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ReachMD
www.reachmd.com
info@reachmd.com
(866) 423-7849

Boosting Colorectal Cancer Screening in Rural Clinics: Insights from SMARTER CRC

Dr. Turck:

Welcome to *Clinician's Roundtable* on ReachMD. I'm Dr. Charles Turck, and joining me to discuss their research on implementation strategies for successful colorectal cancer screening programs in rural clinics are Drs. Gloria Coronado and Amanda Petrik. Dr. Coronado is a Professor of Epidemiology and the Associate Director of Population Science for the University of Arizona Cancer Center in Tucson.

Dr. Coronado, welcome to the program.

Dr. Coronado:

Thank you for having me.

Dr. Turck:

And also joining us is Dr. Amanda Petrik, an investigator at the Kaiser Permanente Center for Health Research in Portland, Oregon, where she focuses on cancer screening and prevention in real-world settings.

Dr. Petrik, thank you for being here.

Dr. Petrik:

Hi, thanks for having me.

Dr. Turck:

Well, Dr. Petrik, let's start with you. Would you tell us a bit about the central goal of the SMARTER CRC trial and why rural clinics were the primary focus?

Dr. Petrik:

The title of the SMARTER CRC project is Screening More Patients for Colorectal Cancer Through Adapting and Refining Targeted Evidence-Based Interventions in Rural Settings, and in SMARTER CRC, we tested the implementation and scale-up of a direct mailed fecal testing program, and this was in combination with a patient navigation program. We really were looking at these two effective multicomponent interventions, and we did this project in partnership with rural clinics as well as with health plans and commercial vendors. In this case, it was mail-in vendors. We did this because we know that disparities in colorectal cancer screening, follow-up, and referral to care exists in rural populations and in rural communities, and particularly for some populations within rural communities. So patients who are Medicaid enrollees or Hispanic have lower rates of screening, so working in these rural communities was really important.

Dr. Turck:

And turning to you, Dr. Coronado, would you elaborate on the coincidence analysis approach you employed in this study and how it helped identify key patterns that led to implementation success?

Dr. Coronado:

Absolutely. So in the past when we worked with Medicaid health plans to implement mailed FIT outreach programs, one of the consistent questions that the Medicaid health plan leaders had is, really, what is the special sauce? So what are the things that either we did or that the clinics did to make the program successful? And coincidence analysis allows us—it's a mathematical method—that allows us to really identify which combination of factors leads to a desired outcome. And so you can think of it as like, if I decide to drive my car across country, there are a variety of paths or routes that I could take, and my enjoyment of that route might depend upon the scenery, the number of Burger Kings along the way, or the distance between restrooms, so all those factors really change the experience of getting to your desired outcome. And so in the same way, we use this mathematical method to identify what is it that either health plans or clinics needed to do to make the program successful.

Dr. Turck:

Now, looking at the results, Dr. Petrik, one key finding was that clinics sending their own introductory letters had significantly higher screening and fecal immunochemical test, or FIT, return rates. Why are those letters so impactful?

Dr. Petrik:

This is actually the second study with this type of analysis with these findings that the introductory letter is part of a pathway that leads to successful implementation. And the first study where we found these same results was in the STOP CRC study, so we've been thinking about what it is about these introductory letters that is important. We think that sending the introductory letter shows that the clinics, first, have the ability to execute the program, so they have the staff that were available. They had time for those staff to be able to commit to the project. It also could indicate that they bought into the—air quotes here—fidelity of the program or our recommendations as the research team that they should follow to have a successful program. And when the introductory letter was sent from the clinic, the messaging was customized to the patient population and branded with clinic materials, potentially creating a greater sense of trust among the patient recipients. So it's coming from their own clinic—maybe from their own provider—who signed the letter. There are some variations that could have happened, but just getting that letter from their clinic entrusted that this is a test that they should be doing. They should do it quickly and return the test as their doctor recommends. It's interesting that we have found these results in two studies. We do think that this is an important step to successful implementation of a colorectal cancer screening program.

Dr. Turck:

For those just tuning in, you're listening to *Clinician's Roundtable* on ReachMD. I'm Dr. Charles Turck, and I'm speaking with Drs. Gloria Coronado and Amanda Petrik about optimizing colorectal cancer screening programs in rural clinics.

So, Dr. Coronado, if we continue to explore the results, another interesting insight was that clinics that didn't change their FIT type performed better. What's the significance of that stability?

Dr. Coronado:

As Dr. Petrik alluded, there were several steps that were part of the intervention. So in this particular program, the Medicaid health plans would identify a list of patients who were due and they would give that list to the clinics, who would then cull that list and remove some names. And then once that list was finalized, the Medicaid health plan worked with a commercial vendor that mailed the FIT kits to patients' homes and then the clinics provided navigation and, in some cases, follow-up phone calls. And then for patients who had abnormal test results, they provided navigation to make sure that those patients got in for a follow-up colonoscopy. In some cases, the clinics were interested in changing the FIT tests that they used, and so I think this would be indicative of clinics that were unsatisfied with the particular FIT test that they were using. They saw this project as an opportunity to really motivate changing that FIT test. Sometimes it was a two-sample test, and they wanted to change to a one-sample test that's easier for patients to do. But as you could imagine, changing your FIT tests often requires contracting with a different lab, setting up those relationships, and introducing new workflows to make sure that providers are well prepared to explain that particular test to the patients. And so I think the finding that clinics that changed their FIT test actually had lower implementation of the program makes a lot of sense just in terms of the steps that were required to accomplish that task.

Dr. Turck:

And, Dr. Petrik, from my understanding, clinics that attended four or more health plan meetings had higher FIT return rates. Why are those meetings so pivotal?

Dr. Petrik:

This finding is similar to the findings as explained with the introductory letter, that the attendance of the meetings was part of the pathway that led to their successful implementation. We think this finding indicates that, again, the clinic had time and resources for the

project, but the meetings themselves were very informative, and a lot of information was shared not only by the health plans but by the research team and in between the clinics that were participating in the study. So the research team would discuss the rates of the screening for each clinic or each system. We also shared successes that we had heard from other sites. For example, I remember one in-depth discussion with a clinic about patients not returning FITs, and other sites chimed in with suggestions for this clinic to get their rates up, for example, calling patients or following up on patients who had never had screening before to explain what the screening was about. So the clinics also discussed their own challenges or successes of their programs. They have received ideas of how to make changes to their own program. And then the health plans discussed the mailings, how they were going, and checked in with the clinics. Overall, the meeting as a group led to buy-in for the program and information on how to make their programs more successful.

Dr. Turck:

Now, before we wrap up our program, Dr. Coronado, how do you recommend clinics go about implementing these strategies, and what resources do they need to set up for success?

Dr. Coronado:

I think what we realize and what we know from the literature is that screening saves lives. You know, there's a variety of research from Kaiser as well as in community health centers showing that colorectal cancer screening saves lives, and we know that colorectal cancer is the second leading cause of cancer death in the US. And what we see in the Kaiser system is that they've showed that their organized FIT testing and follow-up colonoscopy program has led to significant reductions—an over 52 percent reduction—in colorectal cancer mortality, and this is data that came from work by Dr. T. R. Levin. And so it's really important to think about how we can get the successful program out to community clinics and make it successful in that particular setting, and I think that means really promoting stool-based testing and making sure that we're reaching populations that have low screening rates, including rural populations and, as Dr. Petrik mentioned, subgroups within rural populations that have particularly low screening rates, like Medicaid or Hispanic populations in rural areas. So really focusing on getting that screening rate higher is, I think, a really important message.

The other message is to receive timely screening. So we know that the screening recommendations now call for starting screening at age 45 and making sure that patients are well prepared to start the screening once they become age eligible and that they do screening according to the guidelines. And so if you're using a FIT test, that requires annual screening, and it requires that if you have an abnormal test result that you get a follow-up colonoscopy. So the important thing is get screened, talk to your family and friends about getting screened as well, and if you have an abnormal test result on a test that's not a colonoscopy, then you need to get that colonoscopy in order to remove the polyps that will prevent cancer or find it in early stages.

Dr. Turck:

Well, with those reflections in mind, I want to thank my guests, Drs. Gloria Coronado and Amanda Petrik, for joining me to discuss how we can successfully implement colorectal cancer screening programs in rural clinics.

Dr. Coronado, Dr. Petrik, it was great having you both on the program.

Dr. Coronado:

Thank you so much.

Dr. Petrik:

Thank you so much, Dr. Turck.

Dr. Turck:

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