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Disaster-Proofing Colorectal Cancer Screening: What We Learned from COVID-19

Dr. Turck:

Welcome to *Clinician's Roundtable* on ReachMD. I'm Dr. Charles Turck, and joining me to discuss the impact of crises like the COVID-19 pandemic on colorectal cancer screening access is Dr. Gloria Coronado. She's a Professor of Epidemiology and the Associate Director of Population Science for the University of Arizona Cancer Center in Tucson.

Dr. Coronado, welcome to the program.

Dr. Coronado:

Thanks for having me.

Dr. Turck:

So, Dr. Coronado, to start us off, how did the COVID-19 pandemic affect colorectal cancer screening rates, and what gaps in screening infrastructure stood out the most to you?

Dr. Coronado:

The COVID-19 pandemic had a pretty substantial impact on all types of cancer screening, including colorectal cancer screening. So we know that during the early days of the pandemic, national organizations recommended that patients not get screened for cancer really because of the need to conserve resources and to prioritize COVID-related care, as well as to reduce the risk of transmission among patients, and the impact that had was, overall, a 21 percent reduction in colorectal cancer screening. And again, we saw this across all different cancer screening types, but it was pretty dramatic in terms of colorectal cancer screening.

We have since worked with a variety of community health centers to understand the impact in the community health center setting because a lot of what's known about the impact of COVID is really from large data systems, and I think it's really important to also understand its impact in community health centers where Medicaid enrollees and generally medically underserved individuals tend to get care.

Dr. Turck:

And during the pandemic, what role did community-based interventions and outreach programs play in maintaining or restoring screening efforts?

Dr. Coronado:

So what we saw in community health centers is that there was a maintenance of stool-based testing approaches. And so, overall, we know that there were significant reductions in colorectal cancer screening, but what we did was look at screening modality, and we found that there was a difference in terms of the use of stool-based testing versus colonoscopy. In the largest community health center setting that we worked in, which is headquartered in Los Angeles, what we found is that during different COVID-related time periods—and so we defined them as the early COVID phase, which was March to December of 2020, and we compared that to January to December of the following year, and then a post-COVID or vaccine-era time period—what we saw is there was a maintenance of stool-based testing. And so the rates of stool-based testing that were present before the pandemic continued during that pandemic era as well as during the vaccine era, suggesting that this clinic was successful at mailing stool tests to patients' homes and maintaining their

rates of colorectal cancer screening.

On the other hand, when we looked at colonoscopy use, we saw substantial reductions comparing the COVID time period to the pre-COVID time period, and we also saw that in this particular community health center that there was not a recovery, and so it made us very concerned about the ability of patients to get colonoscopy as a follow-up to abnormal stool-based tests, as well as to get a screening colonoscopy if that's their preference. And so it was really interesting to sort out the data by screening modality.

Dr. Turck:

Now taking a step back and looking at the broader picture, how do you think other types of crises, like hurricanes or wildfires, might impact screening rates?

Dr. Coronado:

I think there's some really broad lessons that can be gained here, and in the work that we did, we not only looked at the electronic health record data to show us what the rates of screening were, but we also interviewed patients, we interviewed providers, and other clinical staff about, what were the things that they did? What changes did they make in their system as a result of COVID or as part of the COVID recovery? And I think that's where you get some of the really critical lessons learned. And so what we learned is that, as you're alluding to, COVID is not the only natural disaster, that there's natural disasters that are occurring all the time. And scientists will argue that they're actually more frequent than they used to be because of climate change, and so we're seeing more and stronger hurricanes, we're seeing, obviously, more wildfires—and certainly, Los Angeles is a city that was recently impacted by a fire that destroyed many people's homes as well as one of the clinics that was our partner organization. So I think it's important to realize that clinics need to have disaster plans in place that they can deploy during any type of natural disaster.

I think what we also learned was the importance of telehealth. So there were dramatic changes that were made to policies that governed reimbursement of telehealth for people who lived in urban areas and we saw that those were very useful in kind of maintaining care during the COVID lockdowns. And so maintaining an ability to ramp up or ramp down telehealth I think is really important as a way to respond to natural disasters.

We also saw that home-based testing was really critical, and so the reason that stool-based testing was still done during kind of those critical lockdown points of the pandemic is because it could be done in patients' homes. And in the past year—actually, last year in 2024—the US Food and Drug Administration approved self-collection for cervical cancer screening. And I think that's huge in terms of what it can mean for the ability for underserved groups that can't get into clinics to get screened for cervical cancer, and so really thinking about technologies that allow home-based testing I think is really critical. And certainly during the COVID pandemic, we realized that people could do testing at home because everybody probably knows somebody and themselves that did a COVID test during the pandemic. And we figured out how to do it and could do it successfully. And so I think home-based testing is here to stay, and it can actually be a pandemic-proof or a natural disaster-proof strategy that clinics can rely on.

Dr. Turck:

For those just tuning in, you're listening to *Clinician's Roundtable* on ReachMD. I'm Dr. Charles Turck, and I'm speaking with Dr. Gloria Coronado about how natural disasters can impact colorectal cancer screening access.

So, Dr. Coronado, let's dive deeper into the equity side of this topic. How have disasters like COVID-19 magnified existing disparities in colorectal cancer screening?

Dr. Coronado:

This is a really important point. We know that natural disasters tend to impact vulnerable communities more than other communities. Economically disadvantaged communities tend to be hit harder because they may not live in homes that have a solid foundation, or they live in areas that are more vulnerable to natural disasters. And, certainly, during the COVID pandemic, we saw higher infection rates among people whose jobs required that they show up in person, that they couldn't work from home, for example. And so we see that in natural disasters, it tends to be those populations that already have poor access to healthcare and lower cancer screening rates, that tend to be also hit hardest by the natural disaster itself, kind of creating this perfect storm in a sense. And that's where I think the disaster preparedness plans of clinics needs to be responsive to make sure that we are recognizing the needs of the communities that are most vulnerable to these naturally occurring events.

Dr. Turck:

And from your perspective, how can we make screening programs more resilient and equity-focused moving forward?

Dr. Coronado:

I think there's a variety of things that can be done, and some of them I have already mentioned, like making sure that we maintain the ability to use telehealth is critical, prioritizing home-based testing and making sure that we're innovating in a way that is making the home-based testing possible for more and more people.

But another aspect is that—I mentioned that in this particular health center that stool-based testing rates occurred at the same rate before the pandemic as during the pandemic, but where we saw the drop-off was really in colonoscopy which is, of course, the procedure that's more challenging to do. It requires a patient prep for the procedure. It requires that they go into the clinic in person. And so some of that makes sense, that the rates would drop during the pandemic. What surprised us is that they didn't recover. And there are some health systems in the US that have decided that—during the pandemic—decided to prioritize the scheduling for the follow-up colonoscopy over the screening colonoscopy procedure because they know that a patient who has an abnormal stool-based test has a much higher risk of cancer, so they have about a one in 20 chance of having a cancer found on that colonoscopy where somebody that's coming in for the screening exam has about a one in 400 or one in 1,000 chance of having a cancer found. And so the systems implemented different rules for prioritizing the patients who are at highest risk during COVID. There's been some health systems that have maintained that since COVID, and I think that's another lesson learned, that that's an important thing to do, and the more that we can do it even in community-based settings, the more lives that we'll actually save by reducing the barriers to getting those patients in for that procedure, reducing barriers to scheduling, and making sure they can get in within a couple of weeks.

And then I think the final thing is, other than home-based testing, I talked about telehealth and the need to maintain a clinic's ability to do telehealth. One of the things that we saw that varied across health systems was that some of them were able to transition to mailing the FIT test to patients after a telehealth visit, and so they created new workflows that complemented the telehealth visit, which tended to be short, but the provider could still place the order for the FIT test and it could be mailed to the patient's home. And so really making sure that, with the telehealth implementation, there is also the accompanying workflows that allow cancer screening to be done in the home environment.

Dr. Turck:

Now, before we wrap up, Dr. Coronado, what's the main takeaway you hope health systems and providers would remember from the COVID-19 pandemic?

Dr. Coronado:

I think the main takeaway is that screening can still be done. COVID was hard on a lot of people, and it took a toll on a lot of health systems, but that really good recovery is possible, because there's a lot of really key lessons learned. And I think that if these lessons are applied, the health systems can be more resilient for the next natural disaster.

Dr. Turck:

Well, with those insights in mind, I want to thank my guest, Dr. Gloria Coronado, for joining me to discuss how we can maintain and improve colorectal cancer screening rates during crises like the COVID-19 pandemic.

Dr. Coronado, it was great having you on the program.

Dr. Coronado:

Thank you so much.

Dr. Turck:

To access this and other episodes in this series, visit *Clinician's Roundtable* on ReachMD.com, where you can Be Part of the Knowledge. I'm Dr. Charles Turck. Thanks for listening.