



CLOSING GAPS IN CANCER SCREENING:

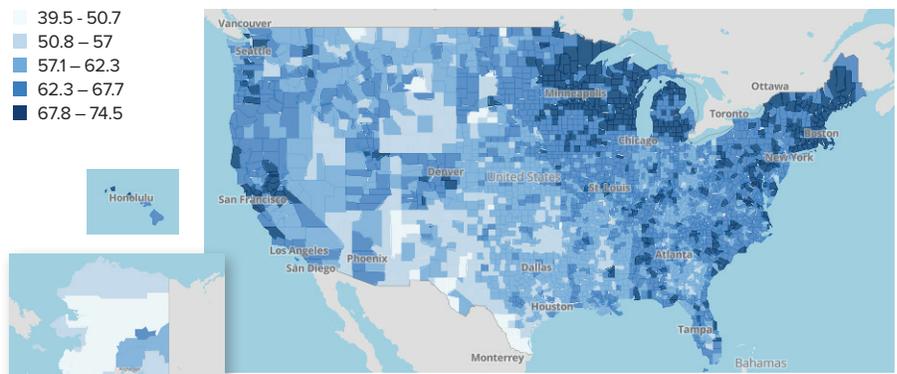
Connecting People, Communities, and Systems to Improve Equity and Access

Colorectal Cancer Companion Brief

In 2020–2021, the President’s Cancer Panel held a series of meetings on the uptake of cancer screening, with a focus on breast, cervical, colorectal, and lung cancers. Cancer screening saves lives; however, gaps in screening uptake and timely receipt of follow-up care after an abnormal screening test result mean too many people are unnecessarily enduring aggressive treatment or dying from cancers that could have been prevented or detected at earlier stages. The Panel’s report, *Closing Gaps in Cancer Screening: Connecting People, Communities, and Systems to Improve Equity and Access*, identifies four critical goals and related recommendations to ensure the benefits of cancer screening reach all populations. Many challenges and opportunities are common across cancer types. This companion brief summarizes issues and recommendations that are highly relevant to colorectal cancer.

FACTS & FIGURES

U.S. Colorectal Cancer Screening Rates by County



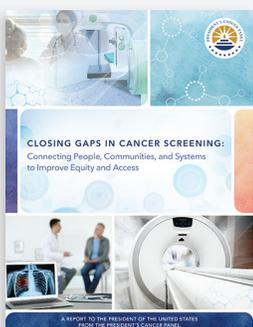
Note: Age-adjusted percentage of adults ages 50 to 75 years who received a fecal occult blood test, sigmoidoscopy, or colonoscopy in 2018. **Source:** Centers for Disease Control and Prevention. PLACES: Local Data for Better Health, County Data 2021 release [Internet]. Atlanta (GA): CDC; [updated 2021 Dec 1; cited 2022 Jan 4]. Available from: <https://chronicdata.cdc.gov/500-Cities-Places/PLACES-Local-Data-for-Better-Health-County-Data-20/swc5-untb>

There were an estimated **149,500 cases** of colorectal cancer and **52,980 deaths** from the disease in the United States in 2021.

Black and **American Indian/Alaska Native men** are more likely to be diagnosed with or die from colorectal cancer than other populations. **Black** and **American Indian/Alaska Native populations** also are more likely to be diagnosed at a later stage of disease.

In 2019, 67.1% of age-eligible individuals were screened for colorectal cancer in the United States. Screening rates vary across the country and are lower among the **uninsured**, those without a **usual source of care**, **recent immigrants**, people with lower **educational achievement** or **income level**, **younger age groups** (<65 years old), and some **racial/ethnic minorities**.

Many eligible patients do not receive appropriate colorectal cancer screening and/or follow-up care after an abnormal screening test result due to **lack of provider recommendation**, **concerns about the testing procedure and/or outcome**, lack of **access** to medical facilities, concerns about **cost**, and **logistical challenges** such as transportation and time.



ACCESS THE FULL PRESIDENT’S CANCER PANEL REPORT AT:

<https://PresCancerPanel.cancer.gov/report/cancerscreening>

Sources: National Cancer Institute. Cancer stat facts: colorectal cancer [Internet]. Bethesda (MD): NCI; [cited 2021 Nov 3]. Available from: <https://seer.cancer.gov/statfacts/html/colorect.html>; Siegel RL, et al. CA Cancer J Clin. 2020;70(3):145-64. Available from: <https://www.ncbi.nlm.nih.gov/pubmed/32133645>; National Cancer Institute. Cancer Trends Progress Report: early detection [Internet]. Bethesda (MD): NCI; [cited 2021 March 9]. Available from: <https://progressreport.cancer.gov/detection>; Sabatino SA, et al. MMWR Morb Mortal Wkly Rep. 2021;70(2):29-35. Available from: <https://www.ncbi.nlm.nih.gov/pubmed/33444294>; Muthukrishnan M, et al. Prev Med Rep. 2019;15:100896. [Epub 2019/06/14]. Available from: <https://www.ncbi.nlm.nih.gov/pubmed/31193550>; May FP, et al. Clin Gastroenterol Hepatol. 2019;17(3):469-76. Available from: <https://www.ncbi.nlm.nih.gov/pubmed/29857147>

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GOAL 1: IMPROVE AND ALIGN CANCER SCREENING COMMUNICATION



Communications campaigns for colorectal cancer screening are needed. These campaigns should raise awareness, increase understanding, and empower people to be screened. Key messages should address common knowledge gaps or misperceptions about colorectal cancer screening. They also should be tailored to different populations and designed to help individuals overcome identified barriers to optimal cancer screening.

Support for the National Colorectal Cancer Roundtable (NCCRT) should be increased so it can continue its work and expand its reach to communities with low rates of screening and follow-up care. NCCRT should prioritize equity and alignment of messaging about cancer screening and cancer screening guidelines.

KEY MESSAGES

- There are multiple effective options for colorectal cancer screening, including stool-based tests.
- Colorectal cancer screening should begin at age 45 for individuals at average risk.
- People at high risk of colorectal cancer may benefit from early and/or more frequent screening.

GOAL 2: FACILITATE EQUITABLE ACCESS TO CANCER SCREENING



Community-oriented outreach and support services are needed to promote appropriate screening and follow-up care after an abnormal screening test result. Community health workers (CHWs), who have a deep understanding of the culture and life experiences of their communities, can help address barriers to colorectal cancer screening, particularly those experienced by populations less likely to be screened. This could include help with transportation or coordination of follow-up colonoscopy after an abnormal stool-based test result. Sustainable funding, institutional commitment, and training are essential to establish effective CHW programs.

Stool-based tests should be promoted as an option for colorectal cancer screening. These tests—which can be completed at home or in the offices of providers who do not provide colonoscopies—may help reach people who are hesitant to undergo colonoscopy or live long distances from facilities that offer colonoscopy. It is essential that individuals performing self-sampling for stool-based tests are connected with a healthcare provider or system that will answer questions, provide results, and facilitate next steps in the case of an abnormal result. A colonoscopy must be performed in the case of an abnormal stool-based test result; since these colonoscopies are part of the screening process, they should be covered by insurance at no cost to patients.

GOAL 3: STRENGTHEN WORKFORCE COLLABORATIONS TO SUPPORT CANCER SCREENING AND RISK ASSESSMENT



Systems and processes that support team-based care should be established. Involving multiple healthcare team members can help practices and healthcare systems collect family and medical history to inform possible referral for genetic testing, identify people due for colorectal cancer screening, and ensure appropriate follow-up for abnormal screening test results. All team members should receive education and training to ensure they have the knowledge and skills to support cancer screening.

Access to genetic testing should be expanded. People who harbor mutations in some cancer susceptibility genes—such as those linked to Lynch syndrome—are at higher risk of colorectal cancer and may benefit from earlier or more frequent screening; however, people with these mutations often are not identified until after they are diagnosed with cancer. Providers should regularly collect thorough family and personal health histories and be enabled to offer genetic testing to eligible patients with informed consent. Coverage for genetic testing should not depend on pretest counseling by a certified genetic counselor or medical geneticist. Many providers likely would benefit from education and training about genetics, genetic testing, and interpretation of genetic testing results. Providers should collaborate with genetic counselors to ensure all patients receive the information and support they need. The Centers for Medicare & Medicaid Services should recognize genetic counselors as healthcare providers so they can be reimbursed appropriately for their role.

GOAL 4: CREATE HEALTH IT THAT PROMOTES APPROPRIATE CANCER RISK ASSESSMENT AND SCREENING



Computable guidelines for colorectal cancer screening should be created. The availability of guidelines in a format that can be fully interpreted and executed by a computer would facilitate creation of health information technology that promotes broader, more consistent, and faster guideline implementation.

Effective clinical decision support (CDS) for colorectal cancer risk assessment, screening, and follow-up care should be created and deployed. Computable guidelines can be used to create CDS that helps providers and healthcare systems comprehensively and equitably deliver evidence-based cancer screening. To be optimally effective, CDS should be included in standard electronic health record systems and integrated into clinical workflows. They also should connect team members to ensure seamless delivery of care across providers and sites. For colorectal cancer risk assessment and screening, CDS can help collect information on cancer risk factors, evaluate eligibility for genetic testing, interpret genetic testing results, identify patients due for screening or surveillance, and ensure all patients have received recommended follow-up care in the case of an abnormal screening test result.