Key Messages

- Many more providers report usually offering more than one CRC screening test option to their average-risk patients in 2020 than in 2016.
- Fecal DNA testing has become much more popular since 2016.
- Although there was a significant decrease since 2016 in the proportion of providers who reported offering guaiac of a DRE specimen for CRC screening, more than a third (35%) still rated the test as either somewhat or very effective.
- Patient concerns about the cost of testing was the most commonly reported barrier to CRC screening.

Primary Care Provider Survey: Colorectal Cancer Screening Knowledge and Attitudes

The Montana Cancer Control Programs (MCCP) surveyed primary care providers in Montana to assess their knowledge and practices of colorectal cancer (CRC) screening and to see how knowledge and practices have changed since 2016. The survey was sent to all primary care physicians, nurse practitioners, and physician assistants identified as practicing within Montana through the WIM tracking database and the MCCP cancer screening database (about 870 individuals) starting December 2019 and closing February 2020. 229 providers completed the survey during that time for a response rate of 26%. The majority of respondents were physicians and reported that their primary practice was a hospital associated clinic or an independent clinic (Figures 1 and 2). The response rate and provider characteristics of the 2020 survey were similar to a survey completed in 2016 using the same questionnaire and methods. Comparing results of these two surveys can inform how effective provider education campaigns

Figure 1: Number of respondents by provider type

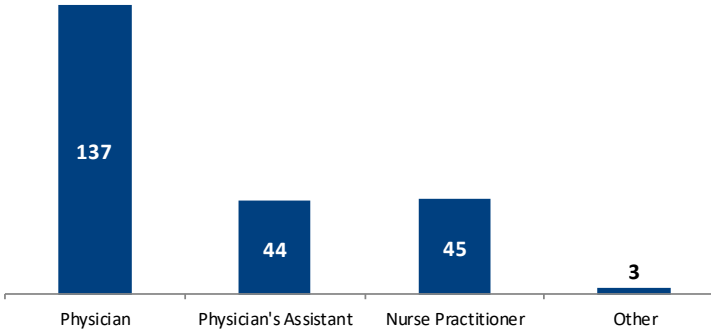
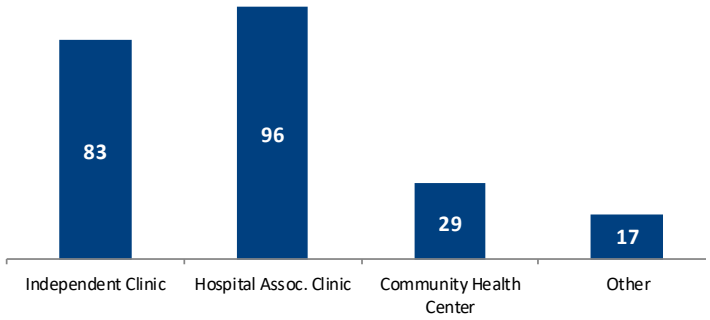


Figure 2: Number of respondents by practice type



Montana Cancer Control Programs

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http://www.dphhs.mt.gov/publichealth/cancer

have been and what interventions are most needed to continue improvements in CRC screening rates in Montana.

Clinic Systems to Support Screening

About three quarters of respondents reported that their clinic had an established system to ensure eligible patients received a recommendation for CRC screening. This proportion was higher in 2020 than in 2016 (Figure 3).

Routine use of computerized supports for screening was widely reported. More than half of respondents reported routine use of provider reminder systems, patient reminder systems, and clinical care measures (Figure 4). More than 75% of respondents reported using provider and patient reminder systems at least sometimes. However, regular use of clinical care measures was reported less often than the other supports and a higher proportion of respondents reported not knowing about the use of clinical measures.

The MCCP works with health systems to improve CRC screening rates among their patients. One of the most effective interventions to improve screening is to improve the use of computerized supports. Creating a strong work flow that includes both provider and patient reminder systems and checking clinical care measures often can ensure that no screening opportunities are missed. Clinics who are interested in working with MCCP to improve CRC screening rates can find more information at https://dphhs.mt.gov/publichealth/cancer/healthsystems

Figure 3: Does your clinic have a system in place to ensure that all eligible patients get a CRC screening recommendation?

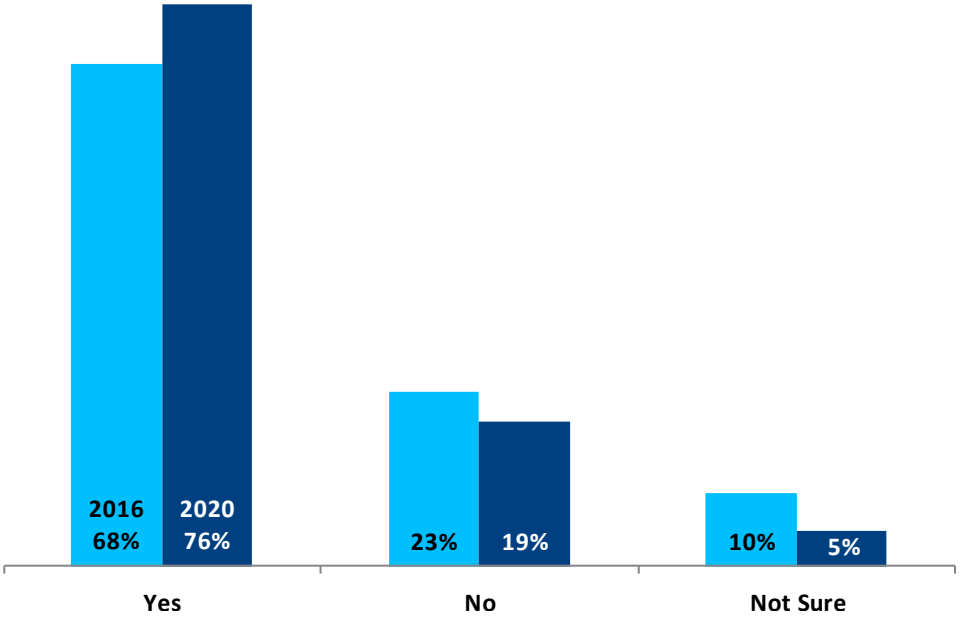
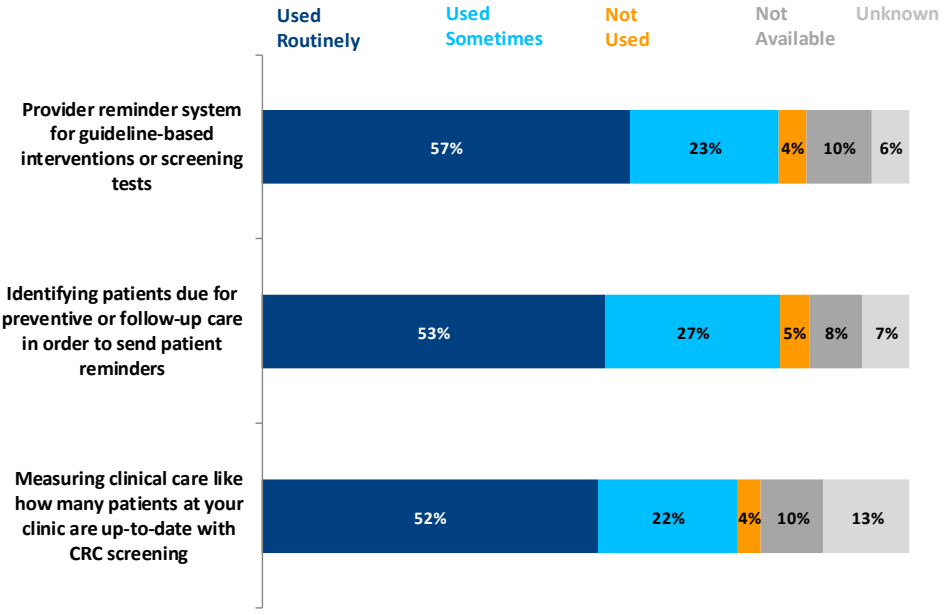


Figure 4: How often are the following computerized capabilities used in your clinic?



Testing Recommendations

There was significant improvement in how often providers reported discussing more than one test option for CRC screening with their asymptomatic, average-risk patients from 2016 to 2020 (Figure 5). In 2016, less than half (45.3%) of providers reported usually discussing more than one test and more than a quarter (27.1%) reported rarely or never discussing more than one test. But in 2020, more than three quarters (77.9%) of providers reported usually discussing more than one test option and only 4% reported rarely or never doing so. Research has shown that patients are much more likely to complete recommended screening when they are offered a choice of screening test rather than being offered only one type of test.

There was also a significant change in which tests providers reported discussing with their patients. Colonoscopy and Fecal Occult Blood Test (FOBT) remained the most commonly presented tests (Figure 6). Stool DNA test was reported to be discussed much more frequently with more than a third (35.2%) of providers reporting discussing it with patients in 2020 compared to only 4% in 2016. A higher proportion of providers reported discussing FIT testing in 2020 than in 2016 as well. Fewer providers reported discussing sigmoidoscopy and guaiac of a digital rectal exam (DRE) specimen in 2020 than in 2016. The United States Preventive Services Task Force (USPSTF) recommends use of many different tests and test combinations with no clear evidence to show that one testing plan performs better than another for average-risk patients. [1] Colonoscopy, CT colonography, flexible sigmoidoscopy, high sensitivity guaiac FOBT, FIT, and FIT-DNA are all recommended tests. It is promising that the three most commonly offered tests are recommended. However guaiac of a DRE specimen is not recommended and more education needs to be done to ensure this test is no longer used for CRC screening.

Figure 5: How often do you present more than one test option while discussing CRC screening with your asymptomatic, average-risk patients?

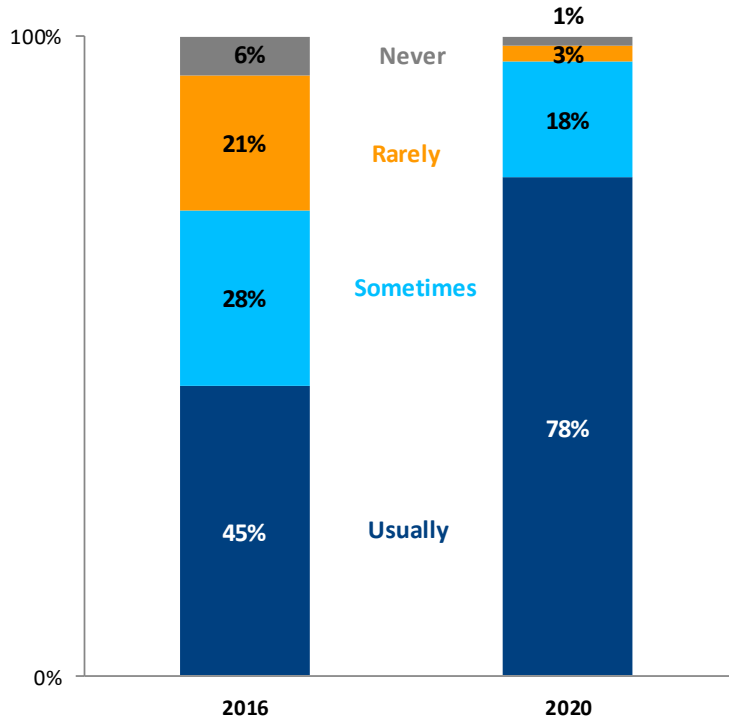
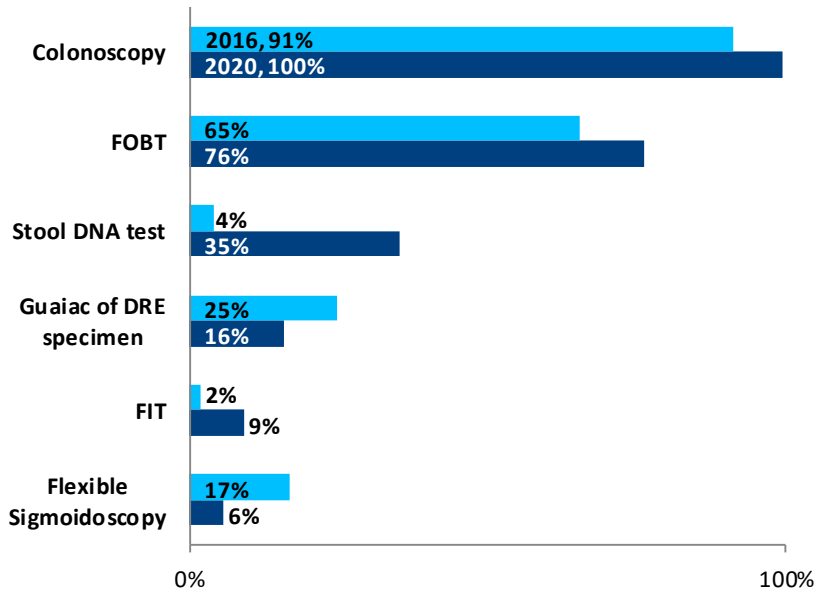


Figure 6: Which of the following screening tests did you discuss with your patients?

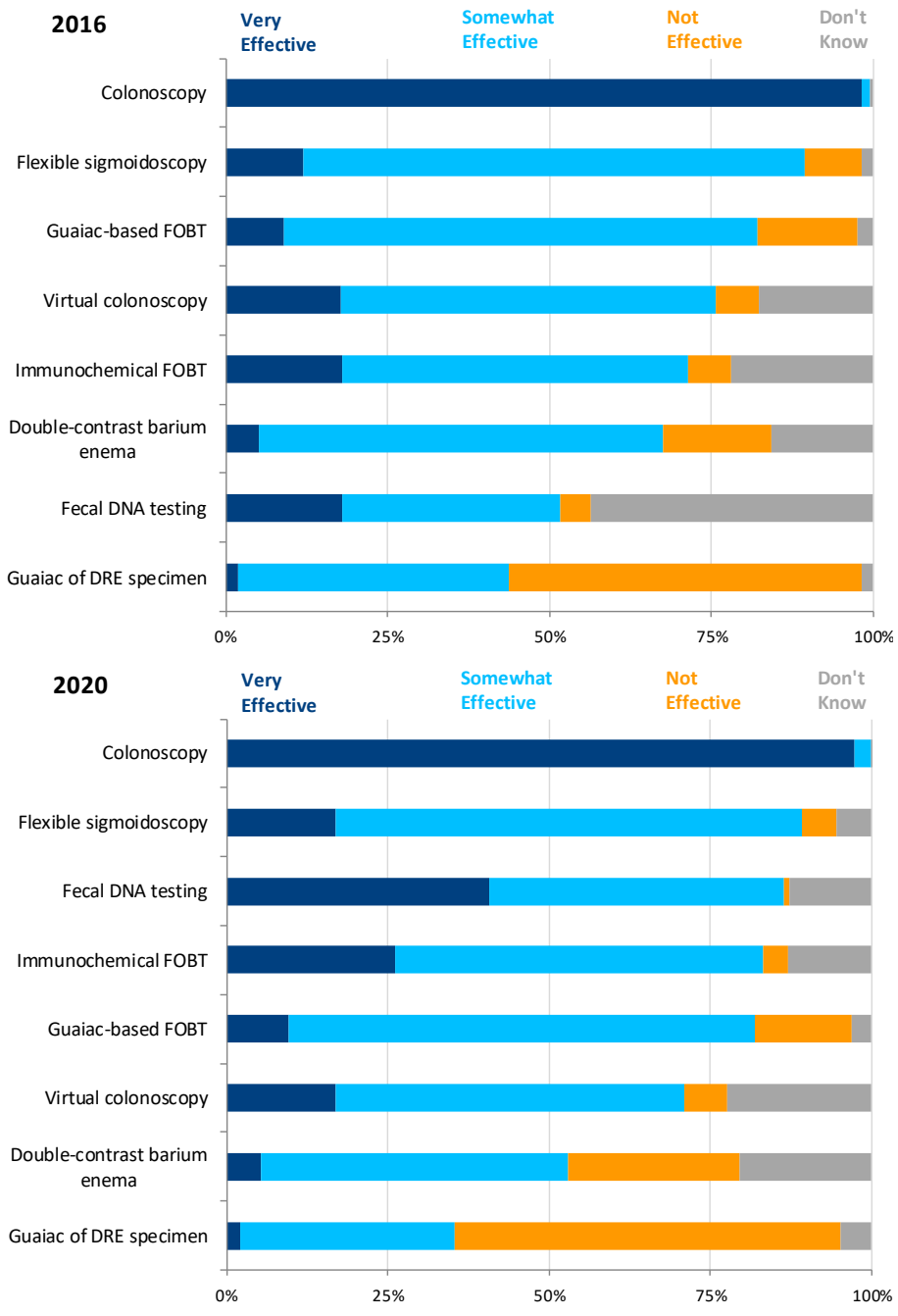


1 *Final Update Summary: Colorectal Cancer: Screening*. U.S. Preventive Services Task Force. June 2016. https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/colorectal-cancer-screening2

Beliefs about effectiveness of CRC tests

In both surveys most providers reported that colonoscopy was very effective and sigmoidoscopy was somewhat effective (Figure 7). However the relative assessment of other screening tests changed significantly between the two surveys. The biggest difference was in how fecal DNA testing was rated. In 2016 about half of respondents reported that fecal DNA testing was somewhat or very effective making it the second lowest ranked test. In 2020, fecal DNA testing was the third highest ranked test with 86% of respondents reporting that it is either somewhat or very effective. Immunochemical FOBT (or FIT) also ranked higher in 2020. Guaiac-based FOBT, virtual colonoscopy, and double-contrast barium enema were all ranked lower in 2020. Guaiac of a DRE specimen was the lowest ranked test in both surveys. The proportion of providers reporting that it is either somewhat or very effective decreased from almost half (44%) in 2016 to about a third (35%) in 2020. This decrease is a step in the right direction but more work is needed to ensure all primary care providers have accurate knowledge about the effectiveness of DRE specimen testing for CRC screening.

Figure 7: In your opinion how effective are the following screening procedures in reducing CRC mortality in average-risk patients aged 50 years and older?



Factors influencing CRC screening recommendations

The factors that were reported to influence pro-vider recommendations for CRC screening the most were clinical evidence and the recommen-dations of the USPSTF (Figure 8). Patient prefer-ences, American Cancer Society (ACS) recom-mendations, and out of pocket cost for unin-sured patients were also reported to be very influential. Focusing provider education on clini-cal evidence and USPSTF recommendations should be an effective strategy for decreasing the use of DRE specimens for CRC screening.

Barriers to CRC screening

The most commonly reported barrier was patient concern about the cost of CRC screening with 83% of providers reporting usually or sometimes encountering this barrier (Figure 9). Other commonly reported barriers were patients not perceiving CRC as a serious threat to their health, patients having concerns about getting time off of work, patients not wanting to discuss screening, and concerns about transpor-tation to CRC screening appointments. Less than half of providers reported not having enough time to discuss screening, patients being unaware of CRC screening and patients having difficulty understanding CRC screening. Working with payers to ensure the requirement for all USPSTF recommended preventive services be available to patients with no out of pocket cost is upheld and clearly communicated may help to mitigate the cost barrier. Contin-ued efforts to raise awareness of the im-portance of CRC screening are also important.

Limitations

Respondents to these surveys may not have been representative of all primary care providers in Montana. As such, caution should be used when generalizing the findings of these surveys to all providers.

Figure 8: How influential are the following factors in your recommendations for CRC screening?

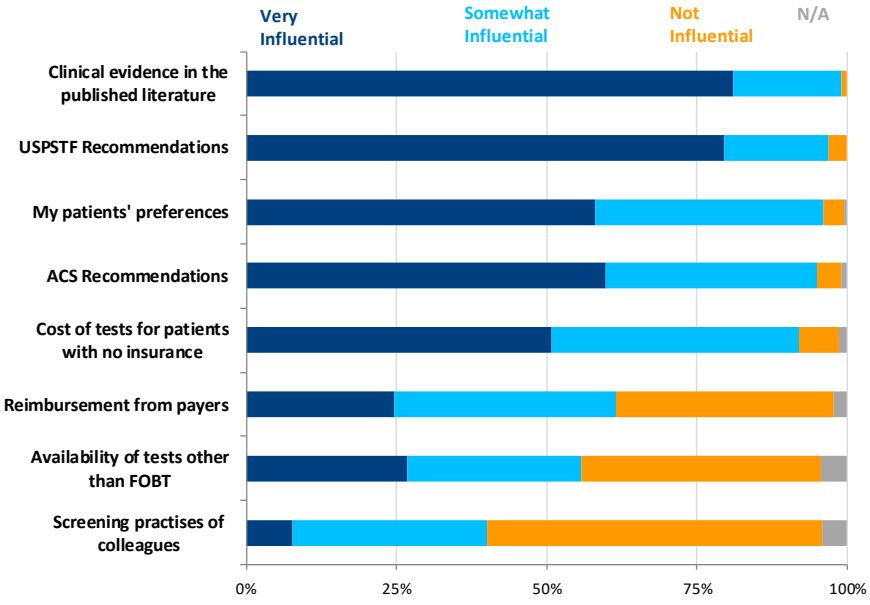


Figure 9: When you talk to your asymptomatic, average-risk patients about CRC screening, how often do you encounter the following?