

Increasing Colorectal Cancer Screening in a Free Primary Care Clinic Using FIT.

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Increasing Colorectal Cancer Screening Rate in a Free Primary Care Clinic Using Fecal Immunochemical Test.

What We Know About Colorectal Cancer

- ❖ In the United States, colorectal cancer is the fourth most common cancer among both men and women and the fourth leading cause of cancer-related death (Centers for Disease Control and Prevention [CDC], 2025).
- ❖ The treatment cost for colorectal cancer amounts to 11.6%, and it is the 2nd highest cancer treatment cost in the United States (CDC, 2025).
- ❖ Incidence rates have increased by approximately 2.9% per year among adults under age 50 during the same period (American Cancer Society, 2026).
- ❖ Despite the well-established benefits of screening, disparities persist, primarily due to limited access to healthcare and a lack of insurance coverage.
- ❖ Uninsured adults are the least likely to undergo colorectal cancer screening.
- ❖ Increasing screening rates to 80% could reduce colorectal cancer incidence by 22% and mortality by 33% by 2030 (CDC, 2025).

Background and Purpose

- ❖ Introduction: The colorectal cancer screening rate at the project site was less than 5%, and there was no screening protocol. The patients at the project site are uninsured and cannot afford colonoscopy. Symptomatic patients with chronic abdominal pain, constipation, and diarrhea are referred for colonoscopy screening, while the rest are left out.

- ❖ Purpose: The goal was to increase the colorectal cancer screening rate at the clinic by providing Fecal Immunochemical Test (FIT) to average-risk patients between the ages of 45 and 75 during their laboratory or clinic visit.

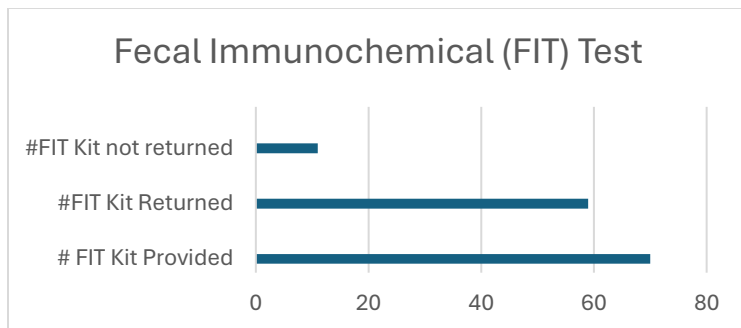
Methodology

- ❖ Approach: IRB approval was obtained from the University and the project site's healthcare system for the Quality Improvement project. A pre-intervention chart review was done from January to April of 2025. Sixty charts were audited, 30 males and 30 females, 2 patients had colorectal cancer screening done with FIT, while one had colonoscopy, resulting in a 3.3% screening rate. The Plan-Do-Study-Act (PDSA) framework guided the project implementation. Staff were educated on using the high-risk cancer screening tool embedded in the electronic medical record (EMR) to identify eligible average-risk patients between the ages of 45 and 75 and using the colorectal cancer screening flowchart, which is an algorithm as a protocol helping with workflow efficiency. FIT kit was provided to eligible patients during their laboratory or clinic visit, and educated about the importance of getting screened. A reminder phone call was made, encouraging patients to collect and return stool samples within 2- 4 days. The project was implemented for 13 weeks between January and April of 2026.
- ❖ Analysis: Data was collected on the number of FIT kits provided, returned, and tested, as well as the number of reminder phone calls made. Descriptive statistics were used to identify participants' demographic distribution and the percentage of the outcome data.

Results

- ❖ Findings: 70 Fecal Immunochemical Test kits were provided to average-risk patients, 32 males and 38 females; 59 were returned and tested. 54 participants tested negative while 5 participants tested positive. Colonoscopy referral was sent for the 5 patients that tested positive; one had the procedure done, and the remaining have colonoscopy dates scheduled. The result showed an 84% increase in colorectal cancer screening rate post-intervention compared to 3.3% pre- intervention. Out of the 24 reminder phone calls made between January and February, 20 FIT kits were returned, while out of the 46 reminder phone calls between March and April, 39 FIT kits were returned.

- ❖ Visuals:



Strengths and Limitations

- ❖ Strengths: Patients were receptive to completing the fecal immunochemical test (FIT) due to its noninvasive nature and ease of sample collection. Staff having a good grasp of the PDSA cycle and using the CRC flow chart led to engagement and participation. The project's success was driven by strong team collaboration, and having a project champion was instrumental in the success of the project.

- ❖ Limitations: The project encountered several limitations that impacted implementation and outcomes. Implementation was demanding, particularly in a grant-funded clinic with limited resources. Inadequate staffing and reliance on volunteer students contributed to delays in making reminder calls, especially during busy clinic hours. The absence of pre- and post-intervention assessment surveys limited the ability to evaluate patient understanding of colorectal cancer screening education. This may have contributed to patient disinterest or failure to complete and return FIT kits. The 13-week implementation period may not have been sufficient to fully assess long-term patient adherence to screening. Additionally, the small sample size limits the generalizability of the findings. Patient-related barriers, such as lack of transportation, also affected the return of completed FIT kits and, consequently, overall project outcomes.

Implications and Conclusion.

- ❖ Implications: The outcomes of this project demonstrate that using fecal immunochemical tests (FIT) for colorectal cancer screening in primary care settings is an effective, noninvasive approach that may improve patient adherence. This model may be particularly beneficial for other grant-funded free clinics serving underserved populations. The use of a colorectal cancer screening flow chart enhances workflow efficiency and supports consistent identification and screening of eligible patients. Implementing structured, evidence-based screening processes can lead to improved patient outcomes and more efficient delivery of care.
- ❖ Conclusion: Despite challenges encountered during implementation, the project demonstrated that continuous patient education on the importance of preventive screening can improve adherence to recommended health practices and lead to better health

outcomes. The implementation strategies and workflow developed through this project can be sustained and adapted for future evidence-based quality improvement initiatives aimed at improving population health outcomes and reducing healthcare costs.

References

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Appendix**Colorectal Cancer Screening Flow Chart**