

Ontario Cancer Screening Programs: Before, During and After COVID-19

Northeast Regional Cancer Program

MODERATOR: DR. JASON SUTHERLAND, REGIONAL PRIMARY CARE LEAD
SEPTEMBER 24, 2021



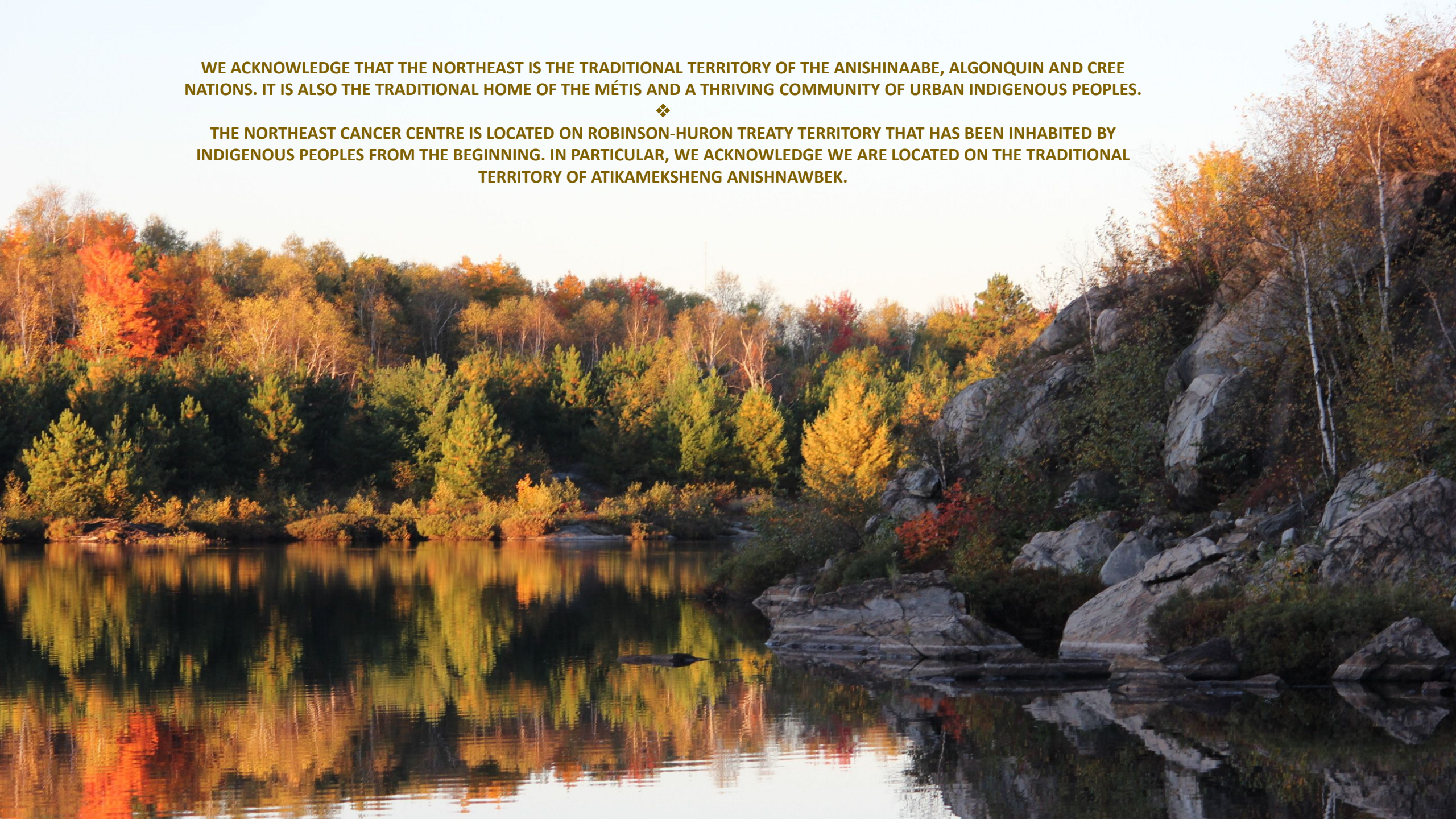
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THE NORTHEAST CANCER CENTRE IS LOCATED ON ROBINSON-HURON TREATY TERRITORY THAT HAS BEEN INHABITED BY INDIGENOUS PEOPLES FROM THE BEGINNING. IN PARTICULAR, WE ACKNOWLEDGE WE ARE LOCATED ON THE TRADITIONAL TERRITORY OF ATIKAMEKSHENG ANISHNAWBEK.



Housekeeping Notes

- Today's session is being recorded and will be available for viewing next week. The link will be on the program website.
- Please be reminded that this session is being recorded and if your camera is on your image may be captured in the recording.
- During the presentation and when you are not speaking please ensure that your microphone is muted.
- We encourage you to use the chat function to interact and ask questions throughout the event. Moderators will be monitoring the chat for questions to be directed to the presenters. If you wish to keep your question anonymous you may send it to the host, Sarah Bazinet
- Sarah Bazinet from NOSM CEPD unit is here to assist with technical issues. Contact via the chat box or email at sbazinet@nosm.ca

Scientific Planning Committee (SPC) Disclosure

Ontario Cancer Screening Programs: Before, During and After COVID-19

Relationships with financial sponsors:

- Grants/research support: none
- Speakers bureau/honoraria: none
- Consulting fees: none
- Patents: none
- Other: As the Northeast Regional Cancer Leads and/or Northeast Cancer Centre employees, the chair and members of the SPC receive payment from the Northeast Regional Cancer Program / Ontario Health (Cancer Care Ontario).

Disclosure of Financial Support

Financial support:

- This program has received financial support from Ontario Health (Cancer Care Ontario) / Northeast Regional Cancer Program in the form of payment for the certification of this module.
- This program has received in-kind support from the Northeast Regional Cancer Program in the form of logistical support.

Potential for conflict(s) of interest:

- The SPC chair and/or member receive funding from the Northeast Regional Cancer Program / Ontario Health (Cancer Care Ontario). Ontario Health (Cancer Care Ontario) administers Ontario's organized screening programs discussed in this program.

Mitigating Potential Bias

- This program is not the opinions of the committee or speakers, but uses evidence-based content developed by Ontario Health (Cancer Care Ontario).
- All speakers have been provided with a speaker letter outlining the certification/accreditation requirements for their presentation.
- The SPC or designate has reviewed the presentation(s) prior to their delivery.

Content Acknowledgement

- Ontario Health (Cancer Care Ontario), is acknowledged for sharing content of their cancer screening continuing professional development materials and resources, including slides with their logo.  **Ontario Health**
Cancer Care Ontario

Gender-Neutral Language

- Gender-neutral language is inclusive and recognizes that not everyone identifies as either a man or woman
 - For example, a person who was born a woman, but identifies as a man, may feel excluded if cancer screening guidelines use the word “woman” throughout
- Using gender-neutral language can help ensure that a person’s gender identity and expression are not barriers to getting screened
- Using gender-neutral language is important to consider in all Cancer Screening products and materials



Learning Objectives

At the end of this program, participants will be able to:

- Identify the evidence supporting the use of organized screening programs for early detection of cervical, colorectal, breast, and lung cancers.
- Discuss the impacts of the COVID-19 pandemic on cancer screening rates in Northeastern Ontario compared to Ontario; and future impacts.
- Describe special considerations and recommendations for cancer screening during the COVID-19 pandemic.
- Identify and utilize tools that are available to primary care providers and their patients to support cancer screening.

Agenda



Overview of Organized Cancer Screening



Ontario's Organized Population-Based Cancer Screening Programs

- Cervical
- Colorectal
- Breast
- Lung



Considerations during COVID-19



Provider Tools for Cancer Screening Recovery



Questions and Discussion with the Leads

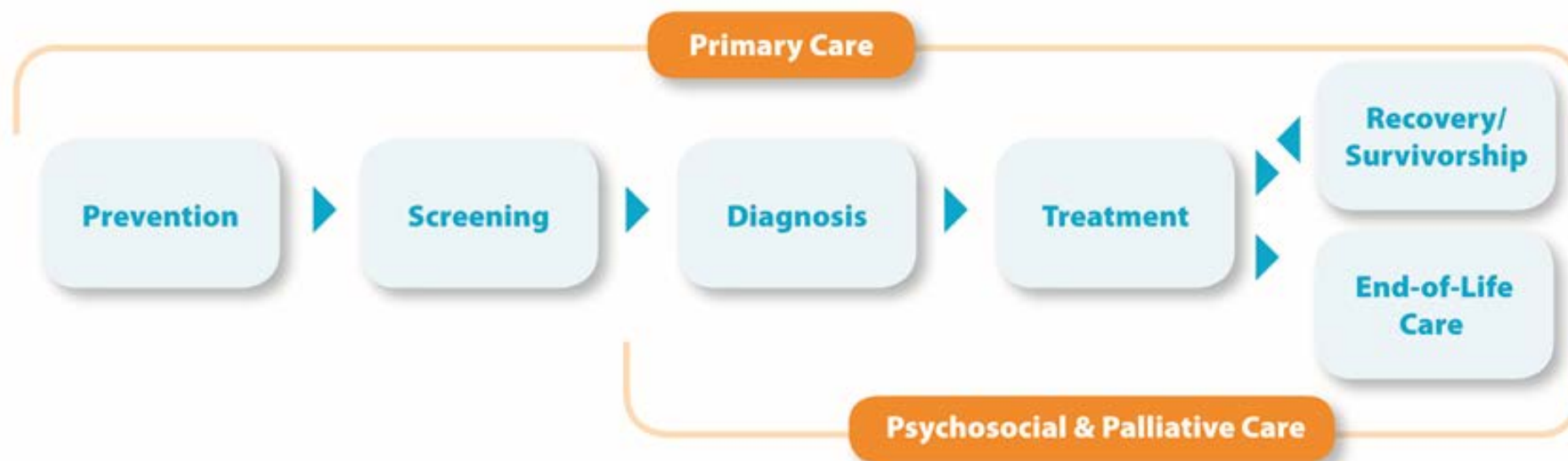


Ontario Cancer Screening Programs

DR JASON SUTHERLAND
NORTHEAST REGIONAL PRIMARY CARE LEAD

The Cancer Care Continuum

THE CANCER CARE CONTINUUM



Primary Care and Cancer Screening

- Primary care providers (PCPs):
 - Identify screen-eligible people
 - Help patients make informed decisions about getting screened for cancer
 - Arrange, facilitate and conduct screening tests
 - Arrange follow-up of abnormal screening results
- Evidence shows a positive relationship between physician recommendation for screening and patient participation in colorectal cancer, breast cancer and cervical screening^{1,2,3,4,5}



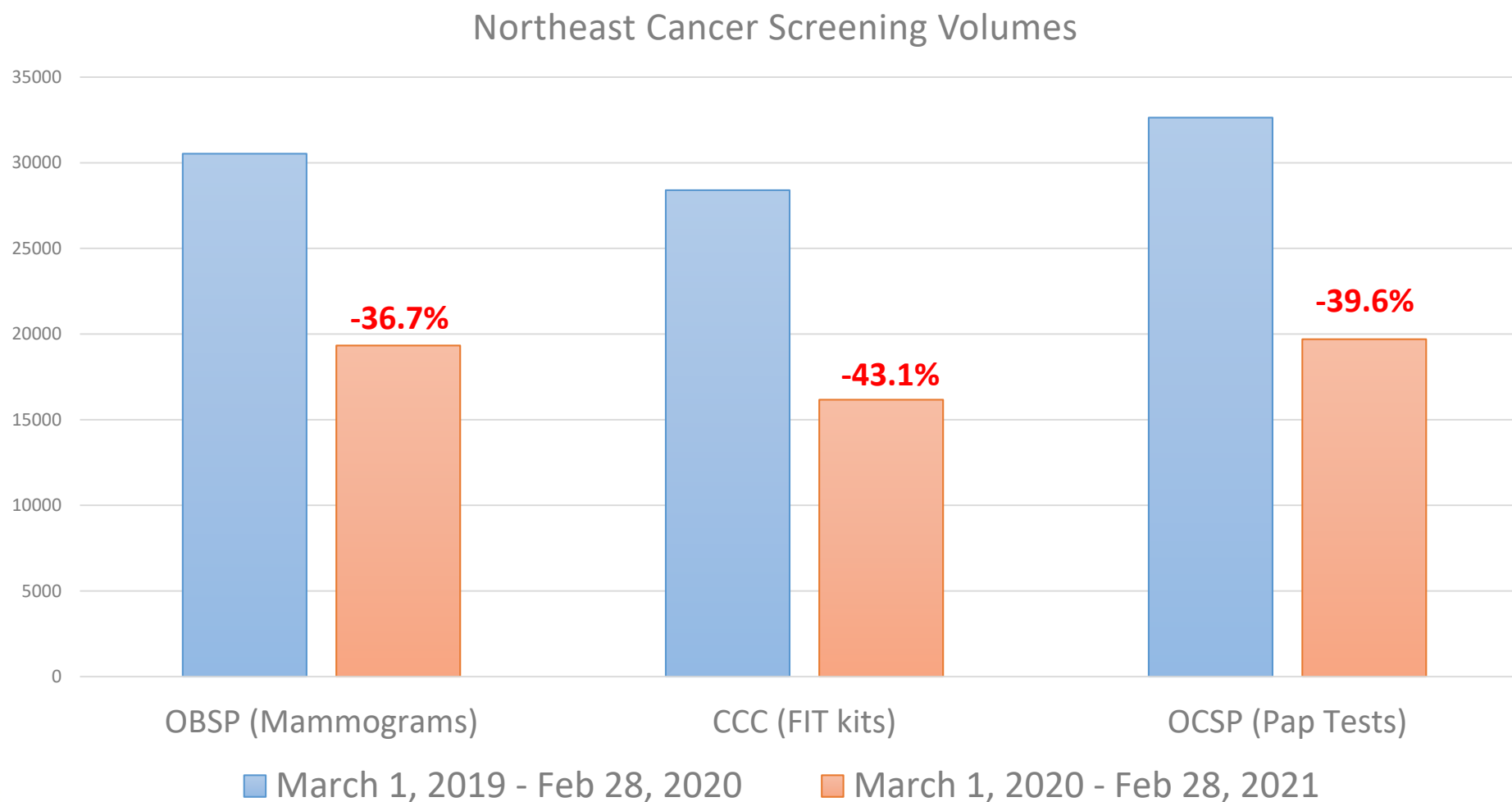
Ontario Cancer Statistics 2020

Cancer Type	Estimated # New Cases	Estimated # Deaths
Breast ¹⁸	11,945 (F)	1,977 (F)
Cervical ¹⁸	553 (F)	160 (F)
Colorectal ¹⁸	5,047 (M) 4,198 (F)	1,811 (M) 1,548 (F)
Lung ¹⁸	5,127 (M) 5,465 (F)	3,865 (M) 3,549 (F)



Northeast Cancer Screening Volumes

2019-20 vs. 2020-21





“We’re going to lose some of that benefit and may experience what many are referring to as a tsunami of cancer, where people are diagnosed at a later stage than they would have been. There may be significant consequences that trickle down from these delays.”

*Dr. Aisha Lofters
Provincial Primary Care Lead
Ontario Health (Cancer Care Ontario)*



Ontario Cervical Screening Program (OCSP)

DR JENNIFER JOCKO
NORTHEAST REGIONAL CERVICAL SCREENING AND
COLPOSCOPY LEAD

Speaker Disclosure

Speaker:

Dr. Jennifer Jocko, Regional Cervical Screening/Colposcopy Lead
Northeast Regional Cancer Program

Relationships with financial sponsors:

- Grants/research support: none
- Speakers bureau/honoraria: none
- Consulting fees: none
- Patents: none

Speaker Disclosure of Financial Support

Potential for conflict(s) of interest:

- As the Northeast Regional Cervical Screening/Colposcopy Lead, Dr. Jocko receives payment from Ontario Health (Cancer Care Ontario) / Northeast Regional Cancer Program

Mitigating Potential Bias

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Burden of Cervical Cancer

- Every year, about 530 people in Ontario will be diagnosed with cervical cancer and about 160 will die from it. Without cervical screening, these numbers would be much higher¹
- Most cervical cancers are found in people who have never been screened or have been screened less often than recommended²
- Cervical screening significantly reduces cervical cancer incidence (i.e., new cancer cases), morbidity (i.e., damage, such as loss of fertility, which can result from treatment) and cervical cancer-related mortality (i.e., deaths)^{3,4,5}



Northeast Cervical Screening Data

Cervical Cancer Screening Participation (2019)

	Percentage	Numerator	Denominator
Ontario	59% ²⁰	265,973	4,521,561
Northeast	58% ²⁰	90,184	155,489

Percentage of Ontario screen-eligible women, 21-69 years old, who completed at least one Pap test in a 42-month period as of Dec 31, 2019. Denominator is the total eligible count. Numerator is the total screened count.

Northeast Cervical Screening Backlog related to COVID-19

Ontario

Time period	Total # of Pap tests performed
April 1, 2019 - March 31, 2020	892,616
April 1, 2020 - March 31, 2021	551,222
Difference:	341,394
% change:	-38.2%

Northeast

Time period	Total # of Pap tests performed
April 1, 2019 - March 31, 2020	30,900
April 1, 2020 - March 31, 2021	21,105
Difference:	9,795
% change:	-31.7%



Recommendations during the COVID-19 pandemic

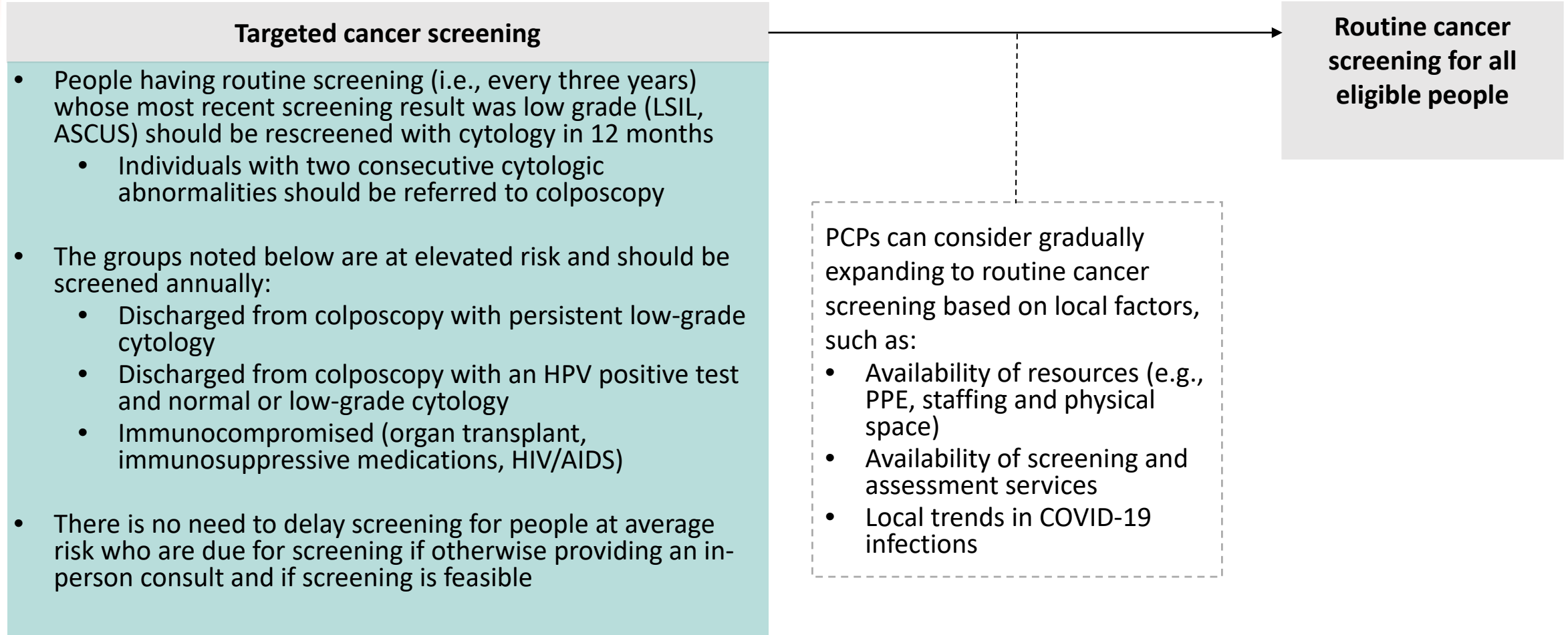
Cervical Screening and Colposcopy During the COVID-19 Pandemic

Two tip sheets have been created to supplement guidance on resumption of healthcare services issued by the MOH* and Ontario Health:

- *COVID Tip Sheet for Primary Care Providers #15: Guidance for Resumption of Cancer Screening*
- *COVID-19 Tip Sheet for Facilities Performing Colposcopy #12: Guidance for Increasing Colposcopy*



Gradual Resumption of Cervical Screening Through the OCSP



Guidance for Resumption of Screening as Part of the OCSP

- Consider not screening people with a negative HPV test in the past 5 years
- People with a first time LSIL or ASCUS should be rescreened with cytology within approximately **12 months**
 - However, people with a first time LSIL or ASCUS who have had an HPV test and are HPV 16/18 positive should be referred to colposcopy
 - Colposcopy referrals for people with first time ASCUS or LSIL results should be declined



Cervical Screening at Age 25

- Primary care providers are encouraged to start cervical screening for patients at age 25 based on moderate quality evidence suggesting that people under age 25 do not benefit from cervical screening⁶
- Cervical cancer is extremely rare in people under age 25; in 2017, there were **no** new cases of cervical cancer in people younger than 25 in Ontario
- Many screening programs recommend starting cervical screening at age 25 or later, including those in BC, AB and NS in Canada, and other countries internationally



Cervical Screening at Age 25 (cont'd)

- The OCSP will formally change the age of initiation for cervical screening from 21 to 25 with the implementation of HPV testing in the program
- Until then, we will continue to encourage primary care providers to consider delaying screening until age 25
 - Reasons include the impact of COVID-19 on healthcare services, and the limited benefit and potential harms of screening in younger people



HPV Testing Implementation

HPV Testing Overview

- Almost all cervical cancers are caused by persistent infection with oncogenic types of HPV
- HPV testing identifies whether or not oncogenic types of HPV are present
- HPV testing is more sensitive, though slightly less specific than cytology
- For people who screen positive for oncogenic HPV, reflex cytology tests help determine appropriate follow-up
 - People at greatest risk for cervical cancer are sent direct to colposcopy
 - People who do not meet the referral threshold to colposcopy can re-screen with HPV testing (timing under review) to determine if referral is appropriate



Impact of HPV Testing

- Better screening for pre-cancer and cervical cancer
- Eliminate unnecessary colposcopy referral
- Safer, earlier, more appropriate discharge from colposcopy



Improving cervical screening and colposcopy in Ontario





OCCSP Cervical Screening and Colposcopy Best Practice Recommendations

Current vs. Future State Screening Recommendations

Initiation

Screening interval*

Referral to colposcopy

Cessation

Current cytology-based recommendations

Age $\geq$ 21
(or 25, see slide 25)

Every **3 years with cytology** if screening test is negative

- Cytology $\geq$ HSIL;
- 1 or 2 LSIL;
- 2 consecutive ASCUS; or
- ASCUS and HPV positive (where available)

Age 70 if person has had **3 negative cytology results** in routine screening in the previous 10 years

Future HPV-based recommendations

Age $\geq$ 25

Every **5 years with an HPV test** if screening test is negative

- HPV positive (type 16 or 18);
- HPV positive (not type 16 or 18) and cytology $\geq$ ASC-H; or
- 2 consecutive HPV positive

Under review



Key Change: Referral Threshold

HPV status	Reflex cytology result	Clinical next steps
HPV positive (types 16 or 18)	Any cytology result	Direct referral to colposcopy
HPV positive (not types 16 or 18)	HSIL, ASC-H, AGC, AIS	Direct referral to colposcopy
HPV positive (not types 16 or 18)	NILM, ASCUS, LSIL	• Repeat HPV testing (timeline under review) • Refer to colposcopy if repeat test result is HPV positive



Additional Information For Future State

- Recommendations are still under development for:
 - People who are immunocompromised
 - Risk-based screening for people who have been recently discharged from colposcopy
 - Vaginal vault screening post-hysterectomy (with history of cervical dysplasia)
- Self sampling will not be included at launch of HPV testing in OCSP
 - Anticipate piloting this post-HPV launch
- Stand-alone cytology as a primary screening test (3-yearly) will not be available within the OCSP once HPV testing is implemented
- Screening within the OCSP will not be available for people under 25* years of age





Questions?



Ontario Breast Screening Program (OBSP)

DR SUPRIYA KULKARNI
NORTHEAST REGIONAL BREAST IMAGING LEAD

Speaker Disclosure

Speaker:

Dr. Supriya Kulkarni, Regional Breast Imaging Lead
Northeast Regional Cancer Program

Relationships with financial sponsors:

- Grants/research support: none
- Speakers bureau/honoraria: none
- Consulting fees: none
- Patents: none

Speaker Disclosure of Financial Support

Potential for conflict(s) of interest:

- As the Northeast Regional Breast Imaging Lead, Dr. Kulkarni receives payment from Ontario Health (Cancer Care Ontario) / Northeast Regional Cancer Program

Mitigating Potential Bias

- This program is not the opinions of the speakers, but uses evidence-based content developed by Ontario Health (Cancer Care Ontario) / Northeast Regional Cancer Program

Breast Cancer: Burden of Disease

- Most frequently diagnosed cancer in women¹⁸
- In Ontario:
 - 1 in 8 women will develop it in their lifetime¹⁸
 - In 2020, 11,945 Ontario women were expected to be diagnosed with the disease, and about 1,977 women were expected to die from it²³
 - Occurs mostly in women ages 50–74 (61% of cases)²²
 - Has one of the highest relative survival rates of all cancer types in Ontario¹⁸

Northeast Breast Screening Data

Breast Cancer Screening Participation (2019)

	Percentage	Numerator	Denominator
Ontario	64% ²⁰	1,447,152	2,265,984
Northeast	63% ²⁰	63,348	100,251

Percentage of Ontario screen-eligible women, aged 50-74, who completed at least one mammogram within a 30-month period as of Dec 31, 2019. Denominator is the total eligible count. Numerator is the total screened count.

Northeast Breast Screening Backlog related to COVID-19

Ontario

Time period	Total # of mammograms performed
April 1, 2019 - March 31, 2020	691,978
April 1, 2020 - March 31, 2021	397,143
Difference:	294,835
% change:	-42.6%

Northeast

Time period	Total # of mammograms performed
April 1, 2019 - March 31, 2020	29,276
April 1, 2020 - March 31, 2021	20,772
Difference:	8,504
% change:	-29.0%



Bullet Review of the OBSP

Screening Recommendations: Average Risk

- Most women ages 50–74
- Asymptomatic
- No requisition required
- No personal history of breast cancer
- No current breast implants
- No screening mammogram within the last 11 months
- No mastectomy

**Mammogram every
two years for most
women**



OBSP High Risk Screening Program

A) WHO IS ELIGIBLE FOR HIGH RISK SCREENING UNDER THE ONTARIO BREAST SCREENING PROGRAM (OBSP)?

Category A: eligible for direct entry into the program

1. Must be an Ontario resident
2. Must have a valid OHIP number
3. Are between the age of 30 and 69 and meet one of the following criteria:
 - a. Known to be a carrier of a gene mutation (e.g. *BRCA1*, *BRCA2*)
 - b. First degree relative of a carrier of a gene mutation (e.g. *BRCA1*, *BRCA2*), has previously had genetic counselling, and has declined genetic testing
 - c. Previously assessed by a genetic clinic (using the IBIS or BOADICEA risk assessment tools) as having a $\geq 25\%$ lifetime risk of breast cancer on basis of family history
 - d. Received chest radiation (not chest x-ray) before the age of 30 and at least 8 years previously

Category B: genetic assessment required (i.e. counselling and/or testing) to determine eligibility for the

1. Must be an Ontario resident
2. Must have a valid OHIP number
3. Are between the age of 30 and 69 and meet one of the following criteria:
 - a. First degree relative of a carrier of a gene mutation (e.g. *BRCA1*, *BRCA2*) and has not had genetic counselling or testing
 - b. Has a personal or family history of breast or ovarian cancer suggestive of a hereditary breast cancer syndrome

- May have current breast implants
- No bilateral mastectomy

1. Client Information (or affix label)		
First name	Last name	
Date of birth (dd/mm/yyyy)	OHIP number	
Telephone number	Secondary telephone number	Address (including postal code)

To receive high risk breast screening (i.e.: annual MRI and mammogram), women must be **between 30 and 69** and be at high risk for breast cancer as identified through Category A **OR** Category B, after genetic assessment. Women with bilateral mastectomies **are not eligible**.

Category A: eligible for **direct entry** into the program. To fall under this category, **at least one** of the following criteria must be met:

- ☐ Known carrier of a gene mutation (e.g. BRCA1, BRCA2 - **fax results with form**)
- ☐ First degree relative of a carrier of a gene mutation (e.g. BRCA1, BRCA2), has previously **had** genetic counselling, and has **declined** genetic testing
- ☐ Previously assessed as having a $\geq 25\%$ lifetime risk of breast cancer on basis of family history (a genetic clinic must have used **at least one** of the tools below to complete this assessment – **fax results with form**)

IBIS 10 Year Risk:	BOADICEA 5 Year Risk:
IBIS Lifetime Risk:	BOADICEA Lifetime Risk:
- ☐ Received chest radiation (not chest x-ray) before age 30 and at least 8 years previously (e.g. as treatment for Hodgkin's Lymphoma)

OR

Category B: **genetic assessment required** (i.e. counselling and/or testing) to determine eligibility for the program. To fall under this category, **at least one** of the following criteria must be met:

- ☐ First degree relative of a carrier of a gene mutation (e.g. BRCA1, BRCA2) and has **not** had genetic counselling or testing
- ☐ A personal or family history of **at least one** of the following (please check all that apply):

☐ Two or more cases of breast cancer and/or ovarian* cancer in closely related blood relatives†	☐ Invasive serous* ovarian cancer
☐ Bilateral breast cancers	☐ Breast and/or ovarian* cancer in Ashkenazi Jewish families
☐ Both breast and ovarian* cancer in the same woman	☐ An identified gene mutation (e.g. BRCA1, BRCA2) in any blood relatives
☐ Breast cancer at ≤ 35 years of age	☐ Male breast cancer

* Includes cancer of the fallopian tubes and primary peritoneal cancer

† Closely related blood relative: 1st degree = parent, sibling, or child; 2nd degree = grandparent, aunt, uncle, niece, or nephew

2. Clinical History		
Date and location of most recent mammogram	Previous breast cancer? Yes No	
Date and location of most recent MRI (if done)	Breast implants? Yes No	
Previous genetic assessment for inherited breast cancer risk? Yes (attach results) No	Specify genetic assessment centre	

3. Referring Physician		
First and last name	CPSO Number	
Address (including postal code)	Telephone number	
Signature	Date (dd/mm/yyyy)	Fax number

By signing this form, you authorize your client to receive screening mammography and MRI (or, if appropriate, screening ultrasound). You also authorize the OBSP to book these screens, additional screens, as well as any follow-up appointments, including imaging tests and biopsies for evaluation of abnormal results. Fax completed form to the OBSP High Risk Screening Referral Contact in your area (cancercare.on.ca/obsp/highrisk).

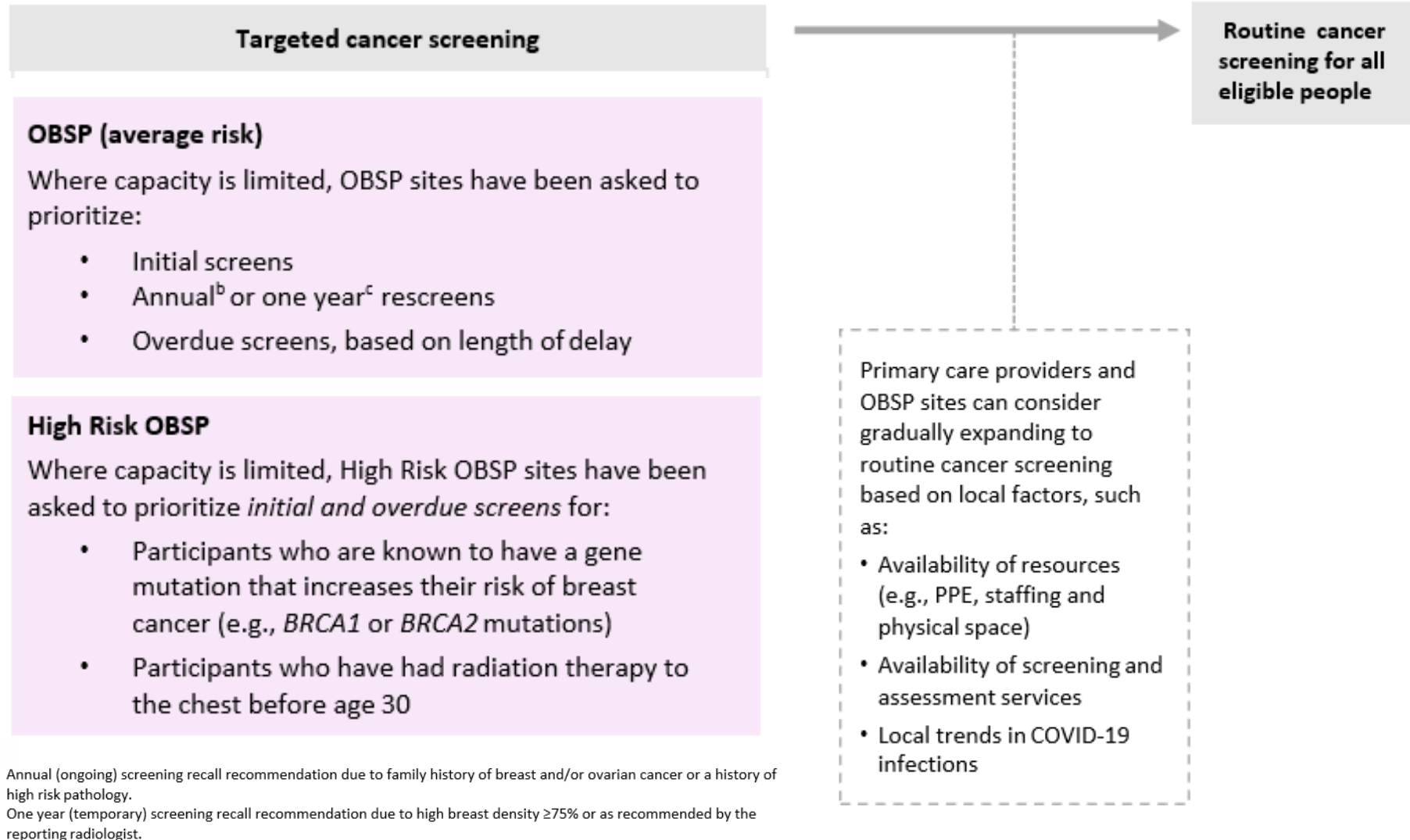
Screening Recommendations: Intervals

OBSP	OBSP High Risk
• Biennial recall for most women • Increased risk: annual (ongoing) recall ○ High-risk pathology lesions ○ Family history of breast or ovarian cancer • Increased risk: 1-year (temporary) recall ○ Breast density $\geq 75\%$ ○ Radiologist recommendation	• Annual recall ○ Ages 30–69: mammography and MRI ○ Ages 70–74: mammography **Patient navigator guides women through the referral pathway (including genetics assessment), and through screening and breast assessment



Breast screening recommendations during COVID-19

Gradual Resumption of Breast Screening Through the OBSP

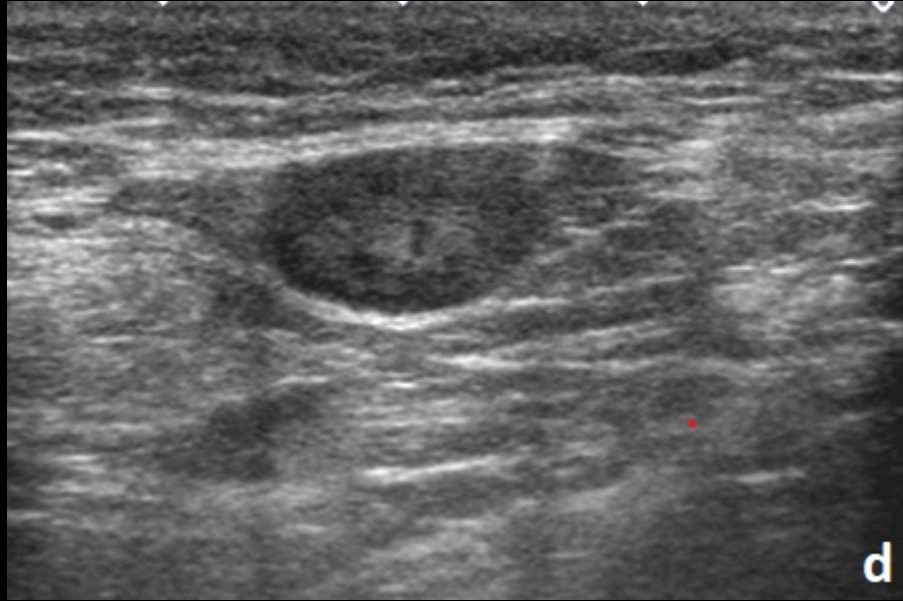
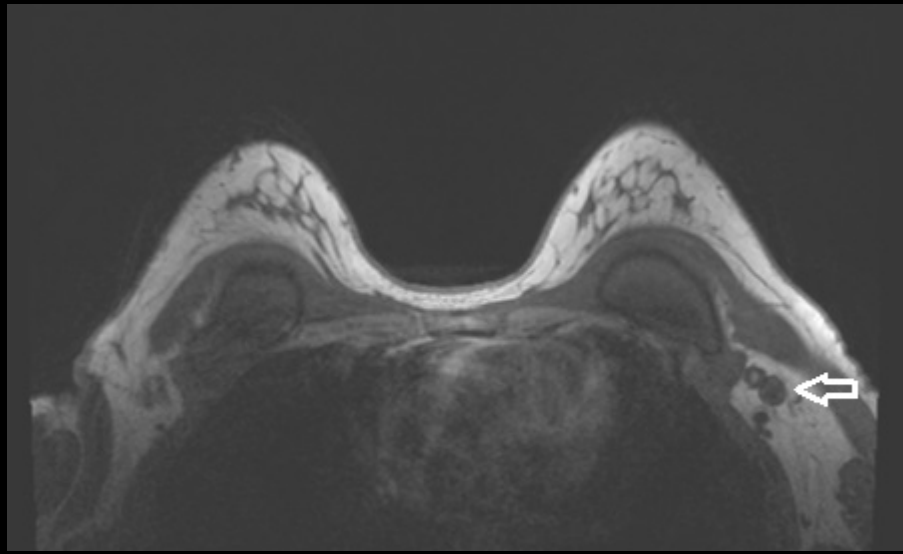


COVID-19 Vaccine Lymphadenopathy

Recommendations

- Where possible schedule screening appointments for participants before they receive the COVID-19 vaccine, or 6 weeks after vaccination
- Collect COVID-19 vaccination information (last 3 months) and provide it to the interpreting radiologist
OBSP sites should collect the following vaccination information for all OBSP participants:
 - Vaccination status; Dates of vaccination for the first and second dose; Side of vaccination (left or right arm); Vaccine type (e.g., Moderna), if known
- Provide participants with information regarding vaccine-related adenopathy
- Management of axillary adenopathy in screening mammography
- Radiologists should note all suspected vaccine-related adenopathy in OBSP screening reports (paper report and dictated) for the awareness of the primary care provider







Ontario Health
Cancer Care Ontario

Guidance for Primary Care Providers: Adenopathy Related to Vaccination 2021-04-16

Available at:

cancercareontario.ca/sites/ccocancercare/files/assets/AdenopathyGuidanceForPrimaryCareProvider.pdf



Northeast Cancer Centre

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Vaccine-related lymphadenopathy recommendations

Detection	Recommendation
Detected during breast screening – Ontario Breast Screening Program (OBSP)	To support the management of vaccine-related lymphadenopathy in breast screening, OBSP sites have been asked to do the following: - Schedule screening mammograms for participants prior to receiving the COVID-19/other vaccine or 6 weeks after vaccination, where possible and when it does not unduly delay care. - Collect COVID-19 (or other recent vaccination) history at the screening appointment. - Note all suspected vaccine-related lymphadenopathy in OBSP screening reports for the awareness of the PCP. When lymphadenopathy is detected on screening mammogram within 4 weeks of vaccination and is ipsilateral to the vaccination site, the following is recommended: - Where clinical history suggests lymphadenopathy is likely due to vaccination, radiologists could consider the finding benign and participant can return to routine screening; follow up with PCP to ensure lymph nodes are not palpable 6 weeks after most recent vaccination is recommended. - When clinical and/or vaccination history suggests the participant may be at risk from other etiology, participant will be recalled by the radiologist for further assessment and short interval follow up, as appropriate. When lymphadenopathy is detected on screening mammogram 4 weeks or longer after vaccination, participants will be recalled by the radiologist for further assessment and short interval follow up as per usual practice.
Detected during general medical imaging	General medical imaging facilities have been provided with similar guidance as OBSP sites with regards to lymphadenopathy detected incidentally during imaging of the neck, shoulder or chest.
Patient-detected	If patient reports palpable unilateral lymphadenopathy that is ipsilateral to the vaccination site, and is within 6 weeks of vaccination: - Monitor clinically for up to 6 weeks from the date of vaccination; patient may self-monitor during this period. - If adenopathy resolves, no further follow up is advised. - If adenopathy persists for more than 6 weeks after vaccination date, in-person physical examination and appropriate imaging is advised; ultrasound or mammography (where relevant), is often recommended for initial assessment. - Patients at risk of adenopathy from other etiologies (e.g., cancer surveillance patients) may require more timely follow up.

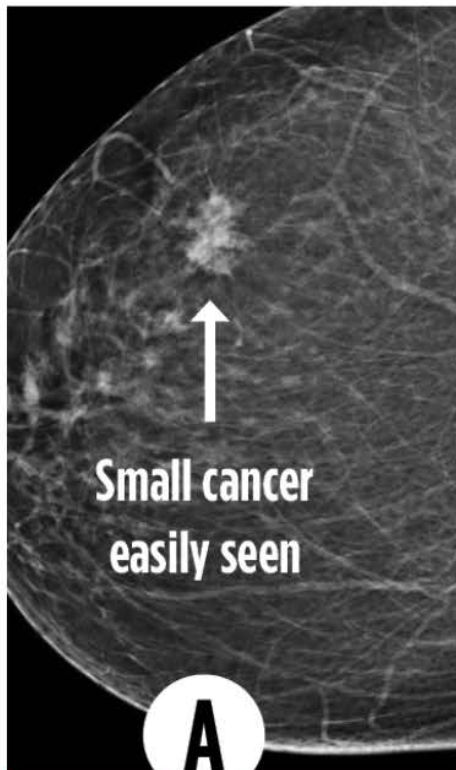


New and Upcoming OBSP Initiatives

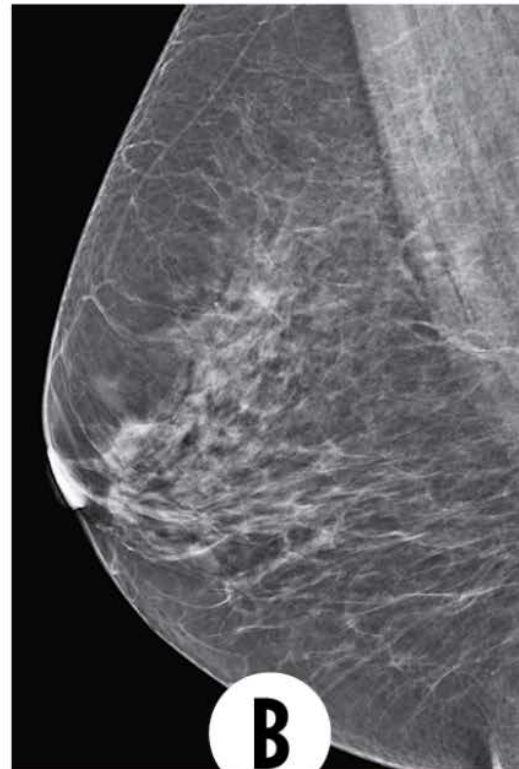
Breast Density Notification to Patients

About Breast Density

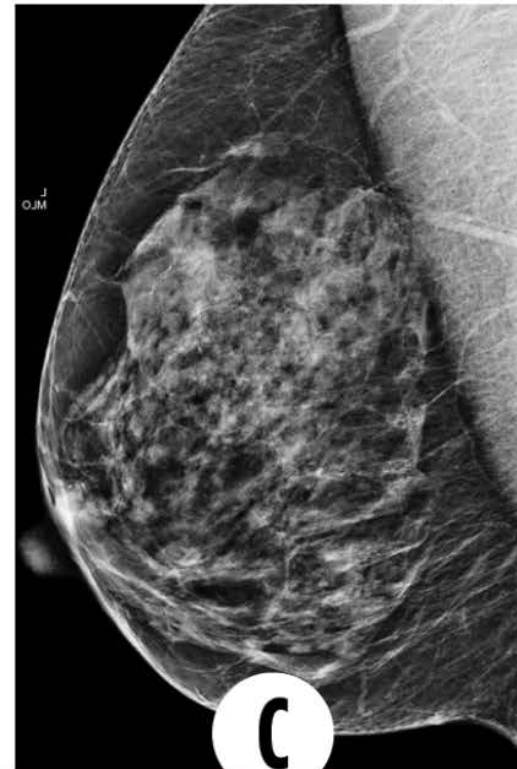
- Breast density describes the amount of fibroglandular (dense) tissue in the breast relative to fatty tissue
- High breast density relates to breast cancer for two reasons:
 - Dense breast tissue makes it more difficult to detect cancers on a mammogram (both appear white)
 - The risk of developing breast cancer is higher for women with denser breasts



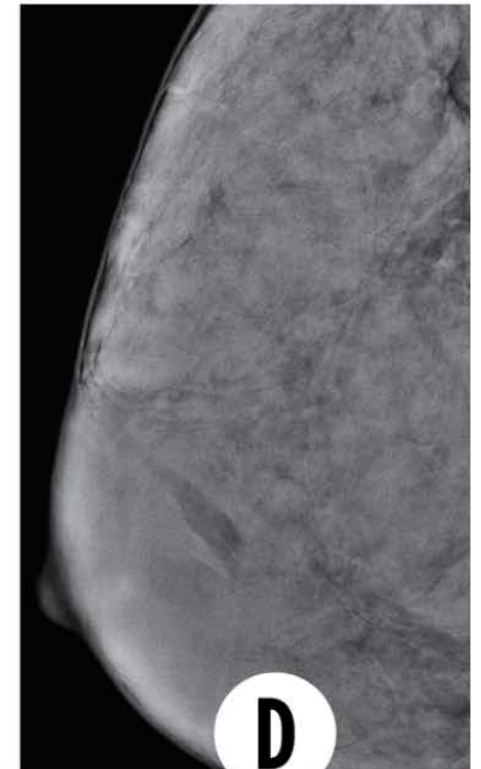
FATTY
<25% DENSE TISSUE



SCATTERED AREAS OF DENSITY
25-50% DENSE TISSUE



HETEROGENEOUSLY DENSE
50-75% DENSE TISSUE



EXTREMELY DENSE
>75% DENSE TISSUE

Breast Density Notification to Patients

The following work has been completed and launched (June 2021):

- Updated the paper-based OBSP Screening Mammogram Report form to include BI-RADS breast density;
- Updated the two-year normal result letter to indicate how participant can access their breast density information with a link to the new educational breast density web page;
- Developed educational web page content to support participants, PCPs and OBSP sites

- *Breast Density Information for Ontario Breast Screening Program Participants:*

- cancercareontario.ca/breastdensity

- *Breast Density Information for Healthcare Providers:*

- cancercareontario.ca/breastdensity-providerinfo



Overarching Policy for Screening Trans People in the OBSP

- In March 2019, the Overarching Policy for Screening of Trans People in the Ontario Breast Screening Program (OBSP) and the Ontario Cervical Screening Program (OCSP) (the policy) was released
- The policy contains 17 recommendations on screening for trans people at average and increased risk of breast and cervical cancer
- Of note: OBSP eligibility will include trans men and people with breast implants
- The policy is available on the Ontario Health (Cancer Care Ontario) website



Questions?



Ontario Lung Screening Program (OLSP)

DR ERIN PELTIER
NORTHEAST REGIONAL INDIGENOUS CANCER
LEAD (SOUTH)

Speaker Disclosure

Speaker:

Dr. Erin Peltier, Regional Indigenous Cancer Lead

Northeast Regional Cancer Program

Relationships with financial sponsors:

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- Speakers bureau/honoraria: none
- Consulting fees: none
- Patents: none

Speaker Disclosure of Financial Support

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The Importance of Lung Cancer Screening

Impact of lung cancer in Ontario:¹

- In 2020, lung cancer was expected to be the leading cause of cancer death for people in Ontario
- In 2020, approximately 7,100 people were expected to die from lung cancer – more than colon, breast and prostate cancers combined

Importance of screening for lung cancer:

- Lung cancer is usually diagnosed at an advanced stage, when treatment has less of a chance of working
- Regular screening is important because it can find lung cancer early when treatment has a better chance of working



Lung Cancer and Risk Factors in Indigenous Populations

First Nations

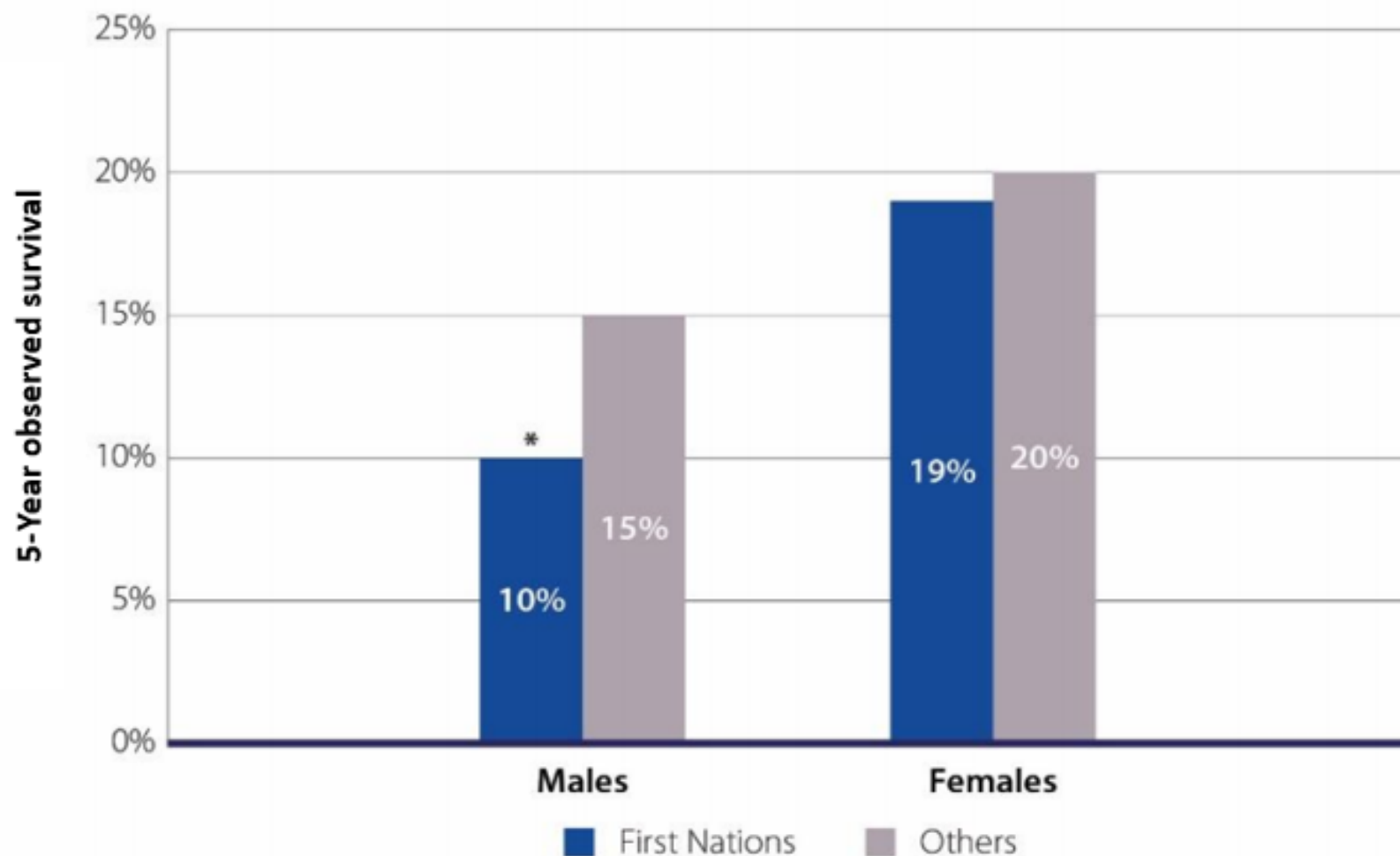
- The prevalence of smoking among First Nations men and women is nearly two times that of the non-Indigenous population²
- Lung cancer was the most commonly diagnosed cancer and leading cause of cancer death in First Nations people in Ontario³
- Lung cancer incidence and mortality were significantly higher for First Nations males and females than for non-First Nations people in Ontario³



Lung Cancer and Risk Factors in Indigenous Populations

First Nations

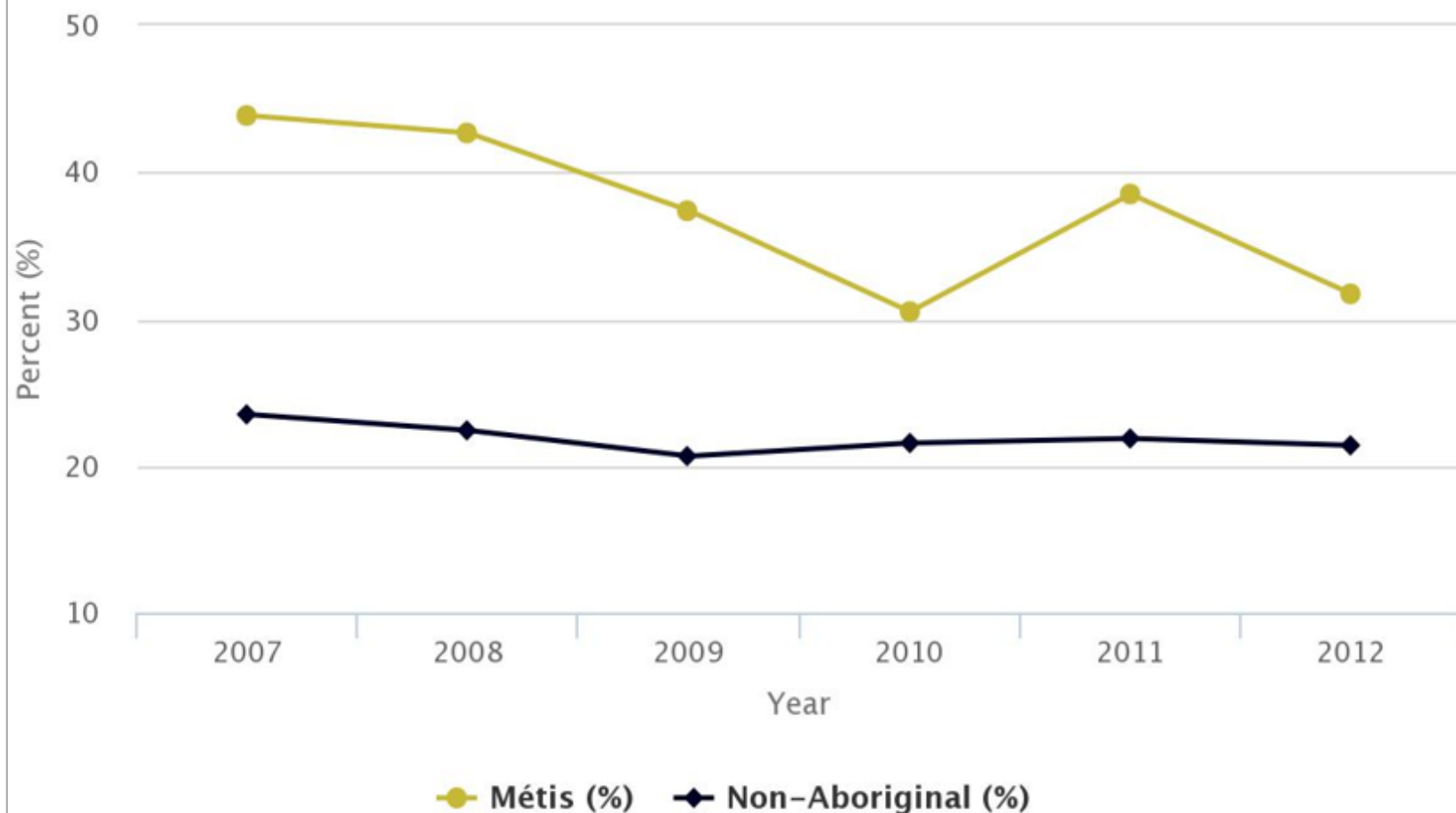
5-Year Lung Cancer Survival in First Nations People and Other People in Ontario, Ages 15–74 at Diagnosis, by Sex, 1991–2010³



Lung Cancer and Risk Factors in Indigenous Populations

Métis

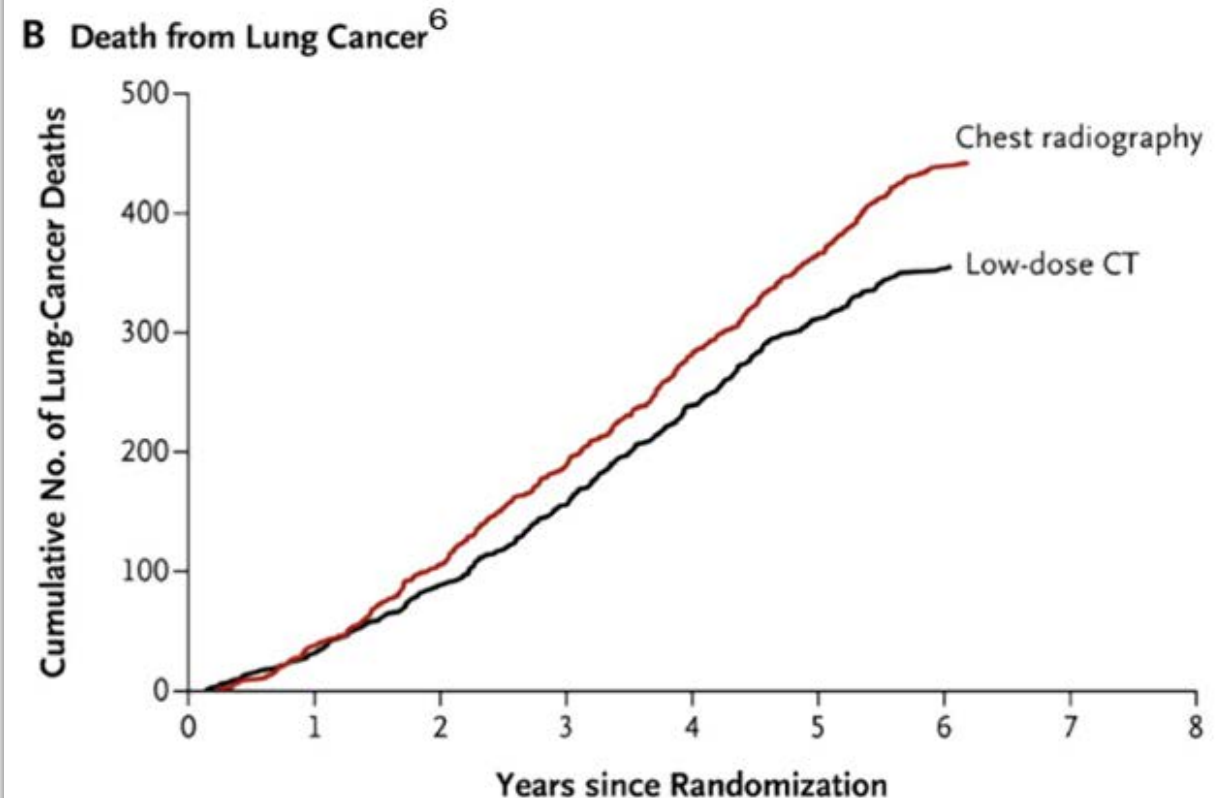
Current smoking prevalence among Ontario adults (age 20+), Métis and Non-Indigenous, 2007–2012⁵



Evidence for Screening People at High Risk for Lung Cancer

Evidence from the National Lung Screening Trial (NLST):⁶

- The NLST was a randomized controlled trial with over 50,000 participants ages 55–74 at the time of randomization
- It compared people at high risk of getting lung cancer who got screened with an LDCT scan to people who got a chest X-ray
- Screening with LDCT resulted in a 20% relative reduction in lung cancer mortality over 6 years



Program in Evidence-Based Care Guideline

Screening High-Risk Populations for Lung Cancer⁸

- To minimize harms, lung cancer screening should take place within an organized cancer screening program
- LDCT should be the lung cancer screening test used in high risk populations
- Smoking cessation should be embedded in the lung cancer screening program

Note: Chest X-ray should not be used to screen high risk populations for lung cancer⁹



Potential Benefits and Risks of Lung Cancer Screening

Potential Benefits of Organized Lung Cancer Screening

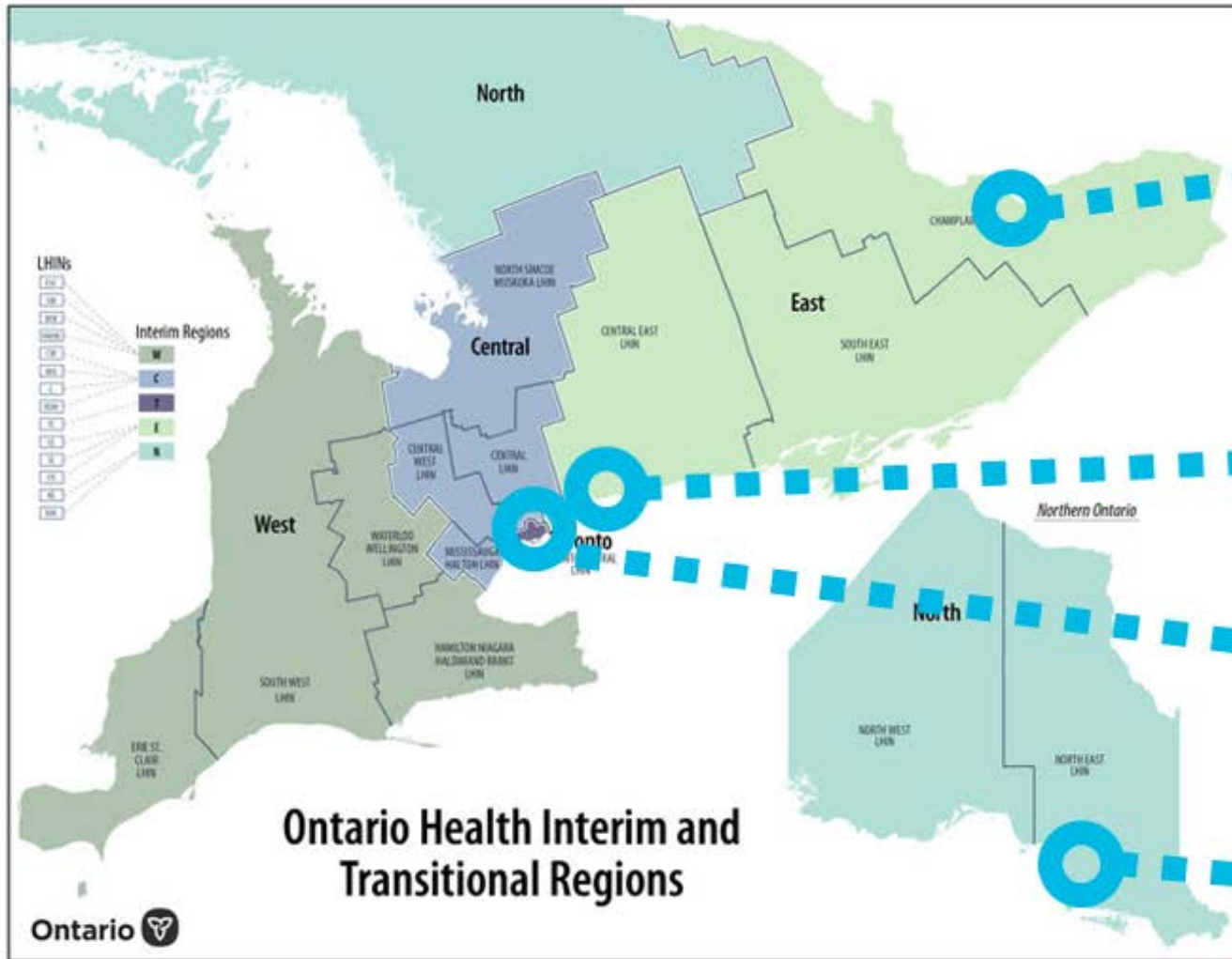
- Lung cancer may be found at an early stage, when treatment has a better chance of working
- Screening with LDCT reduces the chance of dying from lung cancer^{6,7}
- Organized cancer screening through the OLSP provides:
 - Standardized reporting of results and follow-up recommendations for lung nodules, reducing false-positives and associated harms
 - Direct access to smoking cessation services and resources
 - Smooth transition for lung diagnostic assessment, if necessary

Potential Risks of Lung Cancer Screening

- LDCT scans give off a small amount of radiation¹⁰
 - Although the amount of radiation is low, there is a small chance that the extra radiation from many LDCT scans over time could cause cancer
- False-positive results may cause stress and anxiety, and lead to unnecessary diagnostic assessments with the risk of complications (e.g., bronchoscopy, needle biopsy, thoracotomy, thoracoscopy)
- Screening can lead to over-diagnosis (i.e., identifying a cancer that would not have caused someone harm if they had not been screened)



Ontario Lung Screening Program (OLSP) Sites



The Ottawa Hospital with
Renfrew Victoria Hospital
and Cornwall Community
Hospital

Lakeridge Health

University Health Network

Health Sciences North



Ontario Health
Cancer Care Ontario

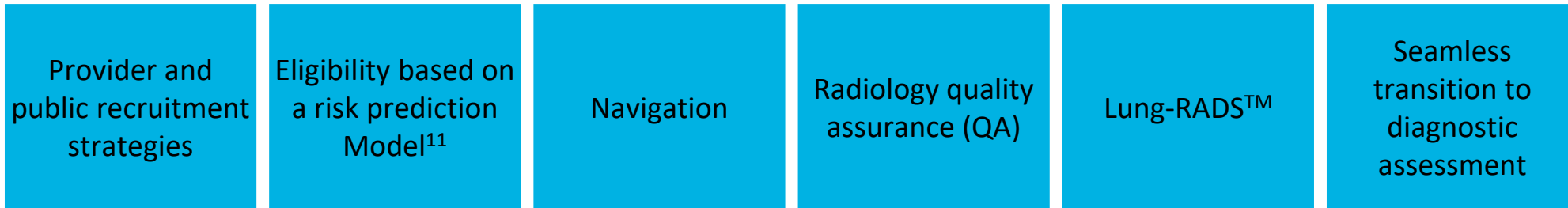


Northeast Lung Cancer Screening for People at High Risk (HR LCSP) HSN Pilot Results



***NEW* Ontario Lung Screening Program**

Key Aspects of Program Design in the OLSP



Referral Process for the OLSP

- Determining eligibility for the OLSP is a two-step process
 - **Step 1 (referral criteria)** : Physicians refer current and former smokers ages **55 to 74** who have smoked cigarettes daily for at least **20 years** (not necessarily 20 years in a row, which means there could be times when they did not smoke) to an OLSP site
 - **Step 2 (eligibility criteria)**: An OLSP site screening navigator conducts a risk assessment with anyone who meets the smoking history and age criteria in step one. The results of the risk assessment in step two determine whether someone is eligible to get screened for lung cancer through the OLSP



Referral Process for the OLSP

- **Not everyone** who meets the referral inclusion criteria will be eligible for lung cancer screening in the OLSP – it is important to tell your patient they may not end up being eligible
- In the first year of the pilot for all pilot sites, over 66% of people who completed a risk assessment were found to be eligible for lung cancer screening¹²

The Risk Prediction Model

- The risk prediction model for OLSP is more sensitive for identifying people who will develop lung cancer than the NLST eligibility criteria¹¹
- The outcome of the risk assessment is a risk score that represents the probability of developing lung cancer in the next 6 years
- People are eligible for screening if they have a risk score of **2% or greater**

Physician Referral to the OLSP – Exclusion Criteria

- Physicians should not refer people if they:
 - Have been diagnosed with lung cancer;
 - Are under surveillance for lung nodules;
 - Have had hemoptysis of unknown cause or unexplained weight loss of more than five kilograms in the past year; or
 - Are currently undergoing diagnostic assessment, treatment or surveillance for life-threatening conditions (e.g., a cancer with a poor prognosis) as assessed by the referring physician



Informed Participation

A discussion about the benefits and risks of lung cancer screening (an informed participation conversation) will occur:

1. **After the telephone risk assessment:** A screening navigator will provide a brief overview of the potential benefits and risks of lung cancer screening
2. **At the first screening visit:** The screening navigator will give the participant an information sheet to facilitate a conversation about:
 - Lung cancer signs and symptoms
 - The LDCT scan
 - Possible results and next steps
 - Benefits, risks and limitations of screening
 - Smoking cessation



Low Dose CT (LDCT)

- LDCT uses much less radiation than a diagnostic CT¹⁰ and does not require contrast
- Participants get their screening result and next steps within 2 weeks of their scan
- The standardized lung cancer screening radiology report includes:

Screening results*:

- Size and characteristics of lung nodules
- Next steps for screening based on Lung-RADS® score

**Responsibility of the OLSP site to manage*

Incidental findings**:

- Abnormalities unrelated to lung cancer seen on LDCT (e.g., aortic aneurysm, osteoporosis)

***Responsibility of the referring physician to manage*



Lung-RADS® Protocol for Follow-Up and Recall

Lung-RADS® Score	Category Descriptor	Management
0	Incomplete	Requires: Additional lung cancer screening CT images and/or comparison to prior chest CT examinations is needed
1	Negative: No nodules or definitely benign nodules	Recall: LDCT screening in 12 months
2	Benign appearance or behaviour: Nodules with a very low likelihood of becoming a clinically active cancer due to size or lack of growth	Recall: LDCT screening in 12 months
3	Probably benign: Short term follow-up suggested; Includes nodules with a low likelihood of becoming a clinically active cancer	Follow-up: LDCT screening in 6 months
4A	Suspicious: Findings for which additional diagnostic testing is recommended	Follow-up: LDCT screening in 3 months
4B	Very suspicious: Findings for which additional diagnostic testing and/or tissue sampling is recommended	Referral for lung diagnostic assessment For new large nodules that develop on an annual repeat screening CT, a 1 month LDCT may be recommended to address potentially infectious or inflammatory conditions
4X		Referral for lung diagnostic assessment



Actionable Incidental Findings

Example:¹⁴

Incidental Finding	Not Actionable	Actionable
Indeterminate renal nodule or mass	1. Simple renal cysts (-10 - 20 HU), cysts >70 HU, and nodules too small to characterize. Fatty nodules without calcification (angiomyolipomas) RECOMMENDATION: No further evaluation	1. All other lesions: Defer to judgement of reading radiologist. RECOMMENDATION: Ultrasound or additional imaging as per institutional practice

- These will be reported as “actionable” by the radiologist
- Recommendations are listed
- Referring physicians are responsible for coordination and follow-up of the recommendations



Referral Form

Available at
www.hsnsudbury.ca/neccforms



Northeast Cancer Centre

Health Sciences North

a Cancer Care Ontario partner



Ontario Health
Cancer Care Ontario

Ontario Lung Screening Program Referral Form

Submit this completed form to the Ontario Lung Screening Program (OLSP) site hospital in your area. Please visit cancercareontario.ca/lungscreeninglocations to get the contact information for the OLSP site hospitals you can refer patients to. Health Sciences North OLSP site fax: 705-523-7306

1. PATIENT INFORMATION (OR AFFIX LABEL)			
FIRST NAME		LAST NAME	
DATE OF BIRTH (YYYY/MM/DD)		ADDRESS (INCLUDING POSTAL CODE)	
TELEPHONE NUMBER (###) ###-####	ALTERNATE TELEPHONE NUMBERS (###) ###-#### (###) ###-####		OHIP NUMBER
SEX ☐ M ☐ F			
VERSION CODE			
2. REFERRAL CRITERIA			
To be referred to the OLSP for a risk assessment, a patient must be: • 55 to 74 years old • a current or former smoker who smoked cigarettes daily for at least 20 years (not necessarily 20 years in a row, which means there could be times when they did not smoke) ☐ My patient meets all of the above referral inclusion criteria. A patient must have OHIP coverage to participate in the OLSP except for Quebec residents of the Akwesasne First Nation. Not everyone who meets the referral inclusion criteria will be eligible for lung cancer screening in the OLSP (see Frequently Asked Questions). A patient should not be referred to the OLSP if they: • have been diagnosed with lung cancer • are under surveillance for lung nodules • have had hemoptysis of unknown cause or unexplained weight loss of more than 5 kg (11 lbs) in the past year* • are currently undergoing diagnostic assessment, treatment or surveillance for life-threatening conditions (e.g., a cancer with a poor prognosis) as assessed by the referring health care provider * If your patient has these symptoms, please ensure appropriate diagnostic investigation and consultation.			
3. HISTORY OF CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD)			
PREVIOUS DIAGNOSIS OF COPD? ☐ YES ☐ NO ☐ UNKNOWN			
4. HISTORY OF CHEST COMPUTED TOMOGRAPHY (CT)			
PREVIOUS CHEST CT? ☐ YES ☐ NO ☐ UNKNOWN			
DATE (YYYY/MM/DD) AND LOCATION (I.E., HOSPITAL NAME) OF PREVIOUS CHEST CTs			
1.		2.	
5. ADDITIONAL PATIENT INFORMATION: Please indicate if there is any additional information about your patient or any accommodations they may need that would be helpful for OLSP site hospital staff to be aware of (e.g., low vision, hearing loss, anxiety).			
6. REFERRING PROVIDER (OR AFFIX LABEL)			
FIRST AND LAST NAME		REGISTRATION NUMBER	
TELEPHONE NUMBER (###) ###-####	FAX NUMBER (###) ###-####	OHIP BILLING NUMBER	
I AM THIS PATIENT'S PRIMARY CARE PROVIDER ☐ YES ☐ NO (If "no," complete section 7 and if "yes," skip section 7)			
☐ This patient does not have a primary care provider			
7. PRIMARY CARE PROVIDER: Your patient's primary care provider will be copied on all communications related to their lung cancer screening activity. However, you are asked to notify your patient's primary care provider of this referral.			
FIRST AND LAST NAME		TELEPHONE NUMBER (###) ###-####	FAX NUMBER (###) ###-####
8. SIGNATURE			
If your patient is eligible for screening based on a risk assessment, by signing this form as the referring health care provider, you: • authorize the use of low-dose computed tomography (LDCT) for your patient's baseline scan, ongoing routine annual screening and follow-up of nodules, according to OLSP guidance • authorize your patient's referral for lung diagnostic assessment, if recommended by the reporting radiologist • authorize the OLSP to facilitate the booking of LDCT scans • confirm that you are responsible for ensuring appropriate follow-up of incidental findings			
SIGNATURE		DATE (YYYY/MM/DD)	



Questions?



OLSP referral form for HSN:
www.hsnsudbury.ca/neccforms



ColonCancerCheck (CCC)

DR SCOTT SHULMAN
NORTHEAST REGIONAL COLORECTAL SCREENING AND
ENDOSCOPY LEAD

Speaker Disclosure

Speaker:

Dr. Scott Shulman, Regional Colorectal Screening / GI Endoscopy Lead
Northeast Regional Cancer Program

Relationships with financial sponsors:

- Grants/research support: none
- Speakers bureau/honoraria: none
- Consulting fees: none
- Patents: none

Speaker Disclosure of Financial Support

Potential for conflict(s) of interest:

- As the Northeast Regional Colorectal Screening / GI Endoscopy Lead, Dr. Shulman receives payment from Ontario Health (Cancer Care Ontario) / Northeast Regional Cancer Program

Mitigating Potential Bias

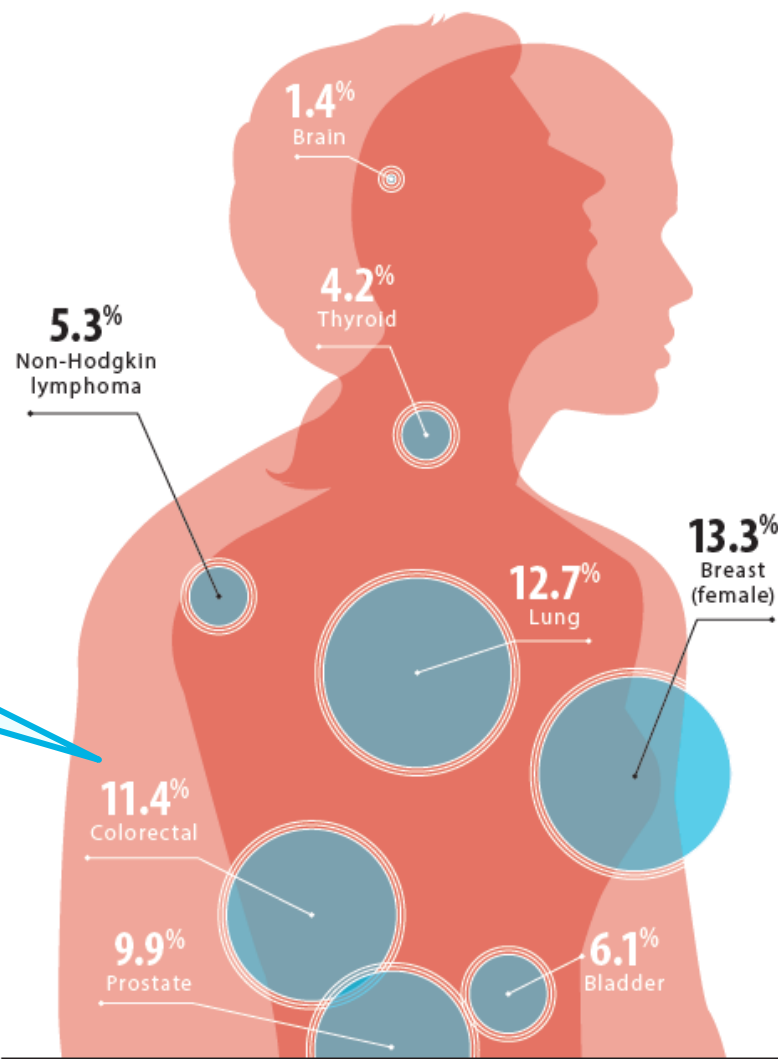
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Burden of CRC in Ontario

CRC is the third most commonly diagnosed cancer in Ontario¹

Distribution of new cases for selected cancers, 2013



Northeast Colorectal Screening Data

Overdue for Colorectal Cancer Screening (2019)

	Percentage	Numerator	Denominator
Ontario	39% ²⁰	1,774,232	4,601,272
Northeast	36% ²⁰	74,928	206,662

Percentage of Ontario screen-eligible individuals, 50-74 years old, who were overdue for colorectal screening as of Dec 31, 2019. Denominator is the total eligible count. Numerator is the total overdue count.

Northeast Colorectal Screening Backlog related to COVID-19

Ontario

Time period	Total # of FIT* kits performed
April 1, 2019 - March 31, 2020	672,406
April 1, 2020 - March 31, 2021	246,880
Difference:	325,526
% change:	-48.4%

Northeast

Time period	Total # of FIT* kits performed
April 1, 2019 - March 31, 2020	28,671
April 1, 2020 - March 31, 2021	16,255
Difference:	14,416
% change:	-43.3%



Bullet Review of the ColonCancerCheck Program

Ontario's CCC Program

- Screening offered to people ages 50–74
 - Via primary care provider (PCP)
 - **Average risk:** FIT*
 - **Increased risk** (≥ 1 first-degree relative with CRC): colonoscopy*
- FIT usability for patients
 - At-home stool sample – 1 sample only and tube designed for easier sampling
 - No dietary or medication restrictions



*Flexible sigmoidoscopy every 10 years is also an acceptable screening test

**Based on emerging evidence, CCC will be reevaluating its recommendations for those with a family history

CCC Eligibility Criteria for Participants

Average risk

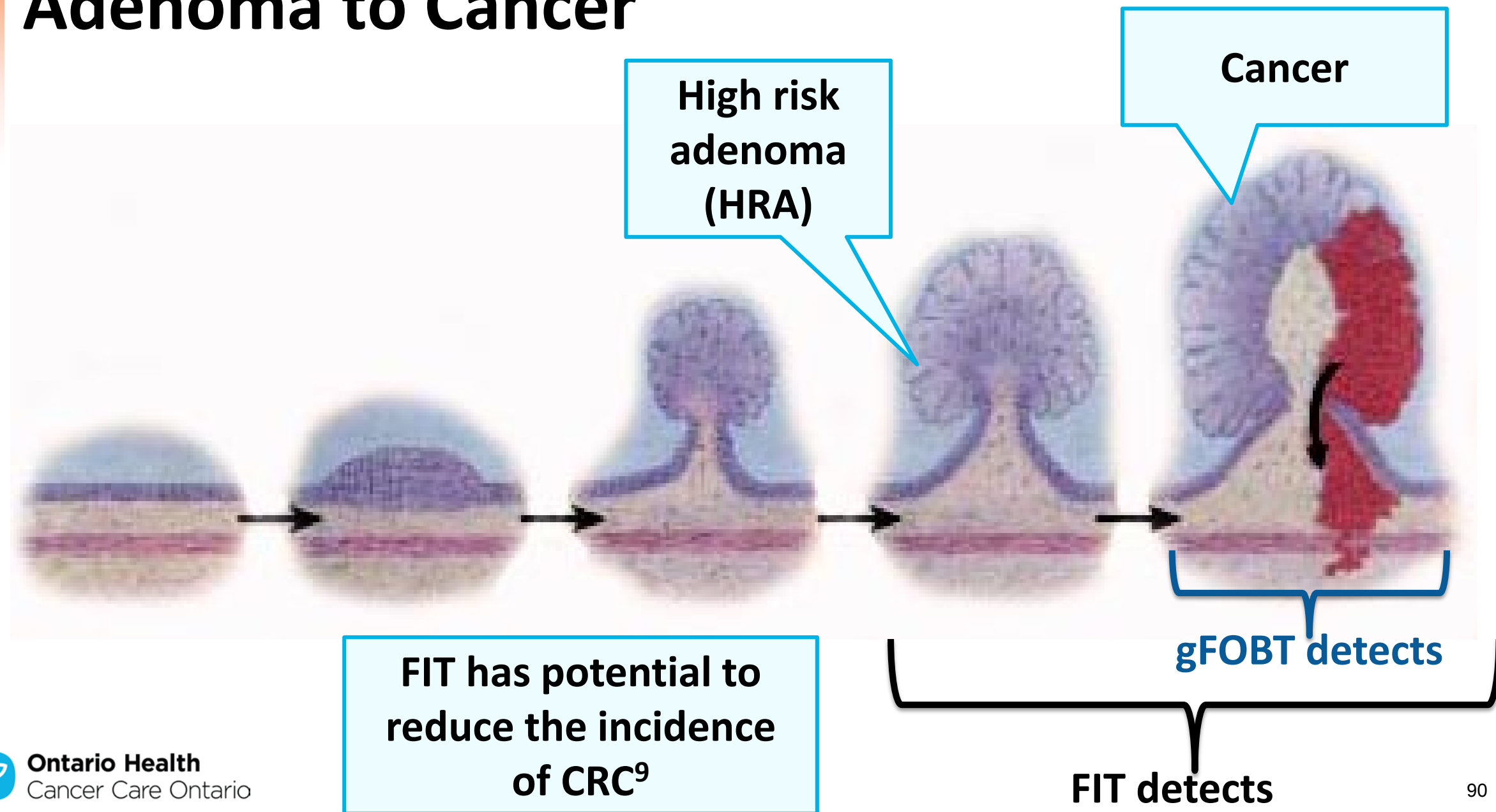


- Age 50–74
- Asymptomatic
- No first-degree relative diagnosed with CRC
- No personal history of CRC, Crohn's disease involving colon or ulcerative colitis
- No colorectal polyps needing surveillance
- Valid Ontario Health Insurance Plan (OHIP) number
- Due for screening (no FIT in the last 2 years, and no flexible sigmoidoscopy or colonoscopy in the last 10 years)

The CCC program does not recommend screening average risk people with colonoscopy



Adenoma to Cancer





Recommendations during COVID-19

Opportunities to improve the delivery of care



Limited FIT kit mailing resumes
Brief initial restart phase (weeks to month(s))



Targeted cancer screening



Routine cancer screening

ColonCancerCheck

Primary care providers should continue to follow recommendations:

- People **at average risk for colorectal cancer should be screened with FIT instead of colonoscopy**, including:
 - People age 50 or over with no first-degree relatives diagnosed with colorectal cancer
 - People with a family history of colorectal polyps
 - People with a history of small hyperplastic polyp(s) in the recto-sigmoid colon or low risk adenomas only at a prior colonoscopy

Send FIT requisitions for

- All eligible people at average risk for CRC

Refer to colonoscopy

- People with abnormal FIT results
- All eligible people at increased risk for CRC
- All eligible people for post-polypectomy surveillance



Opportunities to improve the delivery of care

- Only screen people who are due for colorectal cancer screening:
 - People who have had a colonoscopy or flexible sigmoidoscopy in the previous 10 years or a fecal test in the last two years are not due for colorectal cancer screening and have limited benefit from early re-screening
 - People with a first-degree relative who was diagnosed with colon cancer before age 60 are due for screening with colonoscopy every 5 years, starting 10 years earlier than the age their relative was diagnosed with colorectal cancer
 - People with a first-degree relative who was diagnosed with colorectal cancer at age 60 or older are due for screening with colonoscopy every 10 years, starting at age 50





CRC Screening and Endoscopy Best Practice Recommendations

Ordering FIT for Patients

- Requisition expires 6 months after the FIT kit has been mailed
- Supports patients who opt for a different preferred FIT mailing address
- LifeLabs mails the FIT kit within 2 days of receiving a complete FIT requisition
- Once mailed from LifeLabs, most patients can expect to receive their FIT kit from Canada Post within 5 to 10 days (standard local mail)



Fecal Immunochemical Test (FIT) Requisition – For Colorectal Cancer Screening

Form Completion Fee Code Q150

LifeLabs®

Eligibility Criteria:

- Age 50 to 74
- Asymptomatic
- No personal history of colorectal cancer, Crohn's disease involving the colon or ulcerative colitis
- No first-degree relative diagnosed with colorectal cancer
- No colorectal polyps needing surveillance
- Due for screening (no FIT in the last two years, and no flexible sigmoidoscopy or colonoscopy in the last 10 years)
- Valid Ontario Health Insurance Plan (OHIP) number

Note:

- Do not use for the workup of patients with overt GI bleeding and/or anemia.
- ColonCancerCheck does not recommend routine screening for people over 74 years. Decisions to screen those between the ages of 75 to 85 years should include an assessment of risks and benefits, and take into consideration health, life expectancy, and prior screening history. It is not appropriate to screen people over 85 years of age.

Lab Use Only

☐ Check box if patient requires a new FIT kit (i.e., FIT was lost, damaged, or not received) and complete this form. Call LifeLabs for more questions: 1-833-676-1426

All sections on this form must be accurate and complete. Fax the requisition to 1-877-308-3333.

1. Requester Information

Requester Type (check one):
☐ Physician ☐ Mobile Coach
☐ Nurse Practitioner ☐ Telehealth Ontario

Mobile Coach ID: CPSO or CNO Number: OHIP Billing Number:

Last Name: Middle Name (optional): First Name:

Office Address: Office Phone Number: ()

City: Province: Postal Code: Fax Number: ()

Copy to: Physician/Nurse in Charge for Nursing Stations. If the same as Requester, do not complete this section.

Last Name: Middle Name (optional): First Name:

Office Address: Office Phone Number: ()

City: Province: Postal Code: Fax Number: ()

2. Patient Information (Letters and other correspondence will be sent to the Patient Address)

Last Name (on OHIP card): OHIP card, optional: First Name (on OHIP card):

Date of Birth (on OHIP card: yyyy/mm/dd): OHIP Version: Sex: ☐ Male ☐ Female

Patient Address: Primary Phone Number: () Ext. (optional):

City: Province: Postal Code: Cell Phone Number (optional, if not primary number): () Type: ☐ Work ☐ Home ☐ Cell

3. FIT Kit Mailing Address (for patients who prefer to have their kit mailed to a different address within Ontario)

FIT Kit Mailing Address:

Facility Name (if applicable): Primary Phone Number: () Type: ☐ Work ☐ Home ☐ Cell

City: Province: Ontario Postal Code: Ext. (optional):

4. Requester Verification

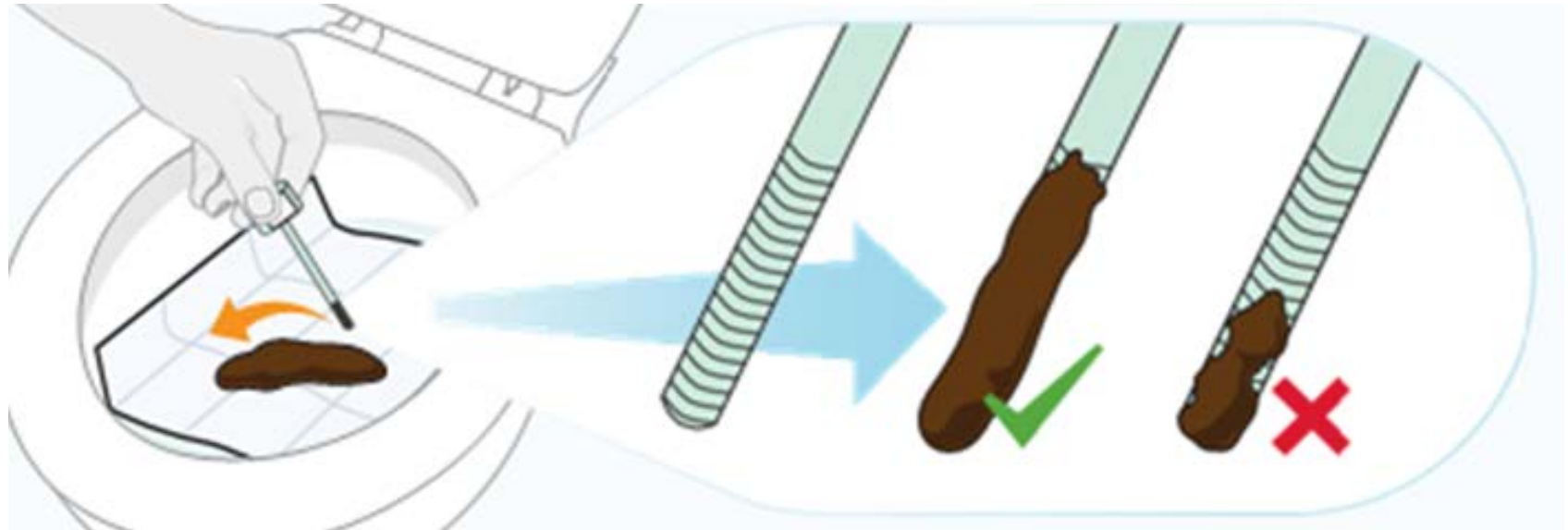
Requester Signature: Date: yyyy/mm/dd

Need this information in an accessible format? 1-855-460-2647, TTY 416-217-1815 publicaffairs@cancercare.on.ca

Ontario
Cancer Care Ontario

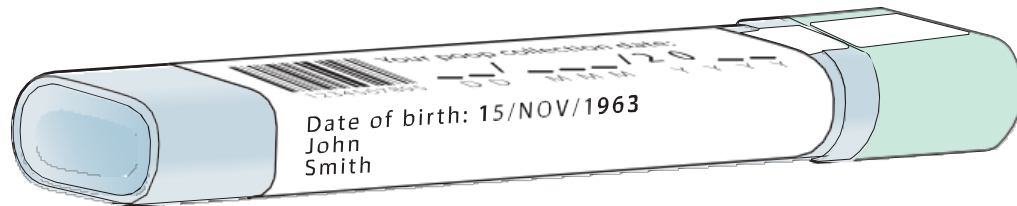
Reduce Rejected FIT Kits

- Remind patients that the stool should cover all of the grooves at the end of the stick, but that the stool should not go past the grooves on the stick

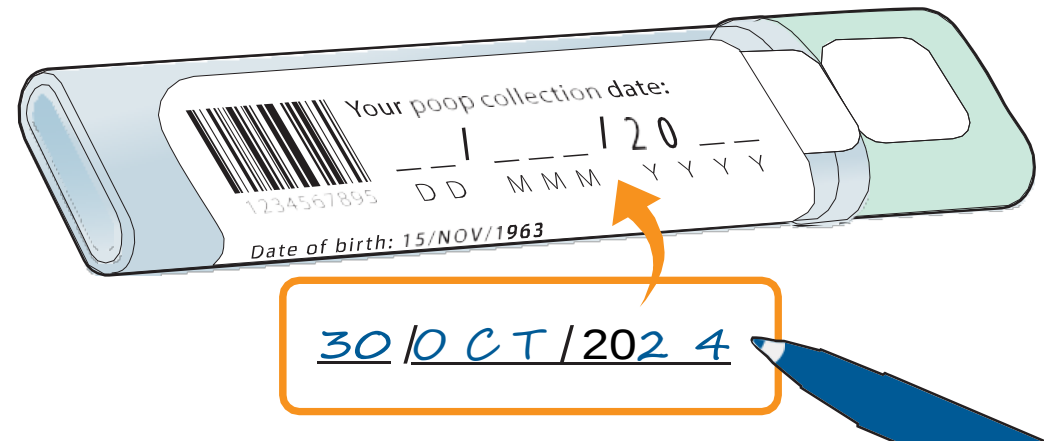


Reduce Rejected FIT Kits

- The CCC program recommends that participants mail or drop-off their test as soon as possible, **ideally within 2 days**, to ensure it arrives to lab within 14 days of specimen collection
- Returned specimens are often missing the collection date



✓ Date of birth ✓ Your name



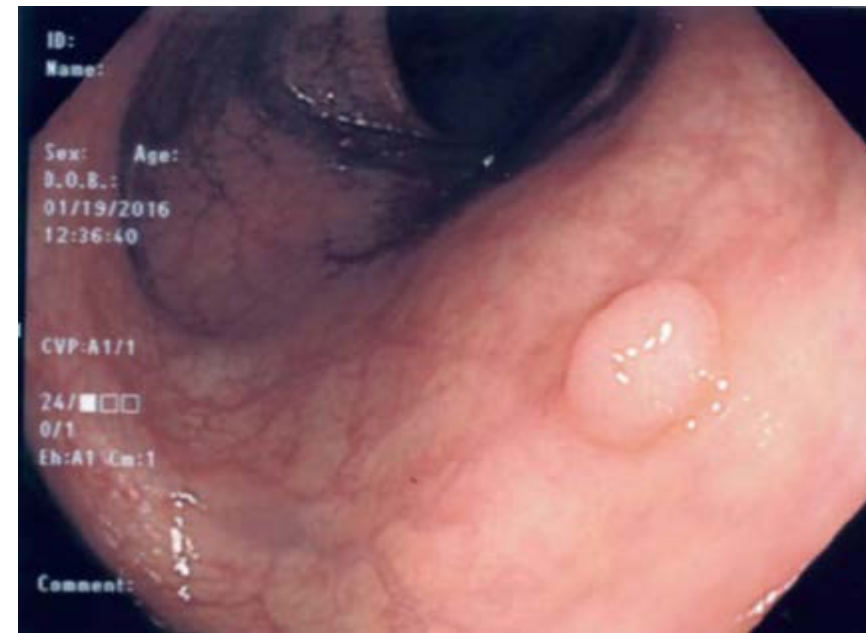
Results are invalid if LifeLabs is unable to confirm the collection date and the result is below the positivity threshold



Time to Colonoscopy After FIT+ ⁸	% of CRC Cases Receiving Colonoscopy After FIT+ ⁸	
	Any CRC	Advanced-Stage CRC
8–30 days	2.97%	0.81%
2 months	2.78%	0.70%
3 months	3.06%	0.69%
4–6 months	3.14%	0.88%
7–12 months	4.56%*	1.49%^
>12 months	7.55%**	3.13%^^^

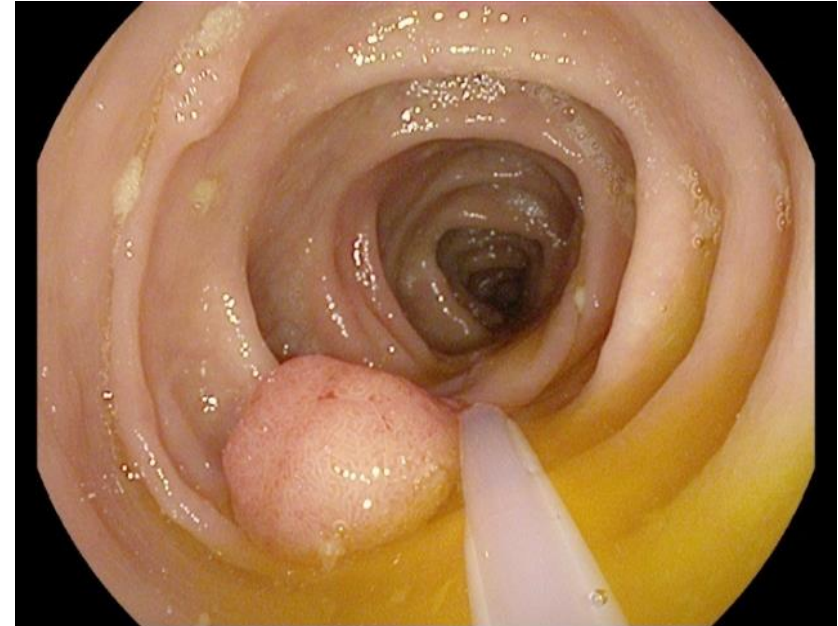
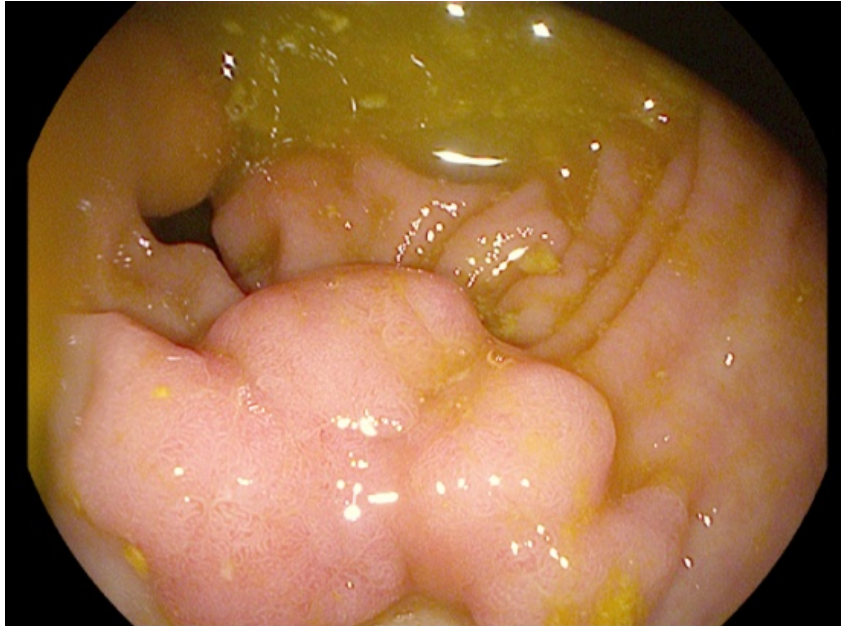
Low Risk Adenomas (LRAs)

- 1–2 tubular adenomas <10 mm in diameter with no high-grade dysplasia



High Risk Adenomas (HRAs)

- Tubular adenoma ≥ 10 mm, adenoma with villous histology or adenoma with high-grade dysplasia
- This also includes people with 3 or more LRAs



ColonCancerCheck (CCC)

Recommendations for Post-Polypectomy Surveillance

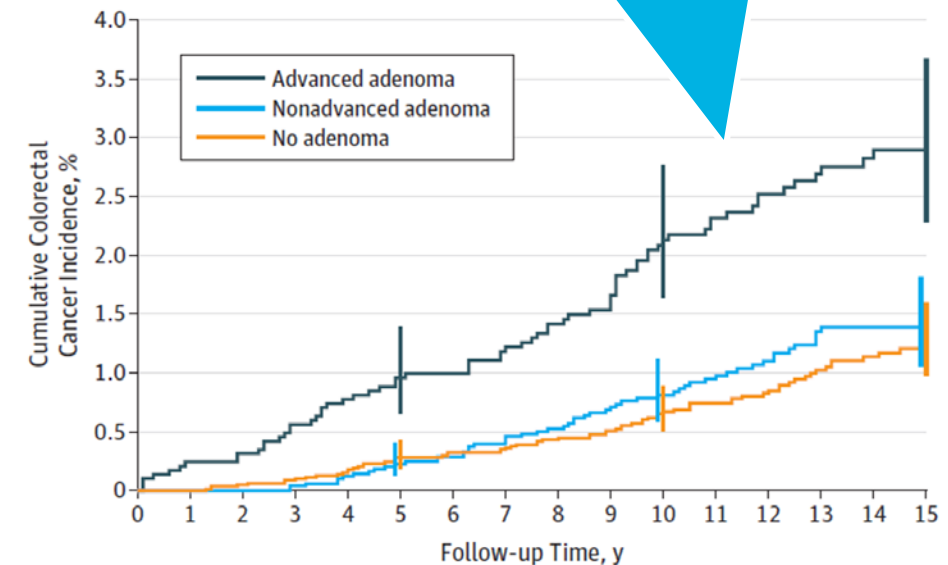
Initial colonoscopy			Subsequent colonoscopy		
Findings	Next test ¹	Time until next test	Findings	Next test ¹	Time until next test
No polyps Hyperplastic polyp(s) in rectum or sigmoid	FIT*	10 years	Not applicable		
Low risk adenoma(s) ²	FIT*	5 years	Not applicable		
High risk adenoma(s) ²	Colonoscopy	3 years	No polyps, hyperplastic polyp(s) in rectum or sigmoid, or low risk adenoma	Colonoscopy	5 years
			High risk adenoma(s)	Colonoscopy	3 years
>10 adenomas	Clearing colonoscopy ³	≤1 year	<3 years at endoscopist discretion ³		
Any sessile serrated adenoma(s) <10 mm without dysplasia	Colonoscopy	5 years	At endoscopist discretion ⁴		
Sessile serrated adenoma(s) ≥10 mm Sessile serrated adenoma(s) with dysplasia Traditional serrated adenoma	Colonoscopy	3 years			
Large sessile polyp removed piecemeal	Colonoscopy to check polypectomy site	≤6 months			
Serrated polyposis syndrome ²	Colonoscopy	1 year	1-2 years at endoscopist discretion		

Risk of CRC and CRC Mortality After Colonoscopy

Only people with HRAs have increased risk of CRC and of CRC death¹⁶

Among people with LRAs (non-advanced):¹⁶

- No difference in CRC risk compared to those with normal colonoscopy (Relative Risk [RR], 1.2 [95% CI, 0.8–1.7]; P=0.30)
- No difference in mortality risk compared to those with normal colonoscopy (RR, 1.2 [95% CI, 0.5–2.7], P=0.68)

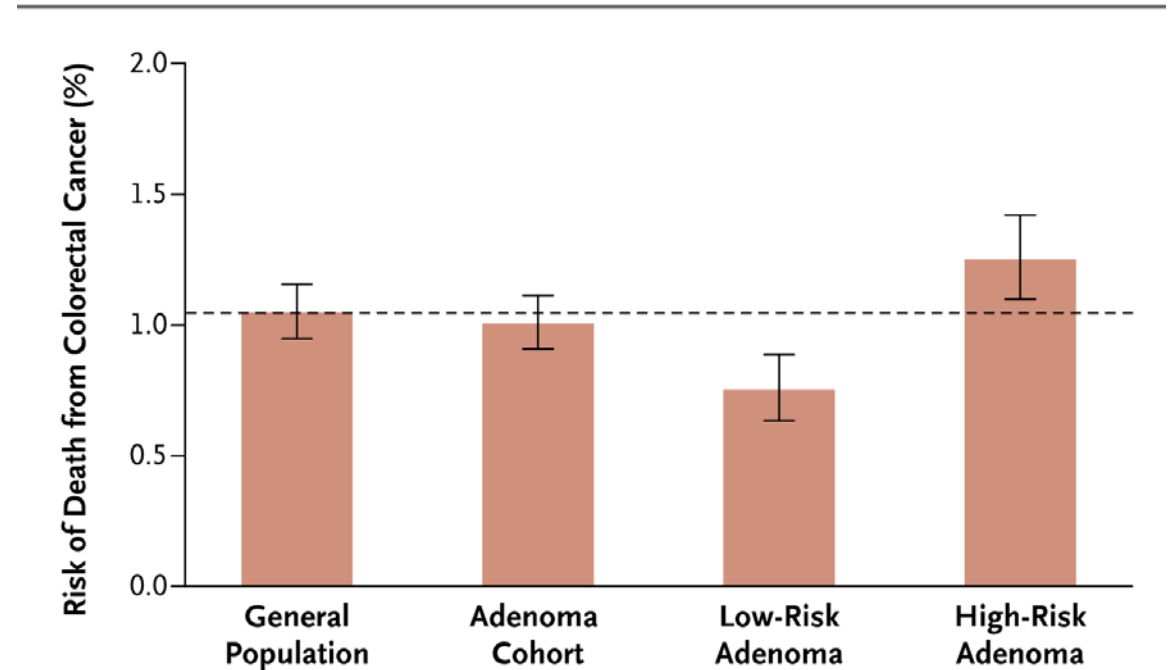


No. at risk								
Advanced adenoma	2882	2836	2756	2656	2480	2187	1812	1294
Nonadvanced adenoma	5068	4993	4879	4696	4393	3753	2949	2082
No adenoma	7985	7898	7730	7445	6955	5734	4294	2964

Risk of CRC Death by Adenoma Type

Among people with LRAs:¹⁷

- Risk of death from CRC is 25% lower compared to the general population
- Standardized mortality ratio = 0.75 (95% CI: 0.63–0.88)



Surveillance is not required for people with LRAs



Post-Polypectomy Surveillance in People With a Family History of CRC

- The recall interval following a normal colonoscopy for people with a family history of CRC (i.e., a first-degree relative with the disease) should be based on family history or surveillance recommendations, whichever recall interval is shortest
- For example, if a patient's colonoscopy is normal and they have a family history of CRC, the recommendations are to repeat colonoscopy*:
 - **Every 5 years** if their first-degree relative with CRC was diagnosed at **<60 years old**
 - **Every 10 years** if their relative was diagnosed at **≥60 years old**



Questions?



Provider Tools to Support Cancer Screening

DR ELAINE INNES
NORTHEAST REGIONAL INDIGENOUS CANCER
LEAD (NORTH)

Speaker Disclosure

Speaker:

Dr. Elaine Innes, Regional Indigenous Cancer Lead

Northeast Regional Cancer Program

Relationships with financial sponsors:

- Grants/research support: none
- Speakers bureau/honoraria: none
- Consulting fees: none
- Patents: none

Speaker Disclosure of Financial Support

Potential for conflict(s) of interest:

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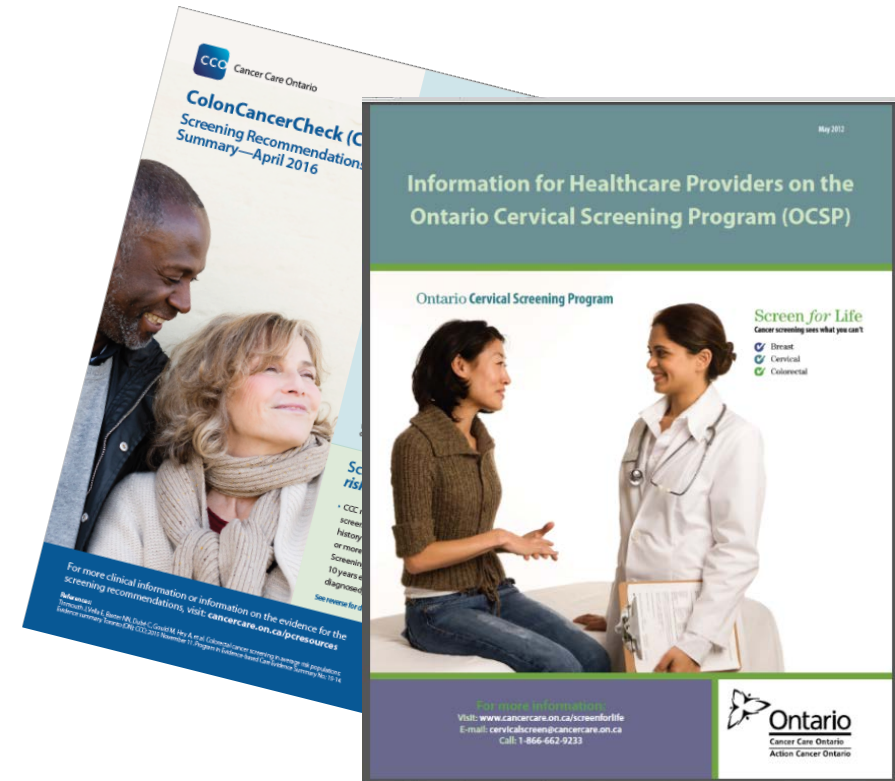
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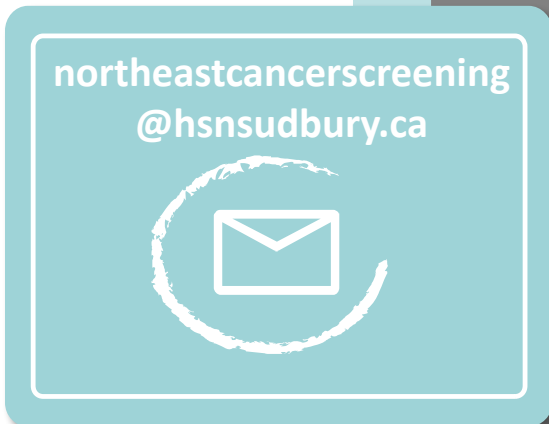
Provider Tools to Support Cancer Screening

- Cancer Care Ontario develops provider tools about:
 - Evidence-informed recommendations for all cancer screening programs
 - Emerging issues/evidence

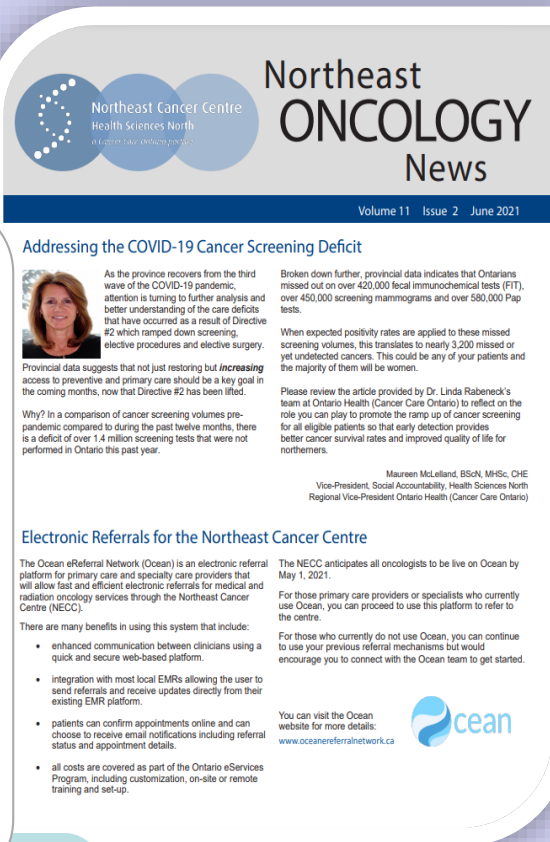
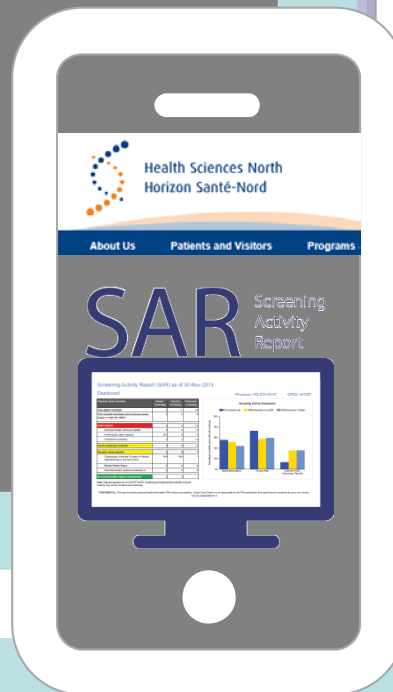


www.cancercareontario.ca/pcresources

NE Provider Tools to Support Cancer Screening



www.hsnsudbury.ca/NECCprimarycareresources

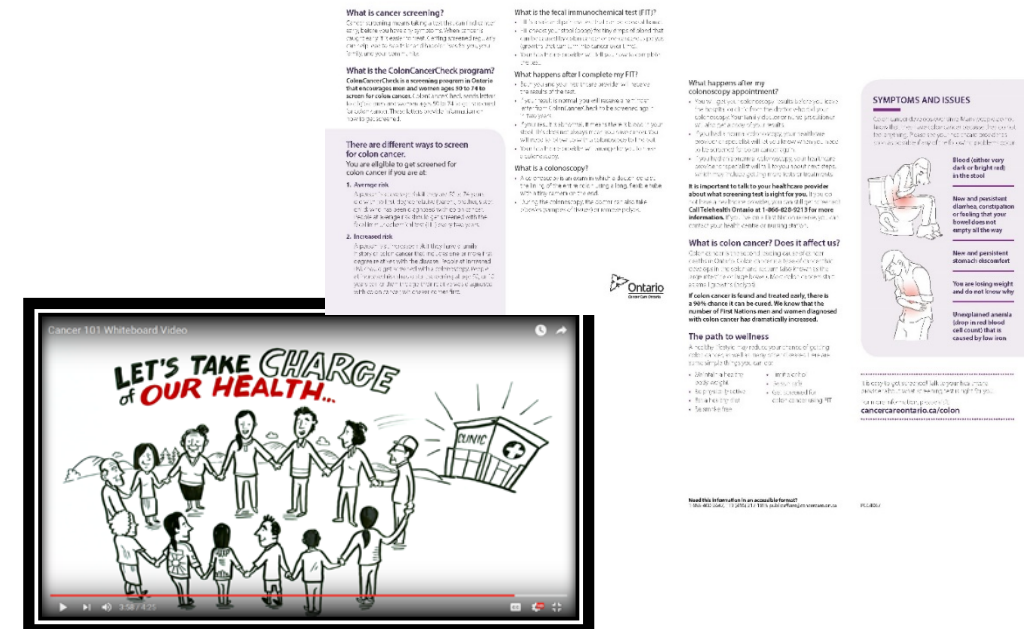


First Nations, Inuit, Métis and Urban Indigenous People

- Northeast Indigenous Cancer Video Series
 - 5 videos on cancer screening programs and NECC services by NE RICL



- NECC Indigenous Patient Navigator
- Cancer Screening Toolkit supports conversations between Indigenous peoples and PCPs about cancer and cancer screening
- Cancer screening fact sheets
- Cancer 101 Whiteboard video provides information on cancer screening



Unattached Patients

- Unattached patients can contact Telehealth Ontario or a mobile coach (where available) to request a FIT kit
- Physicians can register to accept unattached patients who require follow-up or who have self-identified as being at increased risk for developing CRC due to their family history

ColonCancerCheck

Physician Registration for Patient Attachment

Upon completion, please fax or email this form to: 416-971-6888 or screenforlife@cancercare.on.ca

As part of the ColonCancerCheck program, unattached patients (those without a primary care provider) can be screened for colon cancer, for example, by contacting Telehealth Ontario. Unattached patients with an abnormal result need to connect with a primary care provider for appropriate follow-up. By providing the information below, you are indicating you are willing to accept new patients to your primary care practice from the ColonCancerCheck program as of the date of form completion. You can remove your name from the referral list at any time by calling 1-866-662-9233. Please note, if you are a patient enrolment model (PEM) physician and you roster patients referred from Cancer Care Ontario to your practice, you can claim the Q043A New Patient Fee, for FOBT Positive/ Colorectal Cancer Increased Risk.

Personal information on this form, such as sex, is collected under the authority of the Cancer Act and will be used to attach patients to you. Questions about this collection should be directed to primarycareinquiries@cancercare.on.ca

Asterisk (*) indicates mandatory fields

*Physician's First Name: _____ *Physician's Last Name: _____

*Sex: ☐ Male ☐ Female *Languages Served: ☐ English ☐ French ☐ Other: _____

Billing Number: _____ CPSO Number: _____

Organization Name: _____

Practice Model Type:

☐ Community Health Centre	☐ Rural Northern Physician Group Agreement
☐ Family Health Group	☐ Comprehensive Care Model
☐ Family Health Network	☐ Non-PEM Primary Care Provider
☐ Family Health Organization	☐ Other

Please include the requested information for all locations from which you practice and are willing to accept new patients as part of the ColonCancerCheck program.

Practice Location #1	Practice Location #2
*Address Line 1: _____	*Address Line 1: _____
*Address Line 2: _____	*Address Line 2: _____
*City: _____	*City: _____
*Prov: ON	*Prov: ON
*Postal Code: _____	*Postal Code: _____
*Phone Number: _____	*Phone Number: _____
*Fax Number: _____	*Fax Number: _____
Email Address: _____	Email Address: _____
*Physician Signature: _____	*Date: _____



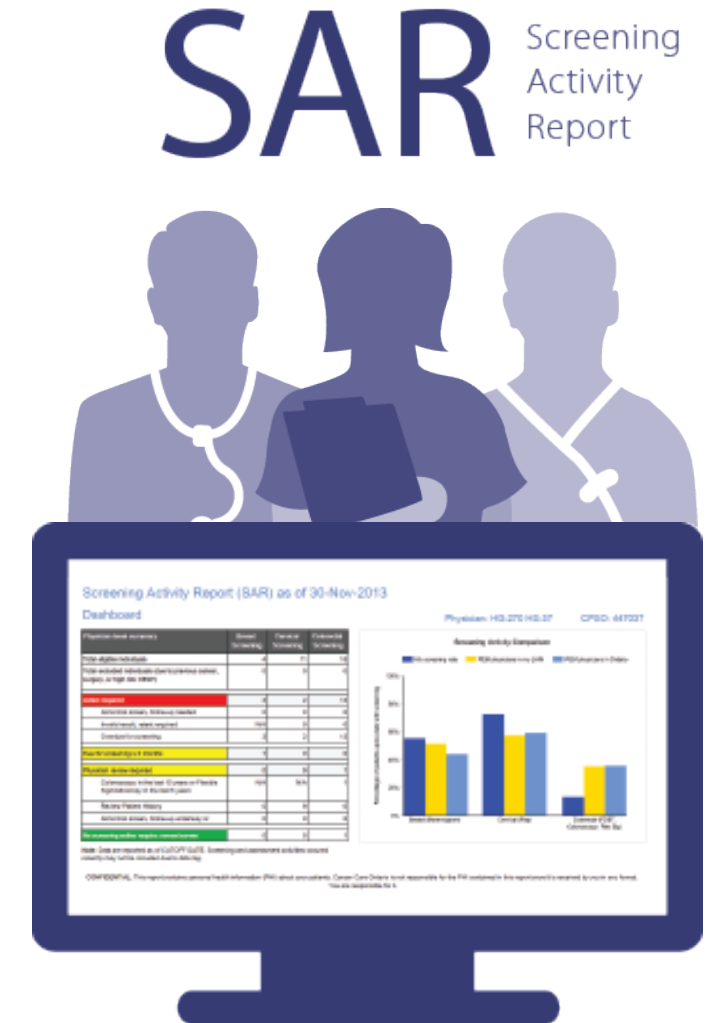
Public Correspondence (Screening Letters)

- Initiative to help increase screening rates by sending personalized letters to eligible Ontarians:
 - Inviting them to get screened for breast, cervical and colorectal cancer
 - Reminding them when it is time to get screened again (recalls)
 - Informing them of their screening test results



Screening Activity Report (SAR)

- Supplementary online tool to help patient enrolment model (PEM) physicians improve their cervical, breast and colorectal cancer screening rates, and appropriate follow-up
- Reports are interactive, updated monthly and can be downloaded to PDF and Excel



How Do Physicians Access the SAR?

- The SAR is accessible online to PEM physicians and their delegates (e.g., designated office staff) who have registered for eHealth Ontario's ONE®ID
- Users must register with a Local Registration Authority (LRA) to get a ONE®ID (LRAs are available through Ontario Health (Cancer Care Ontario) and the Regional Cancer Programs)
 - Users are assigned a username and password that provide them with access to the SAR
- Assistance to sign-up for the SAR is available from the Northeast Regional Cancer Program



COVID Recovery Campaign

- The Ministry of Health (MOH) is supporting a one-time expansion of the materials to support COVID-19 recovery and increase cancer screening volumes
- MOH will also launch a public campaign for cancer screening
- A toolkit with resources is available to support health care providers and staff, regional cancer programs and Ontario Health regions in cancer screening public awareness efforts.
 - Includes: key messages; phone scripts; newsletter content; waiting room screen slides & screen savers; social posts and graphics

Available for download at:
cancercareontario.ca/cancer-screening-regional-resources-hub
 OR
 contact: northeastcancerscreening@hsnsudbury.ca

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Ontario Health
Cancer Care Ontario

Are you overdue?



Cervical cancer is almost always preventable.

bΔ² f_aC∇²Cb¹ L⁴PPΔσσΔ¹
 C⁵qΔσ¹ bΔfN∇²Cd¹Δ⁻ Cb¹
 Λf^ubΔσ¹ Δf⁸Δd¹Δσσ ΔL Δ¹
 Γ_ΔΔσ¹ Δf⁸Δd¹Δa² ΛJf_qΔ¹



Ontario Health
Cancer Care Ontario

Leaving a message: This is *insert name* from *insert doctor's name or office*. I am overdue/due for your colorectal cancer screening test, called a FIT test. It is important because it can find cancer early when treatment has a better chance of working. *insert name* would like to order you a FIT test to screen for colorectal cancer. The

Patient Available: I'm calling today to let you know that we noticed that colorectal cancer screening test, called a FIT test. Regular cancer screening cancer early when treatment has a better chance of working. *insert doctor's name* FIT test to screen for colorectal cancer. This test will be sent you to direct To have the test sent you, I will need you

ents eligible* for the O
(OBSP)

Eligibility criteria

...from *insert doctor's name or office* for screening test, or mammogram. Regular treatment has a better chance of working at the earliest convenience to discuss getting

Patient Available: I'm calling today to let you know that we noticed you have not had a breast cancer screening test, or mammogram. Regular cancer screening is important because it can find a breast lump early when treatment has a better chance of working. You do not need a doctor's referral to get a mammogram. To book your mammogram, please call *insert local/preferred OBSP site (a) (6) booking phone number: 1-800-668-9304*. Or you can visit cancercentre.on.ca to book your screening site and get more information about the Ontario Breast Screening Program.

116



Questions & Discussion: Ask the Leads

Moderator: Dr. Jason Sutherland

OCSP: Dr. Jennifer Jocko

CCC: Dr. Scott Shulman

OBSP: Dr. Supriya Kulkarni

OLSP: Dr. Erin Peltier

Resources: Dr. Elaine Innes

How to reach us:

northeastcancerscreening@hsnsudbury.ca



Please remember to complete your evaluation and obtain your certificate of attendance. The link is in the chat box or can be accessed using this QR code.