Updated Guidelines Remove Barriers for Colorectal Cancer Screening

Forty-five is the new 50 when it comes to colorectal cancer screening. Over the past few decades, there has been a steady increase in patients under the age of 50 getting diagnosed with colorectal cancer. Between 1994 and 2014, colorectal cancer incidence in patients under the age of 50 increased by 51%. By 2030, it is estimated that more than 1 in 10 colon cancers will be diagnosed in people younger than 50.

Recognizing the rising colorectal cancer incidence in younger patients, many organizations, including the American Cancer Society (ACS) and U.S. Preventive Services Task Force (USPSTF), have updated their guidelines to begin colorectal cancer screening for average-risk patients at age 45. An additional ~19 million Americans became eligible for colorectal cancer screening when this change took effect.

Guideline organizations; such as USPSTF and ACS heavily influence decisions made by payers and health systems. The National Committee for Quality Assurance updated its existing colorectal cancer screening Healthcare Effectiveness Data and Information Set (HEDIS®)[1] measure March 31, 2022, to include adults ages 45 to 49 for 2022 reporting. Providers and health systems are now responsible for reporting on this younger patient population in their metrics.

What does this mean for patient coverage? With colorectal cancer screening recommended to begin at age 45, most commercial insurers have an obligation to pay for screening beginning at that age. This shifts the motivation to screen earlier for not only health systems but also providers and patients. Now that providers are responsible for reporting on colorectal cancer screening

beginning at age 45, there is an incentive to start having these conversations with younger patient populations to get more patients screened. This could change the trajectory of colorectal cancer in the United States.

With the support of payers, updated guidelines and revised HEDIS measures, health systems have a unique opportunity to get more patients screened. Generally, younger patients are less likely to be screened than older patients. At the time of the ACS shift to initiating screening at age 45, only 21% of 45-49 year olds reported being up to date with colorectal cancer screening. Health systems have an opportunity to begin educating their providers on the importance of screening average-risk patients beginning at age 45.

Providers may need to take a different approach, though, when engaging these patients. Younger populations prefer to have multiple options presented to them when discussing colorectal cancer screening and often look to their providers as a trusted source of information. With the support of the ACS and USPSTF, providers are now positioned to offer multiple screening options, not just colonoscopy, to ensure patients are choosing the option that is best for them.

In addition to the updated age recommendations, legislative changes have been made to encourage colorectal cancer screening follow-up. If a patient completes a noninvasive colorectal cancer screening test, such as multitarget stool DNA (mt-sDNA), and receives a positive test result, the patient must have a colonoscopy for their screening to be considered complete. Just this year, policy changes were implemented that now require commercial insurers to cover follow-up colonoscopies with no out-of-pocket costs. This change removes potential financial barriers for patients and helps encourage adherence.

In addition to updating their age recommendations for colorectal cancer screening, both the ACS and USPSTF highlight the importance of shared decision-making for colorectal cancer screening. In fact, national colorectal cancer screening guidelines have recommended offering patients choices for more than five years. Offering choices to patients drives meaningful change in colorectal cancer screening rates. In one study, when patients were offered a choice of two screening options, including a noninvasive test, adherence nearly doubled over colonoscopy alone. Because shared decision-making has the potential to improve overall colorectal cancer screening rates, this can make an impact on provider and health system quality measures as well.

As we work to narrow healthcare disparities, health equity has become a top priority for many health systems. When it comes to colorectal cancer screening, information may need to be framed differently for certain racial, ethnic, economic and geographic populations. Black men and women experience a higher incidence of colorectal cancer than white men and women. Many may be unaware of this difference and do not prioritize screening due to a lack of family history and/or symptoms. In cases like this, emphasizing the value of screening to stay healthy for loved ones can potentially shift interest in getting screened. This approach, combined with offering patients a choice of screening modalities, has the potential to increase colorectal cancer screening rates and close gaps among vulnerable populations.

Both the updated colorectal cancer screening guidelines and HEDIS quality measures pose an opportunity for health systems to get even more patients screened. Through provider education, shared decision-making with patients, and technology optimization, this is possible.

A Premier Corporate Partner of ACHE, Exact Sciences collaborates with health systems across the country to optimize health information technology in a way that improves the provider, staff, and patient experience and impacts colorectal cancer screening rates. For more information visit: **www.ache.org/about-ache/corporate-partners/sites/exact-sciences**

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[1]HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).