

Society of Behavioral Medicine Position Statement:

Support the National Colorectal Cancer Roundtable's Call to Action to Reach 80% Colorectal Cancer Screening Rates by 2018

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The Society of Behavioral Medicine supports the National Colorectal Cancer Roundtable's Call to Action to Reach 80% Colorectal Cancer Screening Rates by 2018.

In response to the significant colorectal cancer (CRC) burden and persistent underutilization of screening, the National Colorectal Cancer Roundtable's (NCCRT) initiative 80% by 2018 sets an important goal for CRC screening in older Americans. The primary goal of this initiative is to attain a population screening rate of 80% in adults ages 50 and older by the year 2018. It is estimated that this screening rate could prevent more than 20,000 CRC deaths per year by the year 2030.¹ **The Society of Behavioral Medicine (SBM) supports 80% by 2018 and encourages policymakers and health care providers to implement the recommendations outlined by the initiative.**

Background

As the third leading source of cancer deaths among men and women in the United States, CRC morbidity and mortality remain an urgent public health challenge. Among tumor cancers, CRC is the only cancer that is preventable with the identification and removal of pre-cancerous polyps. Current screening recommendations for individuals at average risk for CRC include timely screening using one or a combination of the following tests²:

- * Colonoscopy (every 10 years, highest performance)
- * Flexible sigmoidoscopy (every 5 years)*
- * Double-contrast barium enema (every 5 years)*
- * CT colonography (virtual colonoscopy) (every 5 years)*
- * High-Sensitivity Guaiac-based Fecal Occult Blood Test (every year)
- * Fecal Immunochemical Test (every year)
- * Stool DNA Test (uncertain frequency)

*Note: Follow up colonoscopy should be done if results are positive.

Despite the potential to prevent an estimated 90% of CRC deaths through screening,³ screening utilization is low and disparities across sociodemographic groups exist.⁴⁻⁷ Barriers to screening include cost, access to health care facilities, lack of recommendation to screen, and psychosocial factors such as fear of the test, testing preparation, fear of a cancer diagnosis, and embarrassment.²



The NCCRT aims to reduce these barriers to screening through a multilevel approach. This approach invites action from clinicians, health care organizations, insurers, policymakers, and researchers, all toward the common goal of reaching 80% screening by 2018. Each recommendation within the initiative is tailored to appropriate stakeholders and addresses unique barriers to CRC screening and their context-appropriate approaches. For more information about the 80% by 2018 initiative, please refer to the Web resources provided in Figure 1.

Additional Considerations

In addition to the key issues raised and recommendations provided by the 80% by 2018 initiative, there are three aspects of CRC screening that remain important considerations:

1. Physician-patient communication regarding CRC screening should be extended beyond primary care to include other settings and modalities.
 - Underserved populations are more likely to receive care from emergency rooms, nontraditional caregivers, and specialty care than primary care.
 - Current practices of limiting CRC screening recommendations to the primary care setting are necessary but not sufficient.
 - Focusing on other modes of communication from non-primary care providers, community health workers, insurance companies, and mass media messaging could help improve public health while also targeting the growing disparities in CRC screening.

FIGURE 1

80% by 2018 Web Resources

NCCRT Initiative Website:

<http://nccrt.org/tools/80-percent-by-2018/>

Introductory Video:

<https://www.youtube.com/watch?v=2C7UuyoGfnk&feature=youtu.be>

CDC Action Guide:

<http://www.cdc.gov/cancer/crccp/pdf/colorectalaction-guide.pdf>

2. It is important to focus efforts to reduce CRC screening disparities across sociodemographic groups.
 - The use of a population-level rate in assessing CRC screening use and setting screening goals may potentially mask the prevalent and persistent disparities across gender, race/ethnicity, socioeconomic status, and insurance coverage.
 - It is unlikely that we will reach an 80% screening rate for the full population if these gross disparities persist.
 - In order to allocate resources necessary to reduce and eliminate health disparities, we must incorporate disparity reduction into benchmarks for success in this screening initiative.
3. CRC testing after symptoms are present is not screening. In order to accurately gauge screening rates, trends, and disparities, we must use measures of CRC screening that exclude diagnostic testing.⁸

Summary and Recommendations

Colorectal cancer morbidity and mortality represent a significant public health challenge. Despite the number of available screening modalities, national screening rates continue to fall far below federally established goals. The 80% by 2018 initiative sets a goal of attaining a population screening rate of 80% in adults ages 50 and older by the year 2018. SBM supports 80% by 2018 and the initiatives' recommendations. Combining the recommendations set forth by 80% by 2018, and the additional considerations described above, SBM encourages policymakers and providers to take an active role in improving population screening rates for CRC.

Recommendations for Policymakers

1. Policymakers play a critical role in ensuring that the instrumental resources necessary to achieve these goals are available, including:
2. Implementing laws and regulations that support CRC screening including funding mechanisms, quality measurements, and Healthy People goals that include population screening rates and targeting disparities across sociodemographic groups;
3. Collaborating with coalitions to plan open communication with the public about changes to CRC screening policies including insurance coverage;

4. Providing instrumental support to regional initiatives designed to reduce CRC screening disparities;
5. Ensuring that Federally Qualified Health Centers are prepared and incentivized appropriately to perform high-quality colonoscopies and refer patients for oncologic care when necessary; and
6. Supporting research funding that examines the complex social determinants of health that impact screening uptake in addition to access to care for marginalized populations.

Recommendations for Health Care Providers

1. All health care providers including primary care, hospital care, and informal care providers can make a difference and promote higher rates of CRC screening. Suggestions for these providers include:
2. Using electronic health records to optimize frequency and type of CRC screening recommendations and track efficiency and use of resources;
3. Engaging patients in the planning of CRC screening resources for themselves and the patient population;
4. Offering patients population-based decision support and navigation services to help patients understand and manage the complex nature of CRC screening planning, preparation, and follow-up;
5. Increasing public awareness of CRC screening guidelines and community resources for care; and
6. Promoting systemwide uptake of evidence-based screening modalities based on patient engagement through one-on-one provider and patient education.

References

1. Meester RGS, Doubeni CA, Zauber AG, Goede SL, Levin TR, Corley DA, Jemal A, & Lansdorp-Vogelaar I. Public Health Impact of Achieving 80% Colorectal Cancer Screening Rates in the United States by 2018. *Cancer* 2015; 121(13):2281-2285.
2. American Cancer Society. Colorectal Cancer Facts & Figures 2014-2016. Atlanta: American Cancer Society; 2015.
3. Subramanian S, Klosterman M, Amonkar M, & Hunt T. Adherence with colorectal cancer screening guidelines: a review. *Prev Med* 2004; 38: 536-550.
4. Ahmed NU, Pelletier V, Winter K, & Albatineh AN. Factors Explaining Racial/Ethnic Disparities in Rates of Physician Recommendation for Colorectal Cancer Screening. *Amer J of Public Health* 2013; 103(7): e91-e99.
5. Ananthakrishnan A, Schellhase K, Sparapani R, Laud P, & Neuner, J. Disparities in colon cancer screening in the Medicare population. *Arch of Intern Med* 2007;167(3): 258-264.
6. Cole AM, Jackson JE, & Doescher M. Urban-rural disparities in colorectal cancer screening: cross-sectional analysis of 1998-2005 data from the Centers for Disease Control's Behavioral Risk Factor Surveillance Study. *Cancer Med* 2012; 1(3): 350-356.
7. James TM. Disparities in colorectal cancer screening: a guideline-based analysis of adherence. *Ethn Dis* 2006; 16(1), 228-33.
8. Becker EA, Griffith DM, West BT, Janz NK, Resnicow K, & Morris AM. Potential biases introduced by conflating screening and diagnostic testing in colorectal cancer screening surveillance. *Cancer Epidemiol Biomarkers Prev*; in press.

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