PDF CME or CE certificate based on your credential and after verification of your name and attendance duration time of at least 75 minutes for this 90-minute webinar.

- The PDF webinar presentation will be available within 6 weeks after webinar date on lacare.org website located at https://www.lacare.org/providers/provider-central/provider-programs/classes-seminars

- Any questions about L.A. Care Health Plan's Provider Continuing Education (PCE) Program and our CME/CE activities, please email Leilanie Mercurio at lmercurio@lacare.org

Presenter's Bio

Fola May, MD, PhD, MPhil, is an Associate Professor of Medicine at the David Geffen School of Medicine at University of California Los Angeles (UCLA), Director of Quality Improvement in the Vatche and Tamar Manoukian Division of Digestive Diseases, Director of the May Laboratory, Associate Director of the UCLA Kaiser Permanente Center for Health Equity, and staff physician in the Veterans Affairs (VA) Greater Los Angeles Healthcare System.

Dr. May's research is funded by several agencies, including the National Institutes of Health (NIH), and aims to improve population preventive health strategies, increase access to cancer preventive services, and eliminate health disparities domestically and internationally.

An Update on Colorectal Cancer

Folasade P. May M.D., Ph.D., M.Phil.
Associate Professor of Medicine
University of California Los Angeles
Veterans Health Administration

September 28, 2023 | WebEx, 12:00 pm – 1:30 pm PST, 1.50 CME / CE Credits
Directly Provided CME / CE Activity by L.A. Care Health Plan

UCLA Health

Disclosures

Folasade P. May MD PhD MPhil

Consultant/Advisor for:	Kimberly-Clarke/Cottonelle; Takeda; Seed Global Health; Medtronic; Johnson & Johnson; Freenome; Owl Peek Laboratories; Saint Supply
Grant/Research support:	National Institutes of Health, National Cancer Institute; Veterans Affairs HSR&D; Exact Sciences; Tobacco-Related Disease Research Program; Broad Institute; Stand up to Cancer
Employee of:	UCLA Health; Veterans Health Administration

I will not discuss off label use and/or investigational, device, product or medication use in my presentation.

Disclosures

The following CME planners do not have any financial relationships with ineligible companies in the past 24 months:

- Leilanie Mercurio, L.A. Care Provider Continuing Education (PCE) Program Manager, CME Planner
- Bridget Freeley, American Cancer Society Associate Director, State Partnerships, CME Planner

All relevant financial relationships of Dr. Folasade May, CME Presenter, with listed ineligible companies have been mitigated.

An ineligible company is any entity whose primary business is producing, marketing, selling, re-selling, or distributing healthcare products used by or on patients.

Commercial support was not received for this CME activity.

Presentation Overview

- Colorectal cancer (CRC) is common, even in young adults.
- Screening for CRC is effective.
- Overview of screening guidelines and tests.
- Screening utilization and barriers to screening.
- Achieving equity in CRC.
- Future priorities.

Learning Objectives

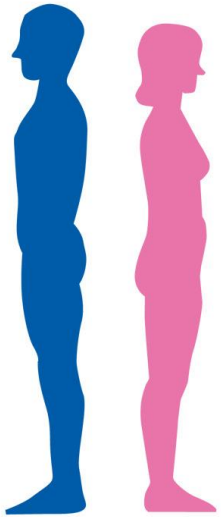
At the completion of the activity, learners can:

1. Summarize updated colorectal cancer screening guidelines.
2. Identify at least 3 symptoms of colorectal cancer.
3. Specify recommendations about colorectal cancer screening modalities.
4. List at least 3 effective interventions to reduce disparities in colorectal cancer screening.

Colorectal Cancer is Common

#3 cause of cancer in men and women in the United

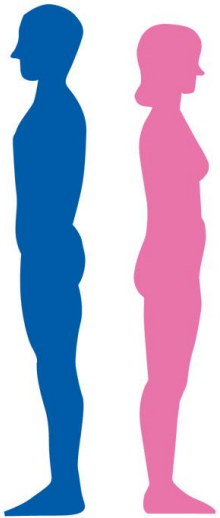
Males			Females		
Prostate	288,300	29%	Breast	297,790	31%
Lung & bronchus	117,550	12%	Lung & bronchus	120,790	13%
Colon & rectum	81,860	8%	Colon & rectum	71,160	8%
Urinary bladder	62,420	6%	Uterine corpus	66,200	7%
Melanoma of the skin	58,120	6%	Melanoma of the skin	39,490	4%
Kidney & renal pelvis	52,360	5%	Non-Hodgkin lymphoma	35,670	4%
Non-Hodgkin lymphoma	44,880	4%	Thyroid	31,180	3%
Oral cavity & pharynx	39,290	4%	Pancreas	30,920	3%
Leukemia	35,670	4%	Kidney & renal pelvis	29,440	3%
Pancreas	33,130	3%	Leukemia	23,940	3%
All Sites	**1,010,310**	**100%**	**All Sites**	**948,000**	**100%**



American Cancer Society, Inc., 2023.

Colorectal Cancer is Deadly

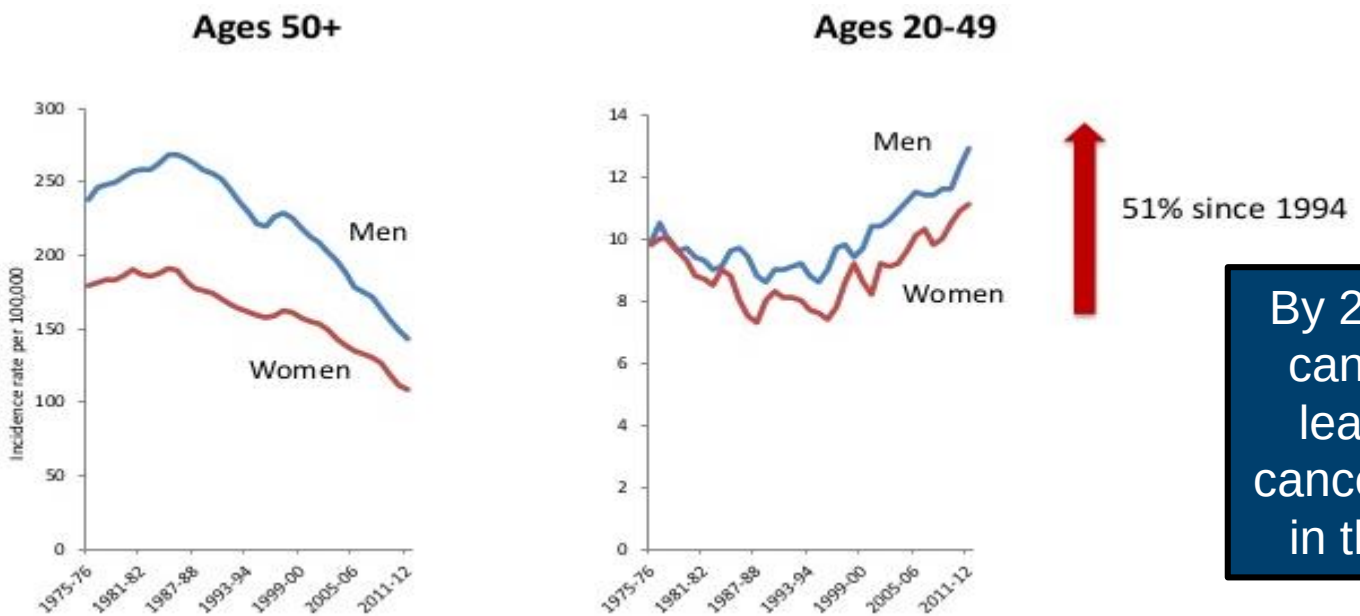
#2 cause of cancer-related deaths in the United



Males			Females		
Lung & bronchus	67,160	21%	Lung & bronchus	59,910	21%
Prostate	34,700	11%	Breast	43,170	15%
Colon & rectum	28,470	9%	Colon & rectum	24,080	8%
Pancreas	26,620	8%	Pancreas	23,930	8%
Liver & intrahepatic bile duct	19,000	6%	Ovary	13,270	5%
Leukemia	13,900	4%	Uterine corpus	13,030	5%
Esophagus	12,920	4%	Liver & intrahepatic bile duct	10,380	4%
Urinary bladder	12,160	4%	Leukemia	9,810	3%
Non-Hodgkin lymphoma	11,780	4%	Non-Hodgkin lymphoma	8,400	3%
Brain & other nervous system	11,020	3%	Brain & other nervous system	7,970	3%
All Sites	**322,080**	**100%**	**All Sites**	**287,740**	**100%**

American Cancer Society, Inc., 2023.

Cases are Rising in Young Adults



By 2040, colorectal cancer will be the leading cause of cancer-related death in this age group.

There has been a 51% increase in CRC incidence in individuals aged 20-49 since the early 1990s.

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SEER 9 database. Delay-adjusted rates, 1975-2012; 2-year averages.
Photo courtesy of Rebecca Siegel.
Rahib et al., JAMA open network, 2021.

What's the Colon for Anyway?

The **colon and rectum:**

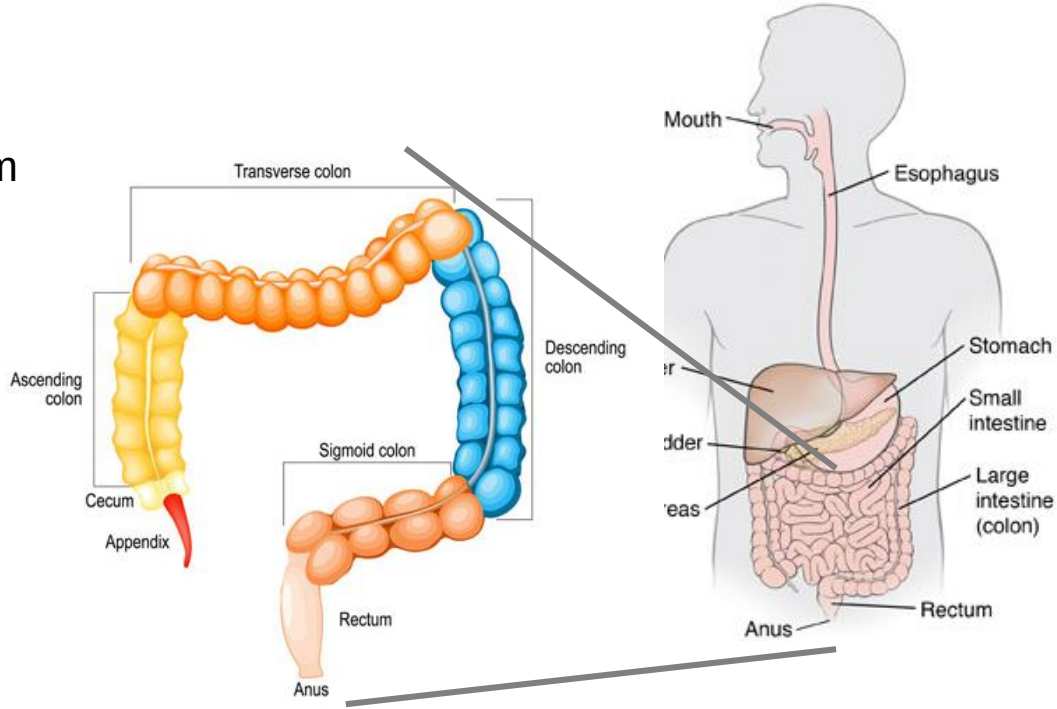
- Large intestine or large bowel
- Last parts of the digestive system

The **colon** functions to:

- Absorb water and salt from food
- Form stool

The **rectum** functions to:

- Store stool until ready to pass



Everyone is at Risk

Risk Factors You Can Not Change

- Age
- Male genotype
- Race (Black Americans)
- Personal history of polyps
- Family history of polyps or cancer
- Inflammatory bowel disease (IBD)
- Inherited polyp syndromes

Risk Factors You Can Change

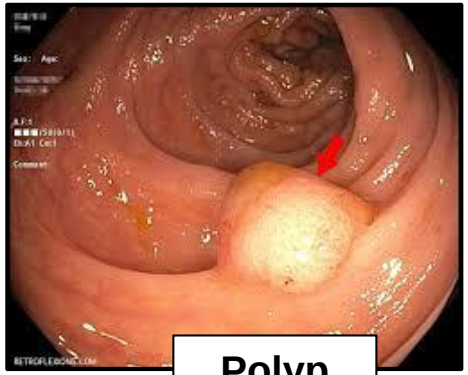
- Diet:
  - Low fiber diet
  - High in animal fat
- Physical inactivity
- Obesity
- Type 2 diabetes
- Tobacco
- Heavy alcohol

Colorectal Cancer Originates as Polyps

Colorectal cancer develops when the cells in polyps begin to grow ***uncontrollably***.

years & years & years

Normal Colon



Polyp

Colorectal Cancer

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How can I prevent colorectal cancer?

USPSTF Recommended Screening Modalities
(Average-risk individuals)

Stool-based strategies

High Sensitivity FOBT *annually*

Fecal Immunochemical Test (FIT) *annually*

FIT-DNA (Cologuard) *Every 1-3 years*

Direct-visualization techniques

Virtual (CT) Colonography *Every 5 years*

Flexible Sigmoidoscopy with (Q10Y) or without FIT (Q5Y)

Colonoscopy *Every 10 years*

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Davidson K, et al. *JAMA.* 2021;325(19):1965-1977.

Colonoscopy

- **Performed** in a hospital or medical clinic
- Requires **bowel preparation**
- Gastroenterologist uses a “colonoscope,” a long flexible tube with a light at the end
- Requires conscious **sedation** or monitored anesthesia care
- Examines the walls of the colon (20-30 minutes)
- Risks are very small (1:1000) and include bleeding, infection, and colon injury
- Considered the **gold standard** for finding colon cancer or precancerous polyps
- If normal, repeated every 10 years

What is a Colonoscopy Like?

A survey of almost **50,000** patients:

- Most (about 8 out of 10) said the colonoscopy was less uncomfortable than they expected.
- People often agree that “It’s not as bad as I thought.”

Several studies have found **high levels of patient satisfaction** and **willingness to return** under the same conditions.

Ghanouni et al., 2016
Charter et al., 2009.

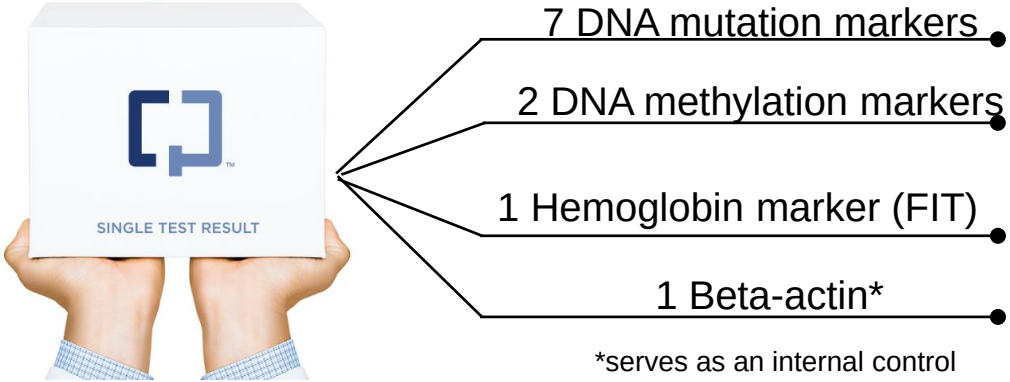
Fecal Immunochemical Test (FIT)

- Second most common screening test
- Stool-based test that can be performed at home
- Tests the stool for small amounts of blood which ***may be*** a sign of colon cancer
- **Very low-risk** screening option
- **Must be completed yearly** to be effective
- If abnormal, **a colonoscopy <u>must</u> be** performed to find the source of blood loss

Multitarget Stool DNA (Cologuard)

- Tests stool for 11 pre-cancer and cancer biomarkers and for human hemoglobin (i.e. DNA+FIT)
- 3-year screening interval
- Test failures and false-positive rate 13%

cologuard



*serves as an internal control

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CRC Screening is Effective

Test	Evidence	Certainty of Evidence
Flexible sigmoidoscopy (v. no screening)	Incidence reduction (0.78; 0.74- 0.83) Mortality reduction (0.74; 0.68-0.80)	High
Annual gFOBT (v. no screening)	Incidence reduction (0.81; 0.71- 0.93) Mortality reduction (0.68; 0.56-0.82)	Moderate to High

Guaiac-based FOBT and flexible sigmoidoscopy shown to reduce incidence and mortality in randomized trials

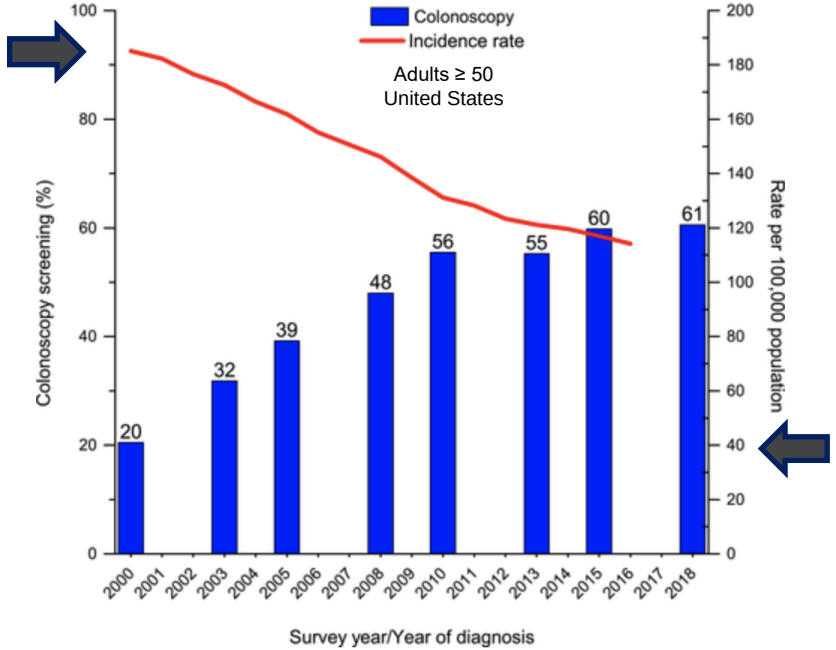
Helsingen, et al. NEJM Evid. 2022, 1.
Bretthauer et al, N Engl J Med 2022; 387:1547-1556.
Siegel et al, CA Cancer J Clin. 2020 May;70(3):145-164.

CRC Screening is Effective

Most common applied tests today are the fecal immunochemical test (FIT) and colonoscopy:

- Supported largely by observational data
- Inferred benefit due to gFOBT and flexible sigmoidoscopy data.

Colonoscopy Prevalence (2000 to 2018) and CRC Incidence (2000 to 2016)



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Helsingen, et al. NEJM Evid. 2022, 1.
Bretthauer et al, N Engl J Med 2022; 387:1547-1556.
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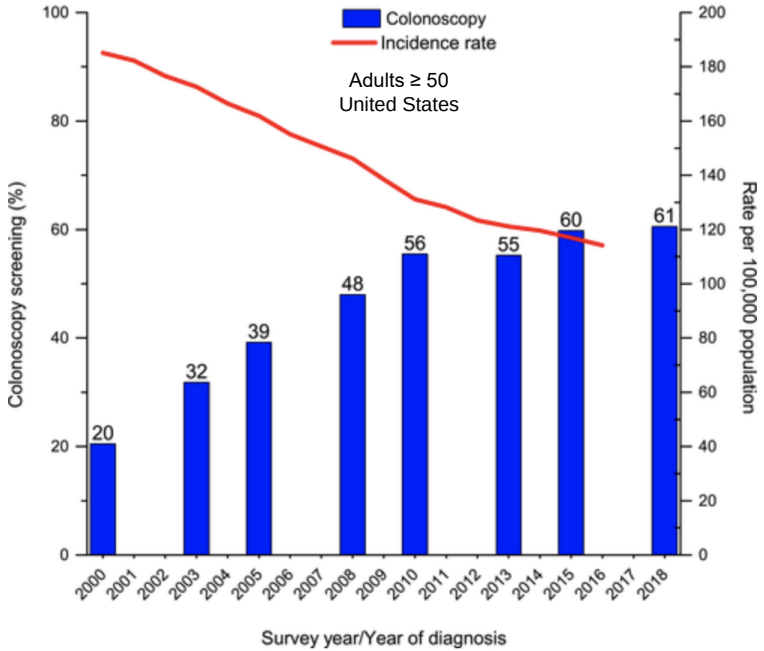
CRC Screening is Effective

NORDICC Trial (Poland, Norway, Sweden, Netherlands; 2009-2014)

- 84,000 men and women age 55 to 64.
- PPA: 18% incidence reduction; no mortality reduction.
- ITT: 31% incidence reduction; 50% mortality reduction.
- But …
  - Only 42% completed colonoscopy
  - Relatively few polyps detected
  - Only 10 years of follow-up
  - US population is different
- My key take aways:
  - Setting likely matters
  - Colonoscopy is effective…if completed
  - The benefits of colonoscopy likely take time

Colonoscopy Prevalence (2000 to 2018) and CRC Incidence (2000 to 2016)



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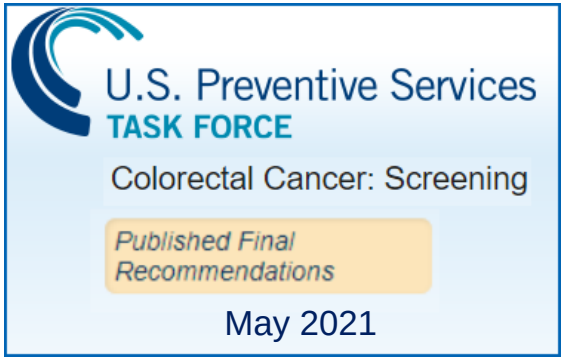
Bretthauer et al, N Engl J Med 2022; 387:1547-1556.
Siegel et al, CA Cancer J Clin. 2020 May;70(3):145-164.

CRC Screening Should Begin at Age 45
(USPSTF Recommendations for Average-risk individuals)



Adults aged 50 to 75 years	The USPSTF recommends screening for colorectal cancer in all adults aged 50 to 75 years.	A
Adults aged 45 to 49 years	The USPSTF recommends screening for colorectal cancer in adults aged 45 to 49 years.	B
Adults aged 76 to 85 years	The USPSTF recommends that clinicians selectively offer screening for colorectal cancer in adults aged 76 to 85 years. Evidence indicates that the net benefit of screening all persons in this age group is small. In determining whether this service is appropriate in individual cases, patients and clinicians should consider the patient's overall health, prior screening history, and preferences.	C

1 in 3 Americans are unscreened.
1 in 2 are unscreened in under-resourced settings.

Davidson, K et al. JAMA. 2021; 325(19):1965-1977.

Age to Start Screening

Risk Group	Age to Start Screening	Age to Stop Screening
Family history of CRC	40 OR 10 years before age of youngest family member diagnosed	Varies
Inflammatory bowel disease; Familial polyposis syndrome; Hereditary colon cancer	Screen early (age varies)	Varies
African-American/Black	45	Grade A: 75 Grade C: 85
Average Risk	45	Grade A: 75 Grade C: 85

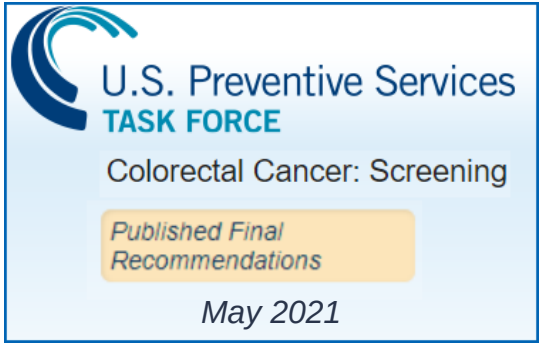
Davidson, K et al. JAMA. 2021; 325(19):1965-1977.

2021 USPSTF CRC Recommendations

- Recommendations based on two commissioned reports:

  1) Systematic review of benefits and harms of screening adults 40 years or older:
     a) Effectiveness and accuracy of screening tests
     b) Comparative effectiveness of screening tests
     c) Serious harms of different screening tests.

  2) Comparative modeling report from the CISNET Colorectal Cancer Working Group:
     a) Life-years gained
     b) CRC cases/deaths averted
     c) Colonoscopy burden
     d) Harms



Davidson K, et al. *JAMA.* 2021;325(19):1965-1977.

USPSTF Recommended Screening Modalities
(Average-risk individuals)

Stool-based strategies

High Sensitivity FOBT *annually*

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Direct-visualization techniques

Virtual (CT) Colonography *Every 5 years*

Flexible Sigmoidoscopy with (Q10Y) or without FIT (Q5Y)

Colonoscopy *Every 10 years*

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Davidson K, et al. *JAMA.* 2021;325(19):1965-1977.

Non-colonoscopic Screening Tests are Two-Step Strategies

Abnormal screening result → Colonoscopy

Completed in only 50% people in U.S.

Test Characteristics of Screening Tests

Test	Sensitivity for CRC	Sensitivity for adv. Adenoma	Specificity for CRC	Evidence	Risk	Deaths averted per 1000 screened
High sensitivity guaiac FOBT	62-79%	7%	87%-96%	Strong	Low	26
FIT	76-95%	27%-47%	89%-96%	Weak	Low	26
FIT-DNA (Cologuard)	93%	43%	85%	Early	Low	28 (yearly) 25 (Q 3 years)
CT Colonography	96%	67%-94% (>10mm) 73%-98% (6mm)	86%-98% (>10mm) 80%-93% (>6mm)	Weak	Low	26
Flexible Sigmoidoscopy	58-75%	72%-86%	92%	Strong	Intermediate	24 (28 with FIT)
		89%-98%				

Davidson K, et al. *JAMA*. 2021;325(19):1965-1977.
Knudsen et al. JAMA. 2021; 325(19): :1998-2011.

Patient Considerations for Screening Options

	HSgFOBT	FIT	FIT-DNA	CT Colonography	FS (+ FIT)	Colonoscopy
Invasiveness	+	+	+	++	++	+++
Home test	Yes	Yes	Yes	No	No	No
Dietary restrictions	Yes	No	No	Yes	Yes	Yes
Interval	1 year	1 year	1-3 years	5 years	5 (10 years)	10 years (if normal)
Complications	Negligible	Negligible	Negligible	Few	Few	Low (0.1%)
Patient Participation	Moderate	Moderate	Moderate	Moderate	Moderate	Lowest
Cost	$	$	$$	$$	$	$$

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Robertson et al. AJG; 2017: 112; 37-53.
Inadomi. NEJM; 2017; 376:1598-1600.

Emerging Non-Invasive Strategies
(Not yet recommended for first-line average-risk)

New Stool-Based Tests

Blood-Based/ MCED

Wireless Capsule Colonoscopy

Urine-based

High Risk Groups

- Personal history of tubular adenomas or CRC
- Family History of CRC/polyps
- Ulcerative colitis
- Crohn's disease

Colonoscopy

Screening Utilization and Barriers to Screening in the Underserved

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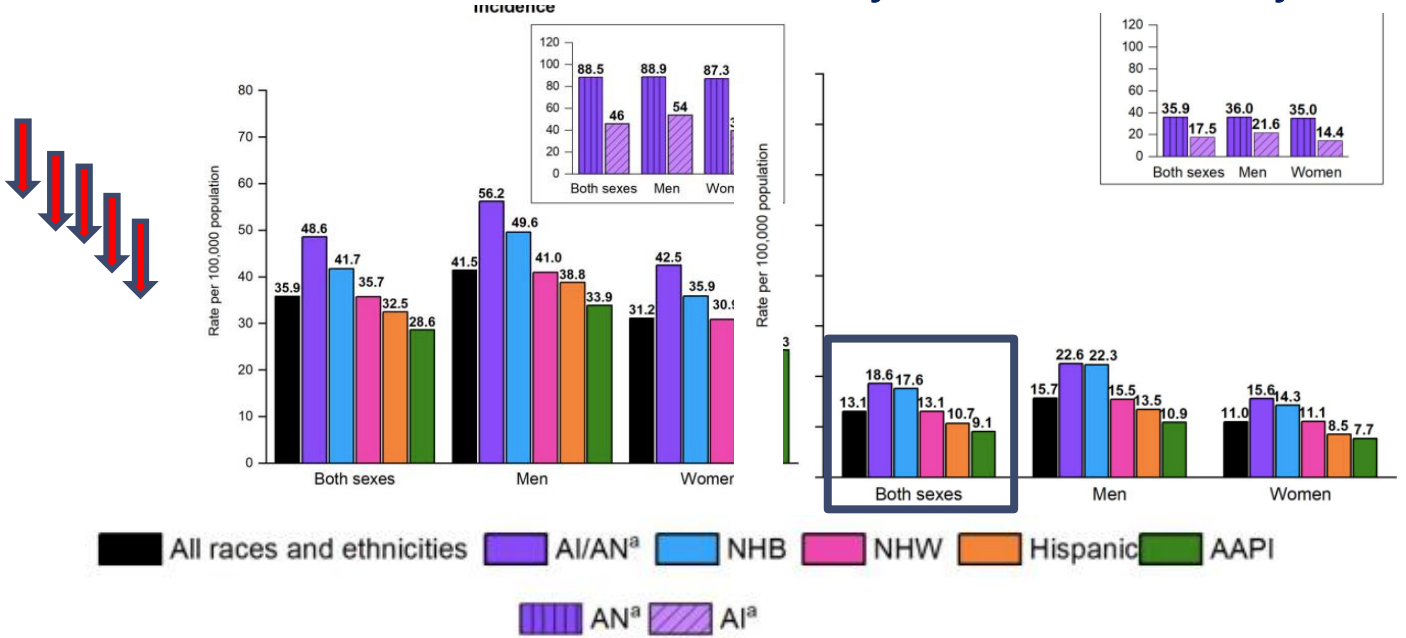
CRC Outcomes Vary by Race/Ethnicity

Colorectal cancer incidence (2015–2019) by sex, race, and ethnicity; US

Colorectal cancer mortality (2016–2020) by sex, race, and ethnicity; US



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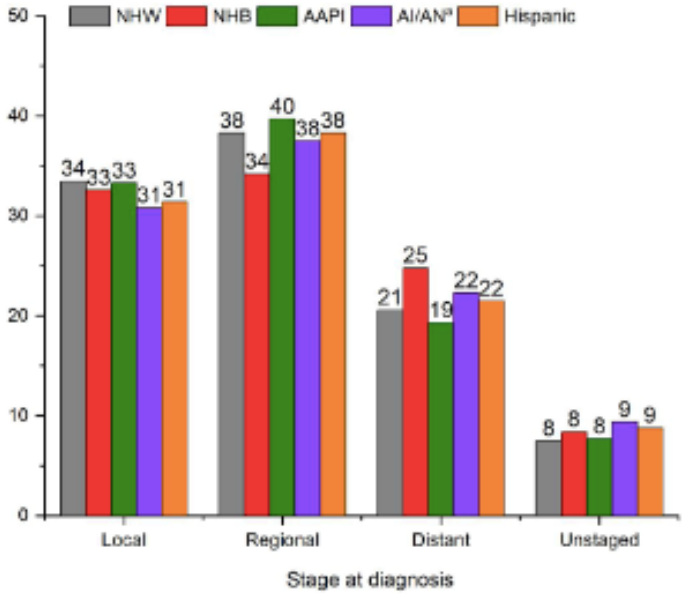
1) Siegel RL, et al. CA Cancer J Clin. 2023; 2) North American Association of Central Cancer Registries, 2022. 3) National Center for Health Statistics, 2022.

CRC Outcomes Vary by Race/Ethnicity

CRC stage distribution in US by race/ethnicity;
2015-2019



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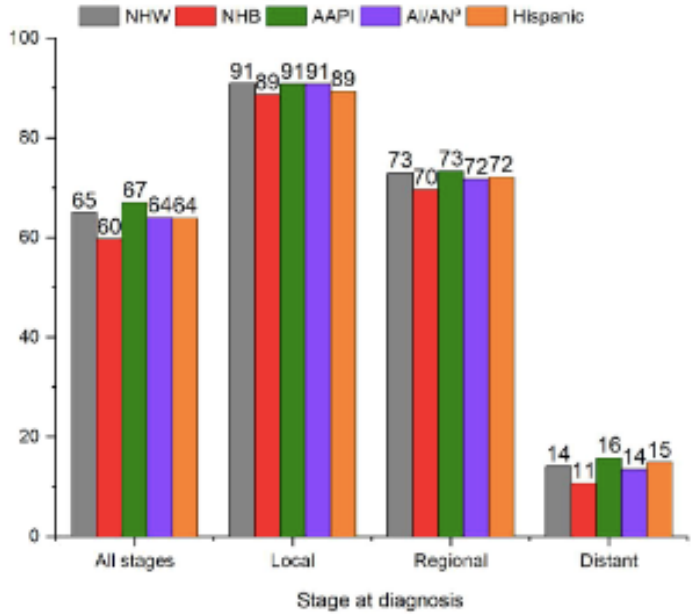
Siegel RL, et al. CA Cancer J Clin. 2023.

CRC Outcomes Vary by Race/Ethnicity

CRC 5-year survival in US by race/ethnicity;
2012-2018



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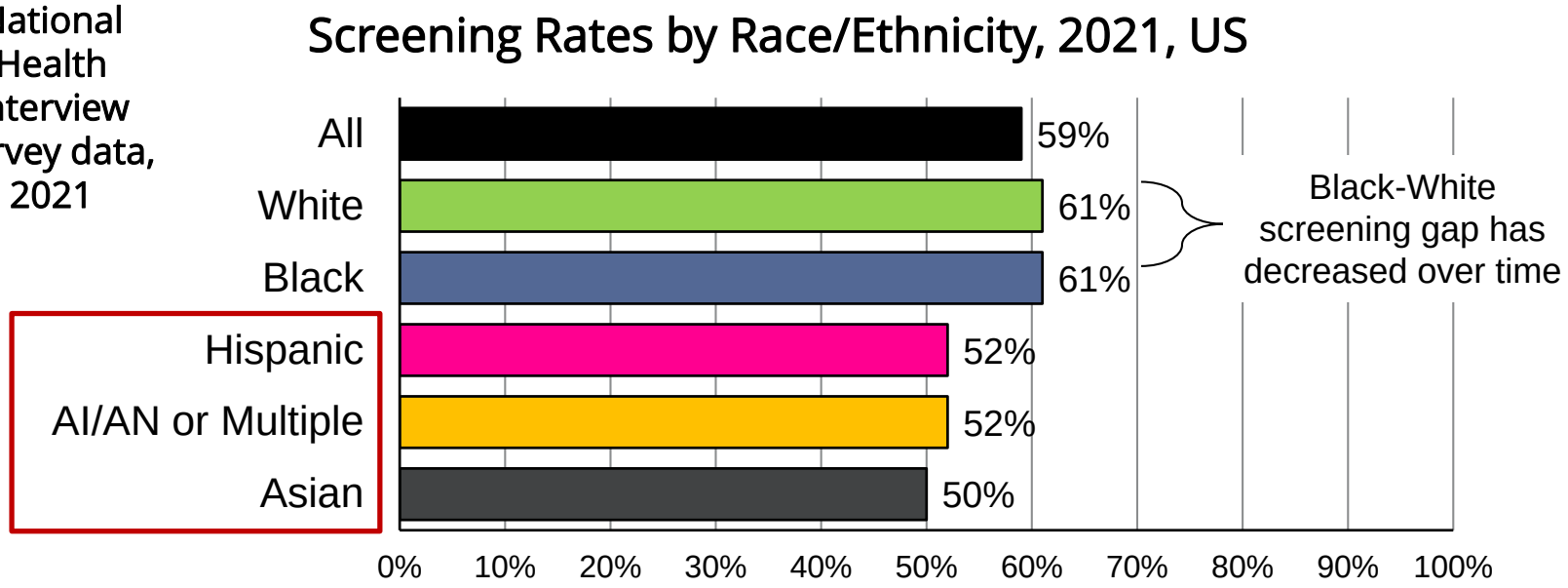
Siegel RL, et al. CA Cancer J Clin. 2023.

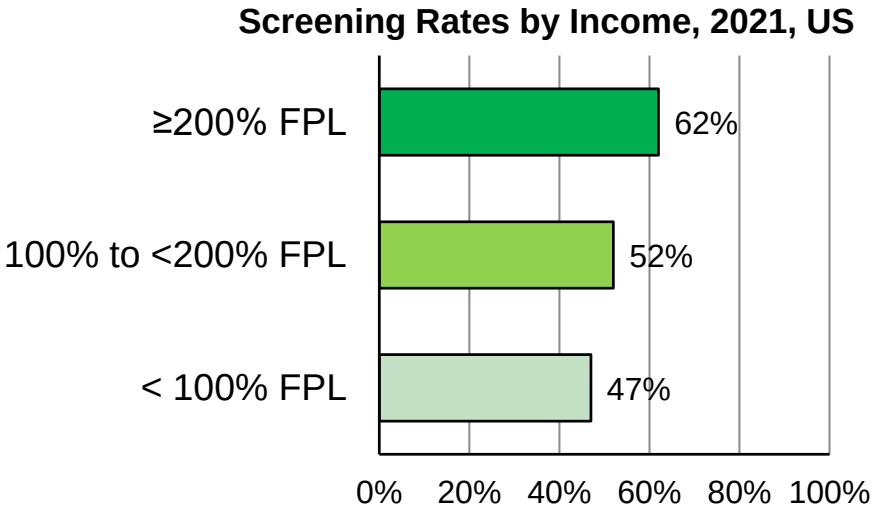
Screening Participation Contributes to Outcome Disparities by Race/Ethnicity

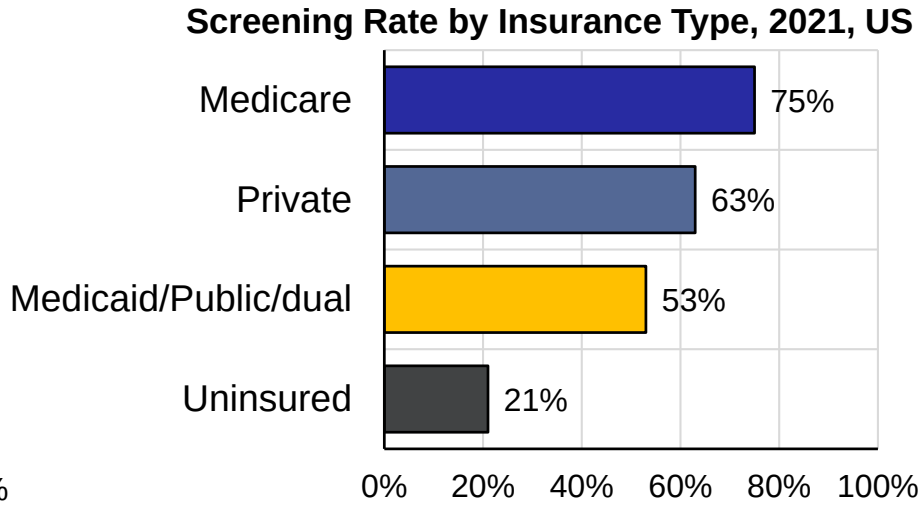
National Health Interview Survey data, 2021



National Health Interview Survey, 2021.

Screening & Social Determinants of Health

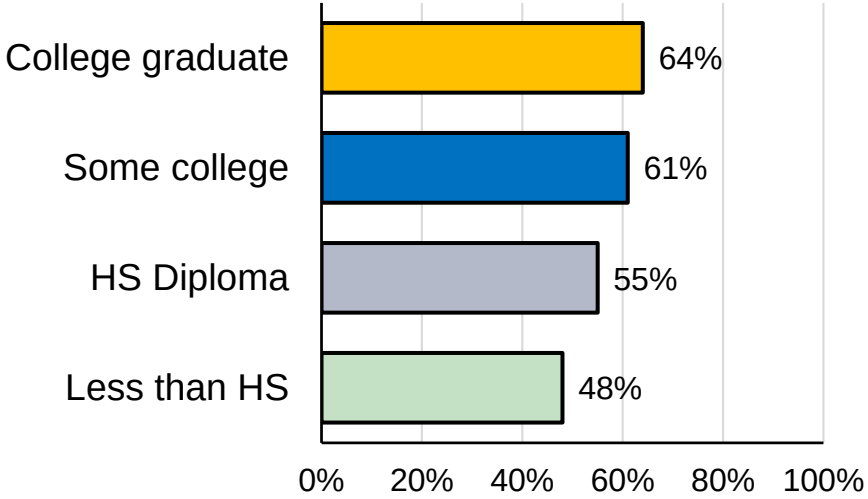




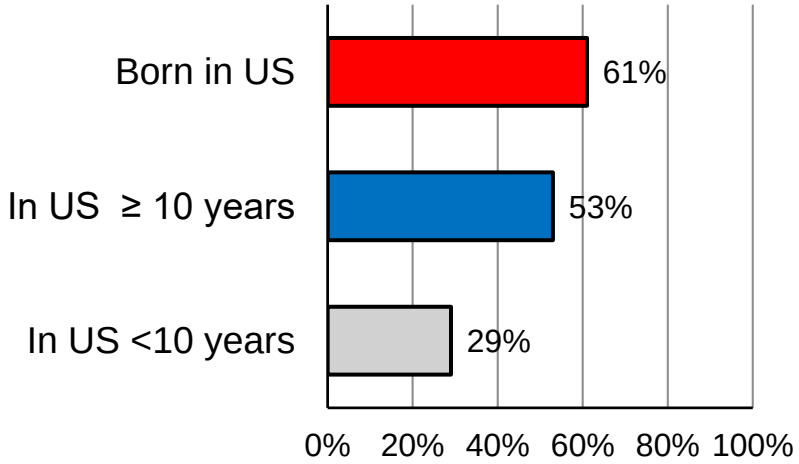
National Health Interview Survey, 2021.

Screening & Social Determinants of Health

Screening Rates by Education Level, 2021, US



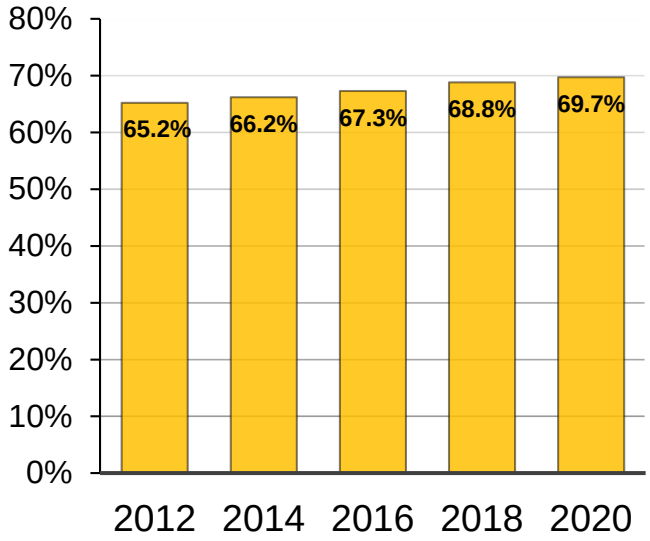
Screening Rates by Immigration Status, 2021, US



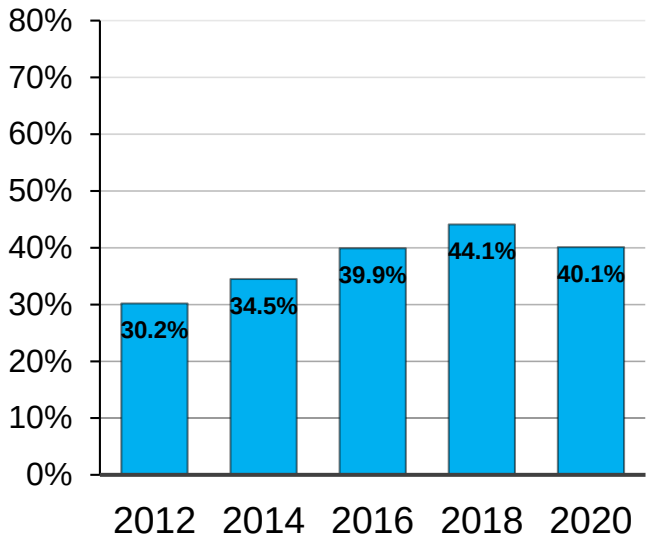
National Health Interview Survey, 2021.

Screening Rates are Low in Safety-Net Care Settings

U.S. adults age 50–75 years up-to-date with CRC screening



U.S. FQHC patients age 50-75 years up-to-date with CRC Screening



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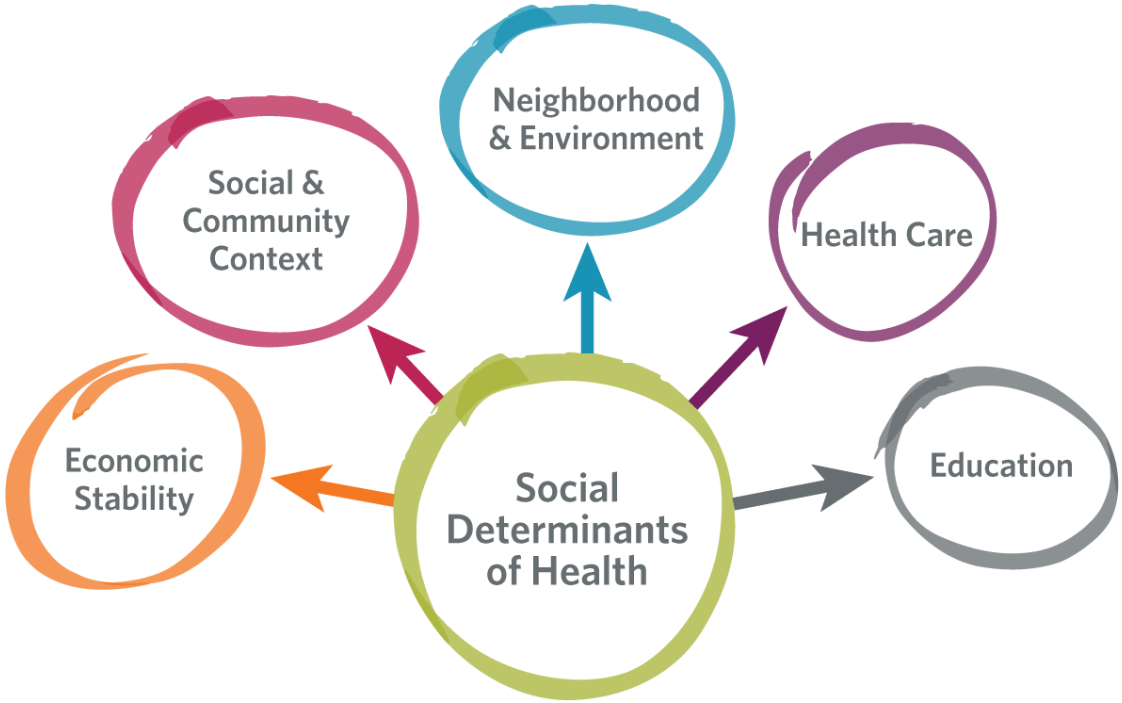
Centers for Disease Control and Prevention. Behavioral Risk Factor Surveillance System. 2012–2020. Uniform Data System: https://bphc.hrsa.gov/datareporting/reporting/index.html.

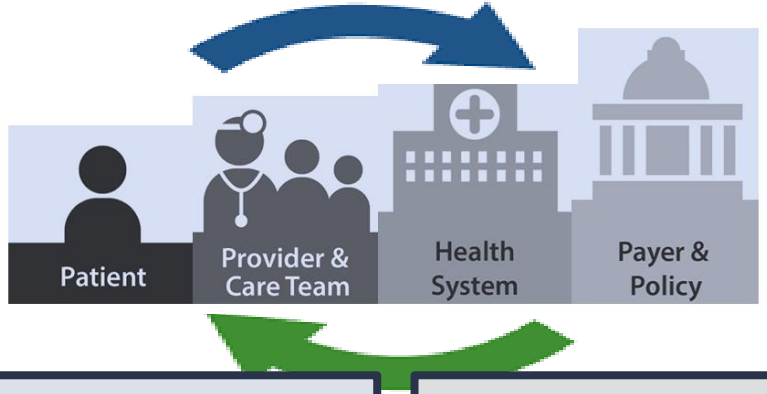
Social Determinants of Health



Barriers to Screening in the Medically Underserved

Patient-Level Factors

Lack of Knowledge
Beliefs/Cultural factors
Health Literacy
Language
Fear of procedure/prep
Fear of cancer diagnosis
Distrust
Concerns re: provider quality
Distance to endoscopy
Cost/Lack of Insurance
Comorbidities
Competing demands
Logistical challenges
Lack of escort
Time off work



Provider-Level Factors

Knowledge/ Beliefs
Practice setting
Lack of recommendation
Counseling practices
Bias (implicit/explicit)
Discrimination
Time constraints
Perceived need
Support/Resources

System-Level Factors

Access to endoscopy
Colonoscopy capacity
Quality of Care
Reminder systems
Care coordination
Coverage policy

Policy-Level Factors

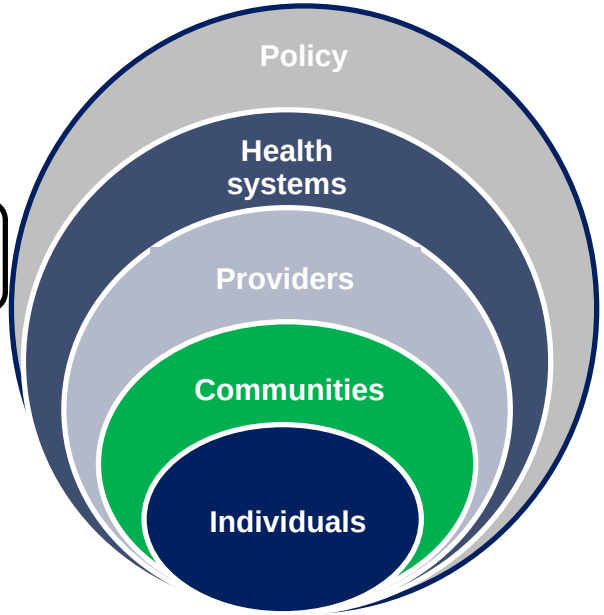
Screening guidelines
Insurance access
Insurance mandate policy
Coverage policy
Cost/Co-pay policy

Williams R et al, Clin Transl Gastroent. 2016.
White P, Itzkowitz S. Curr Gastro Rep, 2020.
Carethers JM, Doubeni CA. Gastro, 2020.
May FP et al, J Ca Educ, 2016.
May FP et al. Am J Gastroenterol, 2015.
May FP et al. Med Care, 2019.

Using Implementation Science to Increase Screening Participation and Eliminate Disparities

Implementation Science Evolution

- **Step I** • Determining the extent of screening disparities
- **Step II** • Identifying mechanisms and Barriers to screening
- **Step III** • Identifying evidence-based solutions
- **Step IV** • Dissemination and scale of effective solutions



Intervention Feature Considerations	
Targets one level	Targets multiple levels (“multi-level”)
Single component	Multiple components
Generic	Culturally tailored
Developed externally	Developed with stakeholders

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Taplin SH et al. J Natl Cancer Inst Monogr. 2012;2012(44):2-10.
Carethers JM, Doubeni CA. Gastro. 2020 Jan;158(2):354-367.

Patient-focused Intervention: Navigation

Patients, setting: Low-income Black and Latino individuals age 50-75 years. One large medical center in Boston. N=843

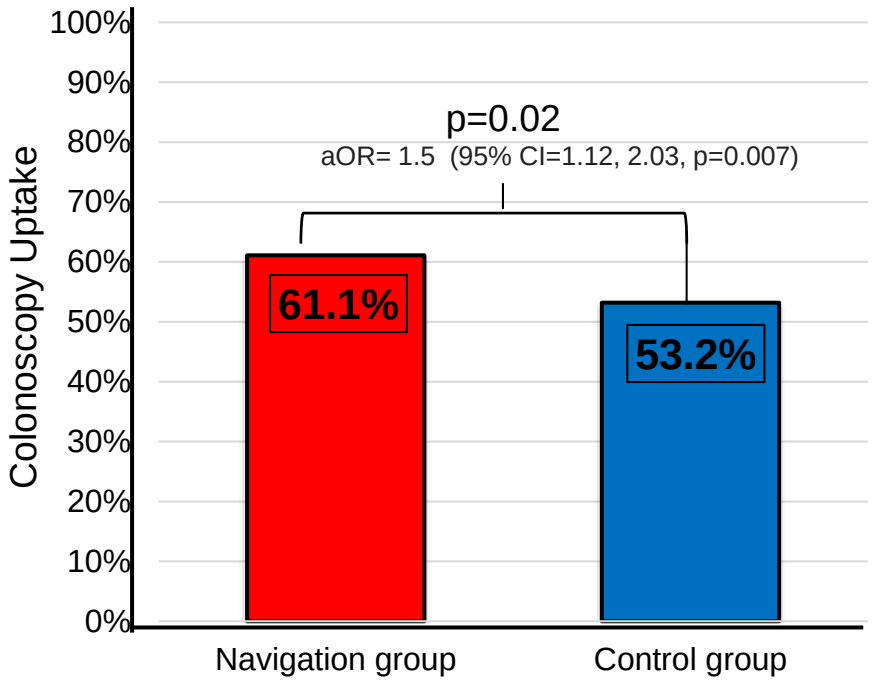
Design: RCT.

Intervention

Arm 1: Telephone-delivered individualized education by two bilingual navigators.

Arm 2: Usual care

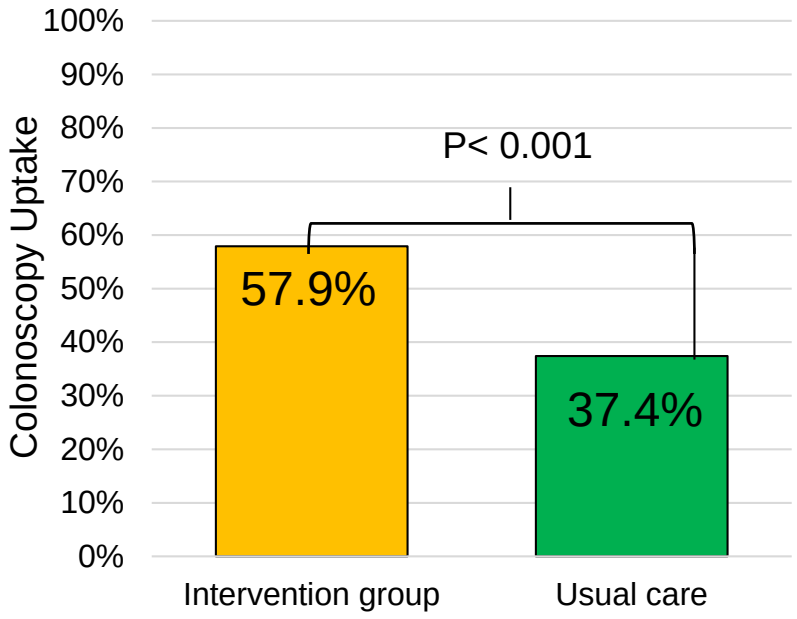
Outcome: Colonoscopy completion within 6 months



UCLA Health

DeGroff A, et al. Am J Prev Med. 2017 Sep;53(3):363-372.

System-level Intervention: Mailed FIT



Patients, setting: Safety-net system (8 clinics); Majority Black and Latino patients age 50-75 years. N=10,820.

Design: Cluster randomized trial

Intervention

Arm 1: Mailed postcard + telephone call + mailed FIT kit + Reminder call

Arm 2: Usual care

Outcome: Screening participation at 1 year

Somsouk M et al. J Natl Cancer Inst. 2020 Mar 1;112(3):305-313.

System-level: Screening improvements reduce incidence and mortality disparities

Patients, setting: Kaiser Permanente Northern California health plan patients; 11% Black individuals; age 50-75 years. N=792,081.

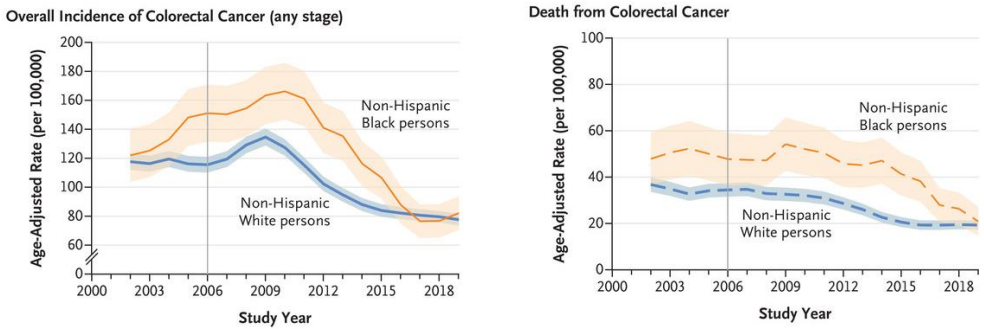
Design: Retrospective cohort

Intervention

Organized, multilevel screening program fully implemented by 2008. Patients followed through age 79.

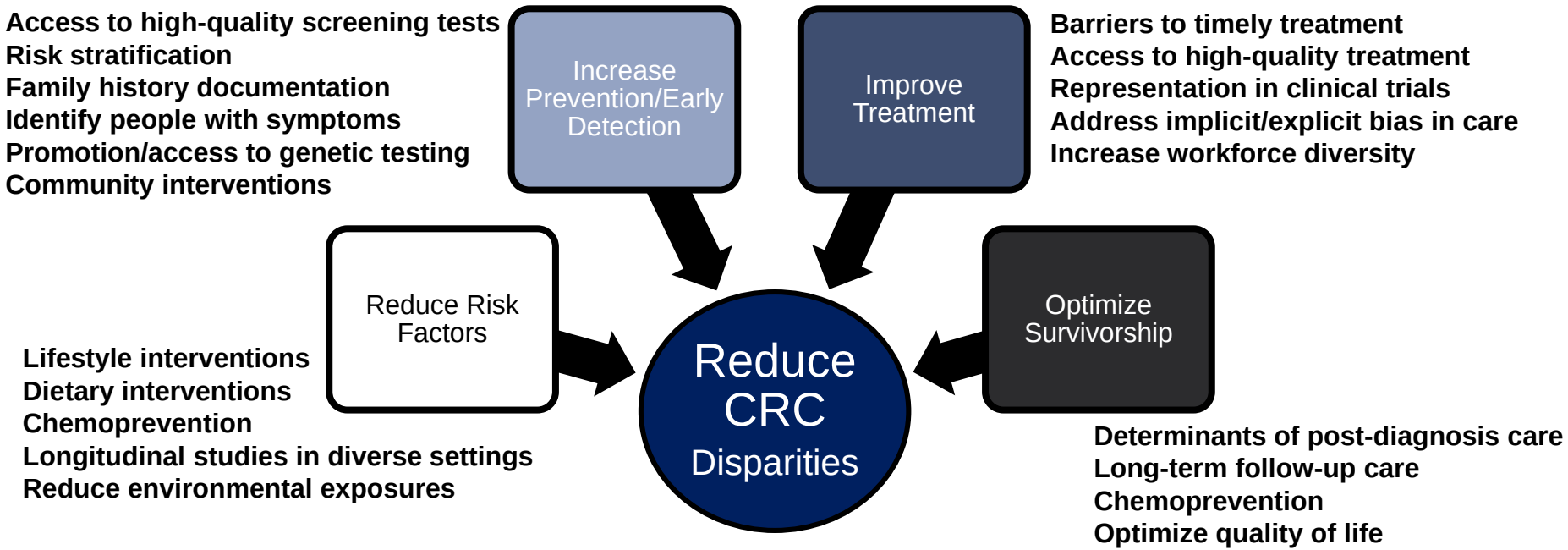
Outcome: Screening participation at 1 year

CRC incidence & mortality by race, 2000–2019



Doubeni CA et al., N Engl J Med 2022; 386:796-798.

Beyond Screening Interventions



Diet Modification

- Minimize processed meats:
  - Ham, bacon, hot dogs, raw sausages (salami), bologna, blood sausage, pate, meat spreads, cold cuts, canned meats, corned beef

- Minimize red meats:
  - Beef, pork, lamb, goat

- Increase intake of:
  - Whole grains, fiber, fruit, non-starchy vegetables, vitamin C-rich foods, fish, vitamin D

Slide credit: UCLA Digestive Health Nutrition Program

Other Lifestyle Changes

- Obesity and diabetes prevention
- Increase physical activity
- Drink alcohol in moderation
    - *Maximum of 2 drinks/day for men; 1 drink/day for women*
    - *Maximum 14 units/week for men and women*
- Avoid tobacco

Key Take Away Points

- CRC is common and deadly but is largely preventable with screening.
- Screening for CRC is evidence-based and recommended for all adults but underutilized.
- Screening should begin at 45 for average-risk individuals (& earlier in high-risk groups).
- There are several recommended screening modalities, and patients should select the modality most appropriate for them.
- Additional prevention strategies include diet modification and avoidance of obesity, tobacco, and heavy alcohol.
- Disparities in screening utilization contribute to inequities in CRC outcomes and warrant tailored, targeted interventions.

Frequently Asked Questions (FAQs)

1. What is the USPSTF recommended age to initiate colorectal cancer screening in average-risk adults?
   - Age 45. This change was made in May of 2021.
2. When should individuals with a family history of colorectal cancer initiate screening?
   - 40 OR 10 years before age of youngest family member diagnosed
3. What is the best colorectal cancer screening test for average-risk individuals?
   - Any of the 7 recommended by USPSTF. “The best test is the test that gets done”
4. What is the appropriate age to stop colorectal cancer screening?
   - Grade A: 75; Grade C: 85

Thank You!

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Q & A Session

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Thank you!