



CANADIAN
PARTNERSHIP
AGAINST CANCER



Colorectal Cancer Screening in Canada

ENVIRONMENTAL SCAN

Version 1.1

Last updated January 13, 2021

2019 - 2020

Background

The Canadian Partnership Against Cancer collects information on national, provincial and territorial colorectal screening guidelines, strategies and activities.

This environmental scan summarizes the data collected from provincial and territorial screening programs and is intended to provide information to inform provincial/territorial decision-making for policy and practice.

The information for this environmental scan was collected in June and July 2019. All provinces and territories responded to the environmental scan. Many provinces and territories provided updated data in early 2020. Due to the COVID-19 pandemic, some of the included data was not vetted by provincial and territorial screening programs prior to publication.

Acknowledgements

Production of this environmental scan has been made possible through financial support from Health Canada. The views expressed herein do not necessarily represent the views of Health Canada.

The Canadian Partnership Against Cancer would like to gratefully acknowledge the provinces and territories for their contribution of data extraction and submission.

Suggested citation: Canadian Partnership Against Cancer. Colorectal Screening in Canada: 2019/2020 Environmental Scan. Toronto, ON: Canadian Partnership Against Cancer; 2020.

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Key Highlights – 2019-2020

- ◆ There are organized colorectal screening programs in one territory and nine provinces.
- ◆ Northwest Territories, Nunavut and Québec do not currently have organized colorectal screening programs; however, Nunavut is currently implementing a territory-wide program and plans are underway to develop provincial/territorial programs in Northwest Territories and Quebec.
- ◆ All provinces and territories screen asymptomatic individuals at average risk of developing colorectal cancer between the ages of 50 and 74 or 75 every 12-30 months with a fecal test (FT), either the guaiac fecal test (FTg) or fecal immunochemical test (FIT).
- ◆ One province offers FTg as an entry level test for their colorectal screening program. All other provinces and three territories offer FIT as an entry level test.
- ◆ Individuals who have an abnormal fecal test are notified of their result and invited for follow-up with a diagnostic colonoscopy. Primary care providers are often responsible for coordinating follow up. Some jurisdictions have coordinated systems in which a program administrator, nurse navigator or patient coordinator contacts the participant to schedule a colonoscopy.
- ◆ Screening of people at increased risk is facilitated on an individual basis by a person's health provider and dependent on their specific risk factors. Individuals at increased risk may be screened differently than individuals at average risk and are often screened outside of organized programs.
- ◆ Nine provinces and three territories have implemented strategies to increase participation in colorectal screening among First Nations, Inuit and Métis populations.
- ◆ Six provinces and two territories have implemented strategies to increase participation in colorectal screening among underscreened populations.

Canadian Strategy for Cancer Control, 2019-2029

Since its launch in 2006, the Canadian Strategy for Cancer Control (the Strategy) has helped reduce the burden of cancer on Canadians—serving as a powerful tool for change and improvement. However, the cancer landscape has changed significantly since the Strategy was first developed, presenting new opportunities as well as new challenges. In 2019, the Canadian Partnership Against Cancer (the Partnership) released the refreshed [Canadian Strategy for Cancer Control](#) – a 10-year roadmap to improve equity in the cancer system and to deliver world-class cancer care to all Canadians, while focusing on a sustainable healthcare system for the future.

As steward of the Strategy, the Partnership has led the modernization and renewal process. The Partnership engaged with Canadians across all provinces and territories, to learn about how cancer affects their lives and what they want from their national cancer strategy. While the Strategy's vision remains as relevant today as it was a decade ago, the priorities and actions have been modernized and refreshed to ensure they continue to guide our collective efforts in the years ahead.

The refreshed Strategy is a visionary and ambitious plan for the cancer and broader health system. Building on its already robust foundation, the refreshed Strategy provides a focused set of priorities and actions that will address the current and persistent challenges in delivering quality care.

Figure 1. Canadian Strategy for Cancer Control Priority 2



PRIORITY 2

Diagnose cancer faster, accurately and at an earlier stage



Action 2: Strengthen existing screening efforts and implement lung cancer screening programs across Canada

Figure 2. Canadian Strategy for Cancer Control Priority 4



PRIORITY 4

Eliminate barriers to people getting the care they need



Action 1: Provide better services and care adapted to the specific needs of underserved groups






Action 2: Ensure rural and remote communities have the resources required to better serve their people

The Strategy calls for the cancer community to continue focusing on the effectiveness of existing screening programs. This includes continuing measures to ensure the right people are getting screened at the right time using the recommended methods, and eliminating barriers to participation in screening, particularly in underscreened communities. Patients in rural and remote communities often need to travel to urban centres to access screening and follow-up services. While not all services and treatments can be located in all communities, the Strategy calls for the adoption of innovations and enablers that allow cancer care to be provided closer to home. For these communities, proven strategies such as self-sampled fecal tests for colorectal cancer should be pursued and expanded.^{1,2}

First Nations, Inuit and Métis continue to experience poorer cancer outcomes than other people in Canada, and face inequities and barriers in accessing care (especially culturally appropriate care).^{3,4,5,6,7} Some of the challenges are similar to the burden experienced by other underserved, remote, rural and isolated communities in Canada; however, there are historical and contemporary realities that amplify those challenges experienced by First Nations, Inuit and Métis. Priorities identified and the actions required are Peoples-specific and represent what the Partnership heard through engagement processes. These priorities and actions are an important element of the refreshed Strategy.

Figure 3. Canadian Strategy for Cancer Control First Nations, Inuit, and Métis Priorities

| | FIRST NATIONS | INUIT | MÉTIS |
|--|--|---|--|
| <p>PRIORITY 6 Culturally appropriate care closer to home</p>  | <ol style="list-style-type: none"> 1 Recognize and reflect the First Nations holistic approach to health and wellness. 2 Recognize and eliminate the impacts of racism within the system. 3 Provide equitable access to basic health supports and cancer services. 4 Provide more services closer to home and improve the journey for those who must travel to access care. 5 Improve understanding of cancer and the cancer journey. | <ol style="list-style-type: none"> 1 Provide equitable access to cancer services closer to home. 2 Improve travel policies. 3 Incorporate Inuit holistic approaches to health and wellness in cancer care. 4 Recognize and eliminate racism within the system. 5 Improve access to basic health supports. 6 Improve understanding of cancer and the cancer journey. | <ol style="list-style-type: none"> 1 Provide equitable access to resources, programs and care across the cancer continuum. 2 Create a holistic system that is responsive to Métis culture. 3 Recognize and eliminate racism within the system. 4 Improve access to basic health supports. 5 Improve understanding of cancer and the cancer journey. |
| <p>PRIORITY 7 Peoples-specific, self-determined cancer care</p>  | <ol style="list-style-type: none"> 1 Design and deliver First Nations-determined programs and services. 2 Reduce jurisdictional barriers. 3 Improve communication, navigation and coordination across the system. | <ol style="list-style-type: none"> 1 Design and deliver Inuit-driven programs and services. 2 Improve coordination and navigation of care. | <ol style="list-style-type: none"> 1 Design and deliver Métis-determined programs and services. 2 Reduce jurisdictional barriers and improve communication, navigation, and coordination. |
| <p>PRIORITY 8 First Nations-, Inuit-, or Métis-governed research and data systems</p>  | <ol style="list-style-type: none"> 1 Collect First Nations-specific data and set First Nations-specific indicators and targets. 2 Invest in First Nations research capacity. 3 Implement First Nations governance of the collection and use of data and research. | <ol style="list-style-type: none"> 1 Collect and report on Inuit-specific data. 2 Determine impact of environmental contamination on Inuit health, specifically cancer risk. | <ol style="list-style-type: none"> 1 Collect Métis-specific data and develop Métis-determined indicators and outcomes. 2 Invest in Métis research capacity. |

Executive Summary

Organized colorectal screening programs are available in Canada to individuals who are asymptomatic (no signs or symptoms of colorectal cancer present) and at average risk for colorectal cancer. Currently, there are organized colorectal screening programs in one territory and nine provinces ([Table 1](#)). Northwest Territories, Nunavut and Québec do not currently have organized colorectal screening programs; however, Nunavut is currently developing a territory-wide program and plans are underway to develop provincial/territorial programs in Northwest Territories and Québec. Where organized screening programs are not available, screening services are provided opportunistically through a primary care provider.

All provinces and territories screen asymptomatic individuals at average risk of developing colorectal cancer between the ages of 50 and 74 or 75 every 12-30 months with a fecal test (FT), either the guaiac fecal test (FTg) or fecal immunochemical test (FIT). One province offers FTg as an entry level test for their colorectal screening program, and all other provinces and territories offer FIT as an entry level test ([Table 2](#)).

Organized colorectal screening programs administer recruitment, reminder and promotional strategies to invite eligible individuals to screen as per guidelines. Recruitment strategies and methods vary across the country and may include primary care provider referral, self-referral or mailed invitation letters ([Table 3](#)). Reminders in the form of letters are sometimes sent to eligible individuals to help increase screening participation rates ([Table 4](#)).

Individuals who have an abnormal fecal test are notified of their result and invited for follow-up with a diagnostic colonoscopy. PCPs are often responsible for coordinating follow up. Some jurisdictions have coordinated systems in which a program administrator, nurse navigator or patient coordinator contacts the participant to schedule a colonoscopy ([Table 12](#)). For individuals at increased risk, screening often occurs outside of organized program and is facilitated on an individual basis by a person's health provider. Most provinces and territories recommend screening for individuals at increased risk starting at age 40 or 10 years earlier than the participant's youngest relative's age at diagnosis, with colonoscopy every 5 or 10 years (outside of the population-based screening program) ([Table 17](#)).

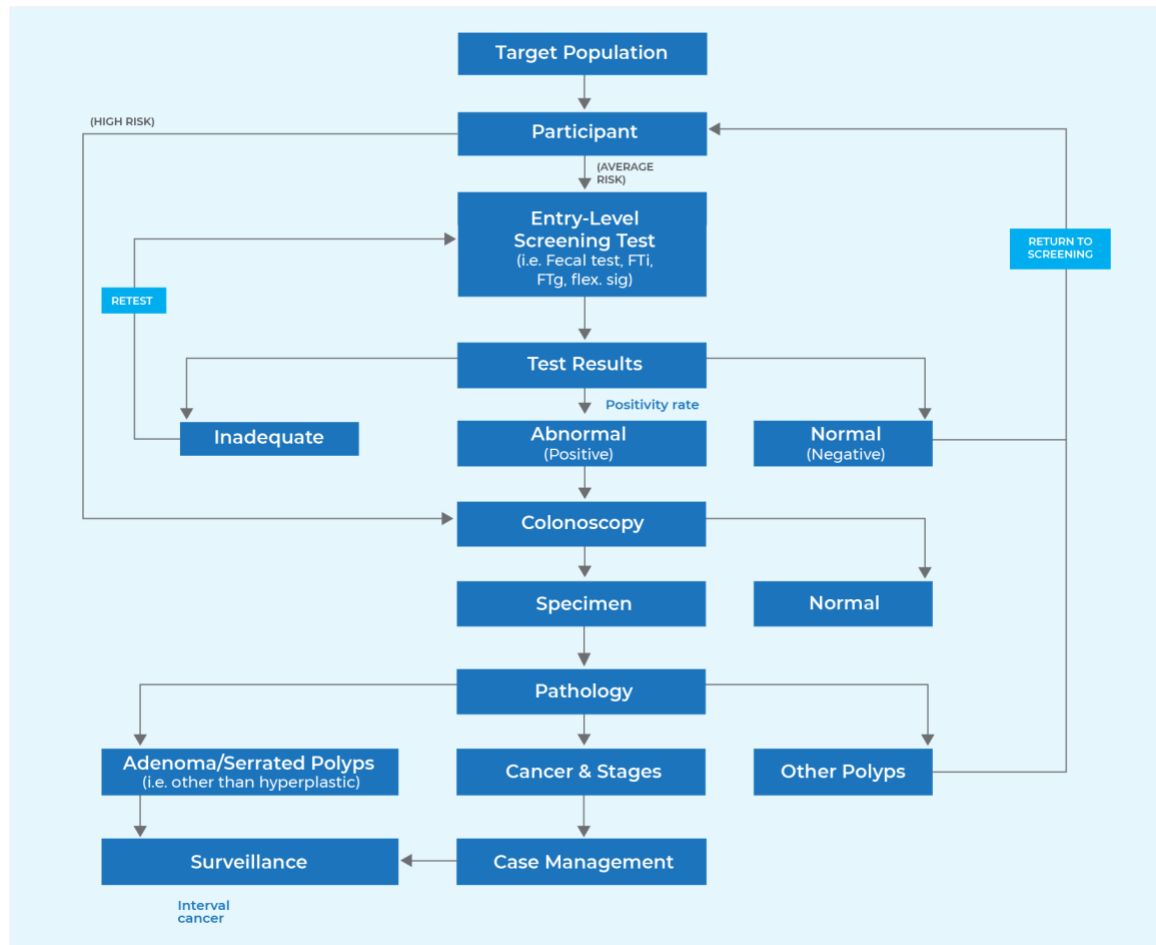
Canadian jurisdictions are engaging with First Nations, Inuit and Métis in decision making and informing approaches to culturally appropriate screening, and program resources specific to First Nations, Inuit, and Métis. Jurisdictions are also engaging with healthcare providers working directly with First Nations, Inuit, and Métis communities (see [Population Outreach - First Nations, Inuit and Métis](#) section).

Six provinces and two territories have implemented strategies to help address participation among underscreened populations (see [Population Outreach – Underscreened Populations](#) section). These strategies aim to increase colorectal screening participation among individuals in rural communities, new immigrants and low-income individuals.

1. Colorectal Screening Programs and Guidelines

1.1 Colorectal Screening Pathway

Figure 4. Colorectal Screening Pathway^{8*}



Organized screening for colorectal cancer in Canada involves four steps:

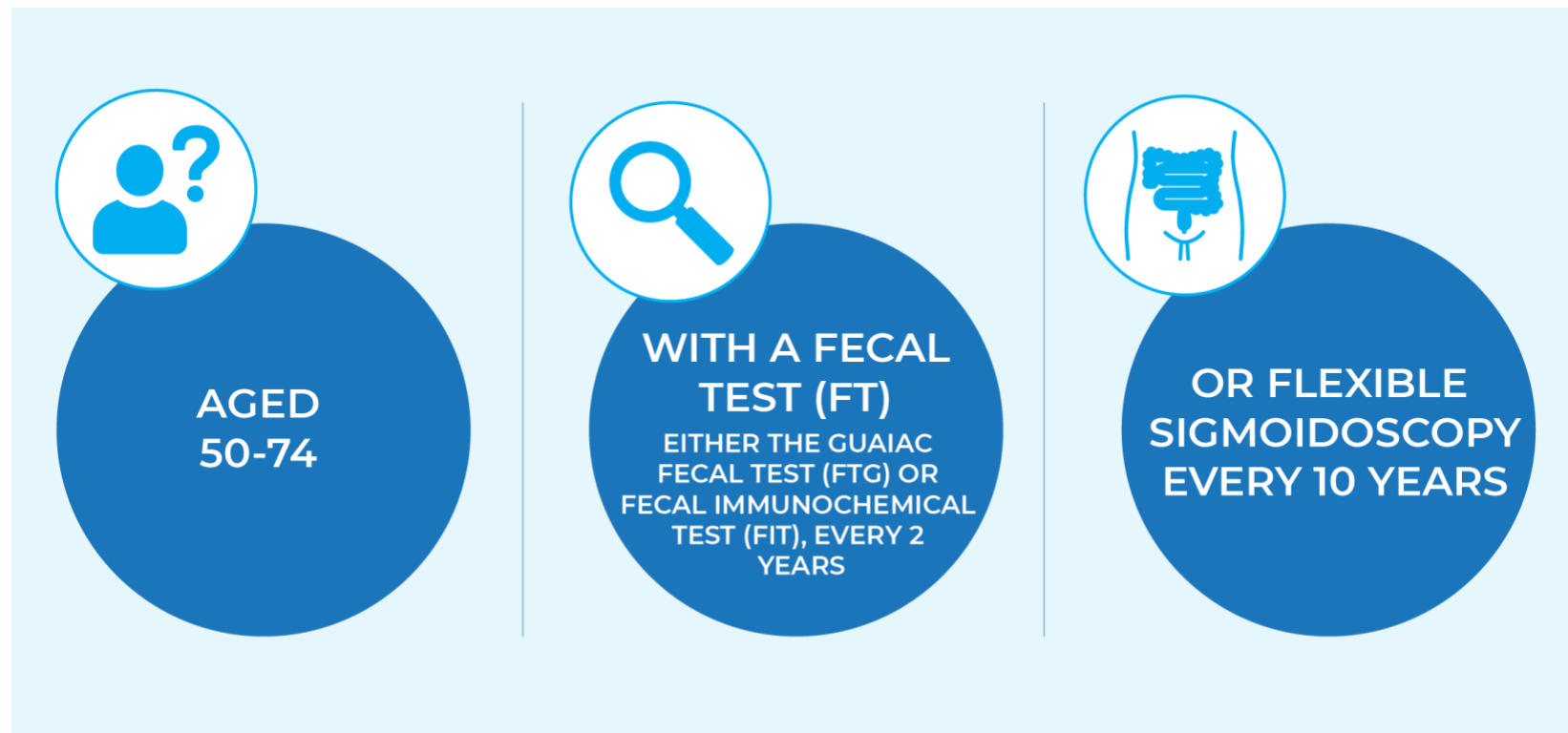
- Identification and invitation of the target population
- Provision of a screening test to the target population
- Follow-up of abnormalities detected by the screening test
- Recall after a normal or non-malignant screening outcome.

*Cancer screening pathways are a general representation of the organized screening process, and may not apply to all jurisdictions, especially those which do not have an organized screening program.

1.2 Canadian Task Force on Preventive Health Care Guidelines

The Canadian Task Force on Preventive Health Care (CTFPHC) develops clinical practice guidelines that support primary care providers in delivering preventive health care.⁹ In addition to supporting primary care providers, the CTFPHC's guidelines are also relevant to community and public health professionals, physician specialists, other health care and allied health professionals, program developers, policy makers, and the Canadian public.

Figure 5. Canadian Task Force on Preventive Health Care Colorectal Cancer Screening Recommendations (2016)



Additionally, the Canadian Task Force on Preventive Health Care does not recommend the following:

- ◆ Screening individuals aged 75 and over for colorectal cancer
- ◆ Using colonoscopy as a screening test for colorectal cancer

1.3 Colorectal Screening Programs in Canada

Organized colorectal screening programs are available in Canada to individuals who are asymptomatic (no signs or symptoms of colorectal cancer present) and at average risk for colorectal cancer.

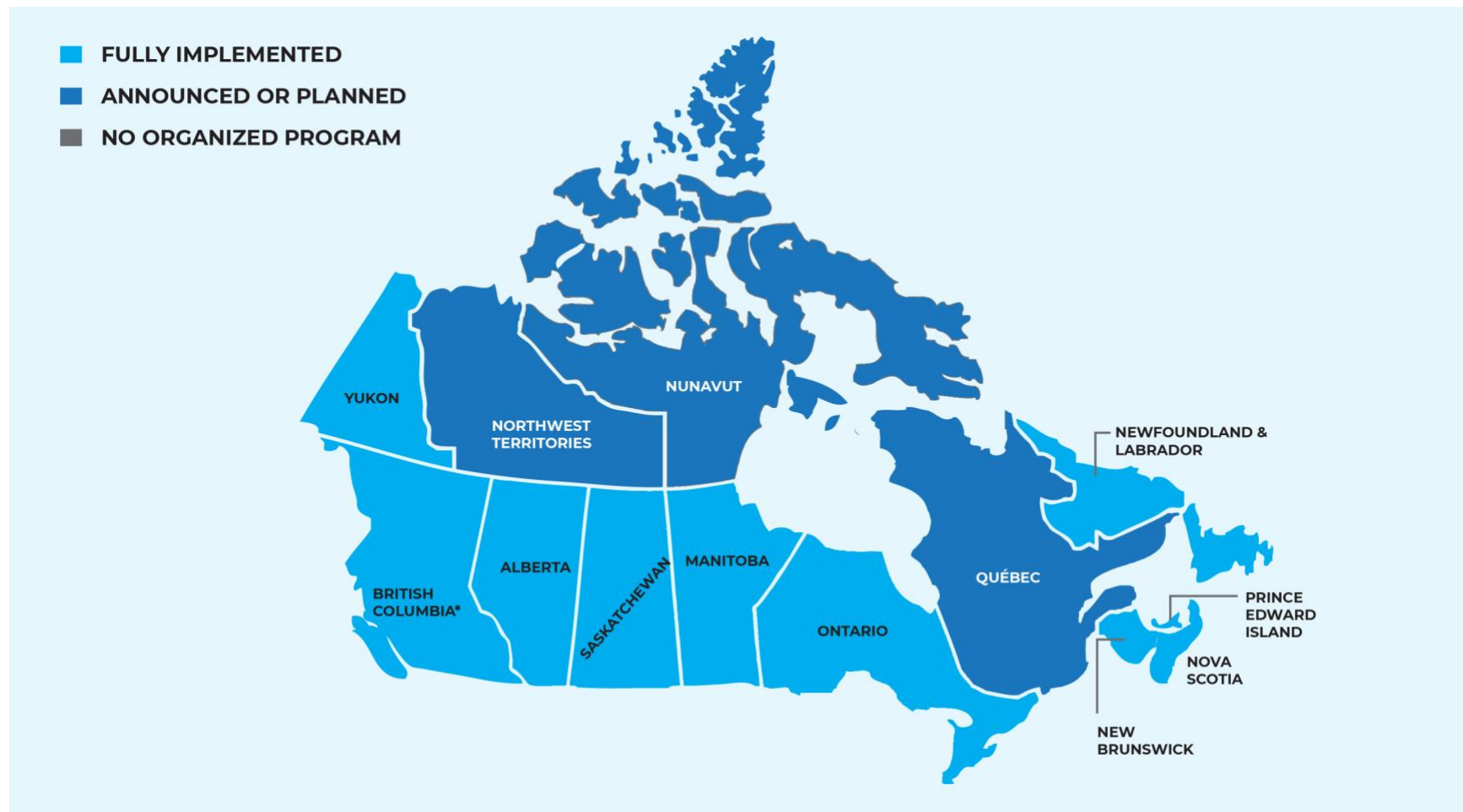
Currently, nine provinces and one territory have implemented organized colorectal cancer screening (with some regions within provinces/territories still without organized programs).[^] Northwest Territories, Nunavut and Québec do not currently have organized colorectal screening programs; however, Nunavut is currently developing a territory-wide program and plans are underway to develop provincial/territorial programs in Northwest Territories and Quebec. Where organized screening programs are not available, screening services may be provided opportunistically by a primary care provider. In this scan, for Northwest Territories, Nunavut and Québec, information on opportunistic screening is provided where available.

Recent Highlight

As of 2017, Yukon has implemented an organized colorectal screening program, and as of 2019, Nunavut is developing a program. All Canadian jurisdictions[^] have now implemented, are developing, or are planning to develop an organized colorectal cancer screening program.

[^] The colorectal cancer screening program in BC is offered province-wide with the exception of The Northern Health Authority, which does not participate in the program.

Figure 6. Status of Colorectal Screening in Canada (July 2019)



* The colorectal screening program in BC is offered province-wide with the exception of the Northern Health Authority, which does not participate in the program.

Table 1. Colorectal Screening Programs in Canada

| Jurisdiction | Program start date | Program status | Program name | Agency responsible for program administration |
|------------------------------------|--------------------|---|---|--|
| Yukon (YT) | 2017 | Full program, territory wide | ColonCheck Yukon | Government of Yukon Health and Social Services |
| Northwest Territories (NT)* | In planning stages | | | |
| Nunavut (NU)* | Under development | | | Nunavut Department of Health |
| British Columbia (BC) [^] | 2013 | Full program, implemented in 4 out of the 5 BC Health Authorities | Colon Screening Program | BC Cancer |
| Alberta (AB) | 2007 | Full program, province wide | Alberta Colorectal Cancer Screening Program (ACRCSP) | Alberta Health Services |
| Saskatchewan (SK) | 2009 | Full program, province wide | Screening Program for Colorectal Cancer | Saskatchewan Cancer Agency |
| Manitoba (MB) | 2007 | Full program, province wide | ColonCheck | CancerCare Manitoba |
| Ontario (ON) | 2008 | Full program, province wide | ColonCancerCheck | Ontario Health (Cancer Care Ontario) |
| Québec (QC)* | N/A | In planning stages | Programme québécois de dépistage du cancer colorectal (PQDCCR) (Québec Colorectal Cancer Screening Program) | Ministère de la Santé et des Services sociaux (Ministry of Health and Social Services) |
| New Brunswick (NB) | 2014 | Full program, province wide | New Brunswick Colon Cancer Screening Program | New Brunswick Cancer Network (NB Department of Health) |
| Nova Scotia (NS) | 2009 | Full program, province wide | Colon Cancer Prevention Program | Nova Scotia Health Authority, Nova Scotia Cancer Care Program |
| Prince Edward Island (PE) | 2011 | Full program, province wide | Colorectal Cancer Screening Program | Health PEI |
| Newfoundland and Labrador (NL) | 2012 | Full program, province wide | Newfoundland and Labrador Colon Cancer Screening Program | Cancer Care Program, Eastern Health |

* Information for NT, NU and QC in this publication refers to opportunistic colorectal screening.

[^] The colorectal screening program in BC is offered province-wide with the exception of The Northern Health Authority, which does not participate in the program.

1.4 Provincial and Territorial Screening Guidelines

All provinces and territories recommend screening asymptomatic individuals at average risk of developing colorectal cancer between the ages of 50 and 74 or 75 every 12-30 months with a fecal test (FT), either the guaiac fecal test (FTg) or fecal immunochemical test (FIT). Most jurisdictions have a screening interval of two years, with the exception of Northwest Territories and Alberta, with an interval of one to two years, and Yukon, with an interval of 30 months.

Table 2. Provincial and Territorial Screening Parameters

| Jurisdiction | Start age | Interval | Stop age | Primary screening test |
|-----------------|-----------|-----------|----------|------------------------|
| YT | 50 | 2 years | 74 | FIT |
| NT* | 50 | 1-2 years | 74 | FIT |
| NU* | 50 | 2 years | 74 | FIT |
| BC [^] | 50 | 2 years | 74 | FIT |
| AB | 50 | 1-2 years | 74 | FIT |
| SK | 50 | 2 years | 75 | FIT |
| MB | 50 | 2 years | 75 | FTg |
| ON [~] | 50 | 2 years | 74 | FIT** |
| QC* | 50 | 2 years | 74 | FIT |
| NB | 50 | 2 years | 74 | FIT |
| NS [‡] | 50 | 2 years | 74 | FIT |
| PE | 50 | 2 years | 75 | FIT |
| NL | 50 | 2 years | 74 | FIT |

* Information for NT, NU and QC in this publication refers to opportunistic colorectal screening.

[^] The colorectal screening program in BC is offered province-wide with the exception of The Northern Health Authority, which does not participate in the program.

[~] In Ontario, people aged 50 to 74 with no symptoms or family history of colorectal cancer may choose to be screened with flexible sigmoidoscopy instead of FT. It is recommended that eligible people who are screened with flexible sigmoidoscopy repeat the test every 10 years.

** FIT implemented June 24, 2019; FTg distributed prior to launch were processed until December 23, 2019.

[‡] The last FIT kit is mailed shortly after the participant's 74th birthday. Participants can request a new kit (if lost or expired) up until their 76th birthday.

1.5 Recruitment and Retention Strategies

Organized colorectal screening programs administer promotional, recruitment and reminder strategies to invite eligible individuals to be screened as per guidelines. Examples of promotional strategies for colorectal screening delivered by provinces and territories include: program-related correspondence, public awareness campaigns (e.g., Colorectal Cancer Awareness Month), social media, education for healthcare providers and more.

Recruitment strategies and methods vary across the country and may include physician referral, self-referral or mailed invitation letters. Many jurisdictions require a referral from a physician prior to distribution of a screening kit, while others distribute kits to eligible individuals with a mailed invitation letter or after an invitation letter has been sent. Participants can also access a screening kit by contacting some screening programs directly.

Of the six jurisdictions that send mailed invitation letters, four provinces send reminders if screening is not initiated.

Table 3. Initial Colorectal Screening Promotional and Recruitment Strategies in Canada

| Jurisdiction | Promotional strategies | Recruitment methods |
|--------------|--|---|
| YT | <ul style="list-style-type: none"> Awareness campaign for Colorectal Cancer Awareness Month (March) (web, social media, posters, radio, community outreach) | <ul style="list-style-type: none"> Physician referral Self-referral in person FIT kits are distributed at public events |
| NT* | <ul style="list-style-type: none"> Public awareness campaigns | <ul style="list-style-type: none"> Opportunistic physician/NP/community health nurse referral |
| NU* | <ul style="list-style-type: none"> Public awareness campaigns | <ul style="list-style-type: none"> Physician referral Self-referral in person Referral through other screening programs |
| BC^ | - | <ul style="list-style-type: none"> Physician referral |
| AB | <ul style="list-style-type: none"> Social media campaign (Facebook, Instagram, Twitter), program website, program brochures, community events, booths at conferences | <ul style="list-style-type: none"> Physician or nurse practitioner referral |
| SK | <ul style="list-style-type: none"> Program website Promotional and educational resources for health care providers and public Radio and print advertisement | <ul style="list-style-type: none"> Mailed invitation letter Physician referral Self-referral by phone |
| MB | <ul style="list-style-type: none"> Education events for healthcare providers Public awareness activities Social media Program website | <ul style="list-style-type: none"> Letter campaigns Physician referral Self-request made online, phone, or in person Referrals through other screening programs |

| Jurisdiction | Promotional strategies | Recruitment methods |
|--------------|--|--|
| ON | <ul style="list-style-type: none"> Physician-linked correspondence program Screening Activity Report (SAR) is an online interactive report for physicians in a Patient Enrollment Model practice, and provides screening data to help improve cancer screening rates and appropriate follow-up. The Sioux Lookout and Zone SAR was developed to support primary care physicians and nurses supporting screening in 27 First Nation communities. Public awareness campaigns (social media) | <ul style="list-style-type: none"> Mailed invitation, recall and reminder letters Physician referral Unattached participants who are eligible for screening can self-refer by calling Telehealth Ontario Self-referral through mobile screening coaches (in certain areas) |
| QC* | <ul style="list-style-type: none"> Promotion to PCP of the current guidelines which indicate that average risk individuals should be screened by FIT test | <ul style="list-style-type: none"> Opportunistic screening by physician referral |
| NB | <ul style="list-style-type: none"> Promotional and educational campaigns for health care providers and professionals (printed materials, program updates) Public awareness campaigns (social media, digital strategy, radio ads, presentations at community events) | <ul style="list-style-type: none"> Mailed invitation letter |
| NS | - | <ul style="list-style-type: none"> Mailed invitation letter and kit sent automatically 2 weeks later |
| PE | <ul style="list-style-type: none"> Awareness campaign for Colorectal Cancer Awareness Month (March) with public advertising (web, print ads, TV, radio) | <ul style="list-style-type: none"> Mailed invitation letter Physician referral Self-referral by phone, email, online or in person |
| NL | <ul style="list-style-type: none"> Education and posters for health care providers Social media campaign (Facebook, Twitter) Presentations at health symposiums and community events | <ul style="list-style-type: none"> Physician referral Self-referral by phone, email or in person (rare) Referral through other screening program Website |

* Information for NT, NU and QC in this publication refers to opportunistic colorectal screening.

^ The colorectal screening program in BC is offered province-wide with the exception of The Northern Health Authority, which does not participate in the program.

- No information was provided at the time the data were collected.

Table 4. Colorectal Screening Reminder Notification in Canada

| Jurisdiction | Reminder letter |
|--------------|--|
| SK | Reminder letter sent 9 weeks after initial invitation |
| MB | Reminder letter sent 56 days after initial invitation |
| ON | Reminder letter sent 4 months after initial invitation |
| NB | Reminder letter sent 12 weeks after initial invitation |

Table 5. Colorectal Screening Promotion and Recruitment for AVERAGE RISK by Province/Territory

| Jurisdiction | Target age | Criteria | Invitation letter? | Participants can self-refer? |
|--------------|------------|---|--------------------|------------------------------|
| YT | 50 - 74 | <ul style="list-style-type: none"> Asymptomatic, average risk individuals | No | Yes |
| NT* | 50 - 74 | <ul style="list-style-type: none"> Based on clinical guidelines | No | No |
| NU* | 50 - 74 | <ul style="list-style-type: none"> Based on Clinical Practice Guidelines | No~ | No |
| BC^ | 50 - 74 | <ul style="list-style-type: none"> Asymptomatic, average risk individuals | No | No |
| AB | 50 - 74 | <ul style="list-style-type: none"> Asymptomatic, average risk individuals | No | No |
| SK | 50 - 74 | <ul style="list-style-type: none"> Asymptomatic, average risk individuals | Yes | Yes |
| MB | 50 - 74 | <ul style="list-style-type: none"> Asymptomatic, average risk individuals | Yes | Yes |
| ON | 50 - 74 | <ul style="list-style-type: none"> Asymptomatic, average risk individuals without a parent, sibling, or child diagnosed with colorectal cancer. People with inflammatory bowel disease (i.e. Crohn's disease involving the colon or ulcerative colitis) and some people who have had polyps removed from their colon may need a regular colonoscopy instead of FIT. | Yes | Yes** |
| QC* | 50 - 74 | <ul style="list-style-type: none"> Asymptomatic, average risk individuals | No~ | No |
| NB | 50 - 74 | <ul style="list-style-type: none"> Asymptomatic, average risk individuals | Yes | No |
| NS | 50 - 74 | <ul style="list-style-type: none"> Asymptomatic, average risk individuals | Yes | No |
| PE | 50 - 74 | <ul style="list-style-type: none"> Asymptomatic, average risk individuals | Yes | Yes |
| NL | 50 - 74 | <ul style="list-style-type: none"> Asymptomatic, average risk individuals | No | Yes |

* Information for NT, NU and QC in this publication refers to opportunistic colorectal screening.

^ The colorectal screening program in BC is offered province-wide with the exception of The Northern Health Authority, which does not participate in the program.

~ Will receive letter under program once established

** Unattached participants (i.e., those who do not have a primary care provider), can self-refer by calling Telehealth Ontario to be assessed for their eligibility to be screened with FIT or by visiting one of the two mobile screening coaches.

Many provincial and territorial colorectal screening programs send a recall letter two years after a client receives a normal result.

Table 6. Receiving Results and Follow Up for NORMAL Colorectal Screening Test Results by Province/Territory

| Jurisdiction | Receive normal results | Recall for screening after normal results |
|--------------|--|--|
| YT | <ul style="list-style-type: none"> PCP responsible for contacting participants to provide results | <ul style="list-style-type: none"> Recall reminder and kit mailed together every 2 years |
| NT* | <ul style="list-style-type: none"> PCP responsible for contacting participants to provide results (some may only follow up for abnormal results) | <ul style="list-style-type: none"> No formal recalls, up to participant or PCP to initiate screening again |
| NU* | <ul style="list-style-type: none"> PCP responsible for contacting participants to provide results Plans are underway to have a Case Manager- for each region~ | <ul style="list-style-type: none"> Recall reminder every 2 years along with patient questionnaire Letters to be mailed out~ |
| BC^ | <ul style="list-style-type: none"> Mailed to participant | <ul style="list-style-type: none"> Requisitions for FIT mailed to participants when next due for FIT |
| AB | <ul style="list-style-type: none"> Mailed to participant PCPs receive FIT results via fax or Netcare | <ul style="list-style-type: none"> No recall reminder. Each eligible individual's cancer screening status and recommended follow-up actions are provided electronically to PCPs via Netcare. |
| SK | <ul style="list-style-type: none"> Mailed to participant | <ul style="list-style-type: none"> Recall reminder and kit mailed together every 2 years |
| MB | <ul style="list-style-type: none"> PCP responsible for contacting participants to provide results | <ul style="list-style-type: none"> Recall reminder and kit mailed together every 2 years |
| ON | <ul style="list-style-type: none"> Mailed to participant PCP is accountable for sharing result unless participant is unattached | <ul style="list-style-type: none"> Recall letter is mailed to participants 2 years after completing FIT |
| QC* | <ul style="list-style-type: none"> Opportunistic: PCP responsible for contacting participants to provide results Program: results will be mailed to participant~ | <ul style="list-style-type: none"> Opportunistic: no formal recalls, up to participant or PCP to initiate screening again Program: will mail a recall reminder every 2 years and participants pick up the kit in person~ |
| NB | <ul style="list-style-type: none"> Mailed to participant | <ul style="list-style-type: none"> Re-invited in 2 years along with eligibility questionnaire that participants must return to receive kit in mail |
| NS | <ul style="list-style-type: none"> Mailed to participant | <ul style="list-style-type: none"> Recall reminder and kit mailed together every 2 years |
| PE | <ul style="list-style-type: none"> Mailed to participant | <ul style="list-style-type: none"> Recall reminder and kit mailed together since 2019, every 2 years Access kit by picking up in person or requesting by mail (same as initial screen) |
| NL | <ul style="list-style-type: none"> Mailed to participant | <ul style="list-style-type: none"> Recall reminder and kit mailed together every 2 years |

* Information for NT, NU and QC in this publication refers to opportunistic colorectal screening.

^ The colorectal screening program in BC is offered province-wide with the exception of The Northern Health Authority, which does not participate in the program.

~ Once program established.

2. Colorectal Screening Fecal Testing Information

Fecal testing is commonly used as an entry level screening test for colorectal cancer. In Canada, a number of screening program features may differ, including the type of fecal test offered (guaiac or immunochemical testing) and sampling details for the particular fecal test.

2.1 - Guaiac Fecal Test (FTg)

Manitoba offers FTg as an entry level test for their colorectal screening program. FTg is offered to eligible individuals every two years. One lab is used to process the results in Manitoba.

Table 7. FTg tests used in Canada

| Jurisdiction | Brand name | Test Name | Number of samples/ number of stools | Number of labs processing test results |
|--------------|----------------------|--------------------|-------------------------------------|--|
| MB | Beckman Coulter Inc. | Hemoccult II SENSA | 2/3 | 1 |

2.2 - Fecal Immunochemical Test (FIT)

Nine provinces and three territories offer FIT as an entry level test for colorectal screening. FIT is offered to eligible individuals every one or two years or every 30 months. Most provinces and territories require one sample collection for the FIT, with the exception of Prince Edward Island and Newfoundland and Labrador which require two samples. FIT cut-off values also vary across the country from ≥ 50 ng/ml to ≥ 175 ng/ml. In most jurisdictions, one lab processes FIT test results, with the exception of Alberta, which uses two labs.

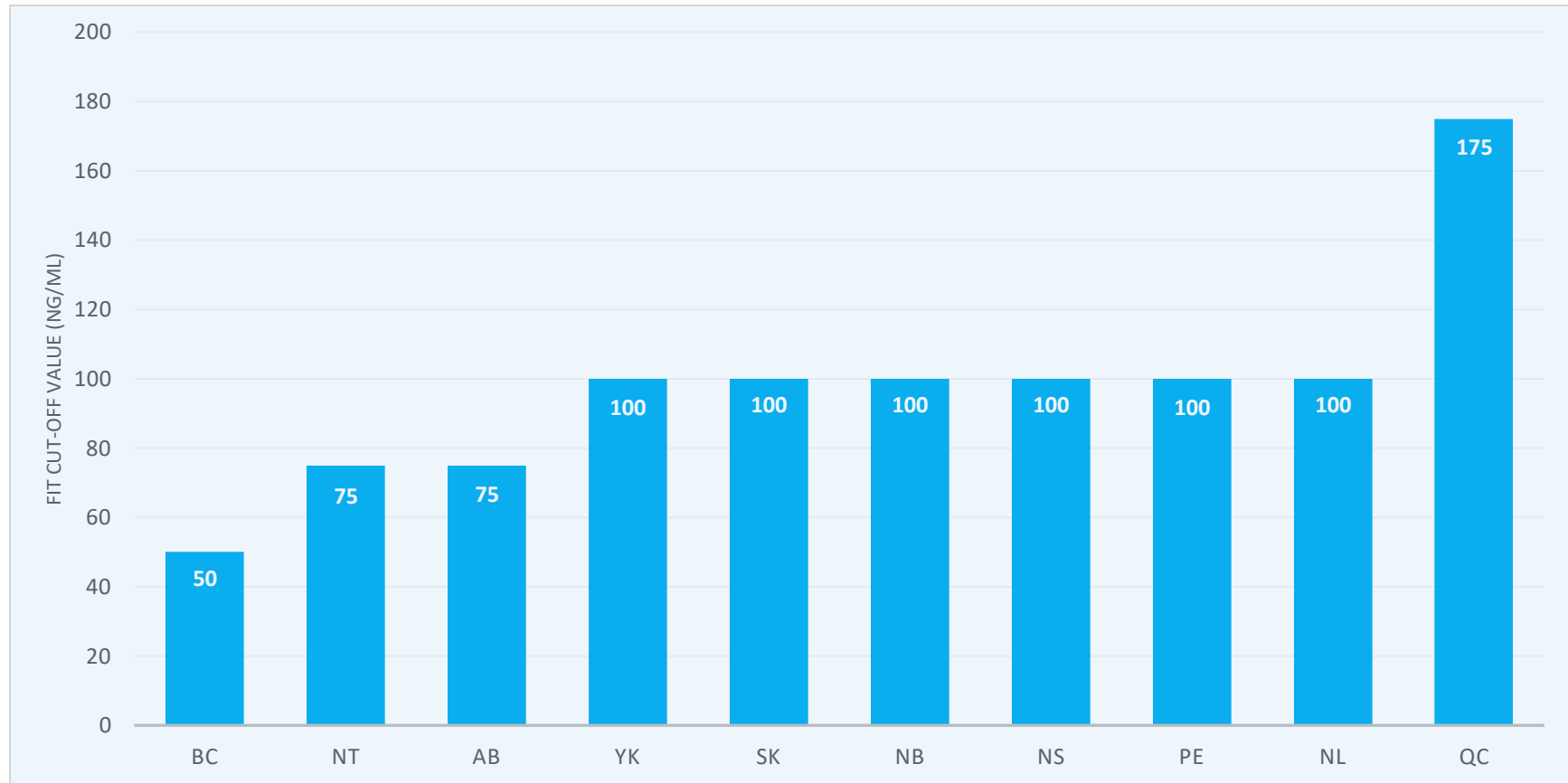
Table 8. FIT tests used in Canada

| Jurisdiction | Manufacturer | Distributor | Number of samples/ number of stools | FIT cut-off value | FIT cut-off value (in mcg of Hgb/g) | Number of labs processing test results |
|--------------|-------------------|--------------------|--|-------------------|--|---|
| YT | Alfresa Pharma | Alere N/S Prime | 1/1 | ≥ 100 ng/ml | 20 mcg of Hgb/g | 1 |
| NT | Polymedco | Somagen | 1/1 | >75 ng/ml | - | 1 |
| NU | Alfresa Pharma | Abbott | 1/1 | - | 50 µg of Hgb/g | 1 |
| BC | Eiken | Somagen | 1/1 | ≥ 50 ng/ml | 10 mcg of Hgb/g | 1 |
| AB | Polymedco | Somagen | 1/1 | ≥ 75 ng/ml | - | 2 |
| SK | Polymedco | Somagen | 1/1 | ≥ 100 ng/ml | 20 mcg of Hgb/g | 1 |
| ON | Polymedco | Somagen | 1/1 | - | - | 1 |
| QC | Polymedco | Somagen | 1/1 | ≥ 175 ng/ml | - | 1 |
| NB | Polymedco | Somagen | 1/1 | > 100 ng/ml | - | 1 |
| NS | Alfresa Pharma | Abbott | 1/1 | ≥100 ng/ml | 20 mcg of Hgb/g | 1 |
| PE | Alfresa Pharma | Abbott | 1/2* | ≥ 100 ng/ml | 20 mcg of Hgb/g | 1 |
| NL | Alfresa Pharma | Abbott/Alere | 2/2* | ≥ 100 ng/ml | 20 mcg of Hgb/g | 1 |

* If 1 of 2 samples is over cut-off value, overall result is positive.

- No information was provided at the time the data were collected.

Figure 7. FIT Cut-Off Value for Colorectal Screening in Canada



Three provinces and two territories limit the use of non-stool-based methods for screening individuals at average risk.

Table 9. Limits on Non-Stool-Based Methods for Screening Individuals at Average Risk

| Jurisdiction | Access is limited | Considering or planning to limit | No current plans | Guidelines on use of FIT and non-stool based methods for screening individuals at high-risk |
|-----------------|---|--|------------------|---|
| YT | | | ✓ | Current guidelines indicate that average risk individuals should be screened by FIT test, but guidelines are not enforced |
| NT* | ✓ Access is limited. Referral required. | | | |
| NU* | ✓ Access is limited | | | |
| BC [^] | | | ✓ | The Guidelines and Protocols Advisory Committee (GPAC) guidelines in BC outline the screening recommendations |
| AB | ✓ Access is limited. Referral is required. | | ✓ | Strongly recommend the use of FIT for average risk |
| SK | | | | Current guidelines indicate that average risk individuals should be screened by FIT test, but guidelines are not enforced |
| MB | | | ✓ | No current plans, but strongly recommend the use of FOBT for average risk screening |
| ON | ✓ Access is limited and continue to consider additional strategies~ | Continue to consider additional strategies | | |
| QC* | ✓ Access is limited | | | |
| NB | | | ✓ | |
| NS | ✓ Access is limited and FIT is strongly encouraged | | | |
| PE | | | ✓ | |
| NL | ✓ Access is limited and FIT is strongly encouraged | | | |

* Information for NT, NU and QC in this publication refers to opportunistic colorectal screening.

[^] The colorectal screening program in BC is offered province-wide with the exception of The Northern Health Authority, which does not participate in the program.

~ With the transition to FIT, Ontario Health (Cancer Care Ontario) developed funding models to incent the performance of high-yield (FIT positive) colonoscopies over low-yield (average risk) procedures

Table 10. Access to Colorectal Screening Test by Province/Territory

| Jurisdiction | Test used | Role of PCP in access to test | Access to screening | | | | |
|--------------|-----------|--|--------------------------|---------------|---|---|----------------------|
| | | | Request kit to be mailed | Kit is mailed | Pick up at lab or from PCP | Lab location information | Requisition required |
| YT | FIT | <ul style="list-style-type: none"> PCP provides kits Kits are available at all community hospitals, community health centres, and program. Program mails subsequent rounds of requisitions. | Phone, fax, or online | ✓ | <ul style="list-style-type: none"> PCP gives participants a kit and completed requisition (for lab testing of the kit) | | ✓ |
| NT* | FIT | <ul style="list-style-type: none"> Kits can only be obtained from PCP (physician, nurse, or community health nurse) | | | <ul style="list-style-type: none"> From PCP | | ✓‡ |
| NU* | FIT | <ul style="list-style-type: none"> Kits can only be obtained from PCP (physician, nurse, or community health nurse) | | | <ul style="list-style-type: none"> From PCP | | |
| BC^ | FIT | <ul style="list-style-type: none"> PCP provides initial requisition Program mails subsequent rounds of requisitions | | ✓ | <ul style="list-style-type: none"> At lab | <ul style="list-style-type: none"> Lab location information available online or from PCP | ✓ |
| AB | FIT | <ul style="list-style-type: none"> PCP provides requisition Requisition can be obtained at a walk-in clinic if no PCP | | | <ul style="list-style-type: none"> At lab | <ul style="list-style-type: none"> Lab location information available online or from PCP | ✓ |

| Jurisdiction | Test used | Role of PCP in access to test | Access to screening | | | | |
|--------------|-----------|--|-------------------------------|---|--|--|----------------------|
| | | | Request kit to be mailed | Kit is mailed | Pick up at lab or from PCP | Lab location information | Requisition required |
| SK | FIT | <ul style="list-style-type: none"> • PCP referral not required • PCP can order a test for pick up by participant | | <ul style="list-style-type: none"> • FIT mailed to all clients age 50-74 with active Saskatchewan health card | <ul style="list-style-type: none"> • At lab | | |
| MB | FTg | <ul style="list-style-type: none"> • PCP referral not required • PCP can contact program to request a kit be sent to their patient. Kit will be accompanied by a letter indicating that PCP has requested one be sent. | Online, in person or by phone | <ul style="list-style-type: none"> • Program actively mails FOBt kits to eligible persons and sends reminder letters if not completed within 56 days. PCP and eligible persons can also request a kit be mailed to home address. | <ul style="list-style-type: none"> • Kits can be picked up at the ColonCheck program | | |
| ON** | FIT | <ul style="list-style-type: none"> • PCP (family physician or nurse practitioner) or Telehealth Ontario/mobile screening coach (for participants without a PCP) submits requisition | | <ul style="list-style-type: none"> • If eligible for screening, PCP will submit requisition for FIT and the lab will mail a FIT kit to the participant | | | ✓ |
| QC* | FIT | <ul style="list-style-type: none"> • Opportunistic: PCP provides requisition for kit • Program: PCP involvement not required | | <ul style="list-style-type: none"> • Program exploring mailing kits to participants, but not the proposed pathway for now | <ul style="list-style-type: none"> • At specimen collection centre • Program: Bring invitation letter to pick up kit | <ul style="list-style-type: none"> • Program: participants informed of 3 closest centres in their invitation letter | ✓ |
| NB | FIT | <ul style="list-style-type: none"> • PCP referral not required~ | | <ul style="list-style-type: none"> • Sent by mail only | | | |

| Jurisdiction | Test used | Role of PCP in access to test | Access to screening | | | | |
|--------------|-----------|--|---|--|---|--------------------------|----------------------|
| | | | Request kit to be mailed | Kit is mailed | Pick up at lab or from PCP | Lab location information | Requisition required |
| NS | FIT | <ul style="list-style-type: none"> • PCP referral not required • PCP encourages patient participation | | <ul style="list-style-type: none"> • FIT kit mailed to participant 2 weeks after invitation letter • Sent by mail only | | | |
| PE | FIT | <ul style="list-style-type: none"> • PCP referral not required | Phone, fax, or online | <ul style="list-style-type: none"> • Kit mailed to participant or can be picked up | <ul style="list-style-type: none"> • Can pick up at a health centre (12 locations across province) • Can also be picked up from some PCPs and walk-in-clinics | | |
| NL | FIT | <ul style="list-style-type: none"> • PCP referral not required • PCP can submit referral by fax to program and kit will be mailed to participant | Phone (toll-free) or email to request kit | <ul style="list-style-type: none"> • Sent by mail only | | | |

* Information for NT, NU and QC in this publication refers to opportunistic colorectal screening.

^ The colorectal screening program in BC is offered province-wide with the exception of The Northern Health Authority, which does not participate in the program.

** Individuals who do not have a PCP can call Telehealth Ontario or visit a mobile screening coach (in some areas), and if the participant is eligible for screening, a requisition for FIT will be submitted, after which the lab will mail a FIT kit to the participant

~ Participant must complete and mail back eligibility questionnaire (postage-paid envelope provided)

‡ In larger communities, participants may need to see their PCP first for a referral/requisition, and then visit a lab to obtain a kit

Table 11. Returning the Colorectal Screening Test by Province/Territory

| Jurisdiction | Kit return | Recommended Timeframe for Kit Return |
|-----------------|---|--|
| YT | <ul style="list-style-type: none"> Return to any community hospital (2 locations), community health centre (11 locations) or Whitehorse General Hospital lab | <ul style="list-style-type: none"> Drop off within 48 hours of sample collection Complete kit before expiry |
| NT* | <ul style="list-style-type: none"> Return in person to pick up location (CHC or lab) | <ul style="list-style-type: none"> Return kit within 7 days of completing sample. Complete kit before expiry. |
| NU* | <ul style="list-style-type: none"> Return in person to pick up location (CHC or lab) | <ul style="list-style-type: none"> Before kit expiry |
| BC [^] | <ul style="list-style-type: none"> Return to lab | <ul style="list-style-type: none"> Return kit to lab within 7 days of completing sample Complete kit before expiry |
| AB | <ul style="list-style-type: none"> Return to any lab | <ul style="list-style-type: none"> Return kit to lab within 7 days of completing sample Complete kit before expiry |
| SK | <ul style="list-style-type: none"> Return in person to any laboratory collection site Return using postage paid envelope provided with kit (to postal outlet) | <ul style="list-style-type: none"> Before expiry |
| MB | <ul style="list-style-type: none"> Return using postage paid envelope provided with kit | <ul style="list-style-type: none"> Mail completed sample within 7 days Complete kit before expiry |
| ON | <ul style="list-style-type: none"> Return using postage paid envelope provided with kit (any mailbox) Can drop off at testing lab's patient service centres | <ul style="list-style-type: none"> Within 6 months of the date the requisition was received by the lab Ideally mail or drop off within 2 days of collecting stool sample |
| QC* | <ul style="list-style-type: none"> Return to same collection centre where kit picked up | <ul style="list-style-type: none"> Drop off within 48 hours of sample collection |
| NB | <ul style="list-style-type: none"> Return using postage paid envelope provided with kit (any mailbox) | <ul style="list-style-type: none"> Mail completed sample within 7 days Complete kit before expiry |
| NS | <ul style="list-style-type: none"> Return using postage paid envelope provided with kit | <ul style="list-style-type: none"> Kit must be analyzed within 15 days of collecting sample Complete kit before expiry |
| PE | <ul style="list-style-type: none"> Return to health centre (9 locations) or a provincial hospital (6 locations) Maximum travel time to drop off a kit is estimated to be 20-30 mins | <ul style="list-style-type: none"> Drop off within 48 hours of sample collection Drop off within 7 days for refrigerated sample collection Complete kit before expiry |
| NL | <ul style="list-style-type: none"> Return using postage paid envelope provided with kit (postal outlet, not a mailbox) | <ul style="list-style-type: none"> Kit must be analyzed within 15 days of collecting sample Complete kit before expiry |

* Information for NT, NU and QC in this publication refers to opportunistic colorectal screening.

[^] The colorectal screening program in BC is offered province-wide with the exception of The Northern Health Authority, which does not participate in the program.

3. Diagnostic Follow-Up for Colorectal Screening

Individuals who have an abnormal fecal test are notified of their result and invited for follow-up with a diagnostic colonoscopy. Timely follow-up after an abnormal fecal test is optimized with an efficient referral process, which can be facilitated by a navigation system or screening program. Additionally, monitoring colonoscopy quality maximizes the benefits of screening.¹⁰

3.1 - Follow-Up After Abnormal Fecal Test

Colorectal cancer screening programs will follow-up with an individual after they receive an abnormal (positive) fecal test result. Most provinces and territories send result letters, either to both primary care providers (PCP) and participants or just to the participant. PCPs are often responsible for coordinating follow up. Some jurisdictions have coordinated systems in which a program administrator, nurse navigator or patient coordinator contacts the participant to schedule a colonoscopy.

Table 12. Receiving Results and Follow Up for ABNORMAL Colorectal Screening Test Results by Province/Territory

| Jurisdiction | Receive abnormal results | Follow up of abnormal results | Identification of PCP for follow up | Description of follow-up process | Return to screening? |
|--------------|--|---|---|---|--|
| YT | <ul style="list-style-type: none"> PCP responsible for contacting participants to provide results | <ul style="list-style-type: none"> Physicians are responsible for coordinating referral to colonoscopy and informing patients of appointments (colonoscopy referrals can only be made by physician or NPs) | <ul style="list-style-type: none"> Ordering PCP If participant does not have a PCP, the program will refer to a physician who will follow the client throughout screening pathway | <ul style="list-style-type: none"> Health care providers and program receive FIT results directly from Whitehorse General Hospital (WGH) lab through IS systems. Program follows up all positive FIT results. PCP notifies the client of the results and refers for f/u colonoscopy (a standardized colonoscopy referral form is available and is to be copied to program). Follow-up referral is monitored. Reminders to PCP to f/u positive FIT results if copy of colonoscopy referral not received by program. | <ul style="list-style-type: none"> Participants who have a normal colonoscopy will be recalled by the program for routine screening with FIT in 10 years (or as per endoscopist recommendation) |

| Jurisdiction | Receive abnormal results | Follow up of abnormal results | Identification of PCP for follow up | Description of follow-up process | Return to screening? |
|--------------|--|--|---|--|---|
| NT* | <ul style="list-style-type: none"> PCP responsible for contacting participants to provide results | <ul style="list-style-type: none"> PCP responsible for coordinating referral to colonoscopy and informing patients of appointments | <ul style="list-style-type: none"> PCP required for access to screening test | <ul style="list-style-type: none"> The primary care provider receives the abnormal lab result. They are responsible for notifying the patient and completing the referral for colonoscopy. | <ul style="list-style-type: none"> If the results of the colonoscopy are normal, guidelines recommend repeat colonoscopy in 5-10 years |
| NU* | <ul style="list-style-type: none"> PCP responsible for contacting participants to provide results | <ul style="list-style-type: none"> PCP responsible for coordinating referral to colonoscopy and informing patients of appointments | <ul style="list-style-type: none"> PCP required for access to screening test | <ul style="list-style-type: none"> Abnormal result reviewed by health care workers. Referral to colonoscopy in electronic medical records. Requires out of community transportation with exception of Iqaluit. | <ul style="list-style-type: none"> If the results of the colonoscopy are normal, individual can be screened again at interval recommended by endoscopist |
| BC^ | <ul style="list-style-type: none"> Mailed to participant Individuals also receive a phone call from their health authority to provide results and coordinate follow up | <ul style="list-style-type: none"> Health authority contacts participant to conduct pre-colonoscopy assessment (by phone or in person, varies by authority) | <ul style="list-style-type: none"> PCP required for access to screening test | <ul style="list-style-type: none"> Primary care provider receives the abnormal lab result report, the patient is sent a letter indicating that follow-up is required. The patient is referred to their health authority. The patient is contacted by their health authority to complete pre-colonoscopy assessment and book the patient for colonoscopy or advise the primary care provider that the patient is not proceeding. | <ul style="list-style-type: none"> Average risk Participants with a normal colonoscopy will be recalled for FIT screening after 10 years Those with low risk adenoma(s) identified are recalled in 5 years for colonoscopy Those with high risk adenoma(s) identified are recalled in 3 years for colonoscopy Those with a strong family history or personal history of adenomas who have no adenomas identified would be recalled for colonoscopy in 5 years |

| Jurisdiction | Receive abnormal results | Follow up of abnormal results | Identification of PCP for follow up | Description of follow-up process | Return to screening? |
|--------------|--|---|---|---|---|
| AB | <ul style="list-style-type: none"> Mail to participant Individuals advised to contact their PCP for follow up PCP receive results from labs directly via fax or Netcare | <ul style="list-style-type: none"> PCP responsible for coordinating referral to colonoscopy and informing patients of appointments | <ul style="list-style-type: none"> PCP required for access to screening test | <ul style="list-style-type: none"> Letter to patient from provincial program advising to see MD. MD refers to zone-based screening program or directly to Endoscopist. MD has access to FIT test results on Netcare system (lab reporting system). | <ul style="list-style-type: none"> Participants who have had a colonoscopy enter a colonoscopy program in their health zone Recall for screening determined by endoscopist and/or zone-based program (vary by zone) |
| SK | <ul style="list-style-type: none"> Mailed to participant Follow up call from PCP or endoscopy navigator | <ul style="list-style-type: none"> Varies by region: PCP or endoscopy navigator coordinates referral for colonoscopy Navigators complete a pre-endoscopy assessment over the phone and sets up appointment (colonoscopy or consult with specialist depending on assessment results) Appointment times mailed to participants | <ul style="list-style-type: none"> Individuals are asked to identify their PCP on the form when they return their kit If no PCP is identified, participant is sent a list of PCPs taking new patients in their area and encouraged to see them for follow up Program also partners with some walk-in clinics to help connect to primary care if needed | <ul style="list-style-type: none"> Primary care provider and participant notified of abnormal result by direct correspondence. Primary care providers sign medical directives which authorizes client navigators to refer client for a colonoscopy. Client navigator phones participant to discuss test results, refer participant to colonoscopy and complete a standardized assessment. Not all units have consented to client navigation. Approximately 50% of participants are assessed and booked by client navigators. | <ul style="list-style-type: none"> Participants who have a normal colonoscopy will be recalled for routine screening with FIT in 5 years |

| Jurisdiction | Receive abnormal results | Follow up of abnormal results | Identification of PCP for follow up | Description of follow-up process | Return to screening? |
|--------------|---|--|---|--|--|
| MB | <ul style="list-style-type: none"> Participants receive phone call from program to provide results and coordinate follow up (for most participants) Result letter sent to participant and healthcare provider | <ul style="list-style-type: none"> With PCP permission, program coordinates follow up investigations In cases where PCP prefers to make referral, result letter will indicate follow up is being managed by PCP Pre-colonoscopy assessment is conducted, process varies by location | <ul style="list-style-type: none"> Program will assist with connecting participants to the Doctor Finder service if they do not have a PCP | <ul style="list-style-type: none"> ColonCheck's follow-up clerk contacts participant by phone (followed by letter to participant and PCP) regarding the abnormal result and follow up referral process (colonoscopy brochure included in letter) Referral process depends on agreements with each of the 5 Regional Health Authorities, and on permissions granted from primary care provider (ColonCheck has received permission from a majority of PCP to directly refer clients). A pre-colonoscopy assessment is completed by ColonCheck's nurse practitioner for all patients receiving their colonoscopy in Winnipeg. | <ul style="list-style-type: none"> Participants who have a normal colonoscopy will be recalled for routine screening with FOBT in 5 years |

| Jurisdiction | Receive abnormal results | Follow up of abnormal results | Identification of PCP for follow up | Description of follow-up process | Return to screening? |
|--------------|---|---|--|--|--|
| ON | <ul style="list-style-type: none"> Result letter mailed to participant PCP is accountable for sharing result unless participant is unattached | <ul style="list-style-type: none"> PCP responsible for coordinating referral to colonoscopy and informing patients of appointments | <ul style="list-style-type: none"> Program contacts those without a PCP by mail and phone and attaches participant to PCP for follow up Program maintains list of PCPs who have agreed to assist those without a PCP | <ol style="list-style-type: none"> Attached participants (those with a PCP): <ul style="list-style-type: none"> PCP responsible for communicating abnormal FIT result to participant, and referring for timely follow up with colonoscopy Ontario Health (Cancer Care Ontario) also mails result letters to participants Unattached participant (those without PCP or received FIT through mobile coach): <ul style="list-style-type: none"> Ontario Health (Cancer Care Ontario) mails abnormal result letter to participant, advising them to call Ontario Health (Cancer Care Ontario)'s Contact Centre for assistance Contact Centre refers these participants to a PCP for follow up If there are no physicians available, the case is escalated to Ontario Health (Cancer Care Ontario)'s provincial and regional leads | <ul style="list-style-type: none"> Participants who have a normal colonoscopy or rectosigmoid hyperplastic polyp(s) should return to screening with FIT in 10 years. Participants with low risk adenoma(s) are recommended to return to screening with FIT in 5 years. |

| Jurisdiction | Receive abnormal results | Follow up of abnormal results | Identification of PCP for follow up | Description of follow-up process | Return to screening? |
|--------------|--|--|--|---|---|
| QC* | <ul style="list-style-type: none"> Opportunistic: PCP responsible for contacting participants to provide results Program: results will be mailed to participant~ | <ul style="list-style-type: none"> Opportunistic: PCP responsible to complete referral to colonoscopy and send it to the endoscopy unit. Endoscopy nurse calls participant to conduct pre-colonoscopy assessment by phone and book their appointment for colonoscopy or other required follow up Program: program nurse calls participant to conduct pre-colonoscopy assessment by phone and book their appointment for colonoscopy or other required follow up~ | <ul style="list-style-type: none"> | <ul style="list-style-type: none"> Opportunistic: Colonoscopist and PCP responsible for contacting participants to provide results Program: Colonoscopist responsible for contacting participants to provide results and manage diagnostic clinical follow up if required. Screening program will manage diagnostic follow up regarding future screening~ | <ul style="list-style-type: none"> Participants who have a normal colonoscopy will be recalled for routine screening with FIT in 10 years |
| NB | <ul style="list-style-type: none"> Participants receive call from program nurse | <ul style="list-style-type: none"> Program coordinates follow up (referral to colonoscopy) Program nurse calls participant to conduct pre-colonoscopy assessment (by phone) then books the participant for a colonoscopy or consultation with endoscopist based on assessment results | <ul style="list-style-type: none"> For participants without a PCP, the endoscopist remains responsible for follow up care | <ul style="list-style-type: none"> The lab sends a letter to primary care providers as notification of abnormal results. Program nurse calls the participant to discuss results and follow-up procedures. A letter is sent if unable to reach the participant by phone. | <ul style="list-style-type: none"> Participants who have a normal colonoscopy will be recalled for routine screening with FIT in 10 years, if age eligible |

| Jurisdiction | Receive abnormal results | Follow up of abnormal results | Identification of PCP for follow up | Description of follow-up process | Return to screening? |
|--------------|---|---|--|---|---|
| NS | <ul style="list-style-type: none"> Letter mailed to participant Copy of letter mailed to PCP Individuals receive call from program | <ul style="list-style-type: none"> Program initiates referral for colonoscopy Program nurse calls participant to conduct pre-colonoscopy assessment (by phone or in person, participant preference) Program books appointment for colonoscopy and informs individual | <ul style="list-style-type: none"> PCP not required, program coordinates all follow up for individuals regardless of whether or not they have a PCP | <ul style="list-style-type: none"> Screening nurse will contact the participant with an abnormal result to conduct a pre-colonoscopy assessment. After the assessment is completed, the individual is booked for colonoscopy with a physician credentialed by the screening program. | <ul style="list-style-type: none"> Participants who have a normal colonoscopy will be recalled for routine screening with FIT in 5 years |
| PE | <ul style="list-style-type: none"> Mailed to participant It is expected that the PCP will also contact the participant | <ul style="list-style-type: none"> PCP responsible for coordinating referral to colonoscopy and informing patients of appointments | <ul style="list-style-type: none"> If a participant has no PCP, program will connect them with a provider who can manage the follow-up process Contact information for this provider sent to the patient in the same letter as results | <ul style="list-style-type: none"> Colorectal Cancer Screening Program (CCSP) sends letter of abnormal results to clients instructing them to follow-up with a primary care provider. The primary care provider determines follow-up. A standardized colonoscopy referral form is available. Follow-up activity/referral (e.g. colonoscopy) is monitored. Primary care provider is contacted if there is no activity/referral in the client's chart. | <ul style="list-style-type: none"> Participants who have a normal colonoscopy will be recalled for routine screening with FIT in 5 years |

| Jurisdiction | Receive abnormal results | Follow up of abnormal results | Identification of PCP for follow up | Description of follow-up process | Return to screening? |
|--------------|--|---|---|---|---|
| NL | <ul style="list-style-type: none"> Individuals receive call from program with results If unable to reach individual after 2 weeks, results sent by registered mail | <ul style="list-style-type: none"> Program initiates referral for colonoscopy Program nurse calls participant to conduct pre-colonoscopy assessment (by phone) Colonoscopy location contacts individual by letter or phone with their appointment time for colonoscopy (or appointment with endoscopist if needed based on assessment results) | <ul style="list-style-type: none"> Follow up coordinated by the program, PCP not required (program Medical Director acts as physician of referral) | <ul style="list-style-type: none"> Once an abnormal test result is sent to the screening program, nurse coordinators contact the patient and inform them of the test result. The nurse will conduct a telephone health assessment and proceed to refer the patient to the endoscopy unit closest to their home for a colonoscopy. The nurse coordinators will send a package of materials to the patient and also provide information on bowel prep. | <ul style="list-style-type: none"> Participants who have a normal colonoscopy will be recalled for routine screening with FIT in 5 years |

* Information for NT, NU and QC in this publication refers to opportunistic colorectal screening.

^ The colorectal screening program in BC is offered province-wide with the exception of The Northern Health Authority, which does not participate in the program.

~ Once program established.

3.2 - Colonoscopy after Abnormal Fecal Test

Recall recommendation after an individual receives an abnormal fecal test but a negative colonoscopy varies across Canadian jurisdictions. Individuals are recalled for FIT or FTg in two, five, or ten years.

Colonoscopy services are offered in hospitals in twelve jurisdictions, private colonoscopy clinics in five jurisdictions and public colonoscopy clinics in three jurisdictions.

Table 13. Screening Recall After an Abnormal Fecal Test and a Negative Colonoscopy

| Jurisdiction | Recall after an abnormal fecal test and negative colonoscopy result |
|--------------|--|
| YT | Recalled for FIT screening in 10 years or as recommended by an endoscopist |
| NT* | No formal recall process |
| NU* | Recalled for FIT screening in 10 years |
| BC^ | Recalled for FIT screening in 10 years |
| AB | Recalled for FIT screening in 10 years |
| SK | Recalled for FIT screening in 5 years |
| MB | Recalled for FTg screening in 5 years |
| ON | Recalled for FIT screening in 10 years~ |
| QC* | Recalled for FIT screening in 10 years |
| NB | Recalled for FIT screening in 10 years |
| NS | Recalled for FIT screening in 5 years |
| PE | Recalled for FIT screening in 5 years |
| NL | Recalled for FIT screening in 5 years |

* Information for NT, NU and QC in this publication refers to opportunistic colorectal screening.

^ The colorectal screening program in BC is offered province-wide with the exception of The Northern Health Authority, which does not participate in the program.

~ Until June 24, 2019, recall was for FTg test.

Table 14. Locations where Colonoscopy Services are Offered by Province/Territory

| Jurisdiction | Hospitals | Private Colonoscopy Clinics | Public Colonoscopy Clinics |
|--------------------|--|---|----------------------------|
| YT | 1 hospital | | |
| NT ^{*,**} | ✓ | | |
| NU ^{*,~} | Iqaluit / Hay River Yellowknife/ Winnipeg Inuvik/ Edmonton | | |
| BC [^] | ✓ | Private facilities contracted by the Health Authority | |
| AB | ✓ | | ✓ |
| SK | ✓ | | ✓ [‡] |
| MB | ✓ | ✓ | |
| ON | ✓ | ✓ | |
| QC [*] | ✓ | ✓ [‡] | ✓ |
| NB | ✓ | | |
| NS | ✓ | | |
| PE | ✓ | | |
| NL | ✓ | | |

* Information for NT, NU and QC in this publication refers to opportunistic colorectal screening.

[^] The colorectal screening program in BC is offered province-wide with the exception of The Northern Health Authority, which does not participate in the program.

[~] Patients in Kivalliq – go to Winnipeg; Patients in Kitikmeot – go to Yellowknife / Inuvik / Hay River; Patients in Qikiqtaaluk – go to Iqaluit

^{**} Colonoscopy services are available in Yellowknife, Inuvik, and Hay River.

[‡] Use of private colonoscopy clinics is already marginal. When the PQDCCR is implemented, none of the colonoscopy referrals will be oriented towards those clinics.

[¥] There is one public colonoscopy clinic within a multidisciplinary Co-operative Health Clinic

Table 15. Strategies Being Implemented to Reduce the Time from Abnormal Fecal Test to Colonoscopy Follow-Up

| Jurisdiction | Strategies to Reduce Wait Times to Colonoscopy Following an Abnormal Fecal Test | Were any of these strategies informed by CPAC work? (e.g. network meetings, other CPAC meetings, etc.) |
|--------------|--|---|
| YT | <p>Colonoscopy Clinic</p> <ul style="list-style-type: none"> Increase in admin staff and experienced colonoscopists Designated colonoscopy rooms Increase in colonoscopies to 4 days/week <p>ColonCheck</p> <ul style="list-style-type: none"> Notice to primary care providers to complete referral for positive FITs sent earlier Repeated provider education and reminder letters Streamline/update colonoscopy referral forms Individual hands on education to providers on where to find appropriate forms Follow-up with Surgeon’s Clinic if program has not received appointment date for colonoscopies | <ul style="list-style-type: none"> National Colorectal Cancer Screening Network Nov 15th meeting Quality Improvement Initiatives March 28/19 meeting presentations Improving Experience from suspicion of colorectal cancer to diagnosis June 19/19 meeting Territorial CRC Screening Collective meeting June 18/19 |
| NT* | <ul style="list-style-type: none"> Organized screening program in planning stages with view to decreased time from positive FIT to colonoscopy. | <ul style="list-style-type: none"> These strategies are fully informed by CPAC work- including network meetings, previous environmental scans, and other work. |
| NU* | <ul style="list-style-type: none"> Case Manager in each Region to coordinate all results~ | - |
| BC^ | <ul style="list-style-type: none"> Facilitated referral to Health Authorities for follow-up. Some HAs have patients complete a pre-colonoscopy assessment questionnaire, if deemed low risk patient, is booked direct to scope. | - |
| AB | <ul style="list-style-type: none"> Dedicated endoscopy slots in screening centres. Wait times regularly monitored by the provincial program with a periodic increase in colonoscopy capacity as needed | - |
| SK | <ul style="list-style-type: none"> Dedicated endoscopy slots Audit and feedback | <ul style="list-style-type: none"> Wait time to colonoscopy is a CPAC network quality indicator (benchmark of 60 days) |
| MB | <ul style="list-style-type: none"> With PCP permission, program will make direct referral to colonoscopy. Program has dedicated spots in Winnipeg, and triage processes in each of the other regional health authorities In two of the five RHA, centralized intake manages direct referral | - |

| Jurisdiction | Strategies to Reduce Wait Times to Colonoscopy Following an Abnormal Fecal Test | Were any of these strategies informed by CPAC work? (e.g. network meetings, other CPAC meetings, etc.) |
|--------------|---|---|
| ON | <ul style="list-style-type: none"> Working with Regional Cancer Programs to support prioritization of follow up colonoscopies, including regular monitoring of colonoscopy wait times Education for PCPs and endoscopists including accredited Continuing Professional Development modules Completion of a pilot project to inform future strategies for improving follow up, such as centralized navigation Process for linking unattached patients (i.e., people without a regular PCP) with an abnormal result to a PCP Laboratory reports for PCPs include messaging emphasizing importance of timely follow up Centralized correspondence program with evidence-based messaging to participant to improve rate of abnormal follow up | <ul style="list-style-type: none"> Pilot project design was informed by navigation processes from other programs and information obtained through CPAC meetings and network contacts. |
| QC* | <ul style="list-style-type: none"> Implementation of a standardized colonoscopy referral form with different priority levels Acquisition of a colonoscopy information system unique to all colonoscopy clinics to follow data Implementation of a new remuneration system for endoscopy units to improve volume and diminish wait times | |
| NB | <ul style="list-style-type: none"> Integrated approach and centralized services Dedicated endoscopy slots Monitoring of wait times and colonoscopy demand | <ul style="list-style-type: none"> Yes, by participating in network meetings |
| NS | <ul style="list-style-type: none"> Nurse navigator assessment with patient direct to colonoscopy if appropriate Centralized booking system and shared endoscopy lists Patients offered booking at sites with shorter wait times | <ul style="list-style-type: none"> National Colorectal Cancer Screening Network meetings Quality Improvement Initiative opportunity Best practice is incorporated into programmatic processes |
| PE | <ul style="list-style-type: none"> Planning for diagnostic navigation plan Monitoring of wait time in place and follow up with PCP for update on referral to colonoscopy | <ul style="list-style-type: none"> CPAC Colorectal Cancer Screening Canada - Monitoring Evaluating Report 2013-14 Yes, informed by meetings, information sharing over the network and seeking funding opportunities for quality improvement initiatives to support program standards and implementation |
| NL | <ul style="list-style-type: none"> Program has dedicated Colonoscopy time in ¼ health regions Endoscopes complete the Skills Enhancement for Endoscopy program Follow CAG** guidelines Nurse navigation results in patients direct to colonoscopy | <ul style="list-style-type: none"> Best practice is incorporated into programmatic processes |

* Information for NT, NU and QC in this publication refers to opportunistic colorectal screening.

^ The colorectal screening program in BC is offered province-wide with the exception of The Northern Health Authority, which does not participate in the program.

~ Once program established.

** Canadian Association of Gastroenterology

- No information was provided at the time the data were collected.

4. Colorectal Screening for Individuals at Increased Risk

Individuals at increased risk have certain risk factors that put them at a greater risk of developing colorectal cancer, developing more aggressive colorectal cancers, or developing colorectal cancer at an earlier age. Individuals at increased risk may be screened differently than individuals at average risk and are often screened outside of organized programs. Screening of people at increased risk is often facilitated on an individual basis by a person’s health provider and dependent on their specific risk factors.

4.1 - Increased Risk Definition

Many provinces and territories have specific factors they consider when identifying an individual at increased risk for colorectal cancer. The most common risk factor documented

by screening programs that places individuals at increased risk is having a 1st degree relative that was diagnosed with colorectal cancer. Some provinces and territories specify that the 1st degree relative needs to be aged < 60 or ≤ 60, whereas in other jurisdictions the 1st degree relative can be of any age.

Other common risk factors used to define individuals at increased risk of developing colorectal cancer is having more than two 1st degree relatives diagnosed with colorectal cancer, having a personal history of colorectal cancer, and adenomatous polyps. In addition, some jurisdictions include having more than two 1st degree relatives with adenomatous polyps, two 2nd degree relatives diagnosed with colorectal cancer and adenomatous polyps in their definition of high risk.

Table 16. Provincial and Territorial Definitions of Increased Risk for Colorectal Cancer

| Jurisdiction | One 1 st degree relative diagnosed with: | | Two or more 1 st degree relatives diagnosed with: | | Two 2 nd degree relatives diagnosed with: | | Personal history of: | |
|--------------|---|--------------------|--|--------------------|--|--------------------|----------------------|--------------------|
| | Colorectal cancer | Adenomatous polyps | Colorectal cancer | Adenomatous polyps | Colorectal cancer | Adenomatous polyps | Colorectal cancer | Adenomatous polyps |
| YT | ✓ age ≤60 | ✓ age ≤60 | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| NT | ✓ age ≤60 | | ✓ | | ✓ | | ✓ | |

| Jurisdiction | One 1 st degree relative diagnosed with: | | Two or more 1 st degree relatives diagnosed with: | | Two 2 nd degree relatives diagnosed with: | | Personal history of: | |
|-----------------|---|--------------------|--|--------------------|--|--------------------|----------------------|--------------------|
| | Colorectal cancer | Adenomatous polyps | Colorectal cancer | Adenomatous polyps | Colorectal cancer | Adenomatous polyps | Colorectal cancer | Adenomatous polyps |
| NU | ✓ age ≤60 | | ✓ | ✓ | | | ✓ | ✓ |
| BC | ✓ age ≤60 | | ✓ | | | | | ✓ |
| AB | ✓ age ≤60 | ✓ age ≤60 | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| SK | ✓ age ≤60 | ✓ age ≤60 | ✓ | ✓ | | | ✓ | ✓ |
| MB | ✓ | ✓ | ✓ | ✓ | | | ✓ | ✓ |
| ON* | ✓ | | ✓ | | | | | |
| QC [^] | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| NB | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| NS [~] | ✓ age ≤60 | ✓ age ≤60 | ✓ | ✓ | | | ✓ | ✓ |
| PE | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| NL | ✓ age ≤60 | | ✓ | | ✓ | | ✓ | ✓ |

* The criteria for definition of increased risk for colorectal cancer are currently under review in Ontario.

[^] In Québec, one 2nd or 3rd degree relative diagnosed with colorectal cancer or adenomatous polyps, one 1st degree relative and one 2nd degree relative from the same side of the family diagnosed with colorectal cancer at any age are considered. Also, slight or moderate increased risk is considered.

[~] Criteria for definition of increased risk of developing colorectal cancer are currently under review in Nova Scotia.

4.2 - Increased Risk Recommendations

Provinces and territories may, outside of their population-based screening programs, recommend specific screening protocols and follow-up measures for individuals at increased risk. The Canadian Association of Gastroenterology (CAG) has issued guidelines for screening individuals at increased risk.¹¹

Most provinces and territories recommend screening individuals at increased risk starting at age 40, or 10 years earlier than the participant’s youngest relative’s age at diagnosis, with colonoscopy every five or ten years. In some cases, the recommendation is that individuals at increased risk are screened similarly to those of average risk, but that they begin screening at age 40. Other provinces follow the recommendations outlined in the CAG guidelines for screening individuals at increased risk.

Table 17. Provincial and Territorial Screening Recommendations for Individuals at Increased Risk of Colorectal Cancer

| Jurisdiction | Screening recommendation for increased risk population | Follow-up recommendations after normal colonoscopy |
|--------------|---|--|
| YT | <ul style="list-style-type: none"> Screening through colonoscopy 1st degree relative diagnosed with colorectal cancer or adenomatous polyps at age ≤ 60 years or 2 or more 1st degree relatives diagnosed at any age with colorectal cancer or adenomatous polyps. Refer at age 40 years, or 10 years prior to index case, whichever comes first. FIT is not recommended. 1st degree relative diagnosed with colorectal cancer age >60 years screen with FIT every 2 years starting at age 50 | <ul style="list-style-type: none"> Colonoscopy in 5 years or as directed by specialist |
| NT | <ul style="list-style-type: none"> Screening through colonoscopy at age 40, or 10 years earlier than the youngest relative’s diagnosis | <ul style="list-style-type: none"> Colonoscopy in 5-10 years |
| NU | <ul style="list-style-type: none"> Screening through colonoscopy, depending on result | <ul style="list-style-type: none"> Varies based on polyp type |
| BC | <ul style="list-style-type: none"> Strong family history of colorectal cancer or personal history of low risk adenoma: Screening through colonoscopy every 5 years Personal history of high risk adenoma on last colonoscopy: Screening through colonoscopy in 3 years | <ul style="list-style-type: none"> Colonoscopy in 5 years |
| AB | <ul style="list-style-type: none"> Screening through colonoscopy | <ul style="list-style-type: none"> Follow-up in 5-10 years If history of colorectal cancer, surveillance 1 year post surgery. Has to have 3 normal colonoscopies to return to 5 year interval. |
| SK | <ul style="list-style-type: none"> 1st degree relative diagnosed at age <60: Screening through colonoscopy beginning at age 40 or 10 years earlier than the youngest relative’s diagnosis 1st degree relatives diagnosed at age ≥60: Screening through FIT starting at age 40 | <ul style="list-style-type: none"> Recommendations at the discretion of the endoscopist and participant, monitored by PCP (based on CAG guidelines) |

| Jurisdiction | Screening recommendation for increased risk population | Follow-up recommendations after normal colonoscopy |
|--------------|---|---|
| MB | <ul style="list-style-type: none"> Screening through colonoscopy | <ul style="list-style-type: none"> Colonoscopy every 5-10 years starting at age 40 or 10 years earlier than the youngest relative's diagnosis. |
| ON* | <ul style="list-style-type: none"> ColonCancerCheck recommends that people who have no symptoms and are at increased risk of getting colorectal cancer be screened with a colonoscopy. Someone at increased risk should start screening at age 50, or 10 years earlier than the age their relative was diagnosed with colorectal cancer, whichever comes first. | <ul style="list-style-type: none"> People with a first-degree relative diagnosed with colorectal cancer before age 60 should get screened again after a normal colonoscopy every five years. People with a first-degree relative diagnosed with colorectal cancer at age 60 or older should get screened again after a normal colonoscopy every 10 years. |
| QC | <ul style="list-style-type: none"> Slightly increased risk: Screening through FIT test starting at age 40 Moderately increased risk: Screening through colonoscopy ever 5 years starting at age 40 or 10 years earlier than the youngest relative's diagnosis | <ul style="list-style-type: none"> Slightly increased risk: FIT test in 10 years Moderately increased risk: colonoscopy every 5 years |
| NB | <ol style="list-style-type: none"> One 1st degree relative with colorectal cancer or adenomatous polyps diagnosed at age <60 or two or more 1st degree relatives with colorectal cancer or adenomatous polyps diagnosed at any age: Screening through colonoscopy at age 40 or 10 years earlier than the youngest relative's diagnosis One 1st degree relative with colorectal cancer or adenomatous polyps diagnosed at age >60 or two or more 2nd degree relatives with colorectal cancer or adenomatous polyps diagnosed at age >60: Screening through FOBT test starting at age 40 and/or referral to a specialist | <ol style="list-style-type: none"> Colonoscopy every 5 years FOBT test every 2 years |
| NS | <ul style="list-style-type: none"> One 1st degree relative with colorectal cancer age ≤60; colonoscopy starting age 40 or 10 years younger than first degree relative age of diagnosis Two or more 1st degree relatives with colorectal cancer; colonoscopy starting age 40 or 10 years younger than first degree relative age of diagnosis | <ul style="list-style-type: none"> Colonoscopy in 5 years |
| PE | <ul style="list-style-type: none"> Depends on age, degree and number of relative(s) affected Follow CAG guidelines Recommendation is at discretion of the primary care provider (referral is not coordinated by the Program) | <ul style="list-style-type: none"> Recommendations at the discretion of the endoscopist, follow CAG guidelines |
| NL | <ul style="list-style-type: none"> Screening through colonoscopy | <ul style="list-style-type: none"> Follow-up with colonoscopy |

*Screening recommendations for individuals at increased risk of colorectal cancer are currently under review in Ontario.

Plans to implement stool-based screening rather than colonoscopy for individuals with a family history of colorectal cancer are under consideration in Alberta and Nova Scotia. Currently, no other provinces or territories are considering this change.

Table 18. Plans to Implement Stool-Based Screening Rather Than Colonoscopy for Individuals with Family History of Colorectal Cancer

| Jurisdiction | Plans to implement stool-based screening rather than colonoscopy for individuals with family history |
|--------------|--|
| YT | Individuals with one 1 st degree relative with colorectal cancer who were diagnosed over the age of 60 are offered FIT. No current plans to consider FIT for those with stronger family history. |
| NT | No current plans |
| NU | No current plans |
| BC | Individuals with one 1 st degree relative with colorectal cancer who were diagnosed over the age of 60 are offered FIT. No current plans to consider FIT for those with stronger family history. |
| AB | Under consideration, new CAG and AB guidelines pending |
| SK | The Saskatchewan Screening Guidelines indicate that family history should be followed with colonoscopy but the Saskatchewan screening program invites all clients age 50-74 by mailing a FIT test to the home of all covered population. Therefore, a family history client will receive FIT unless client self-reports the family history and opts out of program or the colonoscopist recommends to the screening program that the client will remain on surveillance colonoscopy. |
| MB | No current plans |
| ON | No current plans* |
| QC | No current plans |
| NB | No current plans |
| NS | First degree relative with colorectal cancer age >60; average risk screening with FIT age 50. |
| PE | No current plans |
| NL | No current plans |

*This may change as the definition for increased risk and the screening recommendations for individuals at increased risk of colorectal cancer are currently under review in Ontario.

The criteria for defining high risk most commonly include age between 50-74 and other criteria based on clinical practice guidelines, such as family history. However, individuals at high risk are not monitored by many screening programs. Some screening registries do not differentiate between average and increased risk, and high or increased risk individuals may still be reached through population screening programs intended for individuals at average risk.

Table 19. Criteria for Defining HIGH RISK by Province/Territory

| Jurisdiction | Target age | Criteria |
|-----------------|---|--|
| YT | Starting at age 50, or 10 years earlier than the age their relative was diagnosed with colorectal cancer, whichever comes first | People who are asymptomatic and have a family history of colorectal cancer that includes one or more first-degree relatives (parent, sibling, or child) who has been diagnosed with the disease |
| NT* | 50 - 74 | Based on clinical guidelines |
| NU* | 50 - 74 | Based on Clinical Practice Guidelines |
| BC [^] | 10 years prior to diagnosis of first degree relative - 74 | - |
| AB | 50 - 74 | Those with personal / family history can begin screening with colonoscopy at 40 |
| SK | 50 - 74 | The program does not intentionally recruit individuals at high risk for FIT screening. High risk individuals can access colonoscopy screening through their healthcare provider. |
| MB | 50 - 74 | The program does not intentionally recruit individuals at high risk for FOBT screening. High risk individuals can access colonoscopy screening through their healthcare provider. |
| ON | Starting at age 50, or 10 years earlier than the age their relative was diagnosed with colorectal cancer, whichever comes first | Increased risk: people who are asymptomatic and have a family history of colorectal cancer that includes one or more first-degree relatives (parent, brother, sister or child) who has been diagnosed with the disease |
| QC* | 50 - 74 | Opportunistic screening by PCP, following algorithm |
| NB | 50 - 74 | Based on Clinical Practice Guidelines |
| NS | Depends on genetic syndrome | High risk individuals should access colonoscopy through their health care provider |
| PE | 50 - 74 | High risk individuals are not identified through the program. Individuals 50-74 with a higher risk are invited to self-identify and discuss screening option with primary care provider (colonoscopy) |
| NL | 50 - 74 | - |

* Information for NT, NU and QC in this publication refers to opportunistic colorectal screening.

[^] The colorectal screening program in BC is offered province-wide with the exception of The Northern Health Authority, which does not participate in the program.

- No information was provided at the time the data were collected.

Lynch syndrome is an inherited condition that increases an individual’s risk of colorectal cancer. Increased colorectal screening, including colonoscopies, are often recommended for those diagnosed with Lynch syndrome.¹² In Canada, most provinces and territories do not include individuals diagnosed with Lynch syndrome (Hereditary Non-polyposis colorectal cancer) in their organized screening program. These individuals are often referred to specialists instead.

Table 20. Provincial and Territorial Screening Recommendations for Individuals with Lynch Syndrome (Hereditary Non-polyposis colorectal cancer)

| Jurisdiction | Does your jurisdiction have screening recommendations for individuals with Lynch Syndrome? | | If yes, please describe the screening recommendations for individuals with Lynch syndrome |
|--------------|--|----|---|
| | Yes | No | |
| YT | | ✓ | Follow recommendations of the Canadian Association of Gastroenterology |
| NT | | ✓ | |
| NU | | ✓ | |
| BC | | ✓ | GPAC [^] Guidelines for screening |
| AB | | ✓ | |
| SK | | ✓ | |
| MB | | ✓ | |
| ON | | ✓* | |
| QC | | ✓ | |
| NB | ✓ | | As per NB Colon Cancer Screening Clinical Practice Guidelines algorithm, Colonoscopy every 1 to 2 years beginning at age 20 or 10 years younger than the earliest case in the family, whichever comes first, is recommended for hereditary nonpolyposis colorectal cancer or Lynch Syndrome |
| NS~ | ✓ | | For family history of hereditary non-polyposis colorectal cancer - colonoscopy every 2-3 years beginning at age 20, or 10 years younger than the earliest case in the family. Genetic counseling is recommended. |
| PE | | ✓ | |
| NL | | ✓ | Follow recommendations of the Canadian Association of Gastroenterology |

*The program plans to develop screening recommendations for individuals with Lynch syndrome in the future.

[^]Guidelines and Protocol Advisory Committee

~Although Nova Scotia has screening recommendations for individuals with Lynch syndrome, these are not part of the organized screening program.

5. Colorectal Screening Pilots and Studies

Several jurisdictions conduct or participate in pilots or studies related to colorectal screening. YT held discussions with First Nations health workers and community members centered on barriers to access, screening strategies, culturally relevant screening education and cancer risk and prevention, in order to identify attributes of success for and barriers to Yukon First Nations and communities participating in screening programs. NT used simulation modeling to estimate endoscopy resource requirements for colorectal screening.

ON has undertaken a study of follow-up adherence and barriers among colorectal screening participants who have obtained an abnormal guaiac fecal occult blood test (gFOBT) result, as part of the ColonCancerCheck program. ON will be exploring cancer screening systems and Indigenous cultural safety, to collaboratively develop culturally safe communications and to culturally safe decision-making strategies for cancer screening.

Table 21. Colorectal Screening Pilots and Studies in Yukon

| | |
|--|---|
| Title | Identifying attributes of success in and barriers to Yukon First Nations and remote communities participating in cancer screening |
| Purpose of the Study | Yukon's cancer mortality rates are above national rates and CRC is the 2nd leading cause of cancer death. Disparities in cancer screening and outcomes continue in YT's rural communities and First Nations. Our objective was to identify attributes of success for and barriers to Yukon First Nations and communities participating in screening programs. |
| Start and end date | May 2016-2017 |
| # of individuals recruited | 11 of the 14 Yukon communities |
| Study/ Pilot Inclusion Criteria | Discussions with First Nations health workers and community members centered on barriers to access, screening strategies, culturally relevant screening education and cancer risk and prevention |
| Results | This initiative helped inform how Yukon First Nations view cancer and screening in their communities and continues to influence the design, planning and delivery of ColonCheck Yukon colorectal screening services. Patient-centeredness and cultural competency are required in the planning and delivery of colorectal screening services. Continued First Nations and community consultations, prevention and screening education, outreach initiatives and improvements in culturally responsive services are required to improve First Nations and community access to and participation in colorectal screening. |
| Recruitment methods | As above |
| First Nations, Inuit and Métis Recruitment | As above |
| Reference (if the study has been published) | N/A |

Table 22. Colorectal Screening Pilots and Studies in Northwest Territories

| | |
|--|--|
| Title | |
| Purpose of the Study | Estimate endoscopy resource requirements for colorectal screening using simulation modeling. |
| Start and end date | Sept 2018-Sept 2020 |
| # of individuals recruited | 1322 (retrospective review) |
| Study/ Pilot Inclusion Criteria | For retrospective review: Positive Fecal Immunohistochemical test Jan 1,2014-Mar 31,2019 Data will be used to populate and validate OncoSim to develop projections of endoscopy resource requirements. |
| Results | Pending |
| Recruitment methods | Identified in Public Health Registries |
| First Nations, Inuit and Métis Recruitment | Retrospective review includes all NWT residents and therefore significant First Nations, Inuit and Métis population. No specific recruitment by Indigenous status. Indigenous patient partner from remote community has been recruited to the research team to provide patient perspective. |
| Recruitment for Underscreened Populations | Retrospective review includes all NWT residents and therefore significant underscreened population. No specific recruitment by community. |
| Reference (if the study has been published) | N/A |

Table 23. Colorectal Screening Pilots and Studies in Ontario

| Title | Abnormal Follow-Up Adherence and Barriers Project | Indigenous Cultural Safety |
|---|--|--|
| Purpose of the Study | To improve follow-up in colorectal screening participants who have obtained an abnormal guaiac fecal occult blood test (gFOBT) result, as part of the ColonCancerCheck program | To improve the cancer screening systems and Indigenous cultural safety, to collaboratively develop culturally safe communications and to develop culturally safe decision-making strategies for cancer screening |
| Start and end date | October 2017-March 2019 | April 2019-March 2024 |
| # of individuals recruited | 192 people with an abnormal gFOBT result that had not received follow up 154 primary care providers with patients who did not receive follow up | TBD |
| Study/ Pilot Inclusion Criteria | PCPs within four Diagnostic Assessment Programs (DAPs) with at least one patient with a positive FOBT between September 2015-March 2016 Patients age 49 – 76 with an abnormal FOBT result, active Ontario Health Insurance Program coverage as of August 1, 2017 and were alive on the date of the FOBT results | TBD |
| Results | Results currently not available | TBD |
| Referral process | Patients were referred into the study by their PCP | TBD |
| Recruitment methods | <ul style="list-style-type: none"> Four colorectal cancer diagnostic assessment programs (DAPs) were selected to provide navigation services PCPs within each DAP were invited to participate and all of their patients with an abnormal result were recruited | TBD |
| First Nations, Inuit and Métis Recruitment | N/A | Exclusively restricted to this population, methods for recruitment TBD after discussion with communities |
| Recruitment for Underscreened Populations | N/A | TBD |
| Reference (if the study has been published) | N/A | N/A |

6. Population Outreach

According to the limited data specific to First Nations, Inuit and Métis, screening participation rates are low among First Nations, Inuit and Métis.¹³ This is also the case for low-income individuals, new immigrants, individuals living in rural communities, and other underserved populations.¹⁴ A variety of strategies have been implemented across Canada to increase screening participation in underscreened populations.

6.1 - Framework for Interventions to Improve Cancer Screening

The Community Preventive Services Task Force (CPSTF), supported by the US Centers for Disease Control and Prevention (CDC), carried out an extensive review of factors related to screening for breast, cervical, colorectal and skin cancer.¹⁵ The review focused on interventions that increase community demand and access and increase provider delivery. The interventions identified aim to increase screening rates across the population but could also support efforts to improve screening equity. The framework outlines evidence-based intervention strategies to support decision making.

Table 24. CDC Framework for Interventions to Improve Cancer Screening¹⁵

| Increase Community Demand | Increase Community Access | Increase Provider Delivery |
|---|--|---|
| <ul style="list-style-type: none"> • Group Education • One-on-one Education • Client Reminders • Client Incentives • Mass Media • Small Media | <ul style="list-style-type: none"> • Interventions to Reduce Client Out-Of-Pocket Costs • Interventions to Reduce Structural Barriers <ul style="list-style-type: none"> ○ Reducing Administrative Barriers ○ Providing Appointment Scheduling Assistance ○ Using Alternative Screening Sites ○ Using Alternative Screening Hours ○ Providing Transportation ○ Providing Translation ○ Providing Childcare | <ul style="list-style-type: none"> • Provider Reminders • Provider Incentives • Provider Assessment and Feedback |

6.2 - First Nations, Inuit and Métis



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CANADIAN JURISDICTIONS WITH IMPLEMENTED STRATEGIES TO INCREASE PARTICIPATION IN COLORECTAL SCREENING AMONG FIRST NATIONS, INUIT AND MÉTIS

According to the limited data specific to First Nations, Inuit and Métis, participation rates for colorectal screening are lower among First Nations, Inuit and Métis than non-Indigenous people in Canada. Colorectal Screening shows the lowest participation rates compared to cervical and breast cancer screening. The data also indicate considerable variation in screening participation among First Nations, Inuit and Métis across geographic location.¹³

The colorectal screening program data collection in Yukon includes Indigenous identifiers (e.g., First Nations, Inuit, and/or Métis identifiers) through participant self-identification. Currently, these data are not being used for specific analysis purposes. No other Canadian jurisdictions collect this type of data.

Screening programs in nine provinces and three territories report work with First Nations, Inuit and Métis to increase participation in colorectal screening. This work includes

engaging with First Nations, Inuit and Métis in decision-making and informing approaches to culturally appropriate screening, development of First Nations, Inuit or Métis-specific program resources, and engaging with healthcare providers working directly with First Nations, Inuit and Métis communities. Specifically, some programs engage with First Nations, Inuit and Métis in the development of cancer plans and through working groups. Dedicated mobile visits have also been implemented into several screening programs in order to reach First Nations, Inuit and Métis communities, along with other programs resources such as culturally appropriate material, presentations and social media campaigns. In addition, some strategies were put in place to provide education to health care providers working directly with First Nations, Inuit and Métis communities.

No strategies related to appointment scheduling, alternative hours, childcare or provider incentives were reported.

Figure 8. Strategies to increase screening participation among First Nations, Inuit and Métis communities (July 2019)

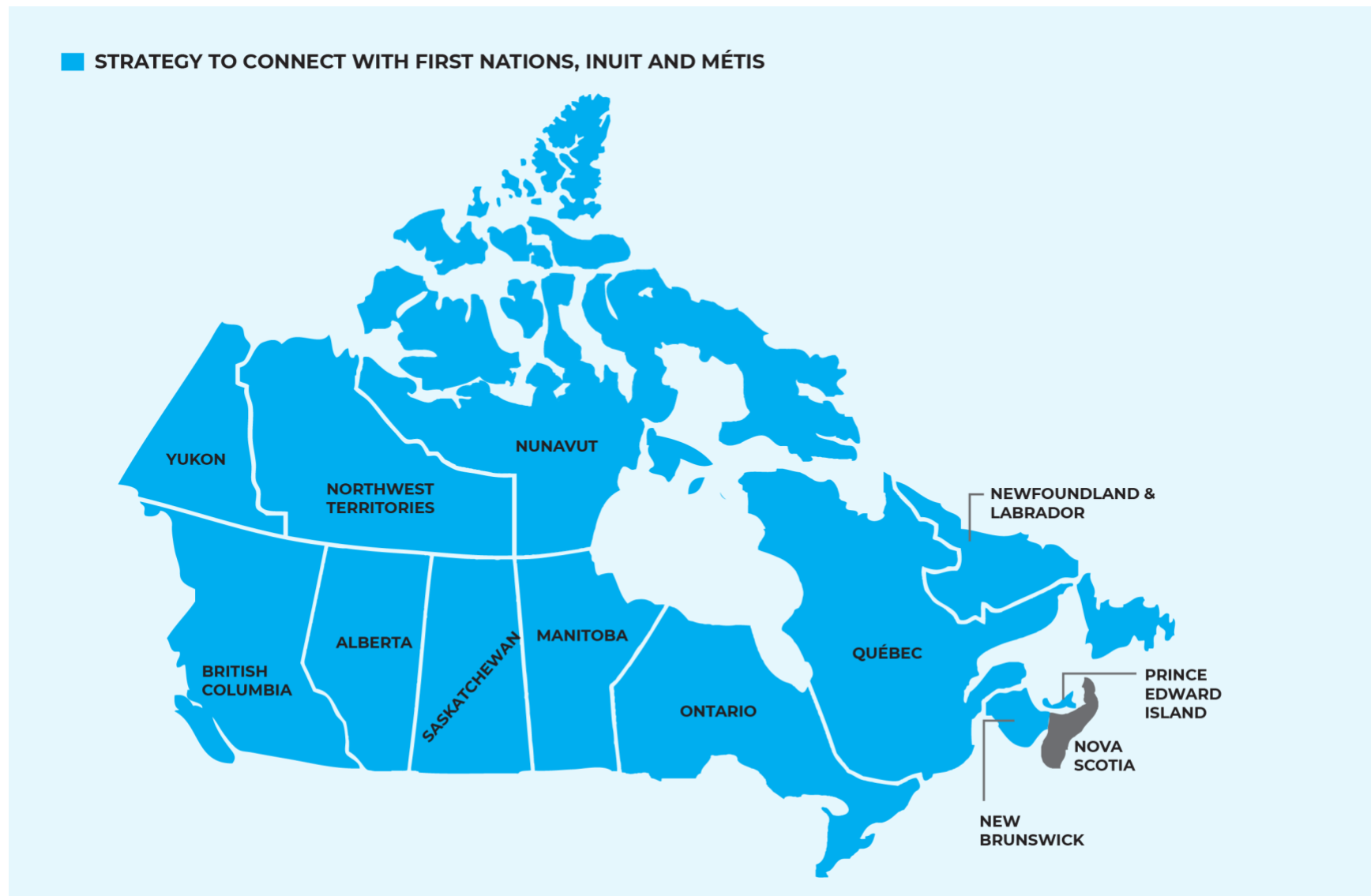


Table 25. Group Education Strategies to Increase Participation in Colorectal Screening among First Nations, Inuit and Métis

| Jurisdiction | Intended Audience | | | Description |
|--------------|-------------------|-------|-------|---|
| | First Nations | Inuit | Métis | |
| AB | - | - | - | ACRCSP works with Indigenous communities to improve colorectal cancer screening and prevention. |
| MB | ✓ | ✓ | ✓ | ColonCheck partners with Community Engagement Liaisons in each regional health authority in the province to provide resources for group education. |
| NB | ✓ | | | Attend and present on Cancer Screening Programs, including Colon Cancer awareness, at First Nation Wellness events or conferences, upon invitation. Currently working on a GIS mapping project to help identify areas of decreased participation and appropriate targeted awareness initiatives- including First Nation Communities. |
| NT | ✓ | ✓ | | Pilot project underway to increase community health representative knowledge of CRC screening and have them act as lay navigators for screening process. Other outreach strategies being considered with planning phases of organized program. These are being informed by CPAC. |
| ON | ✓ | ✓ | ✓ | Through Indigenous Cancer Care Unit (ICCU), Regional Indigenous Cancer Leads and regional teams, communities have been engaged through workshops and health fairs. Primary Care providers are educated through Continuing Medical Education (CME) accredited presentations. |
| PE | ✓ | ✓ | | Attending health fairs/community events with information and educating clinic staff about programs |
| QC | ✓ | ✓ | ✓ | Partner with regional health authorities to coordinate one-on-one education sessions |
| SK | ✓ | ✓ | ✓ | Coordinate group education session at First Nations Health Fairs and Pow Wows |
| YT | ✓ | ✓ | ✓ | Community visits 2 times per year at community health fairs/outreach scheduled events; provides lunch at meetings; Giant Colon to Whitehorse; provider education via telehealth and memoranda |

- No information was provided at the time the data were collected.

One-on-one education activities involve an individual (health care provider or layperson) explaining the benefits of screening and ways to overcome barriers to screening to clients individually either in person or by phone.

Table 26. One-on-One Education Strategies to Increase Participation in Colorectal Screening among First Nations, Inuit and Métis

| Jurisdiction | Intended Audience | | | Description |
|--------------|-------------------|-------|-------|---|
| | First Nations | Inuit | Métis | |
| AB | - | - | - | The program works with Indigenous primary care groups to raise awareness of CRC risk and screening through primary care providers. |
| MB | ✓ | ✓ | ✓ | ColonCheck partners with Community Engagement Liaisons in each regional health authority in the province to provide resources for one-to-one education |
| NU | ✓ | ✓ | ✓ | Partner with regional health authorities to coordinate one-on-one education sessions |
| ON | ✓ | ✓ | ✓ | Partner with regional health authorities and community/organizational leadership to coordinate one-on-one education sessions. There are also more targeted sessions through the Indigenous Cancer Care Unit (ICCU) and regional teams with communities/organizations. |
| YT | ✓ | ✓ | ✓ | One-on-One education with community members at each visit |

- No information was provided at the time the data were collected.

Client reminders (e.g., letters, phone calls) are used to remind clients that screening is due and provide follow-up information (e.g., benefits of screening, ways to address barriers, help to schedule appointments).

Table 27. Client Reminder Strategies to Increase Participation in Colorectal Screening among First Nations, Inuit and Métis

| Jurisdiction | Intended Audience | | | Description |
|--------------|-------------------|-------|-------|--|
| | First Nations | Inuit | Métis | |
| MB | ✓ | ✓ | ✓ | Invitations, recalls, and reminder letters are actively sent to all eligible Manitobans |
| ON | ✓ | ✓ | ✓ | Reminders are sent to all eligible Ontarians through Ontario Health (Cancer Care Ontario)'s cancer screening correspondence program for invitation letters, recall letters, and abnormal result letters. The Indigenous Cancer Care Unit (ICCU) is currently engaged in a study to investigate current correspondence and identify methods to enhance patient reminders. |

Table 28. Client Incentive Strategies to Increase Participation in Colorectal Screening among First Nations, Inuit and Métis

| Jurisdiction | Intended Audience | | | Description |
|--------------|-------------------|-------|-------|--|
| | First Nations | Inuit | Métis | |
| SK | ✓ | ✓ | ✓ | Provide small promotional items at health fairs |
| YT | ✓ | | | First Nations participation in developing YT's Colorectal Cancer Screening campaign poster |

Table 29. Mass Media Strategies to Increase Participation in Colorectal Screening among First Nations, Inuit and Métis

| Jurisdiction | Intended Audience | | | Description |
|--------------|-------------------|-------|-------|---|
| | First Nations | Inuit | Métis | |
| MB | ✓ | ✓ | ✓ | Use social media, radio and newsprint to increase awareness about the importance of cancer screening to eligible Indigenous population. |
| NB | ✓ | ✓ | ✓ | Use social media to increase awareness about the importance of cancer screening to eligible population, including NB's Indigenous population. |
| NU | ✓ | ✓ | ✓ | Use social media to increase awareness about the importance of cancer screening to eligible Indigenous population. |
| ON | ✓ | ✓ | ✓ | Use social media to increase awareness about the importance of cancer screening to eligible Indigenous population. |
| SK | ✓ | ✓ | ✓ | Use social media to increase awareness about the importance of cancer screening to eligible Indigenous population. Use of radio ads to remind and increase awareness of the importance of getting screened. Video on FIT screening in Cree, Dene and English on SCA website |
| YT | ✓ | ✓ | ✓ | Awareness campaign month of March. Web, social media, posters, radio, newspaper adds, community outreach |

Small media include videos and printed materials such as letters, brochures, and newsletters. These materials can be used to inform and motivate people to be screened for cancer. They can provide information tailored to specific individuals or geared towards general audiences.

Table 30. Small Media Strategies to Increase Participation in Colorectal Screening among First Nations, Inuit and Métis

| Jurisdiction | Intended Audience | | | Description |
|--------------|-------------------|-------|-------|--|
| | First Nations | Inuit | Métis | |
| BC | ✓ | ✓ | ✓ | Brochures, videos, and handouts are all available. |
| MB | ✓ | ✓ | ✓ | Brochures, test instructions, bowel prep instructions, and videos are readily available. |
| NL | ✓ | ✓ | ✓ | Some kit contents, and promotional material translated |
| ON | ✓ | ✓ | ✓ | Cancer Screening Fact Sheets, Toolkit, and awareness postcards were designed and tailored for each First Nation, Inuit and Métis population. |
| SK | ✓ | ✓ | ✓ | Provide brochures, posters and postcard handouts with specific information about FIT screening. All promotional material is available at no charge for primary care clinics. All promotional material uses photos representative of the diversity within the province. |
| YT | ✓ | | | CRC awareness pamphlets |

Table 31. Self-Screening Strategies to Increase Participation in Colorectal Screening among First Nations, Inuit and Métis

| Jurisdiction | Intended Audience | | | Description |
|--------------|-------------------|-------|-------|---|
| | First Nations | Inuit | Métis | |
| ON | ✓ | ✓ | ✓ | FIT was implemented in June 2019 to replace gFOBT as a single sample self-sampling test for average risk colorectal screening. This test was implemented across Ontario and was informed by Indigenous communities and providers. |

Table 32. Strategies to Reduce out of Pocket Costs for Screening Participation among First Nations, Inuit and Métis

| Jurisdiction | Intended Audience | | | Description |
|--------------|-------------------|-------|-------|---|
| | First Nations | Inuit | Métis | |
| ON | ✓ | ✓ | | The Indigenous Cancer Care Unit (ICCU) supports individuals (who are approved and eligible through the First Nation Inuit Health Branch) requiring medical transportation benefits under the Non-Insured Health Benefits (NIHB) program in the area of screening. |
| YT | ✓ | ✓ | ✓ | Medical travel and accommodations are paid by NIHB for First Nations, Inuit, and Métis to travel from communities to Whitehorse |

Structural barriers are obstacles (other than those related to economics/finances) that make it difficult to access screening, for example, distance to screening locations, hours of service, setting of screening, administrative procedures, etc. Interventions to reduce structural barriers may include providing mobile screening, reducing administrative burden, providing assistance with scheduling, providing translation, expanding hours of service, etc.

Table 33. Alternative Site Strategies to Increase Participation in Colorectal Screening among First Nations, Inuit and Métis

| Jurisdiction | Intended Audience | | | Description |
|--------------|-------------------|-------|-------|--|
| | First Nations | Inuit | Métis | |
| ON | ✓ | ✓ | ✓ | Ontario has a mobile screening coach that offers cancer screening services (including colorectal screening) in the North West region. |
| MB | - | - | - | Screening programs have two mobile breast screening clinics that travel across the province. While in the community, they offer education on colon cancer screening, and provide information on accessing test kits. |
| YT | ✓ | ✓ | ✓ | Program attends First Nations organized health fairs in remote/rural communities |

- No information was provided at the time the data were collected.

Table 34. Transportation Strategies to Increase Participation in Colorectal Screening among First Nations, Inuit and Métis

| Jurisdiction | Intended Audience | | | Description |
|--------------|-------------------|-------|-------|--|
| | First Nations | Inuit | Métis | |
| NU | ✓ | | | - |
| ON | ✓ | ✓ | ✓ | Ontario has a mobile screening coach that offers cancer screening services (including colorectal screening) in the North West region. |
| SK | ✓ | ✓ | ✓ | Mobile Health Unit travels the northern part of the province providing information to First Nation groups about the importance of getting cervical, colorectal and breast screening. |

- No information was provided at the time the data were collected.

Table 35. Translation Strategies to Increase Participation in Colorectal Screening among First Nations, Inuit and Métis

| Jurisdiction | Intended Audience | | | Description |
|--------------|-------------------|-------|-------|--|
| | First Nations | Inuit | Métis | |
| MB | ✓ | ✓ | ✓ | Individuals can access interpreter services by calling ColonCheck. There is notice of this access point in the kit that is mailed to the individual. |
| NL | ✓ | ✓ | | Program has translated awareness posters, test kit instructions and result letters |
| ON | ✓ | ✓ | ✓ | FIT instructions have been translated into several Indigenous languages. |

Provider reminder and recall systems remind providers that it is time for a client to be screened for cancer or that the client is overdue for a test (e.g., in electronic medical records, via email, etc.)

Table 36. Provider Reminder Strategies to Increase Participation in Colorectal Screening among First Nations, Inuit and Métis

| Jurisdiction | Intended Audience | | | Description |
|--------------|-------------------|-------|-------|--|
| | First Nations | Inuit | Métis | |
| MB | - | - | - | Copies of all reports, including FOBT abnormal result, colonoscopy, pathology, and follow-up recommendations are sent to the PCP. |
| ON | ✓ | | | The Screening Activity Report (SAR) is an online report, which provides screening data to help family doctors improve their cancer screening rates and appropriate follow-up. The report allows family doctors to quickly find specific cancer screening information for each patient, including those who are overdue or have never been screened. In June 2018, the SAR was expanded to Sioux Lookout Zone, which consists of several First Nations communities, providing non-patient enrollment model physicians and nurses access to their community data. This SAR was developed specifically for the Sioux Lookout municipality and the 27 First Nation communities that reside in the Sioux Lookout Zone |
| SK | ✓ | ✓ | ✓ | Abnormal FIT follow-up forms are faxed to providers to ensure client has been assessed for colonoscopy referral |
| YT | ✓ | ✓ | ✓ | Frequent memoranda including reminders to refer all positive FITs for colonoscopy |

- No information was provided at the time the data were collected.

Provider assessment and feedback interventions evaluate provider performance and give providers information about their performance in offering screening services.

Table 37. Provider Assessment and Feedback Strategies to Increase Participation in Colorectal Screening among First Nations, Inuit and Métis

| Jurisdiction | Intended Audience | | | Description |
|--------------|-------------------|-------|-------|--|
| | First Nations | Inuit | Métis | |
| NL | ✓ | ✓ | ✓ | RHA has developed on-line course that staff and providers complete on cultural sensitivity |
| NU | ✓ | ✓ | ✓ | Provide training for healthcare providers working in Indigenous communities to provide increased access to fecal test services |
| ON | ✓ | ✓ | ✓ | Provide training for healthcare providers working in Indigenous communities to provide increased access to fecal test services (Regional Indigenous Cancer Leads and teams provide education and training) |

| Jurisdiction | Intended Audience | | | Description |
|--------------|-------------------|-------|-------|--|
| | First Nations | Inuit | Métis | |
| SK | ✓ | ✓ | ✓ | Provide training for healthcare providers working in Indigenous communities to provide increased access to fecal test services |
| YT | ✓ | ✓ | ✓ | Individual provider reports are sent to community health center and medical clinics |

Table 38. Policies and Guidelines to Increase Participation in Colorectal Screening among First Nations, Inuit and Métis

| Jurisdiction | Intended Audience | | | Description |
|--------------|-------------------|-------|-------|--|
| | First Nations | Inuit | Métis | |
| AB | - | - | - | Implemented several strategies in collaboration with Indigenous communities to improve CRC screening, including Indigenous community health strategy, First Nations cancer screening and prevention strategies. Many communities received grants to support local cancer screening and prevention initiatives. |
| NL | ✓ | ✓ | ✓ | Colon screening messaging and information is incorporated or linked to First Nations, Inuit and Métis Partnership funded projects where possible |
| NU | ✓ | ✓ | ✓ | Developed and signed formalized agreements (Relationship Protocols, Memorandums of Understanding) with PTOs, Independent First Nations, Inuit Service Providers, and the Métis Nation of Ontario which outline our approach to working together |
| ON | ✓ | ✓ | ✓ | Through the relationships developed and fostered by the Indigenous Cancer Care Unit, regional teams have been able to continue working with communities as guided through the Indigenous Cancer Strategy. The ICCU also works across the programs to inform guidelines and engage in studies to address community requests (i.e. assessing age eligibility for screening). |
| YT | ✓ | ✓ | ✓ | Participant in First Nations Advisory group in developing First Nations cancer strategy Yukon and supporting program manager of Yukon First Nations Cancer Care Program |

- No information was provided at the time the data were collected.

6.3 - Underscreened Populations



8/13

CANADIAN JURISDICTIONS IMPLEMENTING STRATEGIES TO SUPPORT PARTICIPATION IN UNDERSCREENED POPULATIONS

Screening participation rates are low among low-income individuals, new immigrants and those living in rural and remote communities when compared to the general Canadian population.¹⁴

Six provinces and two territories have implemented strategies to help address participation in underscreened populations. These strategies focus primarily on individuals in rural communities, new immigrants and low-income individuals. Some of the strategies identified reach underscreened populations through social media campaigns, presentations, and inclusive program material, focusing on increasing awareness and education on colorectal screening. Other strategies are geared towards healthcare providers, who in turn work directly with underscreened populations.

No underscreened population strategies related to client incentives, alternative hours, or childcare were reported.

| Population Examples | | | |
|--|---|---|--|
| <ul style="list-style-type: none"> • Low-Income • Socially Deprived • Materially Deprived • New Immigrants • Long Term Immigrants | <ul style="list-style-type: none"> • Specific Cultural Groups • Refugees • Economic Immigrants • Visible Minorities • Non-English Speakers | <ul style="list-style-type: none"> • Those living in an urban setting • Those living in a rural setting • Those living in a remote setting • LGBTQ2S+ | <ul style="list-style-type: none"> • Those with co-morbidities • Those with mental illness • Those with physical disabilities |

Figure 9. Underscreened Population Outreach Strategies in Canada (July 2019)

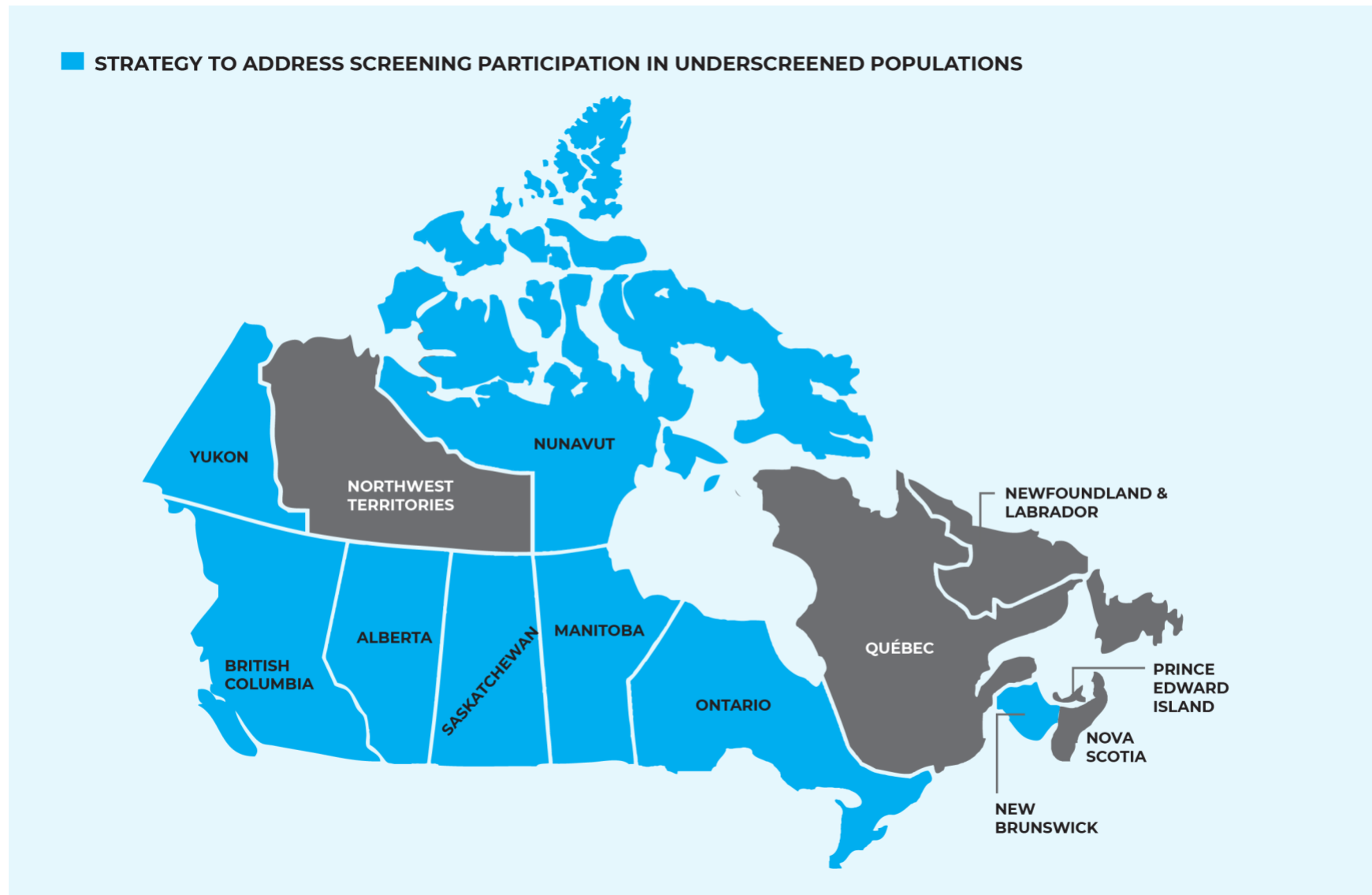


Table 39. Group Education Strategies to Increase Screening Participation among Underscreened Populations in Canada

| Jurisdiction | Intended Audience | Description |
|--------------|--|--|
| AB | <ul style="list-style-type: none"> New immigrants | <ul style="list-style-type: none"> CRC screening educational resources are translated into several languages to support immigrants. |
| MB | <ul style="list-style-type: none"> Newcomers | <ul style="list-style-type: none"> Cancer screening education module created with and for educators with students with low literacy. |
| NB | <ul style="list-style-type: none"> Will be based on Study Results which we expect will include: <ul style="list-style-type: none"> Those living in Rural Settings Those living in Urban settings Non-English speakers Low-income Specific cultural groups | <ul style="list-style-type: none"> Currently working on a GIS mapping project to help us identify areas of decreased participation for us to target increased awareness activities based on the needs of the identified underscreened population. |
| ON | <ul style="list-style-type: none"> Specific Cultural Groups | - |
| SK | <ul style="list-style-type: none"> Specific Cultural Groups | <ul style="list-style-type: none"> Coordinators provide education on colorectal screening at local community centres for immigrants. Education sessions include PowerPoint slides which have several pictures to help new immigrants understand the content. Mobile health unit travels to northern part of province to provide education on cancer prevention and cancer screening. The health unit also partners with primary care to provide other health care needs (example Diabetes and HIV testing) |

- No information was provided at the time the data were collected.

One-on-one education activities involve an individual (health care provider or layperson) explaining the benefits of screening and ways to overcome barriers to screening to clients individually either in person or by phone.

Table 40. One-on-One Education Strategies to Increase Screening Participation among Underscreened Populations in Canada

| Jurisdiction | Intended Audience | Description |
|--------------|---|--|
| MB | <ul style="list-style-type: none"> Individuals with low literacy | <ul style="list-style-type: none"> Curriculum designed for educators to use with adults with low literacy. The curriculum is on our website. |
| NB | - | <ul style="list-style-type: none"> Program Screening Access Coordinators provide education directly to participant with a positive FIT result via phone. Toll free cancer screening line available for people to call with questions or for information on how to participate in Colon cancer screening. |

- No information was provided at the time the data were collected.

Client reminders (e.g., letters, phone calls) are used to remind clients that screening is due and provide follow-up information (e.g., benefits of screening, ways to address barriers, help to schedule appointments).

Table 41. Client Reminder Strategies to Increase Screening Participation among Underscreened Populations in Canada

| Jurisdiction | Intended Audience | Description |
|--------------|--|---|
| NU | <ul style="list-style-type: none"> Low-income individuals | <ul style="list-style-type: none"> Patient Navigator provide reminders via phone calls |

Table 42. Mass Media Strategies to Increase Screening Participation among Underscreened Populations in Canada

| Jurisdiction | Intended Audience | Description |
|--------------|--|--|
| MB | <ul style="list-style-type: none"> All clients | <ul style="list-style-type: none"> Use social media, radio and newsprint to increase awareness about the importance of cancer screening |
| ON | <ul style="list-style-type: none"> LGBTQ2S+ Visible Minorities Specific Cultural Groups | <ul style="list-style-type: none"> Ontario's ColonCancerCheck program's promotional materials are inclusive for different communities. These materials are disseminated through the Regional Cancer Programs and Ontario Health (Cancer Care Ontario) across a variety of platforms (e.g., Facebook, Twitter, LinkedIn, posters, etc.). Ontario holds a Colon Cancer Awareness Month (CCAM) campaign each March. The campaign includes the development and dissemination of promotional materials to provincial regions. These materials include images, which are representative of diverse groups. |

| Jurisdiction | Intended Audience | Description |
|--------------|---|---|
| SK | <ul style="list-style-type: none"> All clients | <ul style="list-style-type: none"> Radio ads during colorectal screening month (March) inform clients of the importance of screening. Northern radio also included recorded interview. Television interview of colorectal screening medical advisor during community interest segment |
| YT | <ul style="list-style-type: none"> All clients | <ul style="list-style-type: none"> Radio ads and posters during colorectal screening month (March) |

Small media include videos and printed materials such as letters, brochures, and newsletters. These materials can be used to inform and motivate people to be screened for cancer. They can provide information tailored to specific individuals or geared towards general audiences.

Table 43. Small Media Strategies to Increase Screening Participation among Underscreened Populations in Canada

| Jurisdiction | Intended Audience | Description |
|--------------|--|--|
| MB | <ul style="list-style-type: none"> All clients | <ul style="list-style-type: none"> Brochures, test instructions, bowel prep instructions, and videos are readily available. |
| NB | <ul style="list-style-type: none"> Non-English Speakers Low Literacy | <ul style="list-style-type: none"> All Program brochures, materials and videos are produced in French and English in simple language. |
| SK | <ul style="list-style-type: none"> All clients | <ul style="list-style-type: none"> Effort is made to ensure that all pictures on posters, brochures etc. are representative of the diversity in our province |
| YK | <ul style="list-style-type: none"> All clients | <ul style="list-style-type: none"> Quarterly radio and newspaper ads and posters Program travels to all communities at least once yearly and attends First Nations organized health fairs in communities Outreach clinic and outreach van |

Table 44. Strategies to Reduce Out-of-Pocket Costs for Screening Participation among Underscreened Populations in Canada

| Jurisdiction | Intended Audience | Description |
|--------------|---|---|
| NB | <ul style="list-style-type: none"> • Low-income • Materially Deprived | <ul style="list-style-type: none"> • Provide bowel prep kits free of charge to individuals that cannot afford them. • Prepaid postage on eligibility questionnaire and FIT kits returns to provincial laboratory. |

Structural barriers are obstacles that make it difficult to access screening, for example, distance to screening locations, hours of service, setting of screening, administrative procedures, etc. Interventions to reduce structural barriers may include providing mobile screening, reducing administrative burden, providing assistance with scheduling, providing translation, expanding hours of service, etc.

Table 45. Appointment Scheduling Strategies to Increase Screening Participation among Underscreened Populations in Canada

| Jurisdiction | Intended Audience | Description |
|--------------|--|--|
| SK | <ul style="list-style-type: none"> • Those with physical disabilities | <ul style="list-style-type: none"> • Client navigator assessment includes alert to endoscopy unit of any physical disability accommodation required by the client |

Table 46. Alternative Site Strategies to Increase Screening Participation among Underscreened Populations in Canada

| Jurisdiction | Intended Audience | Description |
|--------------|---|---|
| ON | <ul style="list-style-type: none"> • Low-Income • Those living in a rural setting • Those living in a remote setting | <ul style="list-style-type: none"> • Ontario has a mobile screening coach that offers cancer screening services (including colorectal screening) in the North West region. |

Table 47. Transportation Strategies to Increase Screening Participation among Underscreened Populations in Canada

| Jurisdiction | Intended Audience | Description |
|--------------|---|---|
| ON | <ul style="list-style-type: none"> • Low-Income • Those living in a rural setting • Those living in a remote setting | <ul style="list-style-type: none"> • Ontario has a mobile screening coach that offers cancer screening services (including colorectal screening) in the North West region. |

Table 48. Translation Strategies to Increase Screening Participation among Underscreened Populations in Canada

| Jurisdiction | Intended Audience | Description |
|--------------|--|---|
| BC | <ul style="list-style-type: none"> • Specific Cultural Groups | <ul style="list-style-type: none"> • Brochures, videos and handouts are available in a variety of languages. |
| MB | <ul style="list-style-type: none"> • Cultural groups | <ul style="list-style-type: none"> • Access to the Language Access Interpreter services for those in Winnipeg to assist with informed consent to participate in colon cancer screening. We also have a basic set of information translated into many languages. |
| NB | <ul style="list-style-type: none"> • Non-English Speakers | <ul style="list-style-type: none"> • All program correspondence and communications are available in French. |
| ON | <ul style="list-style-type: none"> • New Immigrants • Long Term Immigrants • Specific Cultural Groups • Refugees • Economic Immigrants • Visible Minorities • Non-English Speakers • Those with physical disabilities • Those with visual impairments | <ul style="list-style-type: none"> • With the transition to the fecal immunochemical test (FIT), 'word-light' visual FIT instructions were developed to help participants successfully complete the test and to reduce the number of rejected tests. This can support those with low health literacy skills and those for whom English is a second language. These instructions are available online in multiple languages • A text version of the FIT instructions, which complies with AODA requirements, is also available online and can be translated into multiple languages by Ontario Health (Cancer Care Ontario)'s Contact Centre • Participants can also access the informational letter provided in mailed FIT packages online in multiple languages |

Provider reminder and recall systems remind providers that it is time for a client to be screened for cancer or that the client is overdue for a test (e.g., in electronic medical records, via email, etc.)

Table 49. Provider Reminder Strategies to Increase Screening Participation among Underscreened Populations in Canada

| Jurisdiction | Intended Audience | Description |
|--------------|--|---|
| AB | <ul style="list-style-type: none"> All | <ul style="list-style-type: none"> Individual cancer screening status and recommended actions are updated regularly and provided electronically to all PCP to support their point of care discussion with their patients about cancer screening |
| BC | <ul style="list-style-type: none"> All | <ul style="list-style-type: none"> Reminders are sent to all providers. |
| ON | <ul style="list-style-type: none"> All | <ul style="list-style-type: none"> The Screening Activity Report (SAR) is an online report, which provides screening data to help family doctors improve their cancer screening rates and appropriate follow-up. The report allows family doctors to quickly find specific cancer screening information for each patient, including those who are overdue or have never been screened. This may support screening in underscreened populations by helping physicians identify individuals from certain populations who have never been screened, such as new immigrants, economic immigrants and refugees. |
| MB | <ul style="list-style-type: none"> Eligible Manitoba population | <ul style="list-style-type: none"> ColonCheck maintains contact with the provider upon permission granted by the patient |
| YK | <ul style="list-style-type: none"> All | <ul style="list-style-type: none"> Reminders sent to providers. List of volunteer providers that will follow participants with no physician throughout screening pathway. |

Table 50. Provider Incentive Strategies to Increase Screening Participation among Underscreened Populations in Canada

| Jurisdiction | Intended Audience | Description |
|--------------|--|---|
| ON | <ul style="list-style-type: none"> Non-specific | <ul style="list-style-type: none"> To support family doctors in ensuring that their patients participate in eligible screening programs, the Ministry of Health has implemented Cumulative Preventive Care Bonuses. Through this program, eligible family doctors who practice as part of a Patient Enrolment Model, where patients are formally rostered to a family doctor, may receive bonuses for maintaining specified levels of preventive care to their enrolled patients. Depending on the specific practice of the physician, the Cumulative Preventive Care Bonuses may support screening in groups such as new immigrants, non-English speakers, those with co-morbidities and those with mental illness. |

Provider assessment and feedback interventions evaluate provider performance and give providers information about their performance in offering screening services.

Table 51. Provider Assessment and Feedback Strategies to Increase Screening Participation among Underscreened Populations in Canada

| Jurisdiction | Intended Audience | Description |
|--------------|--|--|
| BC | <ul style="list-style-type: none"> All | <ul style="list-style-type: none"> Provider quality reports with outcome measures to health care providers who refer patients for colon screening. |
| ON | <ul style="list-style-type: none"> Non-specific | <ul style="list-style-type: none"> The Screening Activity Report (SAR) is an online report, which provides screening data to help family doctors improve their cancer screening rates and appropriate follow-up. The report allows family doctors to quickly find specific cancer screening information for each patient, including those who are overdue or have never been screened. This may support screening in underscreened populations by helping physicians identify individuals from certain populations who have never been screened, such as new immigrants, economic immigrants and refugees. To support initiatives to improve cancer screening participation and follow-up rates, Ontario Health (Cancer Care Ontario) provides each region with a regional primary care provider report (RPCPR) twice a year which display screening data for PCPs in a Patient Enrolment Model (PEM) practice |

Table 52. Policies and Guidelines to Increase Screening Participation among Underscreened Populations in Canada

| Jurisdiction | Intended Audience | Description |
|--------------|---|---|
| BC | <ul style="list-style-type: none"> LGBTQ2S+ Visible minorities Specific cultural groups Physical disabilities Urban/rural/remote | <ul style="list-style-type: none"> All materials are being reviewed for inclusive language/images. |
| ON | <ul style="list-style-type: none"> Low-Income Socially Deprived Materially Deprived | <ul style="list-style-type: none"> As part of the transition to FIT, Ontario Health (Cancer Care Ontario) has switched to mailing kits to the participant. The FIT requisition submitted by a primary care provider has an optional second address section called "FIT Kit Mailing Address". This section provides patients with the option to receive their FIT kit at an alternative Ontario location. For example, patients who live on a First Nation reserve can have their FIT kit mailed to a health centre or nursing station. People who are currently housing insecure or at future risk of being housing insecure can have their FIT kit mailed to an Aboriginal Health Access Centre, Community Health Centre, Community Family Health Team, doctor's office or Nurse Practitioner-Led Clinic. |

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