

# Addressing Barriers to Colorectal Cancer Screening Learning Collaborative

*Session 1: Colorectal cancer screening  
recommendations*



# National Center for Health in Public Housing (NCHPH)


- The National Center for Health in Public Housing (NCHPH) is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number U30CS09734, a National Training and Technical Assistance Partner (NTTAP) for \$2,006,400 and is 100% financed by this grant. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.
- The mission of the National Center for Health in Public Housing (NCHPH) is to strengthen the capacity of federally funded Public Housing Primary Care (PHPC) health centers and other health center grantees by providing training and a range of technical assistance.



# Housekeeping

- All participants muted upon entry
- Engage in chat or verbally
- Raise hand if you would like to unmute
- Meeting is being recorded
- Slides and recording link will be sent via email



- 
- Complete our Post Evaluation Survey
  - NCHPH is providing Certificates of Completion for attending all sessions

# National Center for Health in Public Housing

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**Molly Black**  
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# Colorectal Cancer Screening: The Science of Screening and Strategies to Increase Screening



**Molly Black**  
Director, Cancer Screening

# Today's Objectives

- 1 **Explain** the benefits of colorectal cancer screening
- 2 **Describe** colorectal cancer screening guidelines.
- 3 **Identify** critical components of guideline activation: regular screening, risk-based screening and follow-up.
- 4 **Summarize** screening trends.
- 5 **Choose** strategies and resources that will increase your CRC screening rates.





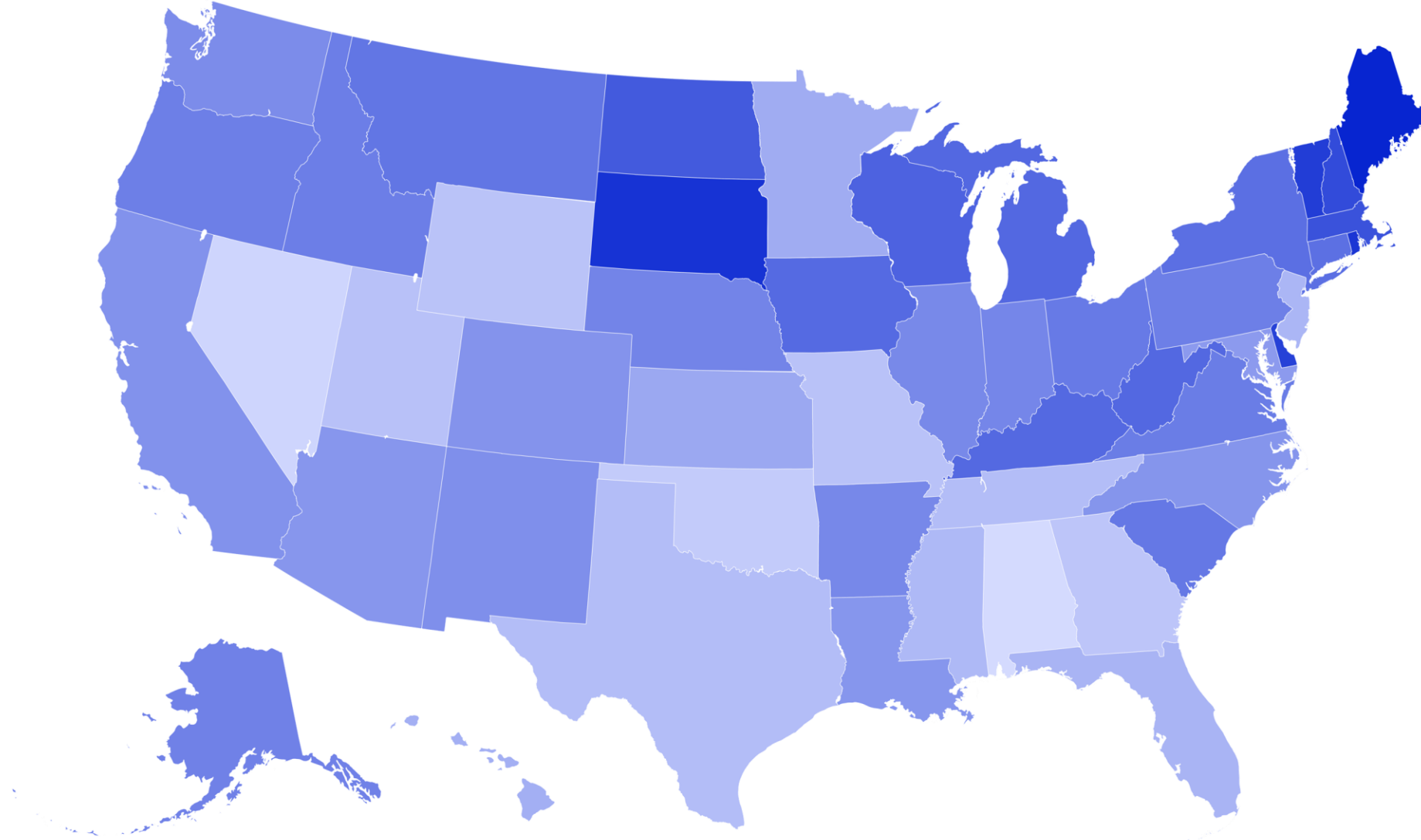


Annotate and tell us where you are joining us from.

## 2022 FQHC Colorectal Cancer Screening Rates

HRSA Uniform Data System (UDS) Data

National Screening Rate = 50.28%







**Do you have  
someone in your  
life who needs to  
be screened for  
colorectal cancer?**

# US Colorectal Cancer Stats

Over the past 10 years, rates in people younger than age 50 have **gone up by about 2% each year.**



1 in 5

CRC cases in people under age 55



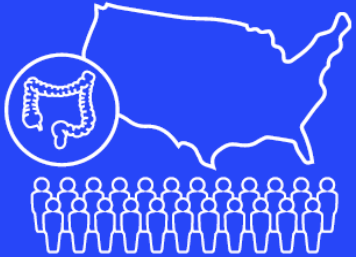
1 in 3

With CRC have a family history

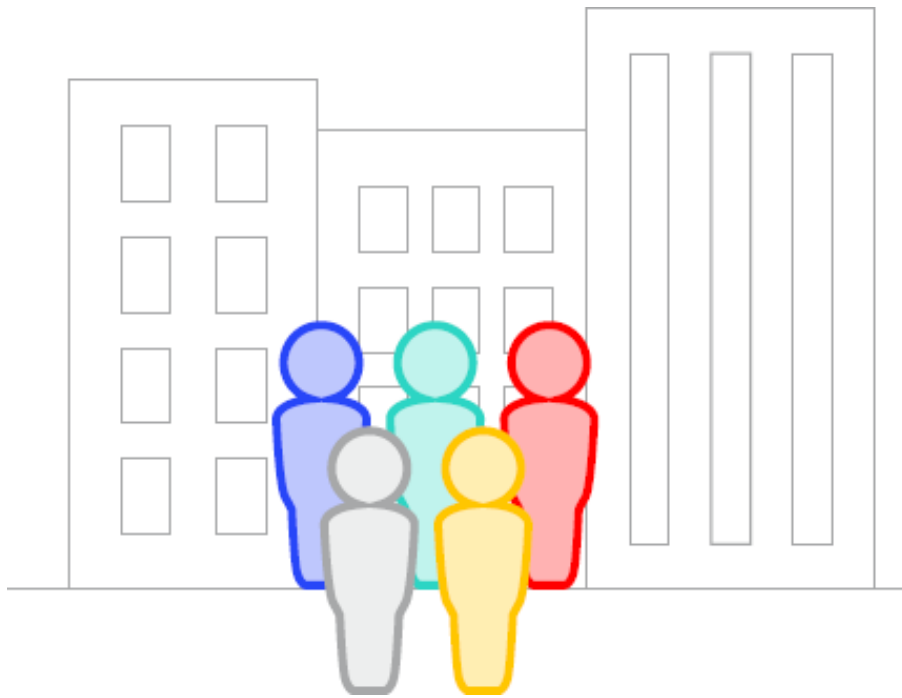


1 in 5

45 –49 year-olds are up-to-date on CRC screening



## Certain communities are at higher risk.



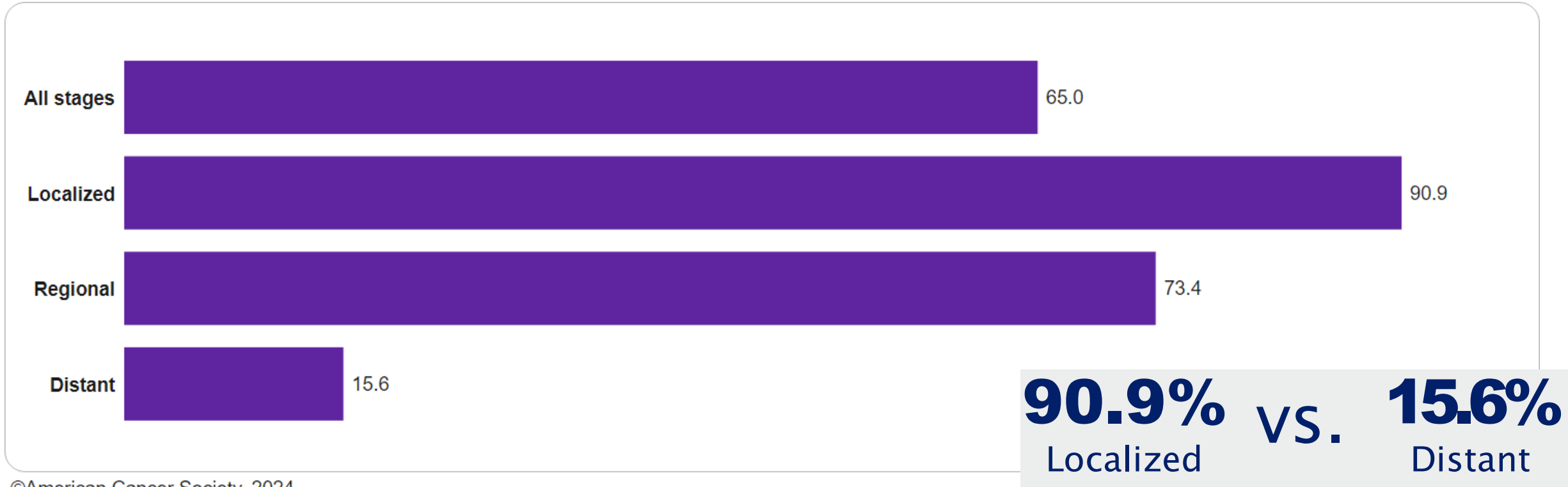
- American Indian and Alaska Native people have the highest rates of colorectal cancer in the US.
- Black individuals have the second-highest rates of colorectal cancer and are most likely to be diagnosed at a later stage, when the cancer has spread to other parts of the body.
- Colorectal cancer rates of new cases are highest in West Virginia, Kentucky, Arkansas, Mississippi, and Louisiana.



# COLORECTAL CANCER **AT A GLANCE**

| Estimated new cases, 2024 | Estimated deaths, 2024 | Incidence rates, 2016-2020   | Death rates, 2017-2021   |
|---------------------------|------------------------|--|--|
| <b>152,810</b>            | <b>53,010</b>          | <b>35.3</b>  | <b>13.0</b>  |
|                           |                        | Average annual rate per 100,000, age adjusted to the 2000 US standard population | Average annual rate per 100,000, age adjusted to the 2000 US standard population |

# 5-year relative survival by stage at diagnosis, Colorectal, 2013–2019



©American Cancer Society, 2024

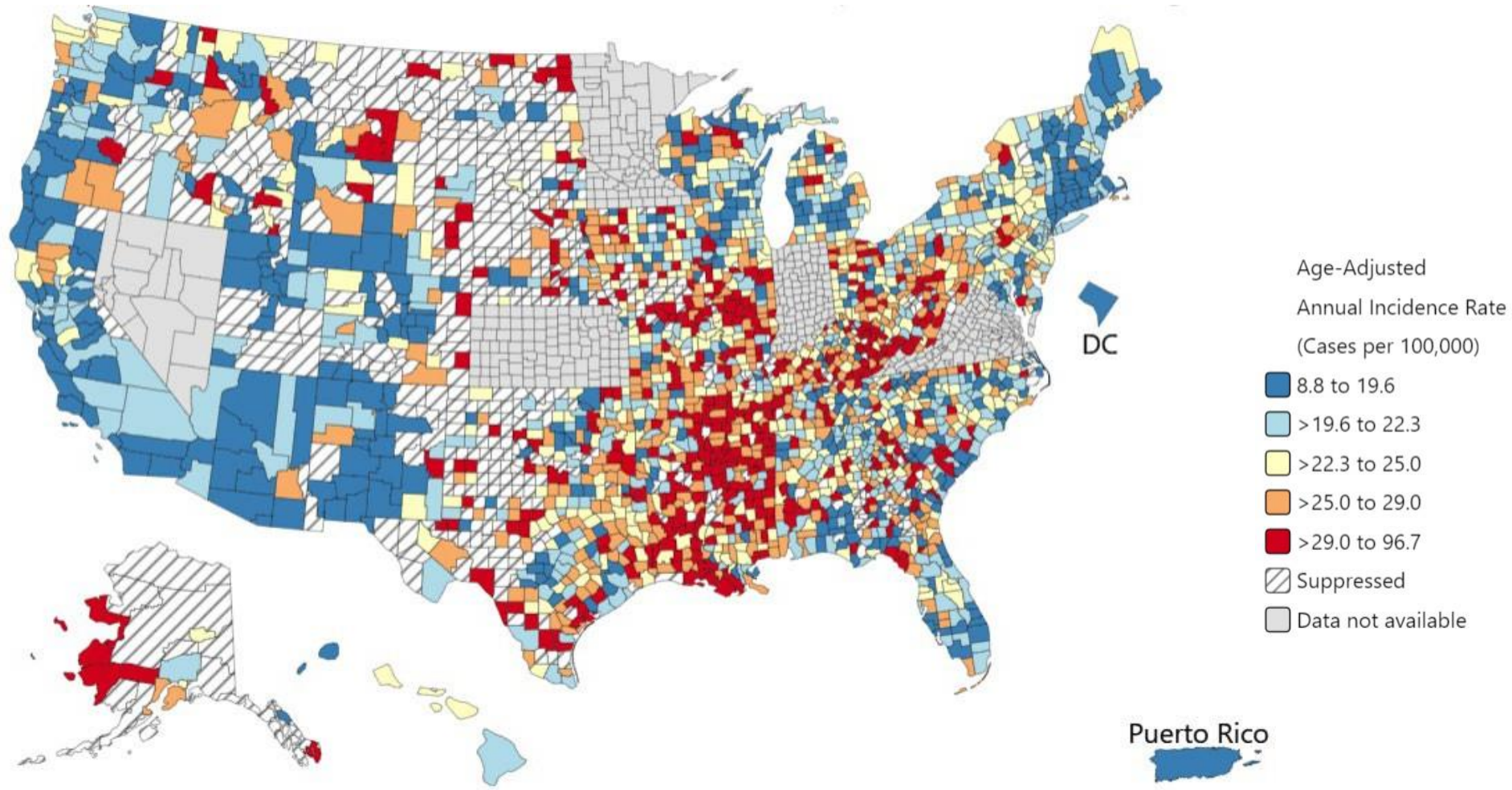
Data source: Surveillance, Epidemiology, and End Results 22 registries, National Cancer Institute, 2023

Survival is adjusted for normal life expectancy and based on cases diagnosed 2013-2019 and followed through 2020.

# Incidence Rates: Colon & Rectum (Late Stage<sup>^</sup>), 2016-2020

All Races (includes Hispanic), Both Sexes, All Ages

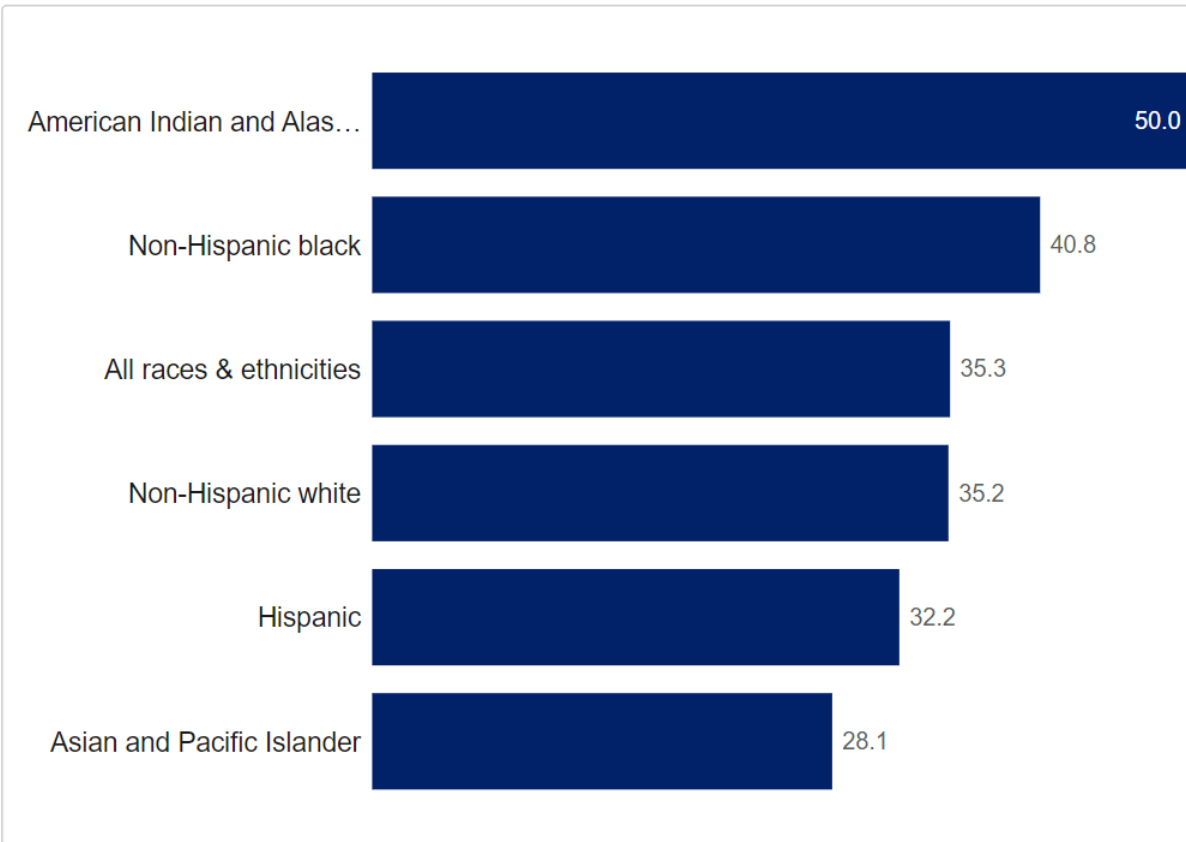
**59.1%** of cases are diagnosed at Late Stage



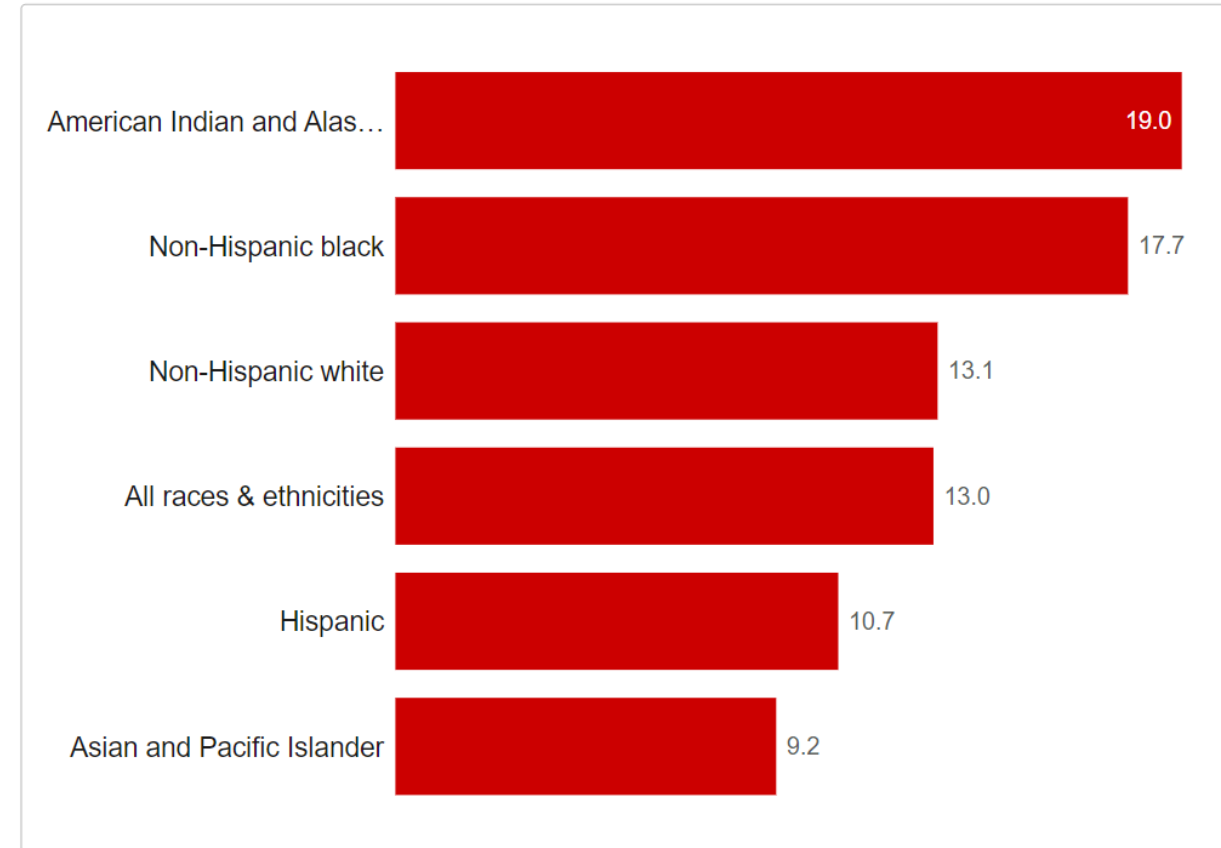
<sup>^</sup> Late Stage is defined as cases determined to be regional or distant. Due to changes in stage coding, Combined Summary Stage (2004+) is used for data from Surveillance, Epidemiology, and End Results (SEER) databases and Merged Summary Stage is used for data from National Program of Cancer Registries databases. Due to the increased complexity with staging, other staging variables maybe used if necessary.

# Colorectal Cancer Incidence & Mortality Rates by Race & Ethnicity

## CRC Incidence Rates, 2016 – 2020



## CRC Mortality Rates, 2017 – 2021



©American Cancer Society, 2024. Incidence Data Source: North American Association of Central Cancer Registries, 2023. Mortality Data Source: National Center for Health Statistics, Center for Disease Control and Prevention, 2023. Average annual rate per 100,000, age-adjusted to the 2000, US standard population. Incidence is adjusted for delays when possible. Nevada and Puerto Rico are not included in national rates (see [Resources page](#)).



# Colorectal Cancer Screening Guidelines

for people at average risk



## Ages 45-75

### **Get screened.**

Several types of tests can be used. Talk to your doctor about which option is best for you.

**No matter which test you choose, the most important thing is to get screened regularly.**

## Ages 76-85

### **Talk to your doctor**

about whether you should continue screening. When deciding, take into account your own preferences, overall health, and past screening history.

## Over Age 85

### **No longer screen.**

People over age 85 should no longer get colorectal cancer screening.

## Testing Options

- Visual exams such as colonoscopy or CT colonography look at the inside of the colon and rectum for polyps (growths) or cancer.
- Stool-based tests look for signs of cancer in stool and can be done at home. These tests include the fecal immunochemical test (FIT), fecal occult blood test (FOBT), and multi-target stool DNA test.
- All abnormal results on non-colonoscopy screening tests should be followed up with a timely colonoscopy.
- People with a family history of polyps or colorectal cancer, or who have other risk factors, might need to start screening before age 45, be screened more often, and/or get specific tests.

**Cancer screening saves lives. Get screened.**

Visit [cancer.org/getscreened](https://cancer.org/getscreened) for cancer screening FAQs, including information about how to schedule a screening test, how to afford screening with and without insurance, and more.



## Colorectal Cancer Screening for Average-Risk Adults: 2018 Guideline Update From the American Cancer Society

Andrew M.D. Wolf, MD<sup>1</sup>; Elizabeth I.H. Fontham, MPH, DrPH<sup>2</sup>; Timothy R. Church, PhD<sup>3</sup>; Christopher R. Howers, MD, MS<sup>4</sup>; Carmen E. Guerra, MD<sup>5</sup>; Samuel J. LaMonte, MD<sup>6</sup>; Ruth Etzioni, PhD<sup>7</sup>; Matthew J. McKenna, MD<sup>8</sup>; Kevin C. Offinger, MD<sup>9</sup>; Ya Chen Iina Shih, PhD<sup>10</sup>; Louise C. Walter, MD<sup>11</sup>; Kimberly S. Andrews, BA<sup>12</sup>; Otis W. Brawley, MD<sup>13</sup>; Durado Brooks, MD, MPH<sup>14</sup>; Stacey A. Fedewa, PhD, MPH<sup>15</sup>; Deana Manassaram Baptiste, PhD, MPH<sup>16</sup>; Rebecca L. Siegel, MPH<sup>17</sup>; Richard C. Wender, MD<sup>18</sup>; Robert A. Smith, PhD<sup>19</sup>

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Additional supporting information may be found online in the Supporting Information section at the end of this article.

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Members of the American Cancer Society Guideline Development Group (GDG) serve as advisors and received no compensation from the ACS. Current members are: Timothy R. Church, PhD; Ruth Etzioni, PhD; Christopher R. Howers, MD; Elizabeth T. H. Fontham, DrPH (Co-Chair); Carmen Guerra, MD; Samuel J. LaMonte, MD; Matthew J. McKenna, MD; Kevin C. Offinger, MD (Chair); Ya-Chen Iina Shih, PhD; Louise L. Walter, MD; and Andrew M. D. Wolf, MD (Chair of the Consensus Subgroup for CRC Guideline Update).

doi: 10.3322/caac.21457. Available online at [caac.aacr.org](http://caac.aacr.org)

Correction added after online publication 30 May 2018: A statement was corrected in the third paragraph of the Age to Begin CRC Screening section on page 7.

**Abstract:** In the United States, colorectal cancer (CRC) is the fourth most common cancer diagnosed among adults and the second leading cause of death from cancer. For this guideline update, the American Cancer Society (ACS) used an existing systematic evidence review of the CRC screening literature and microsimulation modeling analyses, including a new evaluation of the age to begin screening by race and sex and additional modeling that incorporates changes in US CRC incidence. Screening with any one of multiple options is associated with a significant reduction in CRC incidence through the detection and removal of adenomatous polyps and other precancerous lesions and with a reduction in mortality through incidence reduction and early detection of CRC. Results from modeling analyses identified efficient and model recommendable strategies that started screening at age 45 years. The ACS Guideline Development Group applied the Grades of Recommendations, Assessment, Development, and Evaluation (GRADE) criteria in developing and rating the recommendations. The ACS recommends that adults aged 45 years and older with an average risk of CRC undergo regular screening with either a high sensitivity stool based test or a structural (visual) examination, depending on patient preference and test availability. As a part of the screening process, all positive results on noncolonoscopy screening tests should be followed up with timely colonoscopy. The recommendation to begin screening at age 45 years is a qualified recommendation. The recommendation for regular screening in adults aged 50 years and older is a strong recommendation. The ACS recommends (qualified recommendations) that: 1) average-risk adults in good health with a life expectancy of more than 10 years continue CRC screening through the age of 75 years; 2) clinicians individualize CRC screening decisions for individuals aged 76 through 85 years based on patient preferences, life expectancy, health status, and prior screening history; and 3) clinicians discourage individuals older than 85 years from continuing CRC screening. The options for CRC screening are: fecal immunochemical test annually; high sensitivity, guaiac based fecal occult blood test annually; multitarget stool DNA test every 3 years; colonoscopy every 10 years; computed tomography colonography every 5 years; and flexible sigmoidoscopy every 5 years. *CA Cancer J Clin*. 2018;68:250-281. © 2018 American Cancer Society.

**Keywords:** adenoma, colonoscopy, computed tomography colonography, colorectal and rectal neoplasms, mass screening and early detection, mortality, occult blood, radiography, sigmoidoscopy, stool testing

# Screening for Colorectal Cancer: 2018 Guideline Update



<https://acsjournals.onlinelibrary.wiley.com/doi/epdf/10.3322/caac.21457>

# ACS (2018) vs. USPSTF (2021) Colorectal Cancer Screening Recommendations



|                                      | 2018 ACS   | 2021 USPSTF*  |
|--------------------------------------|--|---|
| <b>Age to Start</b>                  | <b>45 years</b>  | <b>45 years</b>   |
| <b>Testing options and intervals</b> | <p><b>Stool-based tests</b></p> <ul style="list-style-type: none"> <li>•Fecal immunochemical test (FIT), <i>every year</i></li> <li>•High-sensitivity, guaiac-based fecal occult blood test (gFOBT), <i>every year</i></li> <li>•Multitarget stool DNA test (sDNA-FIT), <i>every 3 years</i></li> </ul> <p><b>Structural examinations</b></p> <ul style="list-style-type: none"> <li>•Colonoscopy, <i>every 10 y</i></li> <li>•CT colonography, <i>every 5 y</i></li> <li>•Flexible sigmoidoscopy, <i>every 5 y</i></li> </ul> | <p><b>Stool-based tests</b></p> <ul style="list-style-type: none"> <li>•Fecal immunochemical test (FIT), <i>every year</i></li> <li>•High-sensitivity, guaiac-based fecal occult blood test (gFOBT), <i>every year</i></li> <li>•Multitarget stool DNA test (sDNA-FIT), <i>every 3 years</i></li> </ul> <p><b>Structural examinations</b></p> <ul style="list-style-type: none"> <li>•Colonoscopy, <i>every 10 y</i></li> <li>•CT colonography, <i>every 5 y</i></li> <li>•Flexible sigmoidoscopy, <i>every 5 y</i></li> <li>•Flexible sigmoidoscopy, <i>every 10 years + FIT every year</i></li> </ul> |
| <b>Age to end</b>                    | Individualized decision <b>76 to 85 years</b>  | Selective screening <b>76 to 85 years</b>   |

\* <https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/colorectal-cancer-screening>

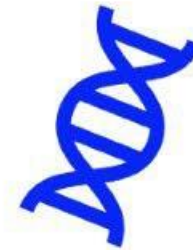
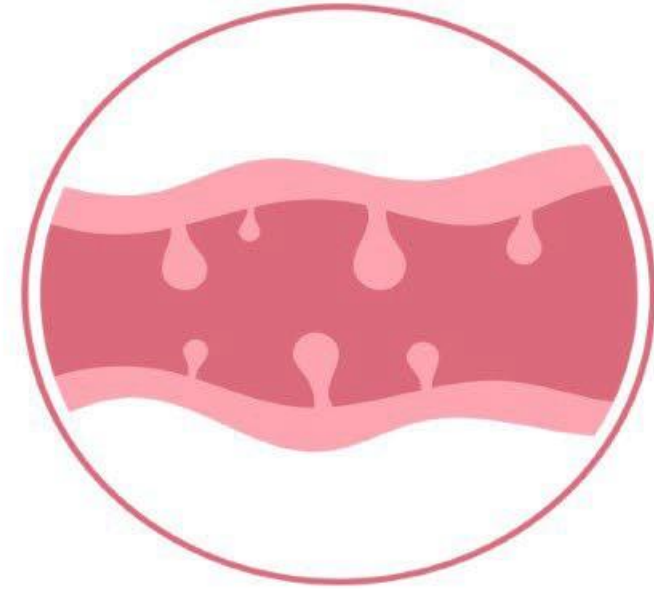
# Non-modifiable risk factors

## Existing polyps

- Personal or familial history of colorectal polyps or cancer

## Genetic risk factors

- **Lynch syndrome (HPNCC)** is the most common hereditary CRC syndrome
- **Familial adenomatous polypos (FAP)** also increases cancer risk



About **5%** of people who develop CRC have inherited gene mutations



# Non-modifiable risk factors



**Personal history of inflammatory bowel disease**



**Aging**



**Racial and ethnic background**

Alaska Natives, American Indians, African Americans and people of Ashkenazi Jewish descent are at higher risk for colorectal cancer.



**Having type 2 diabetes**

# Modifiable risk factors



**Diet:** Monitor what you eat and build a plan.



**Physical activity:** Limit sedentary behavior like watching TV.



**Alcohol use:** Drinking alcohol raises cancer risk.



# Modifiable risk factors



**Excess body weight:** Watch portion sizes, calories, fats, and sugars.



**Smoking:** Tobacco use remains the leading preventable cause of death in the U.S.

# *RISK ASSESSMENT AND SCREENING TOOLKIT*

*TO DETECT FAMILIAL, HEREDITARY, AND EARLY  
ONSET COLORECTAL CANCER*



## **Risk Assessment and Screening Toolkit:** To Detect Familial, Hereditary, and Early Onset Colorectal Cancer



<https://ncrt.org/resource/risk-assessment-and-screening-toolkit-to-detect-familial-hereditary-and-early-onset-colorectal-cancer/>

# RISK ASSESSMENT: 4 QUESTIONS TO ASK

**Question 1:** Does the patient have at least one 1<sup>st</sup> degree family member or two 2<sup>nd</sup> degree family members diagnosed with colorectal cancer (CRC) or adenomatous polyps?

*If diagnosed before age 55, patient requires early screening.*

**Question 2:** In the past 2 years, has the patient noticed blood in their stool or had other symptoms that could be related to CRC?

**Question 3:** Does the patient have a history of colorectal polyps from a prior screening?

**Question 4:** Has the patient ever had a positive FIT/iFOBT result?

**“YES”**  
to any  
question is  
considered  
at least  
**INCREASED**  
**RISK**

*These questions were developed by the Colorectal Cancer Prevention Network based upon peer review of scientific journals. The questions are designed to provide a simple tool to medical staff and patients alike to facilitate discussion related to CRC risk assessment and determining the appropriate CRC screening modality. These questions may not consider all increased and high-risk criteria and may not reflect guidelines published after the date of this publication (August 2021).*



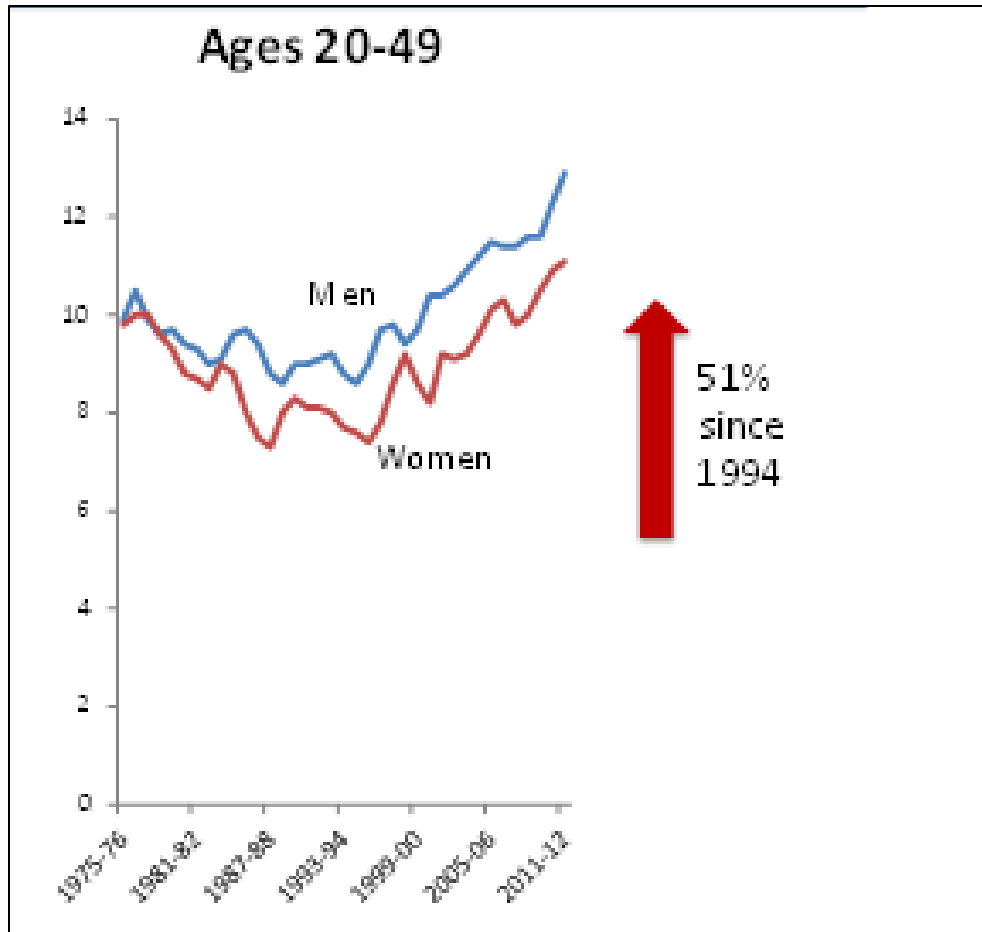


**Do you  
systematically  
assess for risk?**



# Rationale for Screening at Age 45

## Increasing CRC Incidence Under Age 50



- Diagnosis before age 50 has increased by **51%** over past 2 decades
  - Majority of the increase in age 40-49
  - Increases also seen in those in 30s and even in 20s
- Rectal cancer increase > than colon cancer
- Numbers are small overall – but steadily growing

# Increasing Disease Burden of CRC in Adults Aged 45-49

**The proportion of colorectal cancer in adults under age 50 has almost doubled since 1990.**

- In 1990, the proportion of adults under 50 with CRC was 6.4%
- In 2020, the proportion of adults under 50 with CRC will be approximately 12%
- In 2020, approximately 43% of CRC cases under age 50 were in ages 45-49

# CRC Under Age 50: Improving Outcomes

**Increased awareness among clinicians and young adults of symptoms and the need to take action to facilitate earlier detection**

- ✓ Rectal bleeding
- ✓ Abdominal pain
- ✓ Change in bowel habits
- ✓ Weight loss

Remember: Screening guidelines are for asymptomatic only!

Not relevant for symptomatic patients – regardless of age

# Stool-based tests



## About stool-based tests

- Can be done at home
- Low cost
- No bowel prep or sedation
- Need to be done more often than visual tests
- Will need a colonoscopy if test is abnormal
- Can miss many polyps and some cancers

## Stool-based test options

- Guaiac-based fecal occult blood test (gFOBT) **every year** or
- Fecal immunochemical Test (FIT) **every year** or
- Multi-targeted stool DNA test (MT-sDNA) **every 3 years**

# Visual-exam tests



## About visual-exam tests

- Done in doctor's office or health facility
- Bowel prep needed
- Only a colonoscopy can remove and test polyps
- Any test other than a colonoscopy will require a colonoscopy if the test is abnormal.

## Visual exam test options

- Colonoscopy **every 10 years** or
- CT colonography (virtual colonoscopy) **every 5 years** or
- Flexible sigmoidoscopy **every 5 years**



# Colorectal Cancer Screening Decision Aid

## UNDERSTANDING COLORECTAL CANCER SCREENING

### Colorectal Cancer Screening: Which test is right for you?



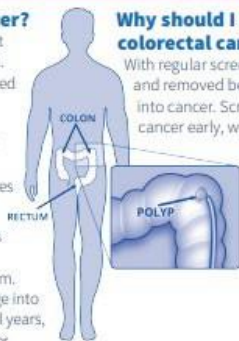
- ▶ **COLORECTAL CANCER IS THE SECOND-LEADING CAUSE OF DEATH FROM CANCER IN THE U.S. FOR MEN AND WOMEN COMBINED. The best way to prevent death from colorectal cancer is to stay current with screening.**
- ▶ **THERE ARE MANY SCREENING TESTS FOR COLORECTAL CANCER.** You and your health care provider have a decision to make about which screening test is right for you. The test you choose will depend on your preference and which tests are available to you. No matter which test you use, the most important thing is to get tested.
- ▶ **THE AMERICAN CANCER SOCIETY RECOMMENDS** that adults ages 45 and older with an average risk of colorectal cancer get screened regularly with a stool test or a visual test. Part of screening is having a follow-up colonoscopy for positive results on any screening test (besides colonoscopy).

*Who is this decision aid for?*  
*This decision aid is for adults who:*  
 \*\*\*\*\*  
 Are 45 years of age or older  
 \*\*\*\*\*  
 Are at average risk for colorectal cancer

### What is colorectal cancer?

Colorectal cancer is a cancer that starts in the colon or the rectum. These cancers can also be named colon cancer or rectal cancer, depending on where they start. Colon cancer and rectal cancer are often grouped together because they have many features in common.

Most colorectal cancers begin as a growth called a polyp on the inner lining of the colon or rectum. Some types of polyps can change into cancer over the course of several years, but not all polyps become cancer.



### Why should I get screened for colorectal cancer?

With regular screening, most polyps can be found and removed before they have the chance to turn into cancer. Screening can also find colorectal cancer early, when it is smaller and easier to treat.

*Colorectal cancer is the second-leading cause of cancer death in the U.S. when men and women are combined, yet it can be prevented or detected at an early stage.*

### How can I lower my risk of getting colorectal cancer?

There are things you can do to help lower your risk, such as staying at a healthy weight, being physically active, not smoking, limiting alcohol, and eating a diet high in vegetables and fruits.



### What screening tests are available?

Several screening options may be available to you.\* All of the screening tests below are effective at finding colorectal cancer. These tests fall into two categories. Stool tests are tests you can do at home by taking a stool sample and mailing it to a

lab. Visual tests are tests that a doctor does to look inside your colon. Most health insurance plans, including Medicare, cover most of these screening tests. Talk with your provider about which screening tests might be right for you.

#### STOOL TESTS

##### Fecal Immunochemical Test (FIT)

HOW OFTEN: **Once a year**

- ▶ You take a stool sample at home using a kit your provider gives you.
- ▶ It checks for blood in samples from 1 bowel movement.
- ▶ You mail your sample to a lab.



#### VISUAL TESTS

##### Colonoscopy

HOW OFTEN: **Every 10 years**

- ▶ Your provider uses a tube with a tiny camera to look for and remove polyps and cancer in your colon and rectum.
- ▶ You take a prep (tablets and something to drink) before the test to empty the colon. It causes diarrhea (watery stool).
- ▶ You will be sedated and need a day off work. You will need someone to drive you.



##### High-sensitivity Guaiac-based Fecal Occult Blood Test (HSgFOBT)

HOW OFTEN: **Once a year**

- ▶ You take stool samples at home using a kit your provider gives you.
- ▶ You mail your samples to a lab.
- ▶ It checks for blood in samples from 3 bowel movements.



##### CT Colonography (CTC)

HOW OFTEN: **Every 5 years**

- ▶ The test is also called virtual colonoscopy.
- ▶ Your provider uses an x-ray machine to look for polyps and cancer in your colon and rectum.
- ▶ You take a prep (tablets and something to drink) before the test to empty the colon. It causes diarrhea (watery stool).



##### Multi-target Stool DNA (MT-sDNA)

HOW OFTEN: **Every 3 years**

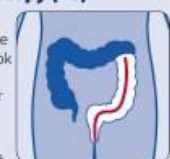
- ▶ You collect a bowel movement and stool sample at home using a kit your provider has shipped to you.
- ▶ It checks stool for blood and abnormal DNA from polyps or cancer.
- ▶ You mail a whole bowel movement and stool sample to a lab.



##### Flexible Sigmoidoscopy (FS)

HOW OFTEN: **Every 5 years**

- ▶ Your provider uses a tube with a tiny camera to look for polyps and cancer in the lower part of your colon and rectum.
- ▶ You give yourself 1 or 2 pre-filled enemas before the test to empty and clean the colon.
- ▶ This test is not available in most places.



\*Not all tests may be available. Talk with your health care provider about which tests are available to you.

### Talking with your health care provider

**Please bring this page to your next primary care appointment.** Your answers will help you and your provider discuss which screening test is right for you.

*Preventing colon cancer or finding it early doesn't have to be expensive. There are simple, affordable tests available. Get screened! Call your doctor today.*

#### WHAT IS IMPORTANT TO YOU?

Think about what is important to you in choosing a screening test. Answer the questions below to help you and your provider decide which test is right for you.

#### How concerned are you about:

|  | NOT CONCERNED         | VERY CONCERNED        |
|--|-----------------------|-----------------------|
| Having to collect samples of your stool?                                 | <input type="radio"/> | <input type="radio"/> |
| Completing screening every year?   | <input type="radio"/> | <input type="radio"/> |
| Completing a prep to empty the colon?                                    | <input type="radio"/> | <input type="radio"/> |
| Having an invasive procedure?  | <input type="radio"/> | <input type="radio"/> |
| Taking time off to complete screening?                                   | <input type="radio"/> | <input type="radio"/> |
| Being sedated and needing someone to drive you home after the screening? | <input type="radio"/> | <input type="radio"/> |

### Myths about colorectal cancer screening

- MYTH: Screening is too expensive.  
**FACT: Most screening tests are covered by insurance, including Medicare. There are also low-cost screening options.**
- MYTH: Nobody in my family has a history of colorectal cancer, so I am not at risk.  
**FACT: Most colorectal cancers are found in people without a family history of colorectal cancer. Those with a family history are at higher risk.**
- MYTH: If my stool looks normal, I should be fine.  
**FACT: You can have colorectal cancer or polyps even if your stool looks normal.**
- MYTH: Colorectal cancer is not that common.  
**FACT: Colorectal cancer is the second-leading cause of cancer-related deaths in the U.S. Screening is the best way to prevent death from colorectal cancer.**
- MYTH: Having a colonoscopy is the only way to get screened.  
**FACT: There are several different screening tests available. Some are simple and can be done at home.**

### Questions for your health care provider

- ▶ Why do I need to get screened now?
- ▶ What tests do you recommend for me?
- ▶ How do I prepare for the test?
- ▶ Will the test be painful or uncomfortable?
- ▶ Is there any risk involved in the test?
- ▶ What happens if the screening test comes back positive?
- ▶ When should I stop screening?
- ▶ How and when will I get my results?



Guidelines from the American Cancer Society, the US Preventive Services Task Force, and others recommend Fecal Immunochemical Tests (FIT), High-Sensitivity Fecal Occult Blood Tests (HS-gFOBT) and FIT-DNA testing as options for colorectal cancer (CRC) screening in men and women at average risk for developing colorectal cancer.

This document provides state-of-the-science information about these tests.



*Clinician's Reference*  
**STOOL-BASED TESTS FOR  
COLORECTAL CANCER  
SCREENING**



The number of colorectal cancer cases is dropping thanks to screening. We are helping save lives. We can save more.

# Clinician's Reference Stool-based tests for Colorectal Cancer Screening



<https://nccrt.org/resource/fobt-clinicians-reference-resource/>





**What is a key success you have made in getting your patients to return their FIT kit?**

## Do

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- ✓ **Do** make a recommendation! Be clear that screening is important. Ask patients about their needs and preferences. The best test is the one that gets done.
- ✓ **Do** use the American Cancer Society and the USPSTF recommendation to start screening in average-risk adults at age 45.
- ✓ **Do** assess your patient's family history, medical history, and age.
- ✓ **Do** be persistent with reminders.
- ✓ **Do** develop standard office operating procedures and policies for colorectal cancer screening, including the use of EHR prompts and patient navigation.
- ✓ **Do** use non-clinical staff to ensure screening and follow-up completion.
- ✓ **Do** streamline referrals and coordinate care across the continuum.

## Don't

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- ✗ **Do not** use digital rectal exams (DREs) for CRC screening. In one large study, DREs missed 19 of 21 cancers.
- ✗ **Do not** repeat a positive stool test. Any abnormal finding should be followed up with a colonoscopy.
- ✗ **Do not** use stool tests on those with a higher risk. A colonoscopy must be performed.
- ✗ **Do not** minimize or ignore symptoms in patients younger than screening age. Evaluate and refer symptomatic patients to colonoscopy as needed, regardless of age.
- ✗ **Do not** let patients with positive stool test go more than 120 days without a follow-up colonoscopy.



“If there isn’t follow-up, you might have not even screened the patient.”





**What strategies are working to get your patients access to follow-up colonoscopies?**

# **Current State of Colorectal Cancer Screening**

# HRSA Uniform Data System\* | Colorectal Cancer Screening Measure

## [CMS130v10](#)

### **Description**

Percentage of adults 50-75 years of age who had appropriate screening for colorectal cancer:

- Fecal occult blood test (FOBT) during the measurement period
- Flexible sigmoidoscopy during the measurement period or the four years prior to the measurement period
- Colonoscopy during the measurement period or the nine years prior to the measurement period
- FIT-DNA during the measurement period or the two years prior to the measurement period
- CT Colonography during the measurement period or the four years prior to the measurement period

### **Initial Population**

Patients 50-75 years of age with a visit during the measurement period

<https://ecqi.healthit.gov/ecqm/ec/2022/cms130v10>

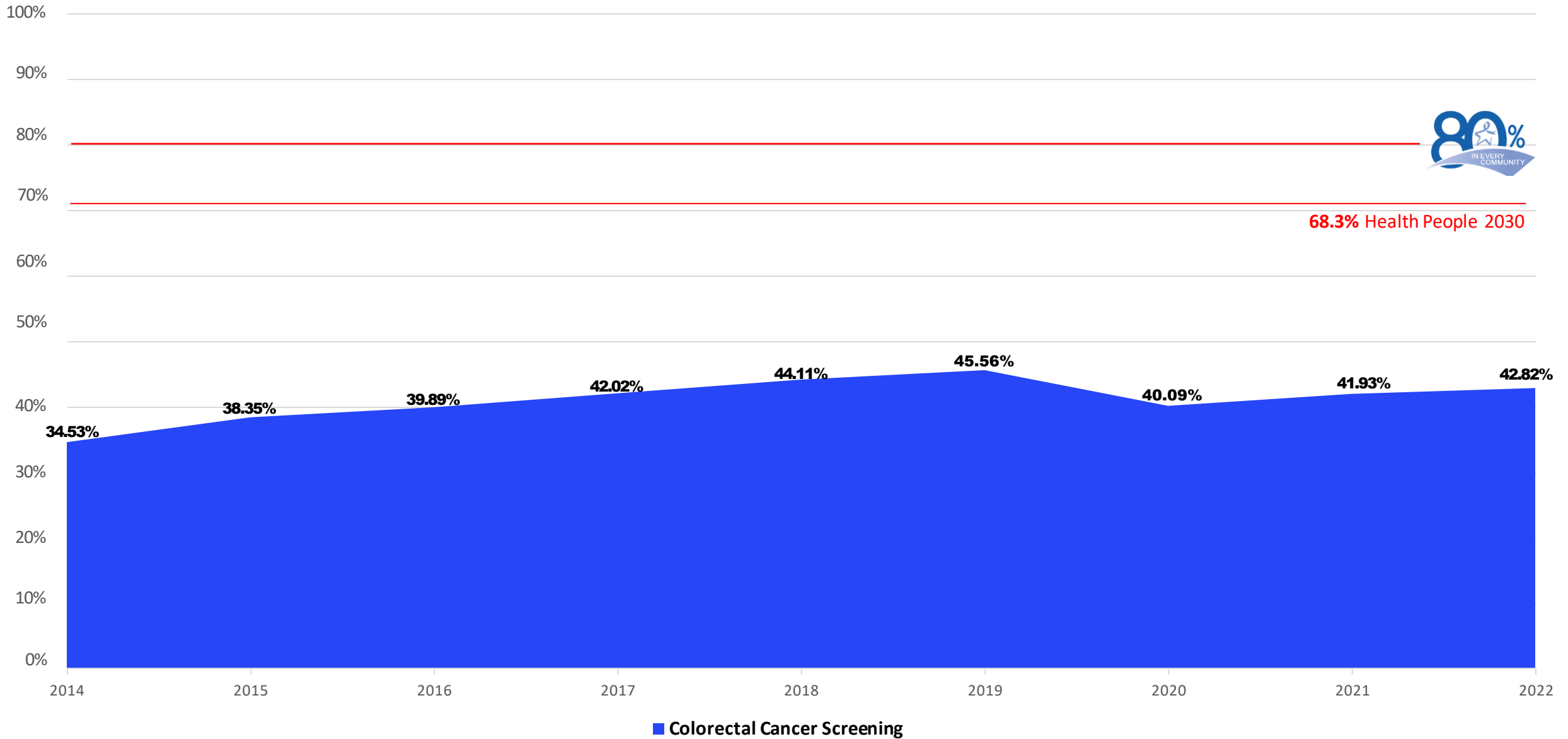
\*HRSA Health Center Program's Uniform Data System is utilized by Federally Qualified Health Centers for annual reporting.

<https://data.hrsa.gov/tools/data-reporting/program-data>



# 2014- 2022 FQHC Colorectal Cancer Screening Trends

HRSA Uniform Data System (UDS) Data

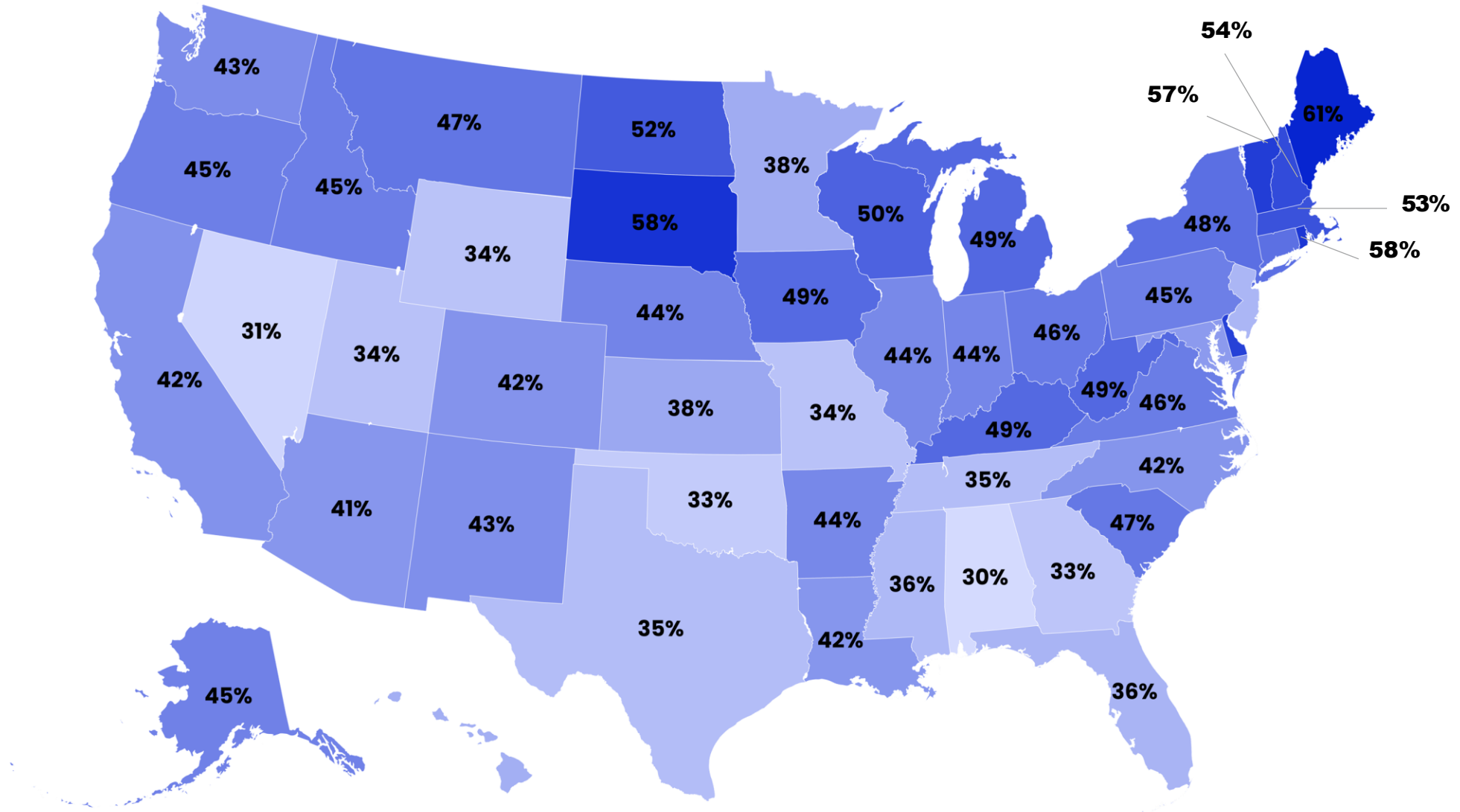


# 2022 FQHC Colorectal Cancer Screening Rates

HRSA Uniform Data System (UDS) Data

**National Screening Rate = 50.28%**

Colorectal Cancer Screening Rates

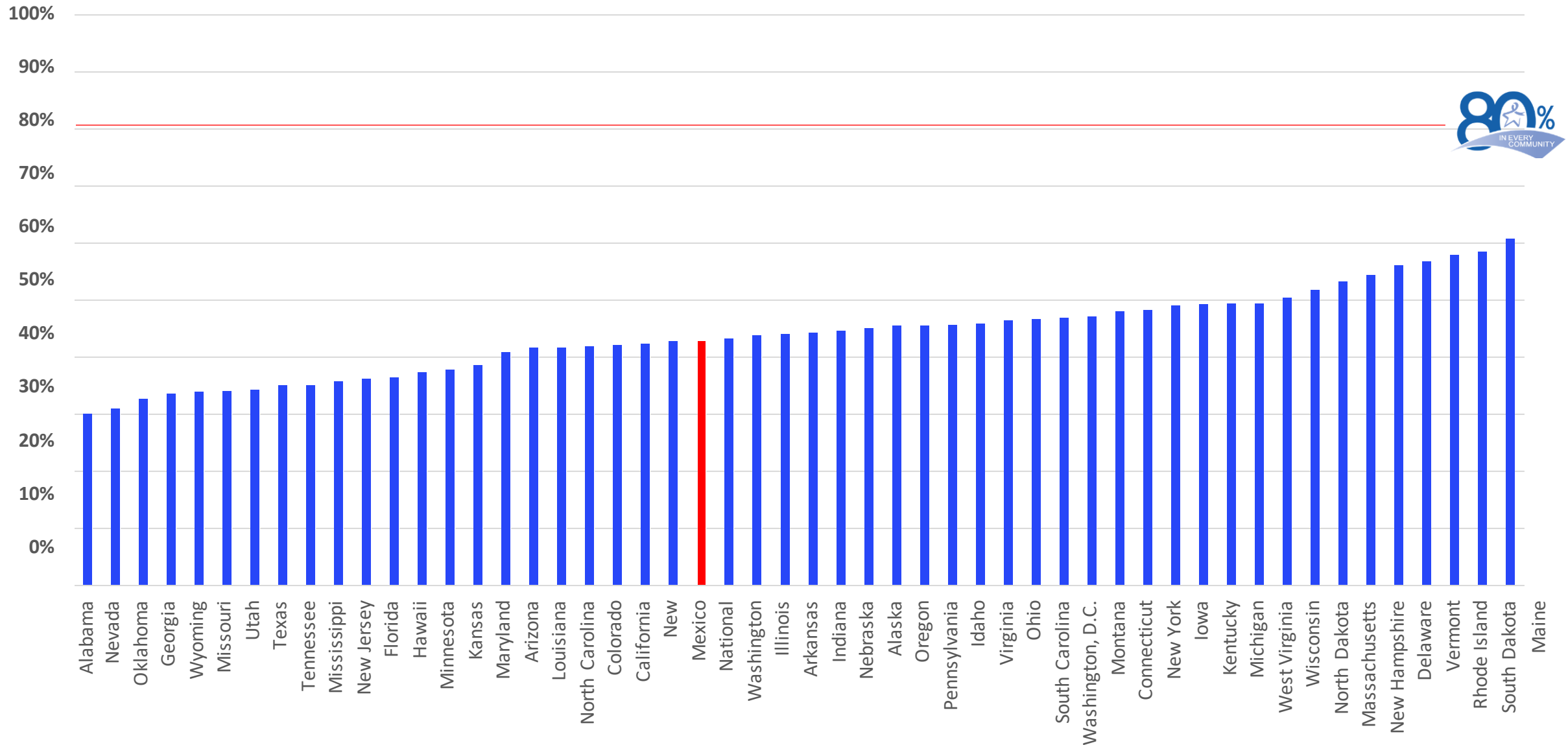


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# National FQHC Colorectal Cancer Screening Data

| Year        | Colorectal Cancer Screening Rate | # Patients Up-to-Date | # Eligible Patients |
|-------------|----------------------------------|-----------------------|---------------------|
| <b>2014</b> | 34.53%                           | 1,523,524             | 4,411,674           |
| <b>2015</b> | 38.35%                           | 1,803,514             | 4,703,353           |
| <b>2016</b> | 39.89%                           | 2,047,900             | 5,133,981           |
| <b>2017</b> | 42.02%                           | 2,271,055             | 5,405,197           |
| <b>2018</b> | 44.11%                           | 2,491,769             | 5,648,800           |
| <b>2019</b> | 45.56%                           | 2,741,612             | 6,017,345           |
| <b>2020</b> | 40.09%                           | 2,448,884             | 6,108,258           |
| <b>2021</b> | 41.93%                           | 2,680,519             | 6,393,355           |
| <b>2022</b> | 42.82%                           | 2,769,283             | 6,467,607           |

## 2022 FQHC Colorectal Cancer Screening Rate by State



**Data Source:** HRSA Health Center Program Uniform Data (UDS) Data, 2022. Public data with calculations and data visualization by the American Cancer Society.  
<https://www.hrsa.gov/foia/electronic-reading>



**Do you know your  
current CRC  
screening rate?**



In 2022, **3,698,324**  
eligible FQHC patients  
were not up-to-date  
on colorectal cancer  
screening.

**Primary Care  
Strategies to  
Increase  
Colorectal Cancer  
Screening Rates**

# ACS NCCRT's 80% in Every Community National Achievement Awards: FQHC Honorees



## 2024 Community Health Center Category: **Family Health Services** | South Central Idaho

Focused efforts on patient education and outreach, barrier identification, provider recommendation navigation to colonoscopy for patients with a positive or abnormal stool test, and an innovative program that fundraisers at least \$25,000 each year for discounted colonoscopies from referral partners.

**2023 Innovative Partnership Category: CommUnityCare Health Centers Central Texas** Working in partnership with the University of Texas Austin's Dell Medical School and supported by funding from the Cancer Prevention and Research Institute of Texas, the partnering organizations undertook a multi-year effort to increase colorectal cancer (CRC) screening among eligible CommUnityCare patients. The team implemented a multi-faceted intervention that featured mailed stool-based testing and bilingual, bi-cultural screening navigation to ensure positive (abnormal) Fecal Immunochemical Test (FIT) results were followed by timely colonoscopy.

# ACS NCCRT's 80% in Every Community National Achievement Awards: FQHC Honorees



## 2023 Community Health Center Category: [Kintegra Health](#) | [North Carolina](#)

Partnered with North Carolina Partnership to Increase CRC Screening (NC PICS), a CDC program. In addition to receiving ongoing technical assistance from NC PICCS, Kintegra Health participated in the American Cancer Society's Learning Collaborative and developed aim statements, process maps, gap analysis, PDSA cycles and implemented patient reminders and reduced structural barriers. Kintegra Health has successfully negotiated a colonoscopy cost rate well below the Medicare rate and developed medical neighborhood for sustainability.

**2022 Community Health Center Category: [Pueblo Community Health Center](#) | [Pueblo, CO](#)** Process improvements included developing provider champions to test and adapt new clinic workflows, reporting outcomes by provider, training medical assistants to educate and engage patients, utilizing case management and navigation staff to reduce barriers, adapting workflows to the telehealth environment, and postcard mailings.

# ACS NCCRT's 80% in Every Community National Achievement Awards: FQHC Honorees



## 2021 Community Health Center Category: [Esperanza Health Centers](#) | [Chicago](#)

Instrumental in Esperanza's improvement is their data dashboard, which tracks screening rates monthly and allows them to identify care teams that are exceeding their goals and capture and share their best practices. With COVID-19, care teams focused on delivering FIT kits with prepaid mailers along with frequent reminders. In 2018 and 2019, they received HRSA's National Quality leader honor.

## 2020 Community Health Center Category: [North Hudson Community Action Corporation](#) | [New Jersey](#)

NHCAC Implemented a number of evidence-based systems changes, including patient navigation, patient and provider reminders, and reduction of structural barriers including transportation and client costs. Screening eligible patients also received a screening recommendation at all health center visits, including dental and behavior health, to avoid critical, missed opportunities. [View a short video describing NHCAC's work](#)





# STEPS

For Increasing  
Colorectal Cancer  
Screening Rates

A Manual for Primary Care Practices

Colorectal Cancer Screening | **Primary Care Resource**



## Steps for Increasing Colorectal Cancer Screening Rates: A Manual for Primary Care Practices



<https://nc crt.org/resource/steps-for-increasing-crc-screening-rates-2022/>



# Practical advice in the manual's four primary sections:

**1** A **Background** section that provides information on the importance of CRC screening

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**2** A **Steps for Increasing Colorectal Cancer Screening Rates** section that maps out a plan for improving your CRC screening rates and gives step-by-step instructions for doing so

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**3** Ten **case studies** from exemplary and diverse practices from across the country

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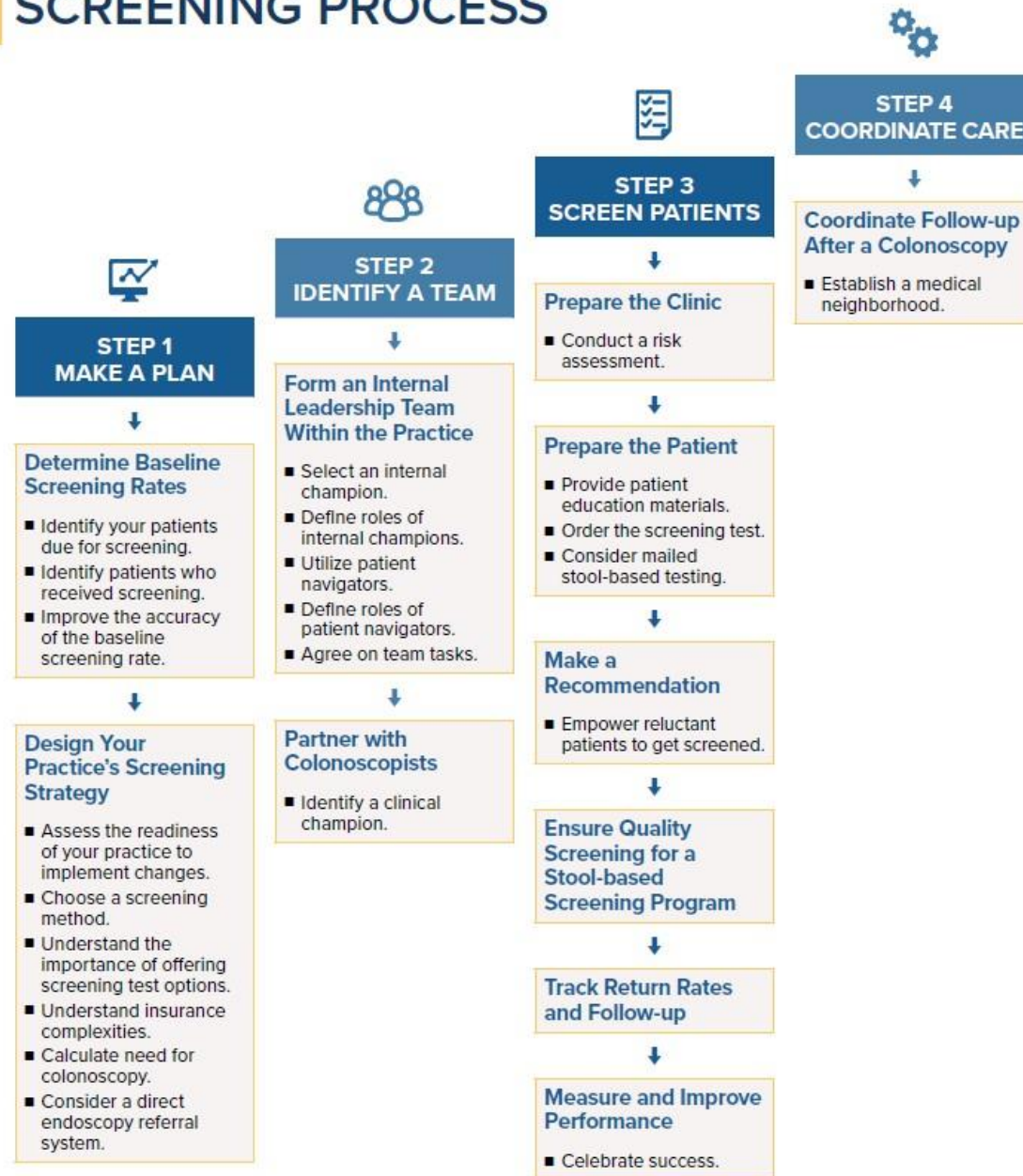
**4** An **Appendices** section that provides field-tested tools, templates, and resources to get you started

# STEPS For Increasing Colorectal Cancer Screening Rates



← COMMUNICATION →  
← CONTINUOUS QUALITY IMPROVEMENT →

# OVERVIEW OF THE SCREENING PROCESS





# **Lead Time Messaging Guidebook: A Tool to Encourage On-Time Colorectal Cancer Screening**



## **Lead Time Messaging Guidebook**

A Tool to Encourage On-Time  
Colorectal Cancer Screening



<https://nccrt.org/resource/2023-lead-time-messaging-guidebook/>

## Key Takeaways

Education gap around screening with younger audiences

Young people agree:

- They have an appetite for being told about screening before recommended screening age.
- They agree you should get screened on time.

Messaging types:

- People aren't looking for quantitative information.
- People want messages that resonate with them.

High on the action list — people know this information but want to hear from their healthcare providers and are motivated to get screened when recommended by someone in health care.

## Intent of This Guidebook



Share best practices for messaging and educating about colorectal cancer screening before recommended screening age



Encourage people starting in their 20s to discuss their Family Cancer History including CRC and colon polyps and take action as needed



Encourage people to talk to their healthcare provider about CRC and learn when they will most likely need to be screened



Motivate individuals to make it a priority to get regular, on-time CRC screening





## CONTENTS

Perceptions and Attitudes About Personal Health Colorectal Cancer Screening

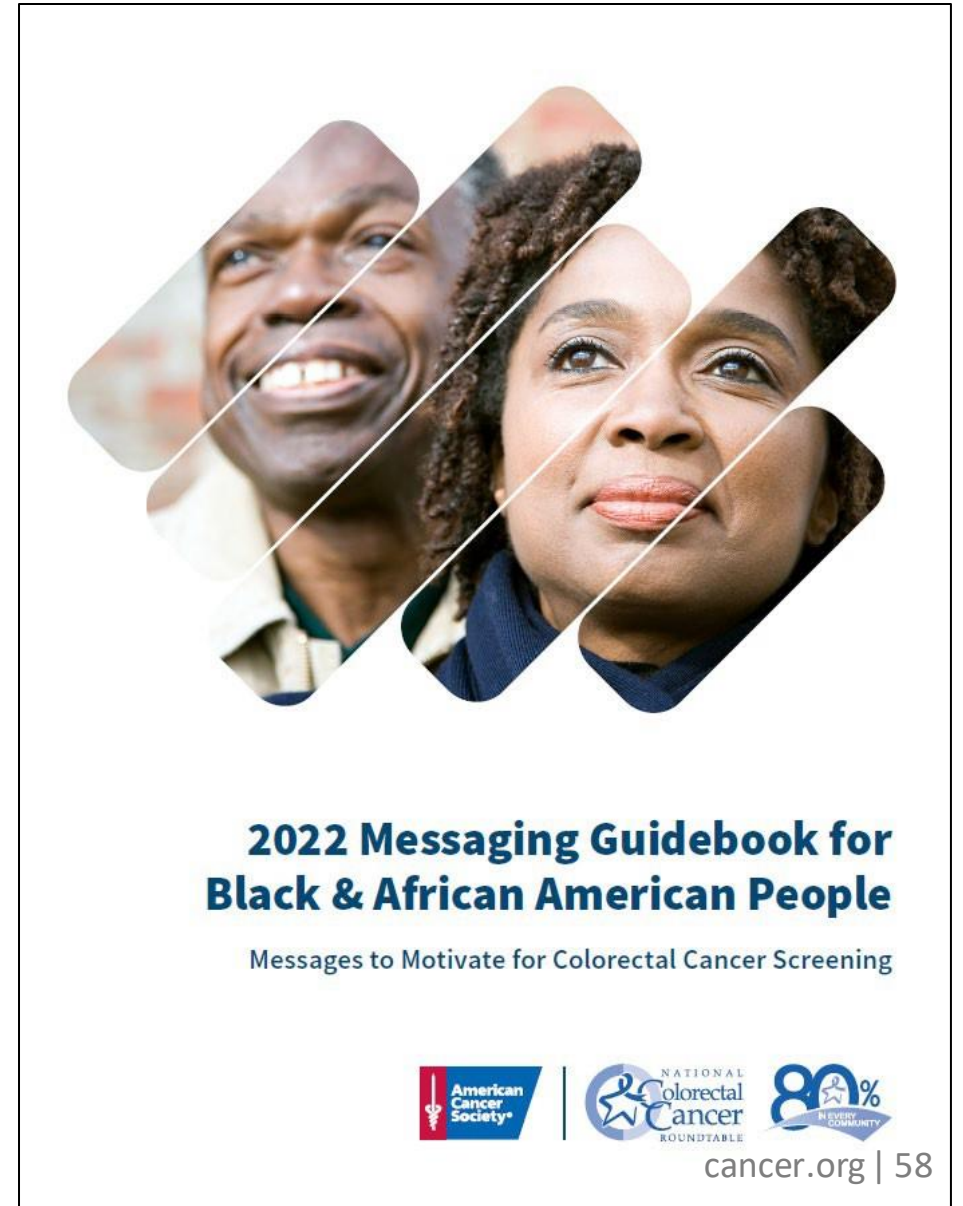
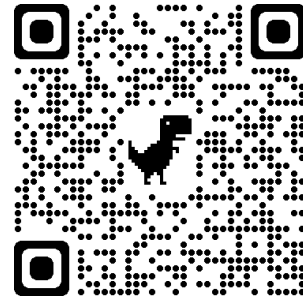
Barriers to Screening

Message Delivery

Preferred Screening Messages

Spotlight on Messaging Groups

<https://nccrt.org/resource/2022-messaging-guidebook-black-african-american-people/>





# BARRIERS TO SCREENING



## DEFERMENT

- This was the leading barrier
- COVID-19
- financial concerns
- test prep
- concerns or fears about the test / test results
- thinking one is unlikely to develop colorectal cancer

## DOCTOR DID NOT RECOMMEND IT

## RACISM

- 1 in 3 people hesitant
- Personal experiences with care impacted by racism

## NO FAMILY HISTORY & NO SYMPTOMS



**A recommendation from a clinician** is the most predictive factor for a patient initiating and completing the cancer screening process.\*

\*Impact of provider-patient communication on cancer screening adherence: A systematic review  
<https://www.sciencedirect.com/science/article/abs/pii/S0091743516302912?via%3Dihub>

# Major Findings

## Mammograms

- **Provider recommendation** was associated with receipt of mammogram ( $p = .002$ )
- Women with **physicians who recommended screening** were more likely to have a mammogram. (OR = 2.29, 95% CI = 1.42–3.69)
- A **lack of doctor recommendation** was significantly associated with lower odds of screening among Latinas (OR = .01, 95% CI = .002, .12) and Arab women (OR = .25, 95% CI = .10, .61) but not significant for Black women

## Cervical Screening

- Pap: A **lack of doctor recommendation** was significantly associated with lower odds of screening among Latinas (OR = .09, 95% CI = .02, .42) and Arab women (OR = .26, 95% CI = .12, .54) but not significant for Black women.
- Women who reported a physician recommendation had a nearly 7.0 higher odds of having been screened for cervical cancer in the preceding 3 years.
- Women whose healthcare providers had recommended screening were more likely to become routine screeners (Adjusted OR = 2.04, 95% CI = 1.32, 3.15).

## Colorectal Screening

- Individuals without a recommendation were significantly less likely to be screened, for both uninsured (95% CI = 0.003–0.083) and insured (95% CI = .054-.0119) individuals.
- Participants who reported that they had discussed colorectal cancer screening with their health care provider had a 10-times greater likelihood of screening compared to those who did not report provider communication about screening (OR = 10.78, 95% CI = 4.85, 29.94,  $p < .001$ ).
- When physicians made a clear recommendation about screening (Advise step), participants were significantly more likely to be screened (OR = 4.31, CI = 1.75, 10.59).



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and collaboration:

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**Molly Black**

Director, Cancer Screening

# Q&A Session



# Upcoming LC Sessions



**Session 1 (03/13/2024):** Colorectal cancer screening recommendations

**Session 2 (03/20/2024):** How to talk with patients about health

**Session 3 (03/27/2024):** Colorectal cancer screening messaging

**Session 4 (04/03/2024):** Interventions engaging CHWs



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Thank you!

