How to prevent disparities in colon cancer screening

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People living in poverty are less likely to be screened regularly for colorectal cancer—and more likely to develop the disease and die from it. How to end these disparities—and raise screening rates, lower disease rates, and prevent deaths? A promising way is to mail fecal immunochemical tests (a newer kind of stool test) to populations, Beverly B. Green, MD, MPH, and Gloria D. Coronado, PhD, wrote in the June 17 *JAMA Internal Medicine*.

Dr. Green is a Group Health physician and an associate investigator at Group Health Research Institute. Dr. Coronado is a senior investigator and the Mitch Greenlick endowed scientist for health disparities at Kaiser Permanente Center for Health Research, in Portland. The journal invited them to write a commentary about a study that David W. Baker, MD, MPH, of Northwestern University led and published in the same issue of the journal.

Drs. Green and Coronado applauded Baker's study for achieving repeat screening rates of more than 82 percent in a largely low-income community. But they were disappointed that only 60 percent of individuals with a positive screening stool test completed follow-up diagnostic colonoscopy. "Lack of a follow-up colonoscopy defeats the purpose of a stool-test screening program," said Dr. Green, who is also an assistant clinical professor at the University of Washington School of Medicine.

Previous studies have shown that when low-income people get colorectal

cancer screening, they tend to prefer the option of doing a stool test in the privacy of their own home. But when the test is "positive" (detecting microscopic blood in the stool), people need to get a second test: a follow-up diagnostic colonoscopy. After a positive stool test, nearly a third of people have advanced pre-cancers that can be removed during the follow-up colonoscopy—and 4 percent have colorectal cancer.

"For many people, the barriers to receiving the needed follow-up diagnostic colonoscopy include cost," Dr. Green said. For instance, the Affordable Care Act (ACA) mandates full coverage of screening tests that the U.S. Preventive Services Task Force (USPSTF) recommends—with no out-of-pocket expenses. But it covers only the first test that a person chooses—a stool test, colonoscopy, or sigmoidoscopy—not any follow-up diagnostic testing. That's why Drs. Green and Coronado previously urged that the ACA be amended to cover co-pays for follow-up colonoscopies after a positive stool test or flexible sigmoidoscopy. Otherwise, people who choose those as their first tests could face high, unexpected costs from follow-up testing—and existing disparities in screening could worsen.

"On the other hand, most states' Medicaid insurance pays for both stool testing and follow-up colonoscopy, with no out-of-pocket patient costs," Dr. Coronado said. "So disparities in deaths from colorectal cancer could decrease rapidly in those states that have opted into Medicaid expansion."

Dr. Green previously showed in a randomized trial that colorectal cancer screening doubled when Group Health's electronic health record was used in a new way to identify people who needed screening and give them stepped increases in support. And Drs. Green and Coronado showed it was feasible to use a population-based program for mailing stool tests to people in safety-net clinics.

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