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Improving Colorectal Cancer Screening Rates: Strategies for Equitable Care

Dr. Turck:

Welcome to *Clinician's Roundtable* on ReachMD. I'm Dr. Charles Turck, and joining me to discuss strategies for optimizing colorectal cancer screening are Drs. Jane McElroy, Jean Wang, and Nuha Wareg. Dr. McElroy is a Professor in the University of Missouri's Family and Community Medicine Department and the Co-Director of its Rural Health Research Center. Dr. McElroy, thanks for being here today.

Dr. McElroy:

Yeah. Thanks for having us.

Dr. Turck:

And Dr. Wang is a board-certified gastroenterologist and Professor of MedicineandSurgery in the Division ofGastroenterology at Washington University School of Medicine in St. Louis. Dr. Wang, welcome to the program.

Dr. Wang:

Thank you so much.

Dr. Turck:

And last but not least, Dr. Wareg serves as a Practice Facilitator for the Missouri Partnership to Improve Colorectal Cancer Screening program at the University of Missouri, which has been funded by the CDC. Dr. Wareg, it's a pleasure to have you here today.

Dr. Wareg:

Pleasure is mine. Thank you.

Dr. Turck:

So, Dr. McElroy, let's start with you. For some context, what does the colorectal cancer screening landscape look like today, particularly with regard to uptake and which patient populations are being under-screened?

Dr. McElroy:

Yeah, uptake continues to be uneven across the populations. When we look at people of color, like Black and Indigenous or Alaskan Native folks, they're less likely to be screened for colorectal cancer, yet they face higher CRC mortality and incidence rates. Also, Hispanics with limited English proficiency have lower colorectal cancer screening rates. When we look at people living in rural areas, they're also less likely to be screened—particularly with colonoscopies—for a couple of reasons, and one of those is lack of access to procedure centers where those can happen. Those are not in your neighborhood or right down the street, so those are often a distance from where people live, as well as shortage of gastroenterologists to be able to perform the colonoscopy.

Dr. Turck:

And turning to you, Dr. Wang, given some of those population-level challenges, what are some quality factors related to procedures that are most critical in determining whether a

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screening program actually prevents cancers?

Dr. Wang:

Well, patients have several options for colorectal screening. The most common options are either a stool-based test that patients can do at home or a colonoscopy where they have to come into a procedure center and get sedated and have a camera put in to look directly inside the colon. Now, the stool-based testing is pretty easy to do on your own at home, but the most important thing is that if you get an abnormal test result on the stool test, you have to then follow up with a colonoscopy. And we are finding that there are many patients who go through the process of the stool test but then don't follow up to get that colonoscopy if their test is abnormal, and so that's one area where we're working to try and increase and make sure that everyone who has an abnormal stool test will go on and get that follow-up colonoscopy.

Now, as far as the colonoscopy, it's very important that both the patient and the doctor do their parts in ensuring a good quality exam for screening. And what the patient has to do before a colonoscopy is a colon cleansing and basically clean out the colon of all the stool that's in there, and so we prescribe a medication which will basically cause the patient to have diarrhea and clean out all the stool from the colon. And it's very important that patients follow those directions carefully so that when we go in to actually do the procedure with the camera, we can get a good look at the inside of the colon without any parts of the colon being covered up with stool. Now, from a doctor's standpoint, it's very important that the doctor has a lot of experience doing colonoscopies for screening and also that they're taking their time and looking carefully around as they're doing the procedure.

Dr. Turck:

Now, Dr. Wareg, in your experience, what interventions have you found most

effective for boosting screening rates in busy clinical settings?

Dr. Wareg:

So in my experience working with rural clinics, there were some interventions that have higher success rates. The first one is handing out a stool-based test during clinic visits with a return date on the kit. And to make that even more successful, follow up systematically, so clinics who follow up on those handed-out stool-based kits see higher return rate and screening completion rate.

The other intervention is stool-based test standing orders and team-based workflow, meaning preparing for the visit either during the huddle with a lot of our clinics called pre-visit planning or some form of checklist that they use during their huddles. So for standing orders, empowering medical assistants or nurses to distribute and explain the stool-based FIT kits offloads a lot of these screening processes from basic clinicians. And for the pre-visit planning, embedding the screening into that routine vital sign workflow or annual wellness visit checklist ensures that the colorectal cancer screening doesn't get overlooked. So this is a whole team approach. When the whole team is involved, screening is viewed as shared responsibilities, and rates improve.

The third and the last one is a type of a patient reminder, but it has to be data-driven patient outreach; that is, clinics who have someone who can pull reports from their EHR or registry to identify patients that are due for screenings or patients who didn't complete their screening and conduct a proactive outreach, either with phone calls, letters, or texts, have better success.

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. Jane McElroy, Jean Wang, and Nuha Wareg about how we can improve colorectal cancer screening uptake and quality.

Now, coming back to you, Dr. McElroy, aside from what we've already discussed, would you talk a bit about clinic level and policy changes that you believe are the most important in increasing uptake and closing equity gaps?

Dr. McElroy:

Sure. And we've worked mostly with federally qualified health centers— most of our federally qualified health centers are in rural Missouri. We've done analysis looking at their data, and we found that their screening rates by race are similar, and that's fantastic because what that means is that Blacks are as likely to be screened as Whites, and that speaks really highly of our FQHCs in closing that gap in the disparity I mentioned previously. This behavior needs to be uniformly practiced throughout the United States so that all people should be screened regardless of race or ethnicity.

A second thing is finding safety net resources for those who have legitimate concerns about the cost of taking care of their health. That continues to be a work in progress. Transportation is a huge problem. Patients literally cannot get to appointments because they don't have a reliable means of transportation, or they can't afford the gas. Transportation systems just don't serve many parts of the United

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States, and figuring out how to support people getting to the clinic appointments will increase the screening rates.

Persistent repeated encouragement is another key factor that can drive increased screening rates, particularly among rural populations. Keep encouraging people to get screened even if they may be resistant or may say “no, thank you” at the yearly appointment. The next time you see them, bringing it up again is important, but also equally important is persistence in outreach efforts along with involvement of trusted community members, such as community health workers. These workers reflect the populations they serve. They look like them, and that’s meaningful. When they speak to what really, truly matters, such as getting screened for the sake of your family or to be there for a future milestone like your grandkid’s graduation, that can make a powerful, relatable impact on people, and it may be that “I’ll get screened not for me, but for my kids or my family,” and that can help improve the screening rates.

Dr. Turck:

And, Dr. Wang, how should we decide when to offer stool or blood-based tests versus heading straight to colonoscopy, especially in those younger and higher-risk patients?

Dr. Wang:

That’s a great question. We consider patients to be higher risk if they have a family history of colon or rectal cancer. Studies have shown that patients with a family history of colorectal cancer have a three times higher risk of cancer themselves in the colon or rectum, and so those patients with a family history should only be getting colonoscopy as their screening option.

Now, if someone does not have a family history of colorectal cancer, then they can choose a noninvasive option, such as a stool test or blood-based test. Now, for the stool tests, there are two main types. One is called the fecal immunochemical test, which detects traces of blood in the stool, and then there’s another common stool test, which is the DNA-based stool test, which looks at not only traces of blood in the stool, like the fecal immunochemical test, but also looks for abnormal DNA changes. These tests are very good for our patients who are average risk, meaning no family history, and who may not be able to take a day off work to come in for a colonoscopy. These stool tests are considered to be almost as good as a colonoscopy as far as detecting early cancer in the colon or rectum, but they’re not as good at detecting the precancerous growths. But they are definitely a good option for screening.

Now, the blood-based tests are very new and have just recently come out, and so far, those studies have shown that the blood-based tests are not as good as the stool or colonoscopy tests for screening for colorectal cancer, but the blood test may still be a good option for patients who, for any reason, do not want to undergo colonoscopy or the stool testing.

Dr. Turck:

And, Dr. Wareg, before we wrap up our program, let’s look ahead for a moment. What should we keep an eye out for in the next few years in colorectal cancer screening, and what new skills or infrastructure will clinics need to sustain equitable and high-quality screening?

Dr. Wareg:

From our experience working with rural clinics here in Missouri, I think in the next few years several important shifts are likely to impact how we approach colorectal cancer screening. One of them is the shift toward multimodal personalized screening, meaning we will likely see more tailored approaches to screening based on patients’ risk profiles and preference and access. And so clinics will need protocols to help patients navigate these new choices and ensure appropriate follow-up for positive results. The other thing is the importance of population health infrastructure, so they need sustainable, equitable screening, like a system in place to track who has been screened and who needs a follow-up. This means investing in the EHR optimization registries and other management tools, and clinics also will need staff trained to use these tools.

The last thing I would say is integration of CRC screening with broader preventive care efforts. Especially in resource-limited settings, CRC screening will increasingly be embedded in cancer prevention bundles during annual wellness visits along with breast cancer and cervical cancer, so they do a bundle together.

Dr. Turck:

With those final insights in mind, I want to thank my guests, Drs. Jane McElroy, Jean Wang, and Nuha Wareg, for joining me to provide their recommendations on optimizing colorectal cancer screening. Dr. McElroy, Dr. Wang. Dr. Wareg, it was great having you all on the program.

Dr. McElroy:

Thank you so much.

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Dr. Wareg:

Thank you.

Dr. Wang:

Thank you.

Dr. Turck:

For ReachMD, I'm Dr. Charles Turck. To access this and other episodes in this series, visit *Clinician's Roundtable* on ReachMD.com, where you can Be Part of the Knowledge. Thanks for listening.

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