Requiring COVID-19 Tests Before a Colonoscopy Led to Disparities

Black, Latino and American Indian people were more likely to have testing-related colonoscopy cancellations.

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The Colon Cancer Foundation had the opportunity to speak with Dr. Shahnaz Sultan, MD, MHSC, AGAF, about her research team's findings that pandemic-related pre-procedure COVID-19 testing caused higher rates of endoscopy cancellations among patients from marginalized populations. A Professor of Medicine in the Division of Gastroenterology, Hepatology, and Nutrition and the Program Director for the Gastroenterology Fellowship Training Program at the University of Minnesota, Dr. Sultan's research interests are focused on reducing colorectal cancer morbidity and mortality by improving adherence and quality of colonoscopy.

Q: What is the main takeaway you want people to understand from your research?

One of the most important things we want to emphasize is that colorectal cancer [CRC] is a very preventable cancer and there is a lot of high-quality evidence that shows that screening for CRC actually leads to a reduction in associated mortality. We really need to think about CRC screening along a continuum—whether you are doing stool-based testing or you're getting a colonoscopy, it's a multi-step process, and at every step, we need to be cognizant about reducing barriers and helping patients complete their CRC screening tests. Adding another step that patients have to complete prior to colonoscopy, such as pre-procedure SARS-CoV2 testing, in addition to completing their bowel prep, following dietary guidelines, finding transportation, and coming in to get a colonoscopy, really makes it that much more challenging. Pre-procedure testing serves as one more step and one more possible barrier in terms of getting people up-to-date with their screening.

Q: As you were conducting your research, were there any findings that surprised you?

Our objective here was to understand the impact of pre-procedure COVID-19 testing—we wanted to see the magnitude of the impact and who was specifically affected by this additional requirement. When we looked at the canceled outpatient endoscopy procedures in our cohort from March 2021 to September 2021, we were surprised that the overall cancellation rate was so high in terms of getting people to complete their colonoscopy. Among the 574 cancellations, a little under 10% were due to pre-procedure COVID-19 testing requirements, and a good proportion of

the remainder, about 51%, were patient-initiated cancellations. There were a lot of additional factors that were potentially holding people back from CRC screening. Additionally, we were surprised that pre-procedure testing was disproportionately affecting certain populations. Persons who self-identified as Black, American Indian, Alaskan Native, or Hispanic were more likely to have testing-related cancellations.

Shahnaz Sultan, MD, a gastroenterology and cancer specialist at University of MinnnesotaCourtesy of University of Minnesota

Q: Of the patients who canceled their colonoscopy, do we know if they went for an alternate form

of testing for colorectal cancer, such as stool-based testing?

That's an interesting question! We do not have that health data within our health system, but you bring up a good point. During the pandemic, a lot of other health systems were shifting gears from colonoscopy to stool-based testing and using programmatic efforts to directly reach out to patients to make sure they were getting some form of CRC screening.

Q: Healthcare challenges, such as the COVID-19 pandemic, have demonstrated an ability to significantly disrupt CRC screening procedures and participation, especially for medically underserved communities. What steps can be taken or what policies can be implemented in the future to support CRC screening participation and prevent significant disruptions to CRC screening?

There is a lot of ongoing research to understand different barriers we can address or different interventions we can take to improve screening at the population level. We really need a multifaceted or multi-pronged approach to screening. We really need to think about interventions that not only focus on patients, but we also need to target providers, health systems, and community leaders, and think about national and federal policy decisions. I think there are a lot of opportunities to decrease barriers at different levels in terms of getting people to be more up-to-date with screening at a population level.

In terms of policy, one of the things that we have been able to fix recently is this loophole that existed in the past where if a test was done for screening purposes, but polyps were removed, then it was no longer counted as a screening test, and that incurred copayments and additional burdens on patients. I think that has been a real coup for us in the gastroenterology community and overall in terms of helping to support the care of our patients. Also, I think there are a lot of opportunities at the national level to support programmatic efforts to improve screening for populations that are underinsured or don't have access to care, and I think we need to do more outreach and find ways to include health educators and patient navigators. We need to make sure we are educating patients about the importance of screening and helping address financial or logistical barriers that might serve as additional challenges for patients to overcome.

Q: Is your team planning partnerships with any organizations or public health groups for future research or to raise awareness? What are the next steps to move your research forward?

The biggest thing we want to do is to bring our data back to our health system. In my capacity as the former Chair of the American Gastroenterology Association (AGA) Clinical Guidelines Committee, and lead author of several guidelines for gastroenterologists caring for patients during the COVID-19 pandemic, we specifically looked at this question of pre-procedure testing requirements and, initially, we believed there may be some value in testing depending on the prevalence of COVID-19. However, once the vaccines were approved and we looked at the data on infections among healthcare workers performing endoscopy, there was very little benefit to testing

and a lot of concern about additional burden on patients. So, we made a conditional recommendation against pre-procedure testing. At that time, we polled gastroenterology members and asked them if they are still doing pre-procedure testing in their settings. Our target audience was not only people working in academic health systems, but also people working in private practice settings or ambulatory care centers, and there was a really big mix of responses: half of the members were still testing, and half were not.

I think we need to bring these data back to those systems and practices that are still requiring pre-procedure testing because the message should be that we really need to work on trying to get screening rates up to where they were before the pandemic. We really need to get rid of this barrier of pre-procedure testing to try to get to 80% participation rates, which is our goal, but instead, we are going in the opposite direction. We know that there are groups of patients and communities of individuals that have been experiencing worsening care and where we are increasing disparities.

Q: Were you able to find any trends in your data in terms of individuals who are being screened for the first time vs. those coming in for follow-up testing?

We didn't look at that data, but that's a very good question. The data in most settings show that people who initially had a prior colonoscopy had less fear, less mistrust, higher comfort levels, and more knowledge about the preparation and steps of a colonoscopy. No-show rates and cancellation rates tend to be higher for individuals who are getting their colonoscopy for the first time compared to those who are getting their follow-up colonoscopy.

Q: What is a general message you want people to understand about colonoscopies and CRC?

While we made a lot of advancements in our understanding of how CRC occurs and we made progress in terms of changing policies to help reduce copayments and additional burdens for patients, I think we have a long way to go. We don't really have a good understanding of why we are seeing so much early-onset CRC, and we really need to focus on efforts on trying to make sure everyone is up-to-date with CRC screening because it is such a preventable disease. We still have a lot of work to do to decrease the overall burden of CRC and reduce CRC-related morbidity and mortality.

Q: In May 2021, the US Preventive Services Task Force (USPSTF) revised the CRC screening age for average-risk adults to 45 years. Disparities in screening rates can potentially extend to adults ages 45 to 49 as the new USPSTF recommendations are implemented. What do you think about these changes? What do you see in the clinic as these updated guidelines are being implemented, especially in the context of insurance coverage.

We were waiting to see how long it would be before that came into effect in Minnesota, and more importantly, how long it would take our providers to implement the guidelines and refer patients for CRC screening. A lot of our referrals come from primary care physicians, family physicians, and OB/GYNs.

What we have observed in Minnesota is our insurances are covering screening, providers are recommending screening, and patients are actually coming in to get their screening done, which is very exciting. We've seen a steady increase in the number of people within the 45–50 age group and within the 50–55 age group who come in for CRC screening. With the 50–55 age group, we've noticed that individuals get guilted or their age is used as leverage to come in to get screened sooner as the updated guidelines now recommend screening for adults ages 45 to 49. One additional detail I have noticed is that more women are coming to get screened at earlier ages compared to men. I think that there are still going to be hard-to-reach communities that will need more intentional outreach, but overall, it is a good trend to see more people coming in to get their screening done sooner.

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