Colorectal Cancer Screening

Impact of Colorectal Cancer in Rural Northern California

- Colorectal cancer is currently the second leading cause of cancer death in the United States[1]. Colorectal cancer screening in adults between 50 and 75 years of age can catch and remove dangerous polyps before they become cancerous, or can detect colorectal cancer in its early stages, when treatment is most effective.
- In rural Northern California, the age-adjusted death rate from colorectal cancer ranges from a high in Shasta County of 16.7 per 100,000 to a low of 10.5 per 100,000 in Del Norte County. The overall death rate in the state is 12.5 per 100,000[2].
- Low-income adults are less likely to receive colorectal cancer screenings. Less than half (48.4%) of low-income adults in rural Northern California are up-to-date with colorectal cancer screening[3].
- Adults with a cancer diagnosis in the rural Northern California region experience significant barriers to accessing needed specialty care.
- The average distance adults living in rural households must travel to access medical providers and emergency care is nearly double that of those in urban households[4].

How Health Centers Provide the Necessary Care

Clinical Interventions

- Integrate the use of Cologuard, a non-evasive screening option, that is available by prescription, as an alternative to colonoscopy when clinically appropriate.
- Use a patient registry to track screening due dates, results, and follow-up.
- Remind patients through letters, postcards, or phone calls that it is time for their colorectal cancer screening. This is particularly effective with fecal occult blood testing, paired with patient incentives. Two week follow-up reminders have been found to be helpful with screening completion.
- Annual flu shot campaigns are an opportunity to reach people who are also due for colorectal screening (e.g., Flu/FIT Campaign).
- Provide education and counseling to patients to reduce fear of and prepare for scheduled screening procedures. Review FIT instructions with the patient while they are still in the office and check for patient understanding and engagement.

Community Interventions

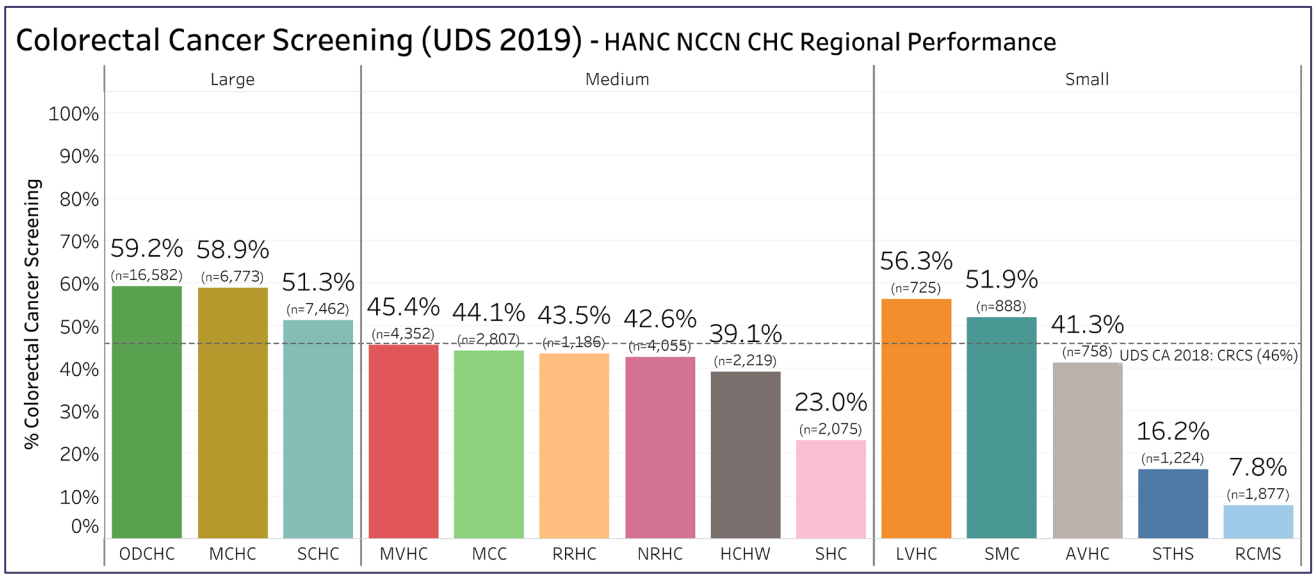
- Share patient handouts or videos at community health fairs and senior centers to increase awareness of colorectal screening and how to access screening services.
- Participate in health care and community-based health awareness campaign to normalize screening and create a culture of prevention.

[1] CDC. Colorectal Cancer Statistics. March 2019.
[2] California Department of Public Health. County Health Status Profiles, 2019.
[3] California Health Interview Survey. CHIS Adult Public Use File. Los Angeles, CA: UCLA Center for Health Policy Research, April 2020.
[4] Edelman MA, Menz BL. Selected comparisons and implications of a national rural and urban survey on health care access, demographics and policy issues. J Rural Health 1996;12:197-205.

Rural Northern California Health Center Data

Key Points

- The demographics of the communities served may impact screening rates, as communities with more retirees and older adults may be more receptive to colorectal cancer screening.
- Access and cost are significant barriers to regular colorectal cancer screening.
- While Fecal Immunochemical Tests (FIT) is a lower cost option, the lack of access to specialists for appropriate follow-up and/or treatment creates barriers to routine screening.



Quality Measure Definitions (UDS)

The percentage of adults aged 50-75 who had appropriate screening for colorectal cancer. Appropriate screening methods may include one of the following:

A. Fecal occult blood test (FOBT) within 1 year;
B. Fecal immunochemical test (FIT)-deoxyribonucleic acid (DNA) within 3 years;
C. Flexible sigmoidoscopy within 5 years;
D. Computerized tomography (CT) colonography within 5 years;
E. Colonoscopy within 10 years

National and State Quality Benchmarks

UDS 2018 CA Average: The average performance among health centers in California was 45.7%.

UDS 2018 U.S. Average: The average performance among health centers in the U.S. was 44.1%.

AVHC – Anderson Valley Health Center; HCHW – Hill Country Health and Wellness Center; LVHC – Long Valley Health Center; MCC – Mendocino Coast Clinics; MCHC – MCHC Health Centers; MVHC – Mountain Valley Health Center; NRHC – Northeastern Rural Health Clinics; ODCHC – Open Door Community Health Centers; RCMS – Redwood Coast Medical Services; RRHC – Redwoods Rural Health Center; SCHC – Shasta Community Health Center; SHC – Shasta Cascade Health Centers; SMC – Shingletown Medical Center; STHS – Southern Trinity Health Services.