FIT and Primary Care Involvement

Insights for Canada

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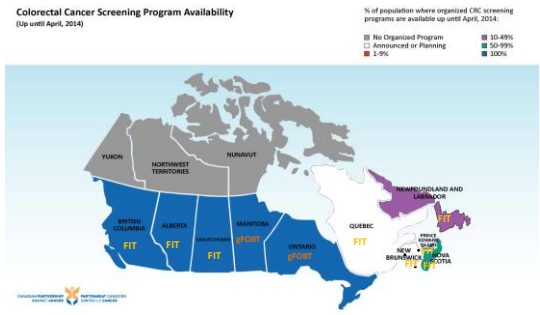
Availability of Colorectal Cancer Screening Programs in Canada



Challenges of primary care based gFOBT Programs

- Participation rates plateaued
  - Provider and patient concerns with efficacy of gFOBT → referrals directly to c'scope
- Gaps for abnormal follow-up
  - ~24% do not have a c'scope in 6 months
- Inappropriate use of kits by PCP
- Unequal access
  - Attached vs unattached patients

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Screening Pathway

In both provinces, screening is offered via family MD

- Ages 50-74
- Average risk → gFOBT
- Increased risk → Colonoscopy

- Family MDs can also refer avrg risk to colonoscopy
  - ON: high capacity through private clinics
  - AB: limited access; 3y wait list

Alberta FIT Pilot

MA Zupancic, H Yang, G van der Lee, G Chenard, S Lengsfeld, V Dias

- Objective: To compare the impact of two primary care-based FIT kit delivery methods on completion and return rates

AB FIT Pilot

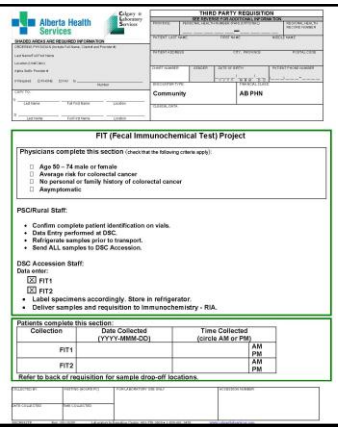
Group 1 (rural)	**Group 2 (urban)**
Calgary Rural primary care network MDs or staff hand out 2-sample kits directly to patients	*South Calgary primary care network* MDs hand out a requisition to patients Patients go to lab to pick up 2-sample kit

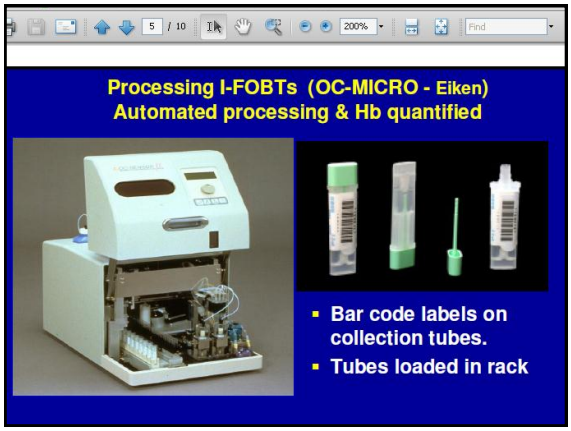
All completed kits are dropped-off by pts to a community lab collection site

Positivity criteria: any one sample =/> 100 ng/ml
All results were sent to the ordering physicians
Patients with abnormal results received a result letter from screening program

Interventions

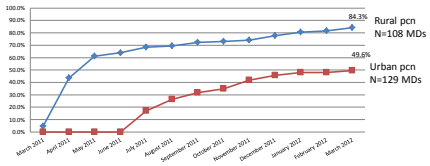
- Educational sessions to GPs and office staff
  - Importance of screening; FIT vs gFOBT
  - Risk stratification (avrg vs increased)
- Dedicated lab requisition
- Patient information
  - Introduction letter, Kit completion instruction, client service line
- Bar coded kits
- Training of laboratory staff





Physician Participation Rates

- 155 out of 237 MDs participated (65.4%)
- Greater participation from rural pcn (earlier start)
- 56% MDs preferred direct FIT kit dissemination



Kit completion rates

- Overall patient participation: 69.5%
  - 4537 patients completed FIT kits
  - 99.7 % return within 15 days
    - Average return time of completed FIT: 3 days
- Direct kit hand out (n= 3420 rural pts):
  - ➢67.6% completion & return
- Kits picked up at lab (n= 1320 urban pts):
  - ➢74.5 % completion & return

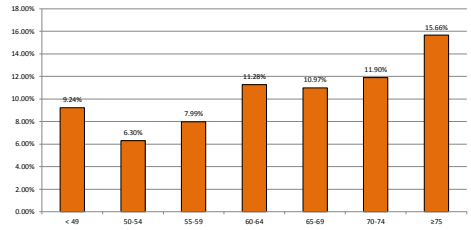
Kit completion and identification

- Requisitions:
  - 90.4 % of requisitions were fully completed
  - 8.5 % did not have any collection information
  - 1 % were partially completed
- No date on samples: 7.6 %
- Unable to obtain FIT result: 5.7%
  - E.g no ID, leaking sample

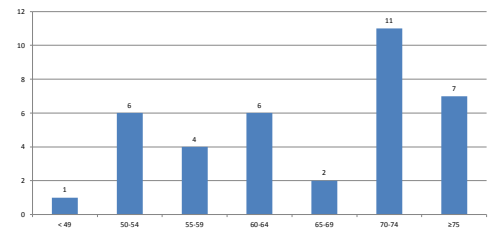
Appropriateness

- Up to 52.2% tests may have been performed outside screening criteria
  - Outside age 50-74: 11.9%
    - 4.7% < 50 yo
    - 7.2% > 74 yo
  - Performed more than once over 12 months: 0.9%
  - Individuals with symptoms
  - Individuals at increased risk

FIT Results- Positivity by Age



Number of Individuals who completed FIT more than once



AB FIT pilot - Conclusions

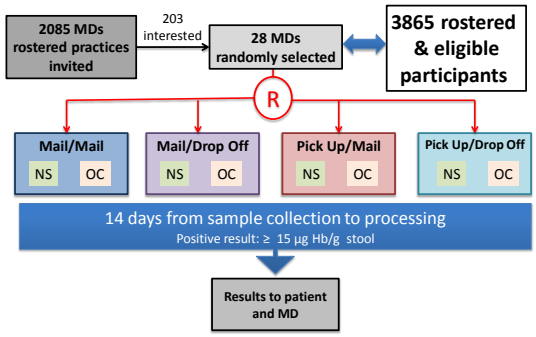
- The use of a primary care-based model of FIT kit distribution resulted in high participation rates – 70%
  - Opportunistic context
- There was no difference between direct kit hand-out vs pick up at lab
- Significant use of FIT outside guidelines

Ontario FIT Pilot – Field Study

J. Tinmouth, N.N. Baxter, S.C. Boss, P. Catomeris, L.F. Paszat, E. Randell, M. Serenity, R. Sutradhar, L. Rabeneck

- Objective: to determine the impact on participation rates of:
  a) 2 methods of FIT distribution
  b) 2 methods of FIT return

Design: Cluster RCT



Interventions

- **Distribution methods**
- Mailed invitation + FIT kit + instructions
- Mailed invitation to visit MD
  - Receive a requisition and pick up kit from lab
- **Return methods**
- Mail kit back (regular Canada Post)
- Drop kit at laboratory Patient Service Centre

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Results

- 18% of participants returned a completed kit
  - 24% of those who received kit by mail (N=1839)
  - 13% of those who picked up kit through GP (N=1941)
- Rate of rejection 7.8%
  - No or invalid collection date 6%
  - Expired sample 1.7%
- Positivity rate 13.6% at 15ug/g

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Results

By Method of Distribution

Delivery method	Kit returned w/in 6 months
All Mail Out	24%
Single mail out	16%
Repeat mail out	28%
Pick Up	13%

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Factors associated with Participation

Factor		O.R. (95% C.I.)
Distribution	Single mail out	2.97 (2.04 – 4.32)
	Repeat mail out	2.75 (2.27 – 3.33)
	Pick up	Ref
Return	Mail back	1.10 (0.81 – 1.49)
	Drop off	Ref
Participant prior gFOBT		2.74 (2.25 – 3.33)
MD prior FOBT use (ref=lowest)		
Highest		1.56 (1.17 – 2.08)
Middle		1.57 (1.33 – 1.85)

Results - appropriateness

- 184 pts received FIT kits opportunistically
  - 18.1% positivity rate at cut-off 15ug/g

Conclusions

- Overall participation 18%
  - Improved with kit mail out, particularly if mailout repeated
  - No difference in return method
- Participation is higher if pts previously used gFOBT and if GPs tend to screen with gFOBT

AB : Year 1 with FIT

- FIT replaced gFOBT in November 2013
  - Polymedco Fecal Immunochemical Test
  - Cut-off 75 ng/ml – expect 9% positivity
  - FIT analysis performed at two labs

AB CRC Screening Program

- FIT Recommended for ages 50 – 74 as primary screening test
  - Annual to Biennial; 1 sample
- Primary care physician orders FIT
- Results reported as positive/negative
- Primary care physician responsible for management of positive FIT
- ACRCSP sends results letter to patient

FIT Test Use Apr-Jun 2014

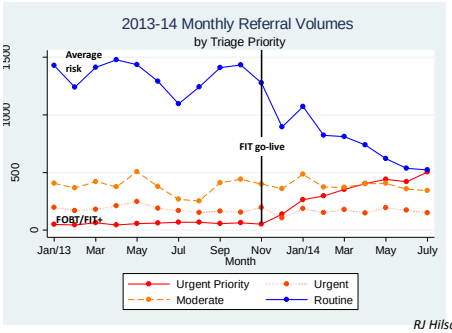
Age Group	Calgary Zone	Alberta
<40	3,82	1,187
40-49	2,204	6,448
50-74	22,541	73,666
75-84	2,570	9,778
85+	446	1,729

~30% eligible target population being screened
20% of FIT tests done in patients outside target age range

RJ Hilsden 2014

Impact of FIT on Colonoscopy Referrals

Colon Cancer Screening Center, Calgary AB



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Conclusions

- Primary MD recommendation to screen remains a strong predictor of patient participation
- Primary care engagement and education about FIT is important
  - Impact on patient participation
  - Impact on colonoscopy referrals
- Primary care-initiated screening leads to significant misuse
  - Outside age range
  - Use in symptomatic patients
  - Frequent retests

Conclusions

- Ideal (?) FIT model:
  - Program distributes kit to screenees
    - Includes attached and non-attached patients
    - Use of FIT is restricted to screening guidelines
    - Enriched by notification and reminder letters
  - GP remains involved to promote screening
    - Program letters sent on behalf of GP
    - GP "checks up" on pts' screening status; emphasizes importance of screening
    - GP is well educated about merits of FIT vs colonoscopy
    - If opportunistic screening is allowed, management of FIT+ outside guidelines needs to be carefully considered