The Future of National Cancer Screening Programs

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Dialogue for Action
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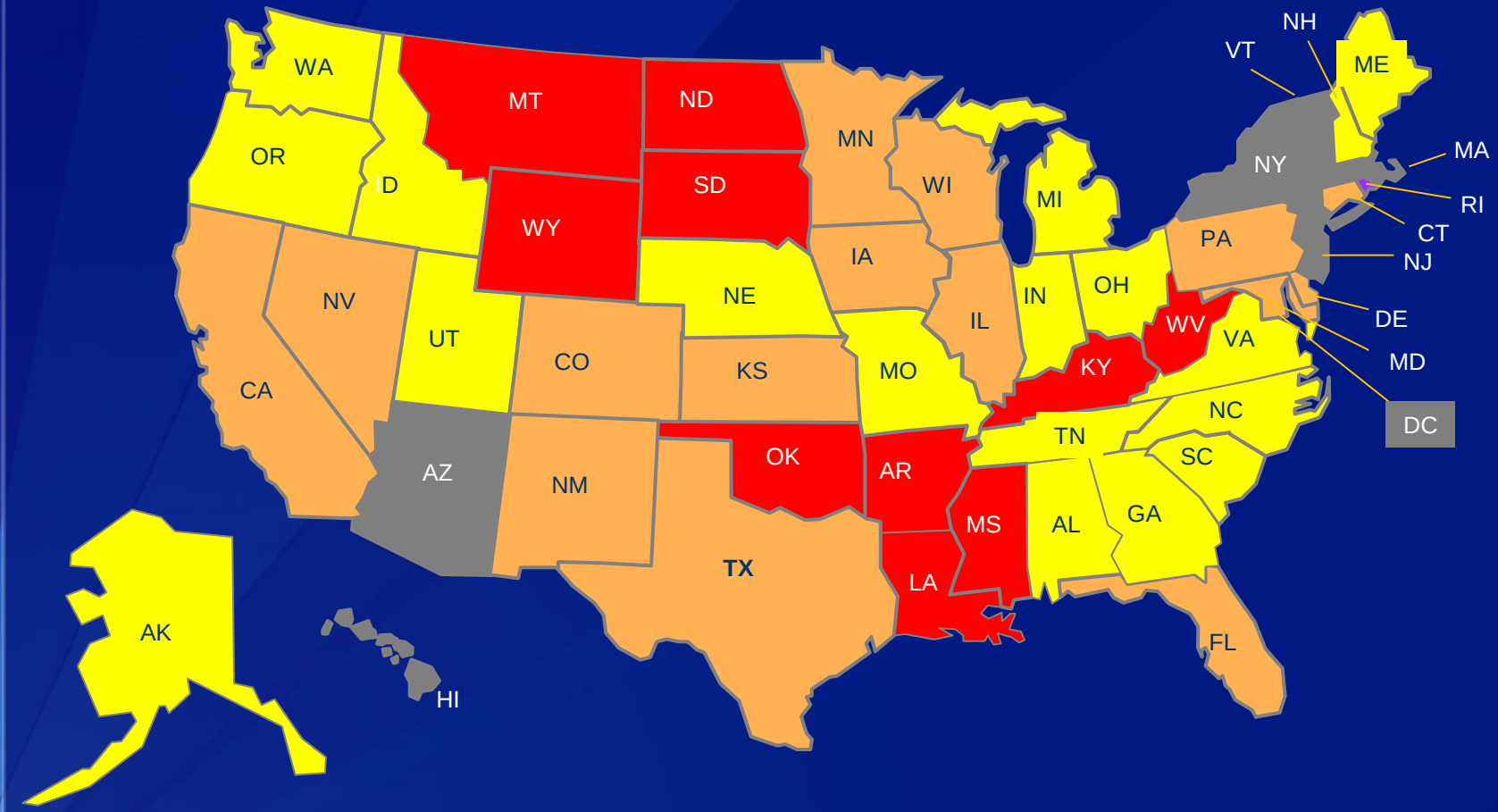
US National Library of Medicine,
National Institutes of Health

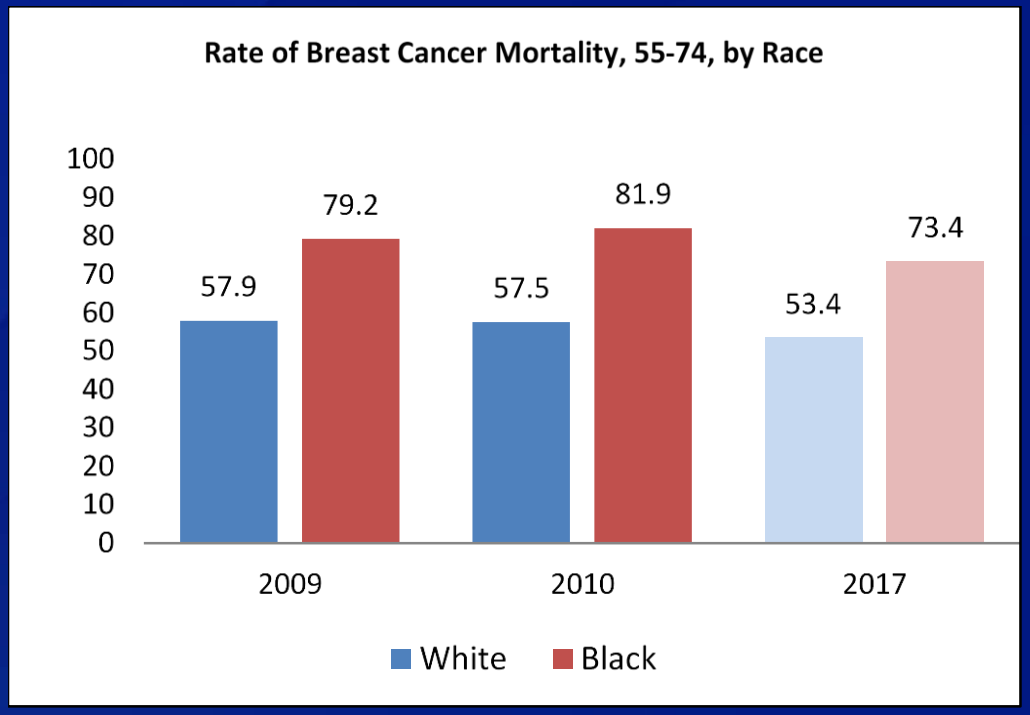
Changes in Eligibility for Breast Cancer Screening Program: 2009-14

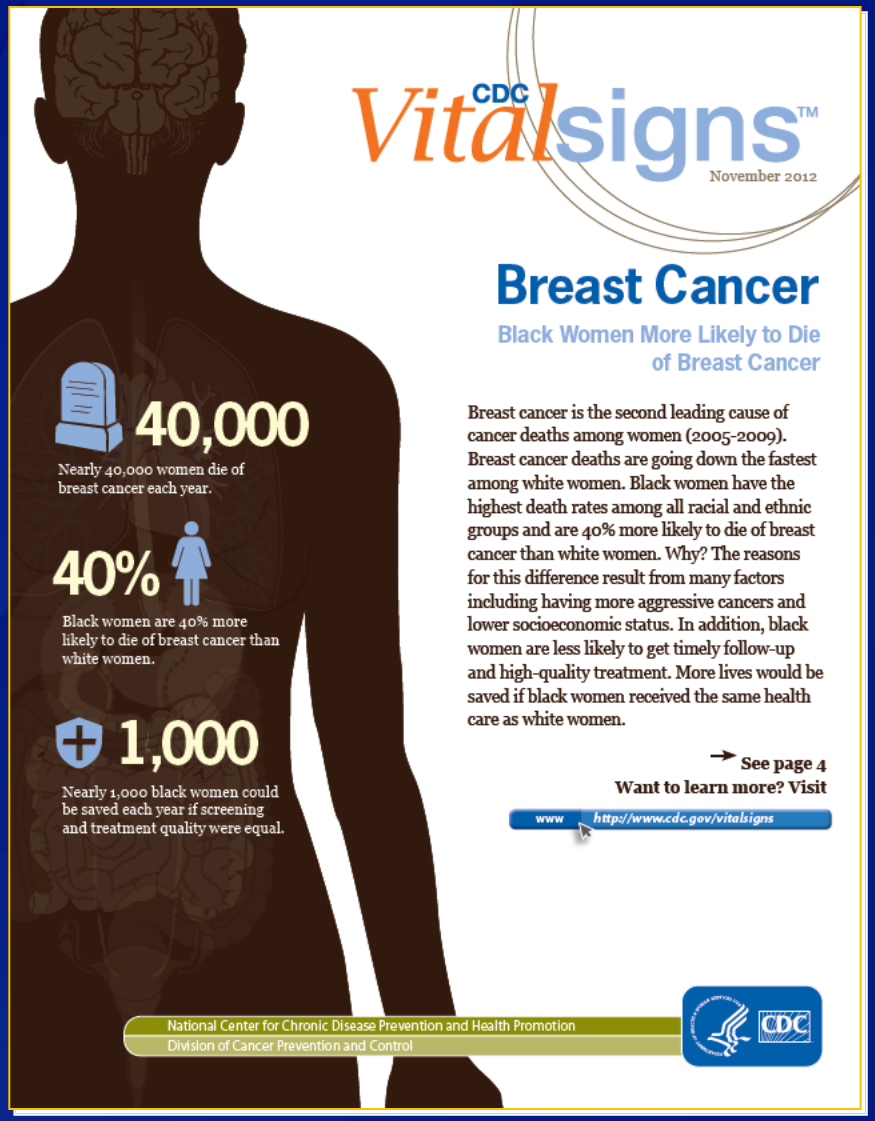


Levy etl al, Prev Chronic Dis 2012;9:120069.

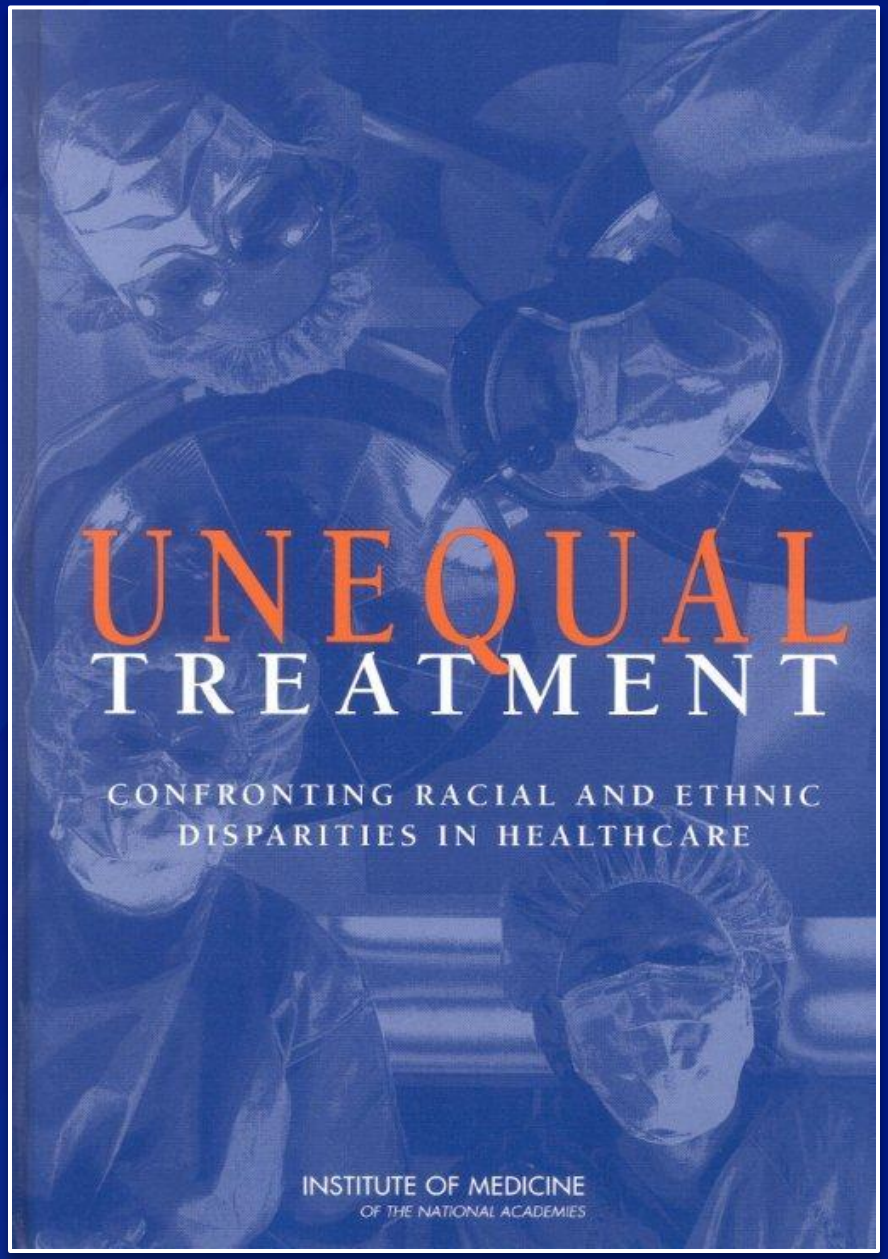
CDC Progress Indicators

Priority 1: Decrease Disparities in Breast Cancer Mortality





Source: http://www.cdc.gov/vitalsigns/BreastCancer/index.html



Smedley BD, Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care. Washington DC: The National Academies Press, 2003

What Can Be Done to Address Breast Cancer Disparities?

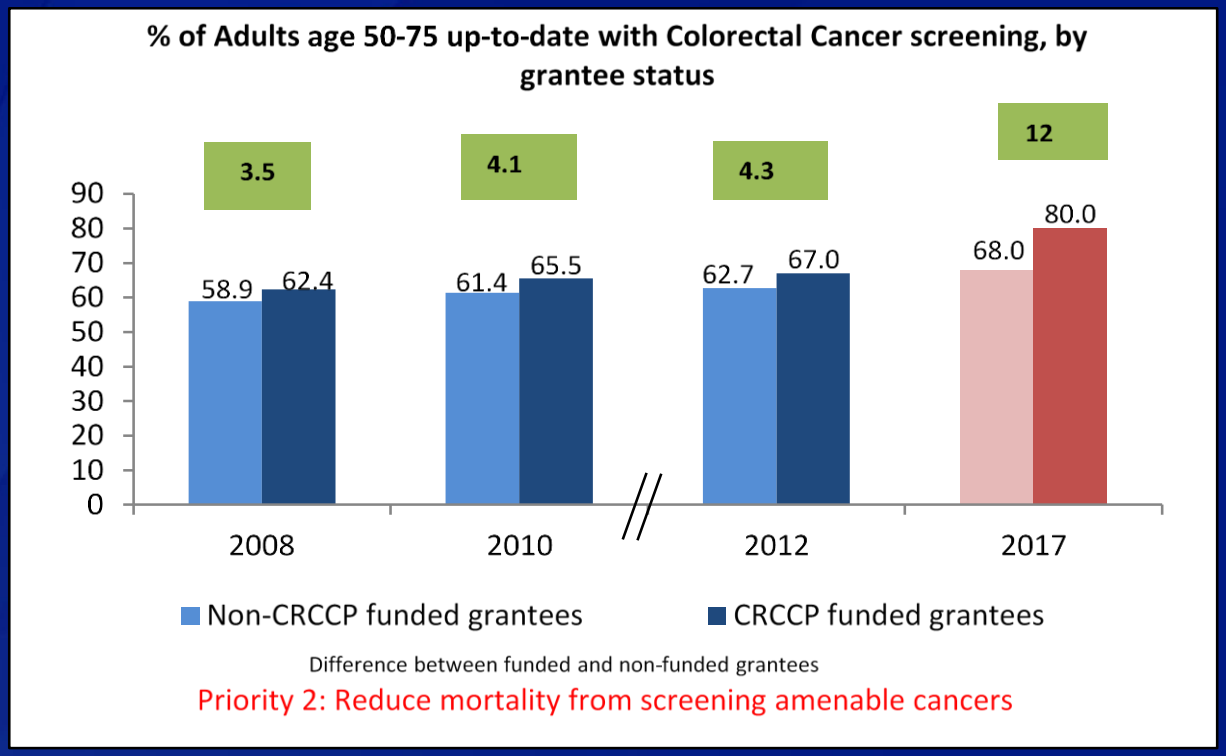
- **Health care systems can**
  - Engage case managers, health educators, and patient navigators to help women understand and guide them through the health care system.
  - Inform doctors about their screening and treatment rates.
  - Explore strategies to enhance doctor-patient communications.

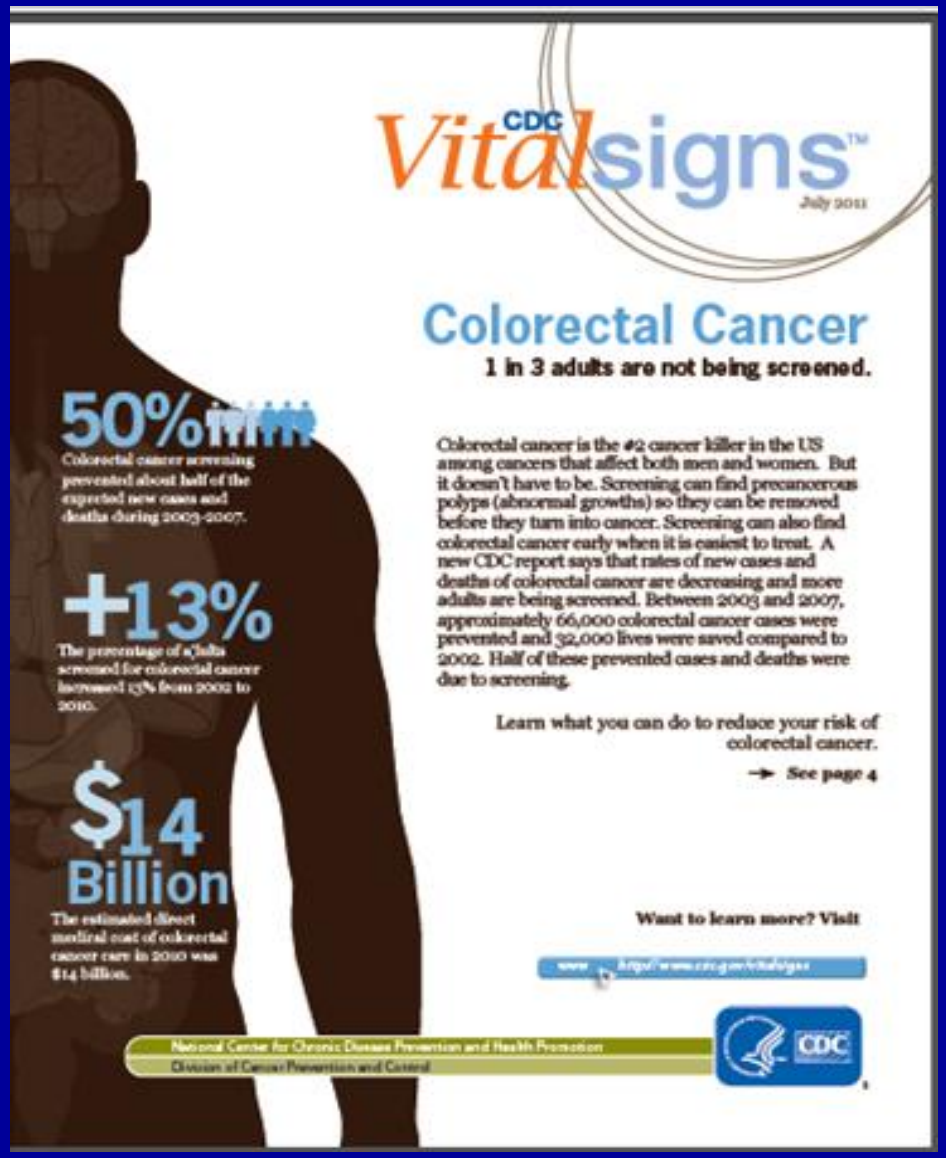
Source: http://www.cdc.gov/vitalsigns/BreastCancer/index.html

CDC Progress Indicators

Priority 2: Reduce Mortality from Screening Amenable Cancers

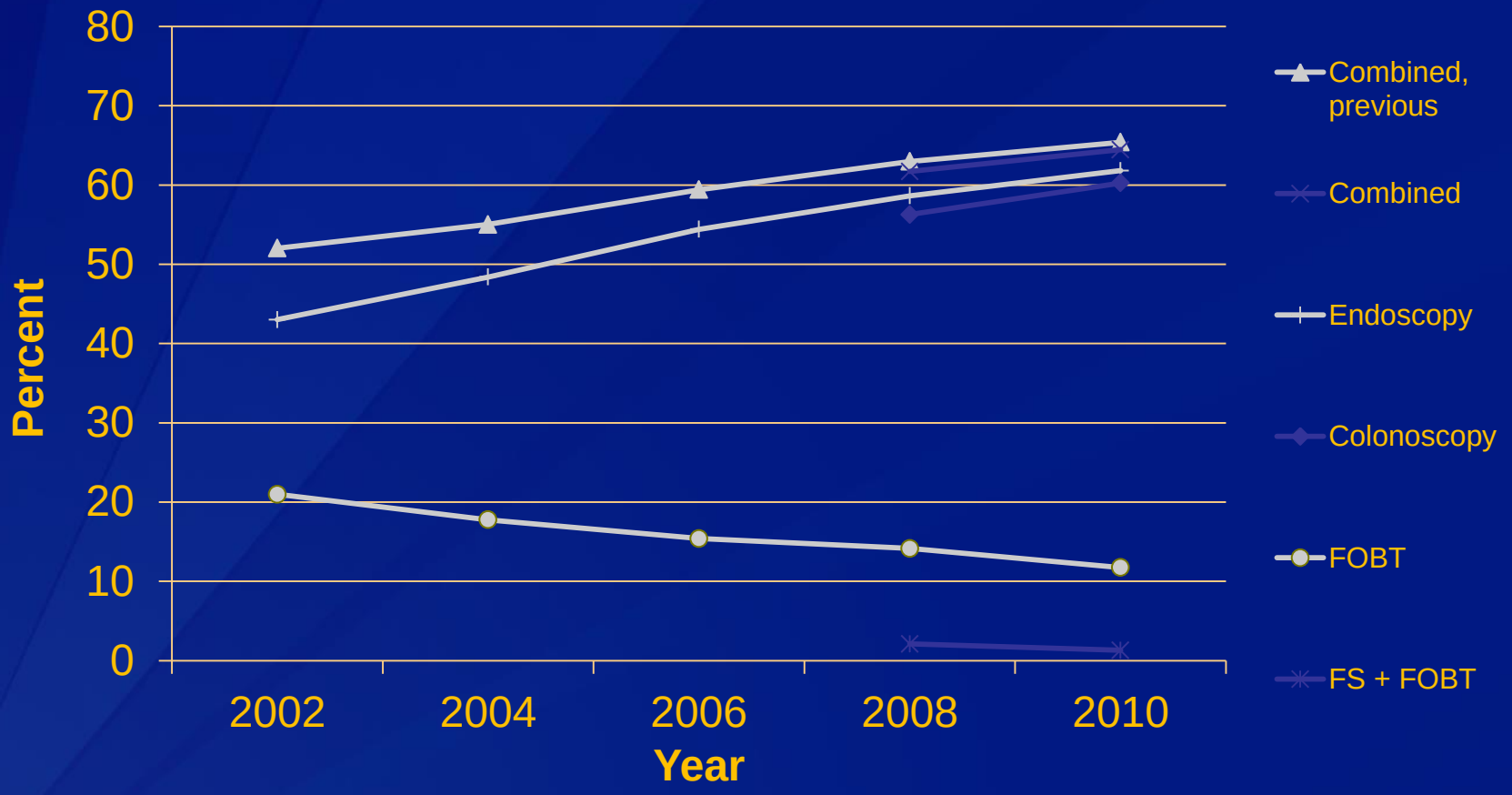
Performance Measure: % of Adults age 50-75 who are up-to-date with CRC Screening




CDC
Vitalsigns™
July 2011
Colorectal Cancer
1 in 3 adults are not being screened.
50%
Colorectal cancer screening prevented about half of the expected new cases and deaths during 2003-2007.
+13%
The percentage of adults screened for colorectal cancer increased 13% from 2002 to 2010.
$14 Billion
The estimated direct medical cost of colorectal cancer care in 2010 was $14 billion.
Colorectal cancer is the #2 cancer killer in the US among cancers that affect both men and women. But it doesn't have to be. Screening can find precancerous polyps (abnormal growths) so they can be removed before they turn into cancer. Screening can also find colorectal cancer early when it is easiest to treat. A new CDC report says that rates of new cases and deaths of colorectal cancer are decreasing and more adults are being screened. Between 2003 and 2007, approximately 66,000 colorectal cancer cases were prevented and 32,000 lives were saved compared to 2002. Half of these prevented cases and deaths were due to screening.
Learn what you can do to reduce your risk of colorectal cancer.
→ See page 4
Want to learn more? Visit
National Center for Chronic Disease Prevention and Health Promotion
Division of Cancer Prevention and Control
CDC

National Trends

Colorectal Cancer (CRC) Screening



Percentages reported for adults aged 50-75 years. (Source: Behavioral Risk Factor Surveillance System, Department of Health and Human Services, Centers for Disease Control and Prevention, 2002, 2004, 2006, 2008, 2010.)

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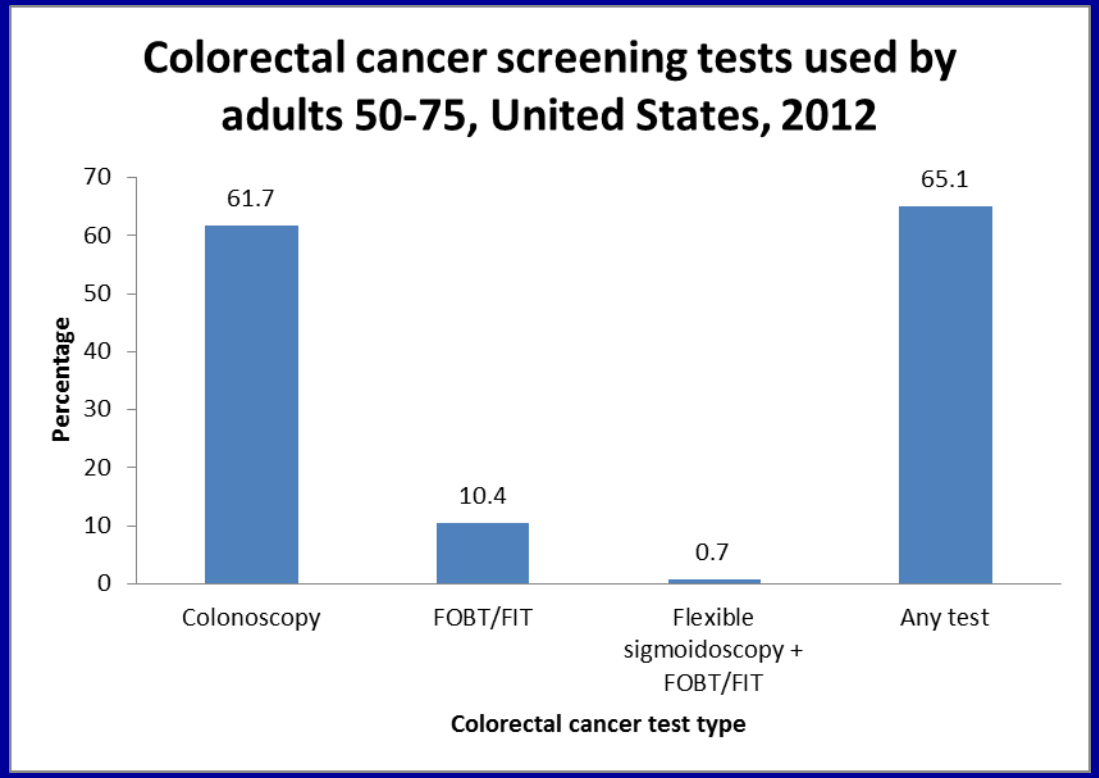

Colorectal cancer screening tests used by adults 50-75, United States, 2012
Percentage
70
60
50
40
30
20
10
0
61.7
10.4
0.7
65.1
Colonoscopy
FOBT/FIT
Flexible sigmoidoscopy + FOBT/FIT
Any test
Colorectal cancer test type

Many Patients Prefer FOBT

Community-based Preferences for Stool Cards versus Colonoscopy in Colorectal Cancer Screening

Ann C. DeBourcy, MD, Scott Lichtenberger, MD, Susanne Felton, MA, Kiel T. Butterfield, BS, Dennis J. Ahnen, MD, and Thomas D. Denberg, MD, PhD

Department of Medicine, University of Colorad

BACKGROUND: In the United States, colorectal cancer (CRC) screening re remains suboptimal. Professional orga cate use of shared decision making i discussions, but strategies to facilitate in CRC screening have not been well el

OBJECTIVE: The objectives of the determine screening test preference scopy-naïve adults after considering a presentation of fecal occult blood test colonoscopy and to assess whether t are associated with demographic char tudes, and knowledge.

Preferences for Colorectal Cancer Screening Among Racially/Ethnically Diverse Primary Care Patients

Sarah T. Hawley, PhD, MPH, Robert J. Volk, PhD,†‡ Partha Krishnamurthy, PhD,§ Maria Jibaja-Weiss, EdD,† Sally W. Vernon, PhD,¶ and Suzanne Kneuper, MS†*

Background: Incorporating patients' preferences into colorectal cancer (CRC) screening recommendations has been identified as a potential mechanism for increasing adherence. This study used conjoint analysis to describe variation in CRC screening preferences among racially/ethnically diverse primary care patients.

Methods: We recruited patients ages 50–80 of a large practice-based research network stratified by white, African American, or Hispanic race/ethnicity to complete a preference assessment instru-

Conclusions: Primary care patients have distinct preferences for CRC screening tests that can be linked to test attributes. Racial/ethnic variations in test preferences persist when controlling for attributes. Tailoring screening recommendations to patients' preferences may increase screening adherence.

Key Words: preferences, colorectal cancer screening, conjoint analysis

(*Med Care* 2008;46: S10–S16)

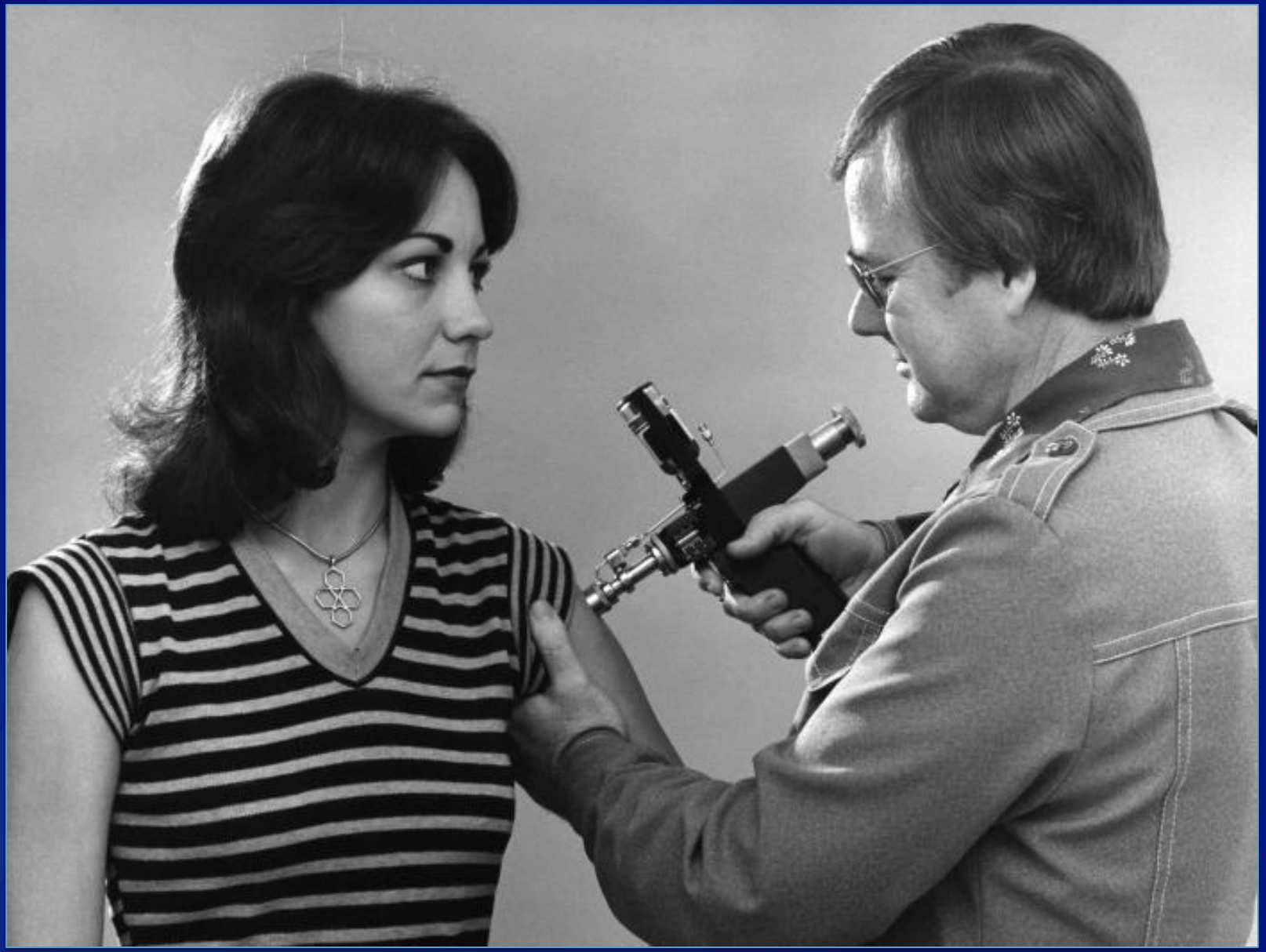
Population-based Approaches to Organized Cancer Screening

PATIENT-ORIENTED

- Patient and provider reminder systems
- Standing orders for screening
- Screening registries, expedited screening referrals

- Community-based outreach and communication
- Enhanced use of electronic data
- Population-level data monitoring

POPULATION-ORIENTED



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“It’s time to add prevention, especially primary prevention, to the paradigm of cancer control, and to recognize that prevention requires not just medical care but also strong public health systems and effective public policy.”

Thomas R. Frieden
CDC Director