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Strategies for Improving CRC Screening Rates in the Primary Care Setting

Announcer:

You're listening to *Clinician's Roundtable* on ReachMD, and this episode is sponsored by Exact Sciences. Here's your host, Dr. Charles Turck.

Dr. Turck:

This is *Clinician's Roundtable* on ReachMD, and I'm Dr. Charles Turck. Joining me to share their perspectives on how we can improve colorectal cancer screening rates are Drs. John Russell and Richard Wender. Not only is Dr. Russell the Director of FMRP and Chairman of Family Medicine at Jefferson Health in Abington, Pennsylvania, but he's also a fellow ReachMD host. Dr. Russell, thanks for being here today.

Dr. Russell:

Great to be with you today.

Dr. Turck:

And Dr. Wender is Chair of and a Professor in the Department of Family Medicine and Community Health at Penn Medicine. Dr. Wender, it's great to have you with us.

Dr. Wender:

Glad to be here.

Dr. Turck:

So why don't we start by reviewing the current screening guidelines for colorectal cancer. Dr. Wender, whom should we be screening and when?

Dr. Wender:

The first thing that every physician has to do with their patients is figure out if they're at, what we call, average risk or at higher-than-average risk. And the key to doing that is taking a personal medical history and a family history. So patients who have a history of Crohn's disease or inflammatory bowel disease have to start colonoscopy screening within 7 or 8 years of the diagnosis because they're at very high risk. Patients with a strong family history or a genetic syndrome like hereditary nonpolyposis colon cancer or familial adenomatous polyposis need to be aggressively screened starting at an early age. But everyone else, which is the vast majority of people, is considered to be at average risk, and screening in this group starts at age 45, not at 50. We've moved that age 5 years earlier because of the higher and increasing rate of colon cancer in young people.

Dr. Turck:

With those guidelines in mind, let's turn to you now, Dr. Russell. What are some barriers that keep patients from getting screened?

Dr. Russell:

That is a great question. But before we start, I think we have to look at our successes. So when the CDC looked at this subject in 2021,

they found that 71.8 percent of the population between 50 and 75 has been screened. So we've already had great successes. When they have queried populations about what are some other barriers, patients have said cost, transportation, logistics, the fear of the outcome, lower priority in their life, complications from the test, they're immodest and this feels like a violation of their personal space, not having a strong referral from their primary care clinician, and it's an unnecessary test. But when we have looked at the people who don't get screened, the number one barrier is not having a referral recommendation from their primary care clinician.

Dr. Turck:

Well, speaking of that, Dr. Russell, what are some strategies primary care physicians can use to overcome those barriers?

Dr. Russell:

Thanks, Dr. Turck. So I think one of the things, like so many things we do in primary care, is a strong recommendation from someone's personal clinician. So when I make a recommendation, I want to tell people why I think it's important. I often will offer a personal endorsement. I'm in my late 50s, and I've had two colonoscopies. I have a sister who is greater than 10 years out from a large colon cancer that was found on a screening colonoscopy. So I share why I think that's important.

I want to address people's biggest concerns. What are their concerns about it? What are some of their fears? What are some of the logistical things? And I will work to see if I can answer some of those questions. What's the real incidence of perforation for a colonoscopy?

We all have EMRs at this point, and they are great ways to reach out to people who don't come in to visits and can't take advantage of that face-to-face recommendation. So they are a great thing that we can utilize to reach out to patients to let them know that they are due for some colorectal cancer screening.

And we need to be patient centered in everything we do. And there are lots of different recommendations. So for some people, doing an endoscopic evaluation for colon cancer is great. For some people, a stool-based test to look for colorectal cancer might be best for them.

And as our numbers get smaller, as we have less and less people who are not screened, we might need to be more creative in figuring out ways to get people screened. Because overall, if we look at our populations who aren't getting screened, they tend to be people who have poor social determinants of health. And overall, one of the last things is the recommendation was just lowered to the age of 45, and that 45 to 50 population is one we really need to work on.

Dr. Turck:

For those just joining us, this is *Clinician's Roundtable* on ReachMD. I'm Dr. Charles Turck, and I'm speaking with Drs. John Russell and Richard Wender about improving colorectal cancer screening rates.

Now coming back to you, Dr. Wender, patient education is a huge factor here. So how do you talk to your patients about the importance of screening and the available options?

Dr. Wender:

So many patients will respond to advice from their primary care clinician, as John indicated. And the education, frankly, is pretty simple. Say you're 45, you've reached the age where you're due to have colon cancer screening, patients may not have known that, but they're ready to go. And that's probably about half of the patients. For another 10 to 15 percent, you do need to do some education about how important it is to be screened for colorectal cancer. Help them understand that it's the second-leading cause of cancer-related death in the United States, and that not only does screening help find small cancers early, but it actually is more likely to completely prevent the cancer by the detection of polyps and removal of polyps before they become cancer. And that speaks to a lot of people; a lot of folks love the idea of never getting colorectal cancer because it was prevented through screening.

But I do also think, for those who have any degree of reluctance, it's important to do some assessment of the barriers that they may be facing and the worries that they may have. "Am I going to have out-of-pocket expenses?" We're able to reassure people that, for virtually every insurance, screening colonoscopy and screening stool tests are completely covered. And that there should not be any cost-sharing or copay, even if a polyp is found. That was a recent change over the past few years in Medicare guidelines, which is now followed by all insurance companies. So there should not be out-of-pocket expense, and we should help address any fears they have, reassuring them about the safety if they opt for colonoscopy.

And the final thing that is so important is helping patients understand that they really do have a choice when they're looking at screening tests. We believe that the best test is the one that gets done. All of the screening tests can reduce colorectal cancer mortality to the

same extent, assuming that the test is followed as recommended: a fecal immunochemical test every year, a FIT-DNA test every 3 years, or a colonoscopy every 10 years. And patients must understand that if the FIT or the FIT-DNA comes out positive, they must have colonoscopy to really get the benefit of the test. But when we first looked at this nationally, we were really pretty disturbed to learn that a lot of people with a positive FIT or a FIT-DNA were not completing the screening process with a colonoscopy, which is an incredibly important missed opportunity. So there's been a lot of focus around the country to make sure that people who opt for stool testing understand that the only way to get the full benefit is to get that colonoscopy if the stool test comes out positive.

Dr. Turck:

And as a follow-up to that, Dr. Wender, are there any programs or initiatives you can tell us about to help improve screening rates that can be implemented at a practice or institutional level?

Dr. Wender:

Yeah, I'm so excited to see the improvements in screening rates that John mentioned earlier. In fact, in the Medicare population, we've kind of hit that 80 percent screening goal, which was a national goal set in 2013 by the National Colorectal Cancer Roundtable, in their 80 by 18 campaign. We now have a goal nationally of hitting 80 percent in every community, addressing disparities in screening that persist.

How have we done it? We've done it by individual clinician offices and health systems implementing evidence-based interventions. Here are just a few of them: for patients coming into the office, having a reminder system or care gap system to identify those patients who are in need of colorectal cancer screening who are out of date; utilizing patient reminders; and tracking those who receive a stool test to make sure that they complete the test.

The other tremendously effective intervention is population outreach to people who have not come in. And one of the advantages of the fecal immunochemical test is that we can mail that test to patients and then use text reminders, which has been the reminder approach proven to be most effective to encourage them to return it. Patient navigation, where it's available, particularly for patients who are facing barriers to screening, such as transportation, is an evidence-based proven way to increase completion of colorectal cancer screening, and it should be implemented particularly for those patients who face a lot of barriers.

Dr. Turck:

Well, we've covered a lot today already. But before we close, Dr. Russell, would you tell us what kind of impact primary care physicians can have on patient adherence when it comes to colorectal cancer screening?

Dr. Russell:

I think we can make a huge difference. And I think some of the things we need to remind our patients is colorectal cancer is the number two cause of fatal cancers in the United States. Screening has great evidence that it saves lives and that it makes people not die from the cancer if we find it. There are lots and lots of recommended options. There are endoscopic-based options like colonoscopy, and there are stool-based options. And all of our care should be individualized. And that's one of the things we aspire to in primary care, and every governing body in medicine endorses it: the American Cancer Society, the United States Preventive Services Task Force, the American College of Physicians, and the American Academy of Family Physicians, just to mention a few. So it's really important. And if a patient has a question, you should be open to answer whatever questions they have.

Dr. Turck:

Well, given just how important it is to screen eligible patients for this serious and common disease, I want to thank my guests, Drs. John Russell and Richard Wender, for joining me to discuss strategies for improving colorectal cancer screening rates. Dr. Russell, Dr. Wender, it was great speaking with you both today.

Dr. Russell:

Thanks for having us.

Dr. Wender:

Thank you.

Announcer:

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