

Closing Disparities in Colorectal Cancer Screening

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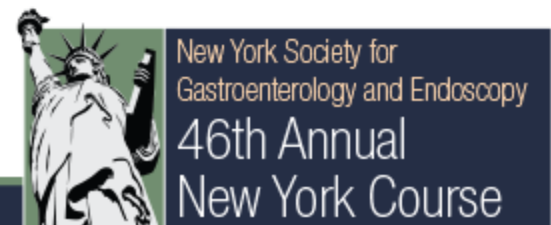
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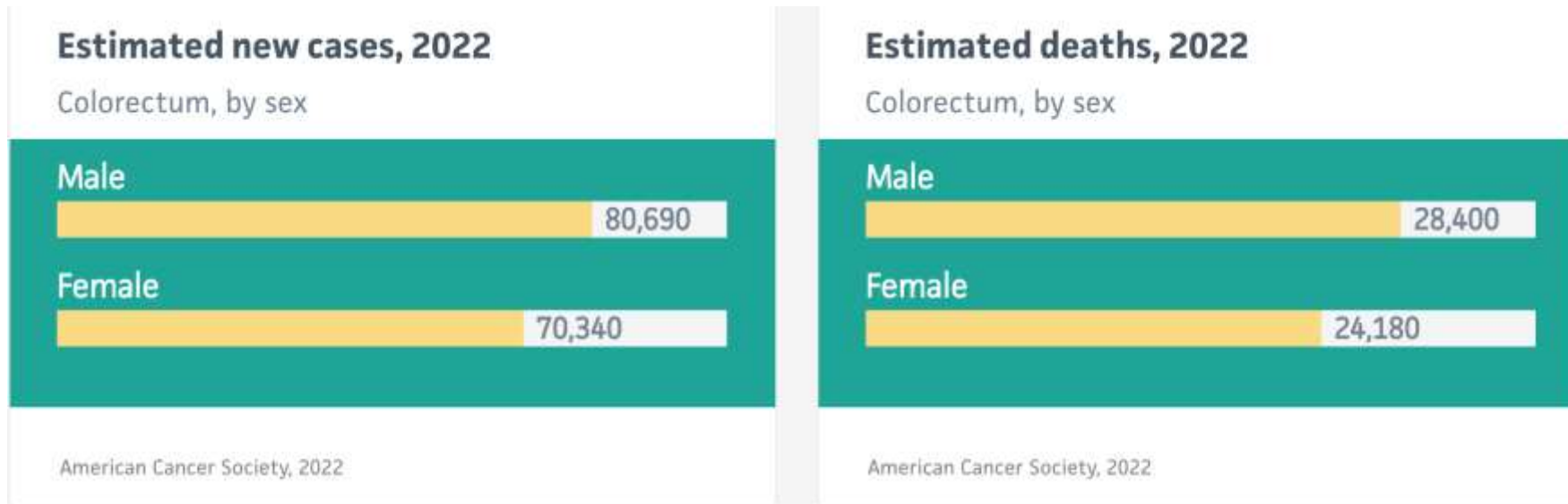
Disclosures

- I do not have any disclosures.

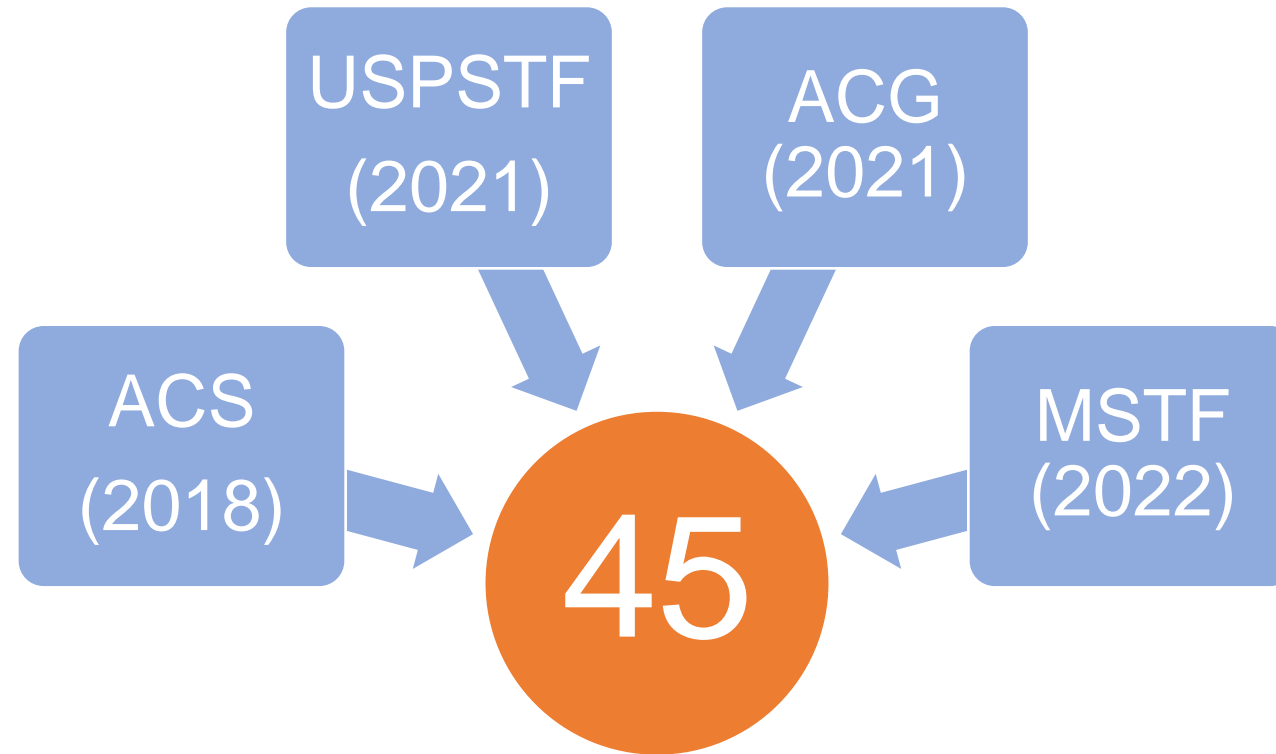
Objectives

- Review CRC disparities in incidence, mortality, and survival among African Americans
- Discuss patient, physician, and health system barriers to CRC screening
- Recognize the interventions of CRC screening champions

Estimated Colorectal Cancer Cases in U.S.



CRC Screening Guidelines



Average-risk:


- No personal or family history of colorectal neoplasia
- Asymptomatic (e.g., no GI bleeding, Iron deficiency)

DISPARITIES

CRC Screening Guidelines for African Americans

American College of Gastroenterology (ACG) Clinical Guideline (2009)

- A separate clinical guideline created by the Minority Affairs and Cultural Diversity Committee.
- African Americans are a high-risk group that should be screened earlier than an average risk patient, starting at 45 years old.

Citation: *Clinical and Translational Gastroenterology* (2016) 7, e185; doi:10.1038/ctg.2016.36
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www.nature.com/ctg

CLINICAL AND SYSTEMATIC REVIEWS

Colorectal Cancer in African Americans: An Update

Prepared by the Committee on Minority Affairs and Cultural Diversity, American College of Gastroenterology

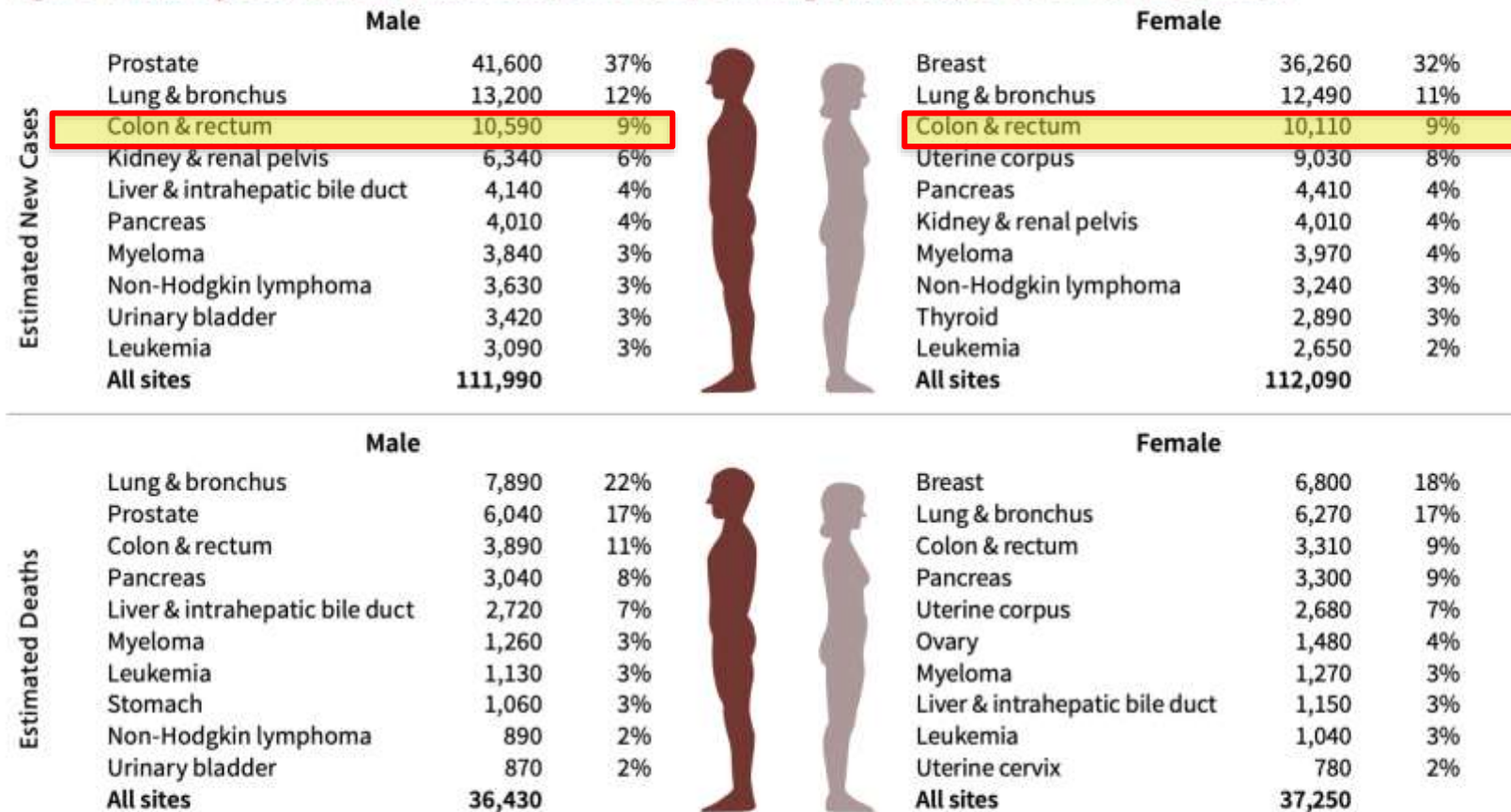
Renee Williams, MD¹, Pascale White, MD², Jose Nieto, DO³, Dorice Vieira, MLS, MA, MPH¹, Fritz Francois, MD, MSc¹ and Frank Hamilton, MD, MPH⁴

- Update published in 2016
- Addressed new topics such as physician- related barriers to screening

Statistics for African Americans

- 41 million African Americans living in the U.S. (12.4%)
- African Americans are about **20%** more likely to get colorectal cancer and about **40%** more likely to die from it than most other groups

Figure 2. Leading Sites of New Cancer Cases and Deaths among Black People in US – 2022 Estimates*



*Estimates are rounded to the nearest 10, and exclude basal and squamous cell skin cancers and in situ cancers with the exception of urinary bladder. Ranking is based on modeled projections and may differ from the most recent observed data.

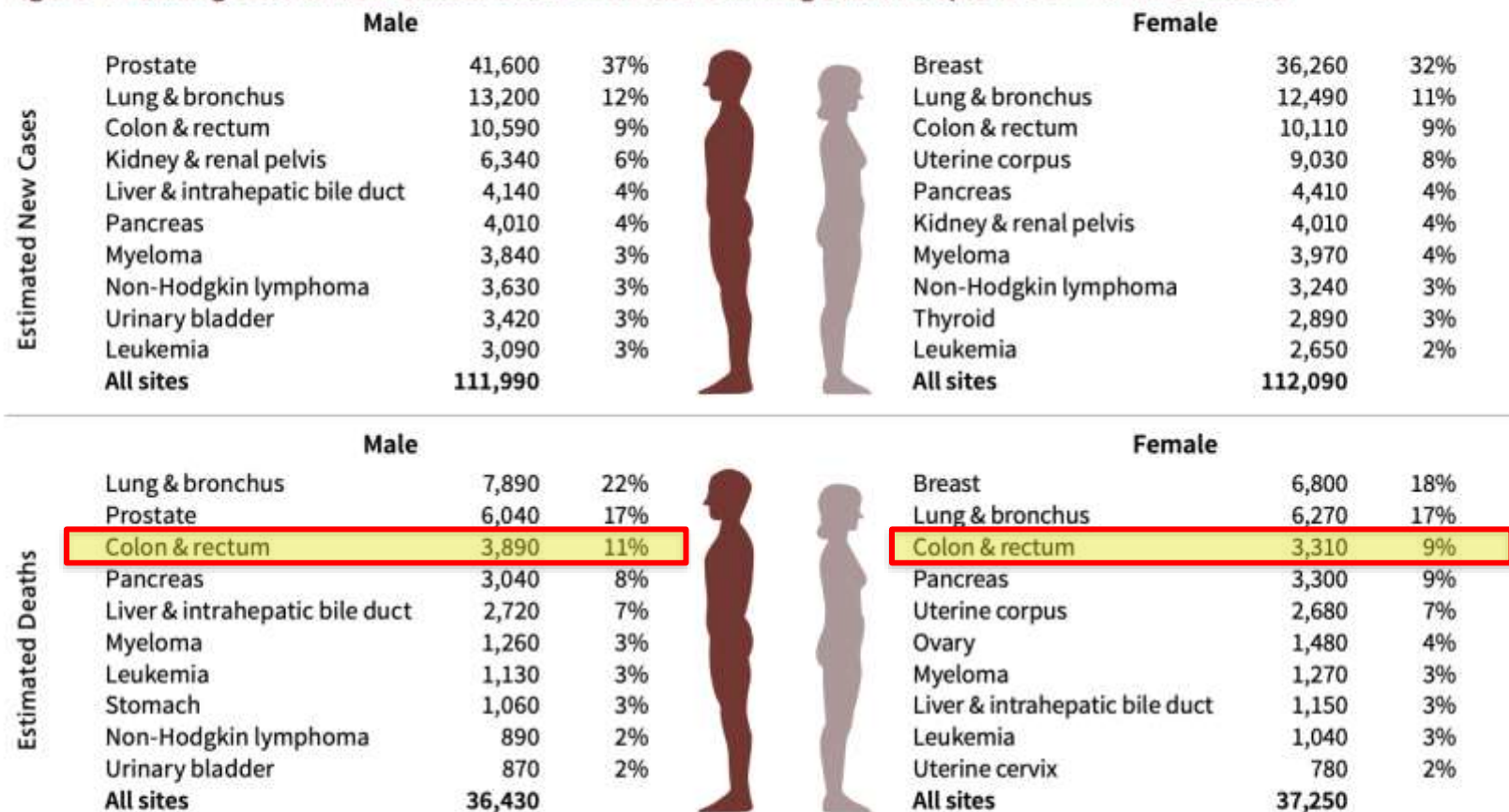
Source: Estimated new cases are based on 2004-2018 incidence data reported by the North American Association of Central Cancer Registries. Estimated deaths are based on 2005-2019 US mortality data from the National Center for Health Statistics, Centers for Disease Control and Prevention. See Sources of Statistics on page 39 for more information.

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New York Society for
Gastroenterology and Endoscopy
46th Annual
New York Course

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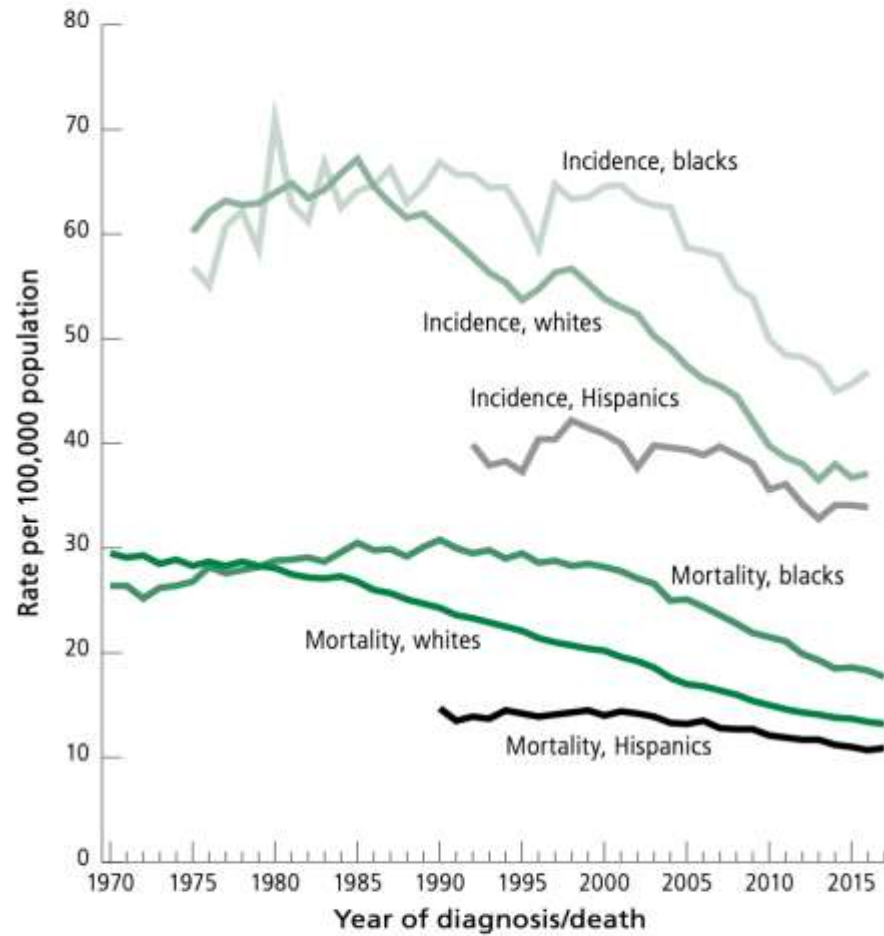
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Figure 8. Trends in Colorectal Cancer Incidence (1975-2016) and Mortality (1970-2017) Rates by Race, US



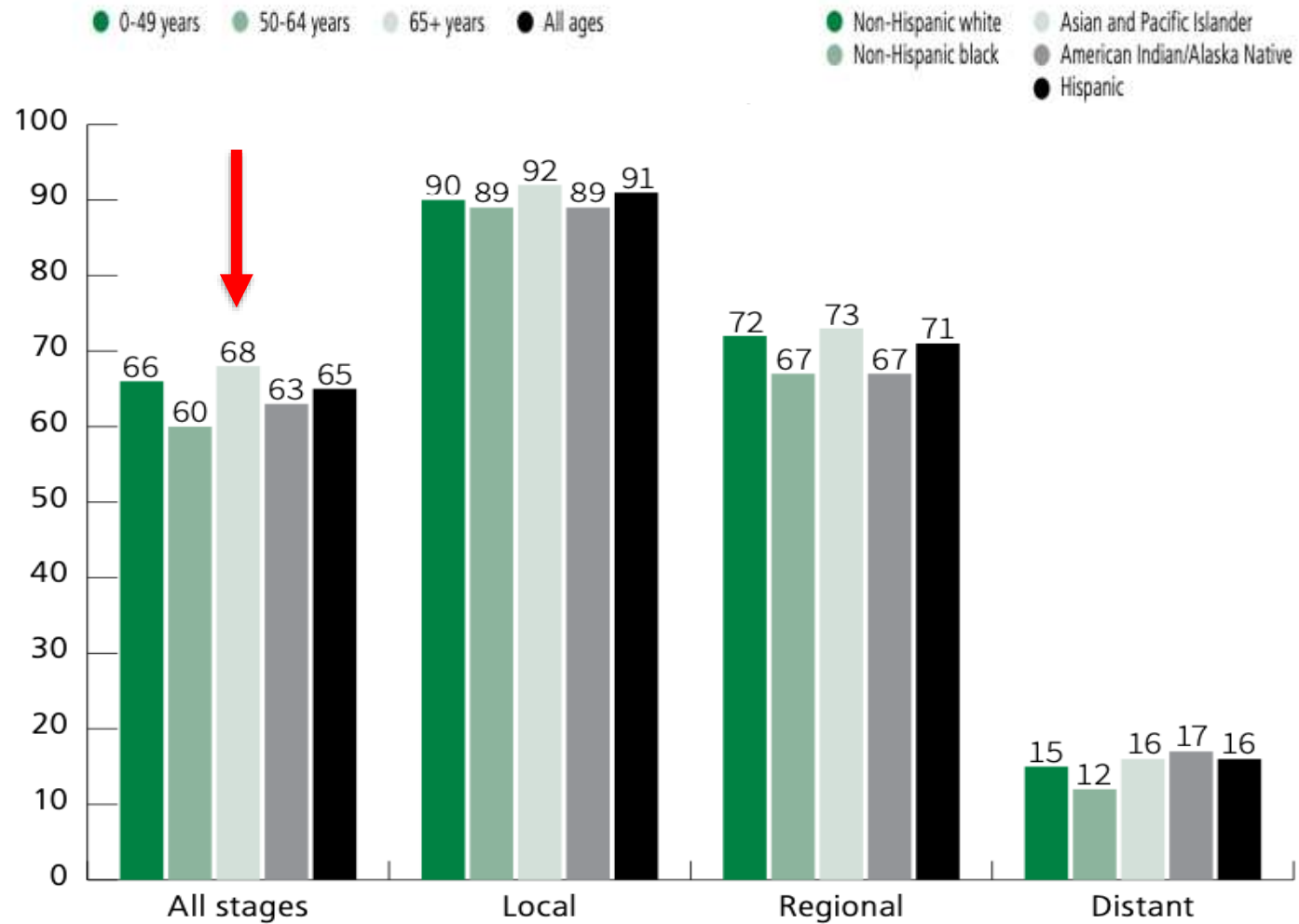
Rates are age adjusted to the 2000 US standard population. Incidence rates are adjusted for reporting delays and exclude appendix. White and black race are not mutually exclusive from Hispanic ethnicity.

Source: Incidence – SEER program, 2019. Mortality – NCHS, 2019.

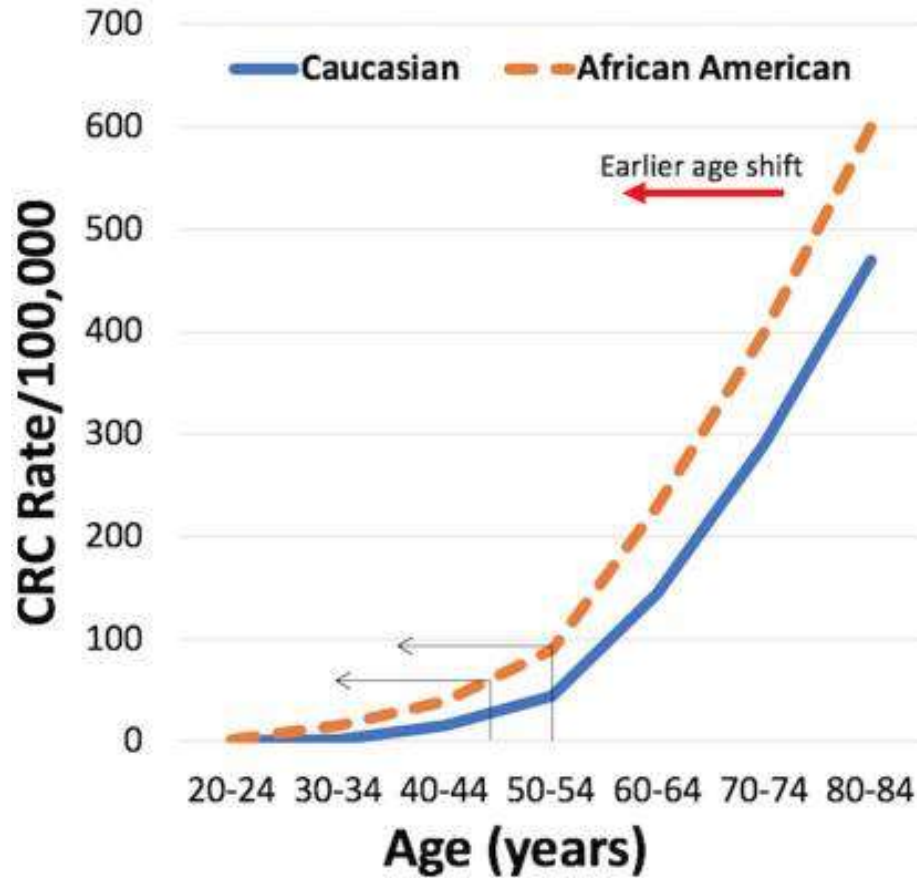
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Figure 10. Colorectal Cancer Five-year Survival (%) by Age and Race/Ethnicity, 2009-2015



Earlier Age for CRC in African Americans



	Proportion of CRCs <i>under</i> target age	Proportion of CRCs <i>over</i> target age
Caucasians screened at 50 years of age	5.5%	94.5%
African Americans screened at 50 years of age	10.6%	89.4%
African Americans screened at 45 years of age	5%	95%

Early Onset CRC

Table 4. SEER 18 adenocarcinoma staging proportion shifts between 2000–2002 and 2014–2016 stratified by race/ethnicity.

Adenocarcinoma proportion shifts: <i>Distant stage</i>										
Subsite/age	Non-Hispanic White			Non-Hispanic Black			Hispanic			
	2000–2002	2014–2016	Δ	2000–2002	2014–2016	Δ	2000–2002	2014–2016	Δ	
Colorectal	20–29	23%	25%	+2	13%	38%	+25	25%	30%	+5
	30–39	21%	29%	+8	22%	29%	+7	25%	27%	+2
	40–49	20%	27%	+7	31%	29%	–2	24%	27%	+3
	50–54	18%	20%	+2	21%	25%	+4	22%	20%	–2
Colon-only	20–29	26%	26%	+0	20%	34%	+14	22%	22%	+0
	30–39	23%	30%	+7	23%	27%	+4	22%	25%	+3
	40–49	22%	30%	+8	33%	31%	–2	25%	28%	+3
	50–54	20%	22%	+2	22%	25%	+3	23%	21%	–2
Rectal-only	20–29	17%	23%	+7	0%	46%	+46	28%	41%	+13
	30–39	18%	27%	+9	21%	33%	+12	29%	29%	+0
	40–49	16%	23%	+7	27%	24%	–3	20%	26%	+6
	50–54	14%	17%	+3	18%	26%	+8	19%	20%	+1

BARRIERS

CRC Screening Barriers



Knowledge
Barriers



Perception
Barriers

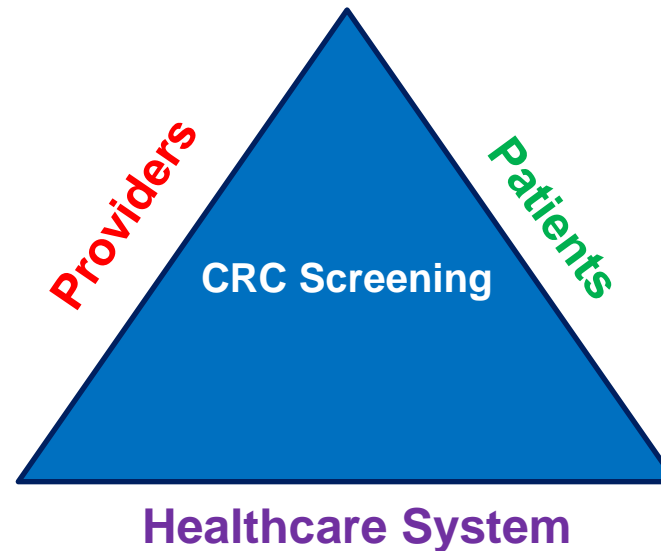


Access
Barriers



Barriers Driving Racial Disparities in CRC Screening in AA

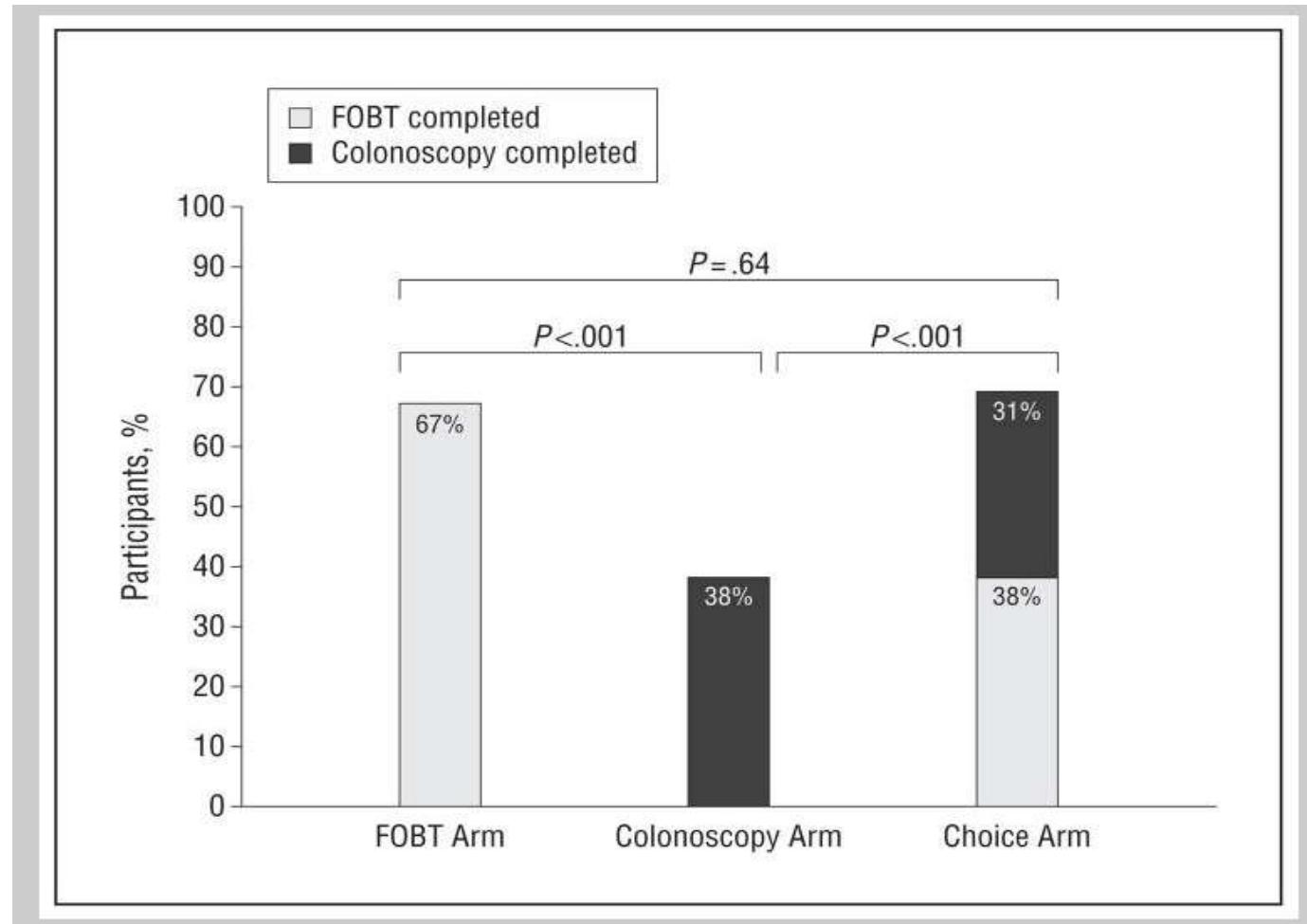
- Lack of Knowledge
- Lack of Recommendation
- Lack of Healthcare access
- Time commitment
- Lack of support



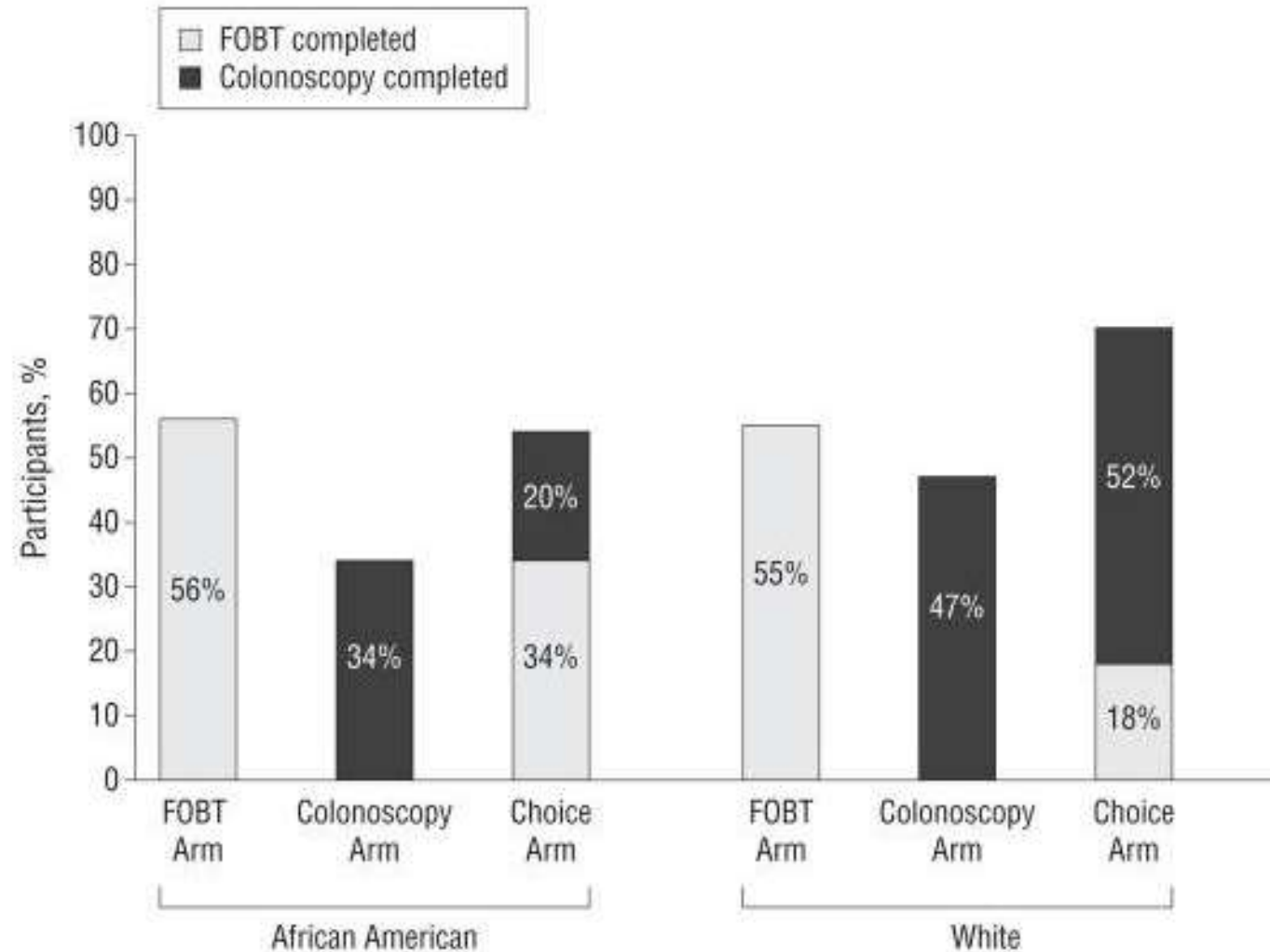
- Lack of Knowledge
- Fear/Embarrassment
- Mistrust
- Lack of Healthcare Access/Insurance
- Socioeconomic factors
- Lack of social support/time commitment

- Inconsistent access to primary care
- Lack of coverage for colonoscopy
- Health Insurance premiums

Giving Choices \neq Less Adherence



Racial Differences in Adherence



Physician Recommendation for CRCs

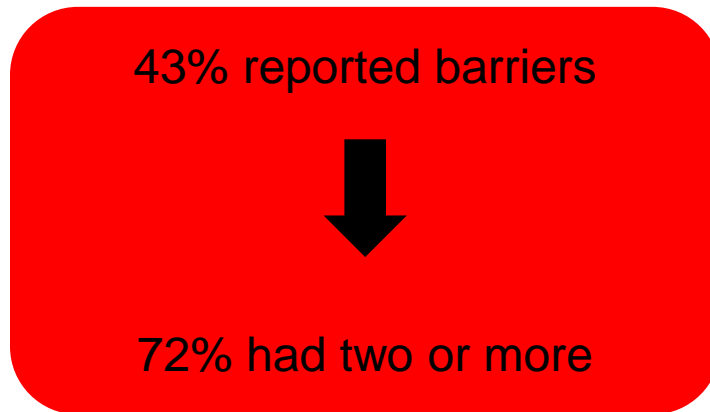
- AA were just as likely as White men and women to get a physician recommendation for FOBT. However, they were **less likely** to get a recommendation for endoscopy versus White men and women.
- **33%** did not remember ever receiving a recommendation for FOBT, sigmoidoscopy, or colonoscopy.
- AA were about a **third less likely** than Whites to receive a physician's recommendation for screening (OR =0.61 (0.53 - 0.71)).

Disparities in Physician Recommendation

Patient factors associated with non-recommendation by their physician:

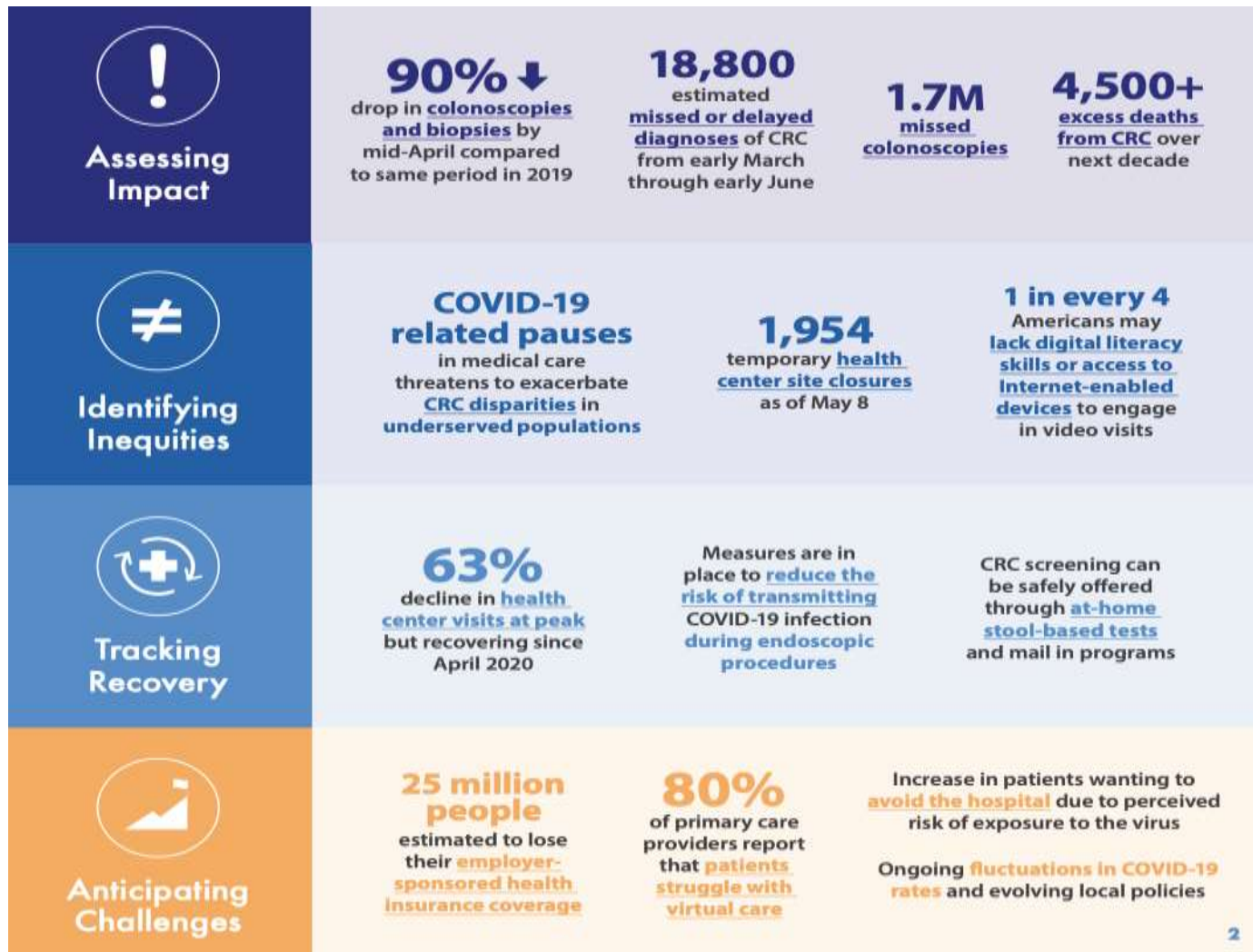
- Lower education
- > 3 children
- Shorter duration in the U.S.
- Income below poverty level
- Unemployment
- No health care`

Physician Identified Barriers



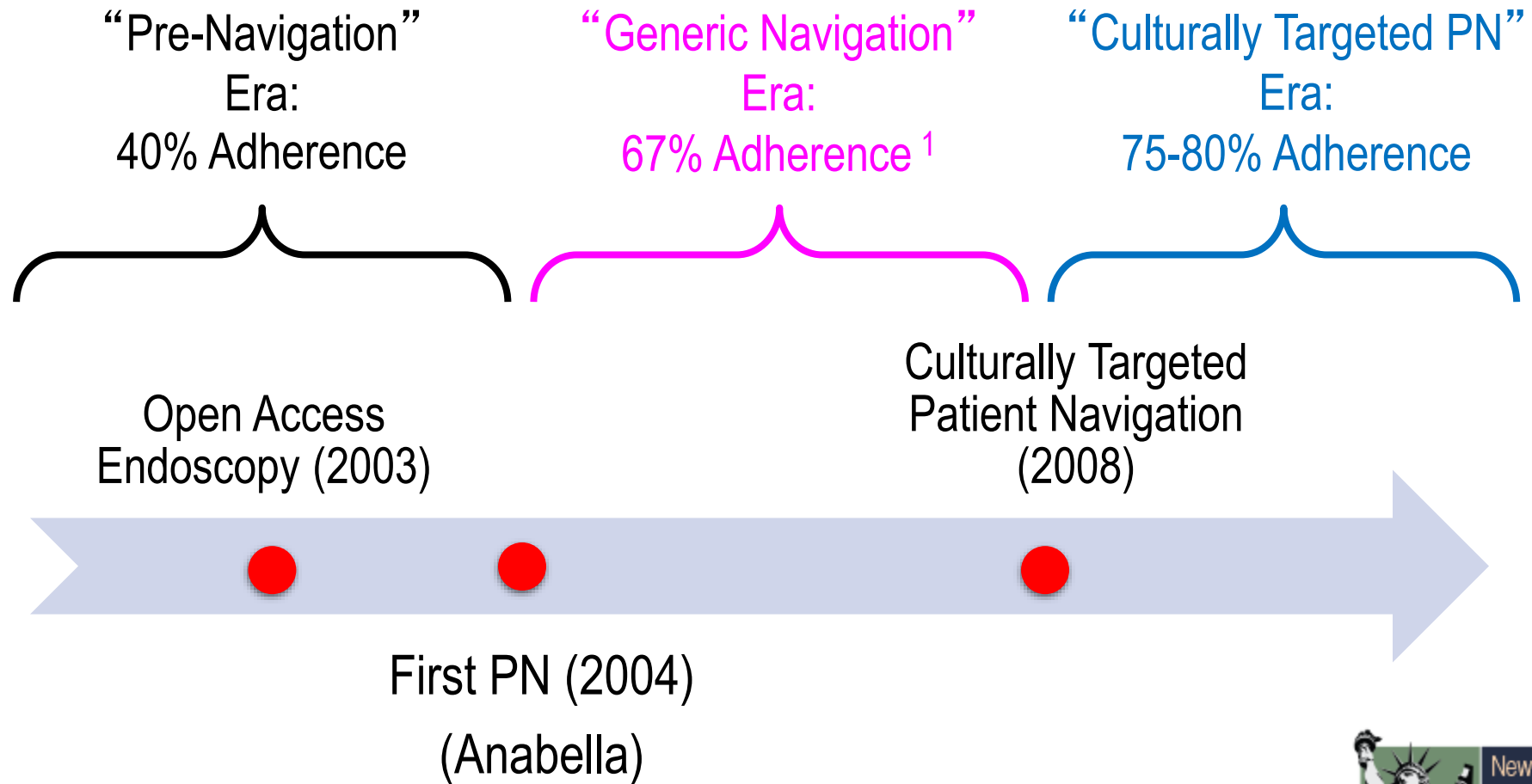
- Patient refusal (69%)
- Lack of insurance reimbursement for early colonoscopy referral (64%)
- Patient anxiety (58%)
- Unaware of the current guidelines (23%)
- Lack of evidence to support efficacy of earlier screening (14%)
- Time constraints on taking full family history (12%)

CRC Screening During COVID-19

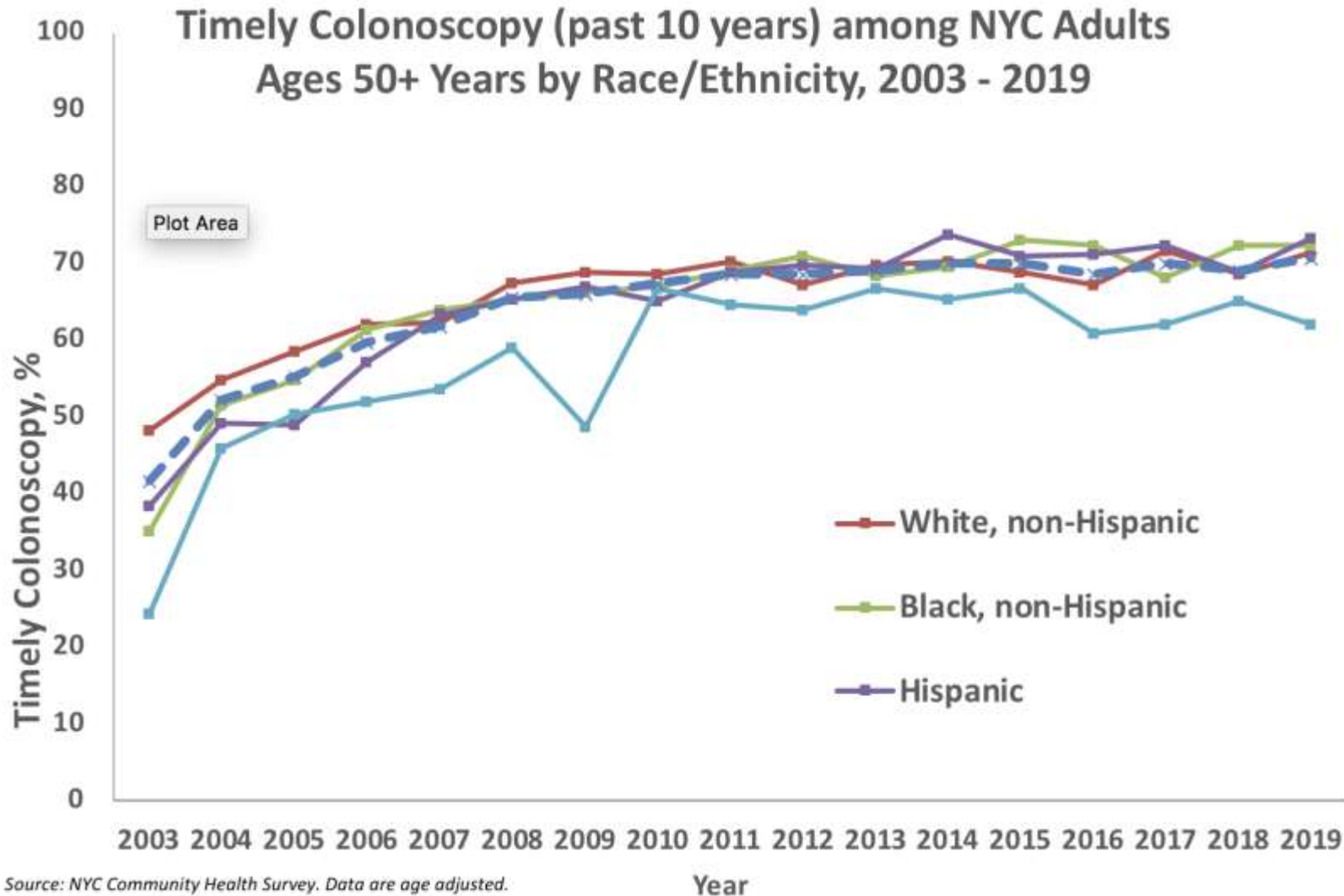


CHAMPIONS

Mount Sinai Colonoscopy Navigation Program

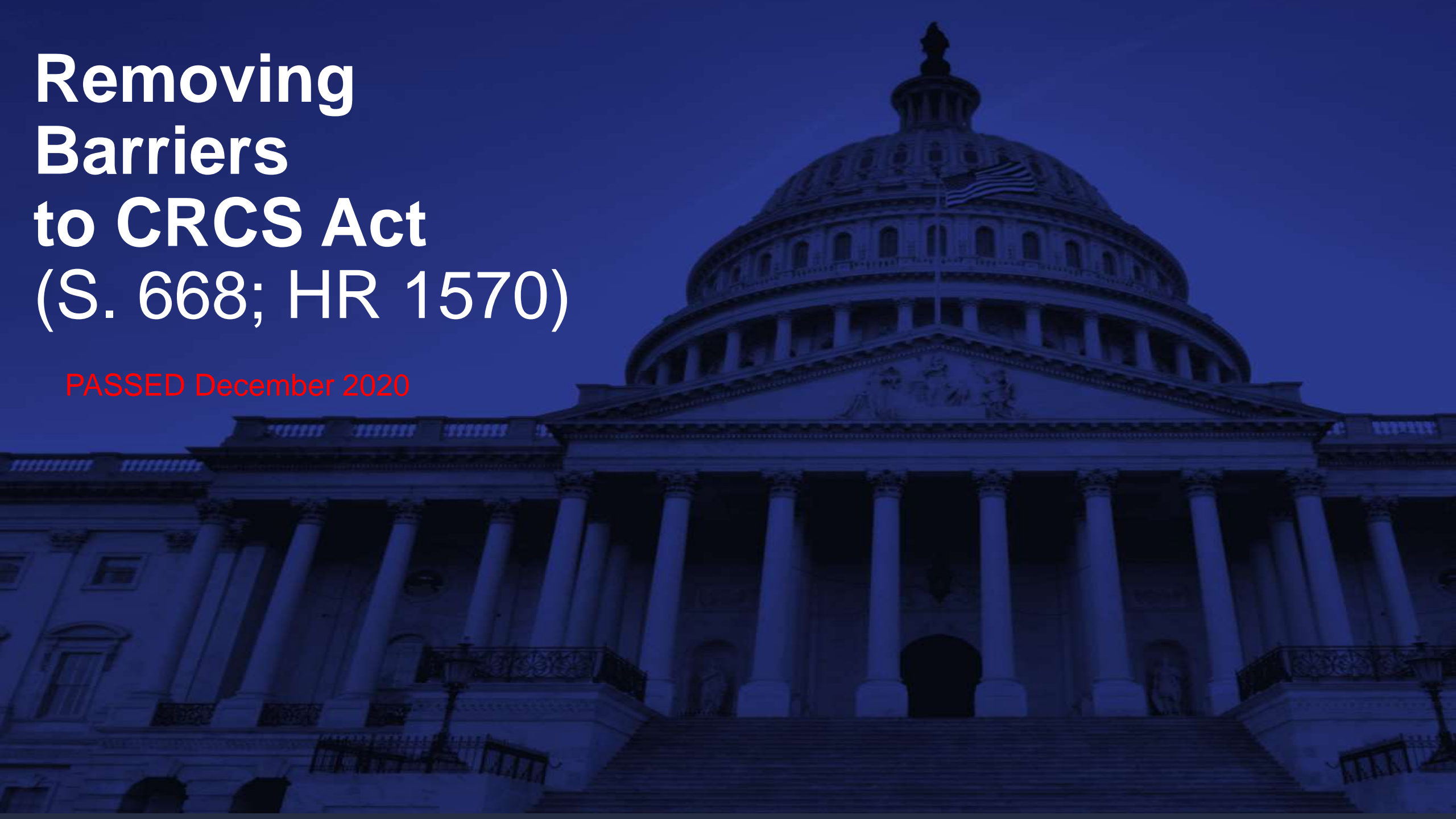


ELIMINATION OF SCREENING DISPARITIES FOR WHITE, BLACK, HISPANIC AND ASIAN NEW YORKERS



Removing Barriers to CRCS Act (S. 668; HR 1570)

PASSED December 2020



CRC Screening Co-Insurance

Positive:
FIT
Multitarget Stool DNA
Hemoccult Sensa



No Cost Sharing after Positive Stool Tests!

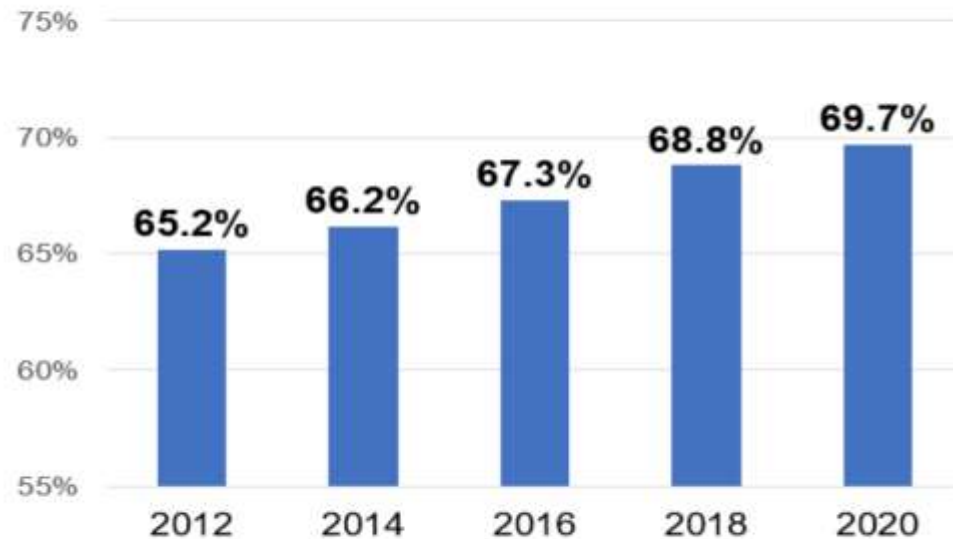
Positive:
FIT
Multitarget Stool DNA
Hemoccult Sensa



NCCRT - 80% in Every Community

NATIONAL SCREENING RATE – BRFSS

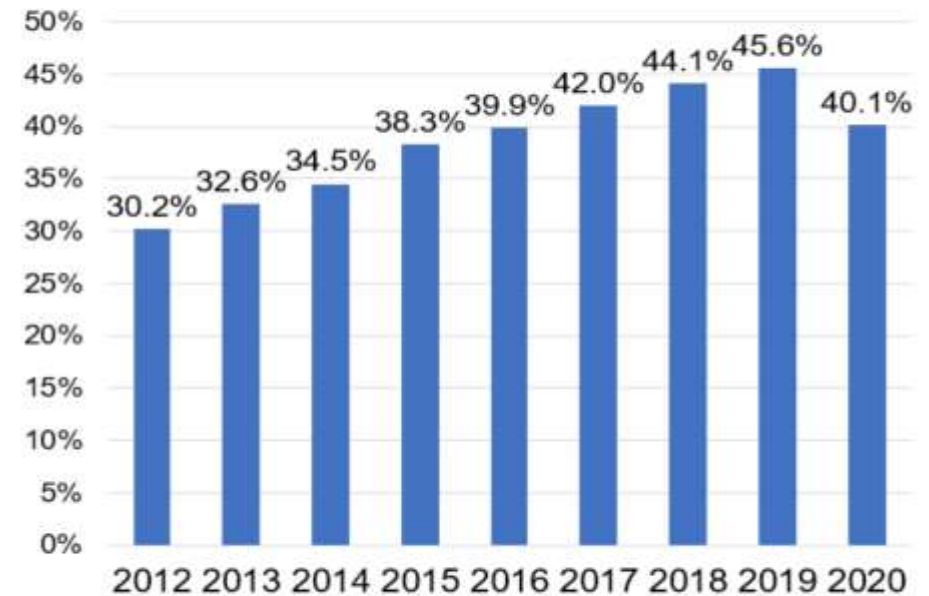
Percentage of U.S. Adults Age 50-75 years Up-to-Date with CRC Screening, Behavioral Risk Factor Surveillance System⁴



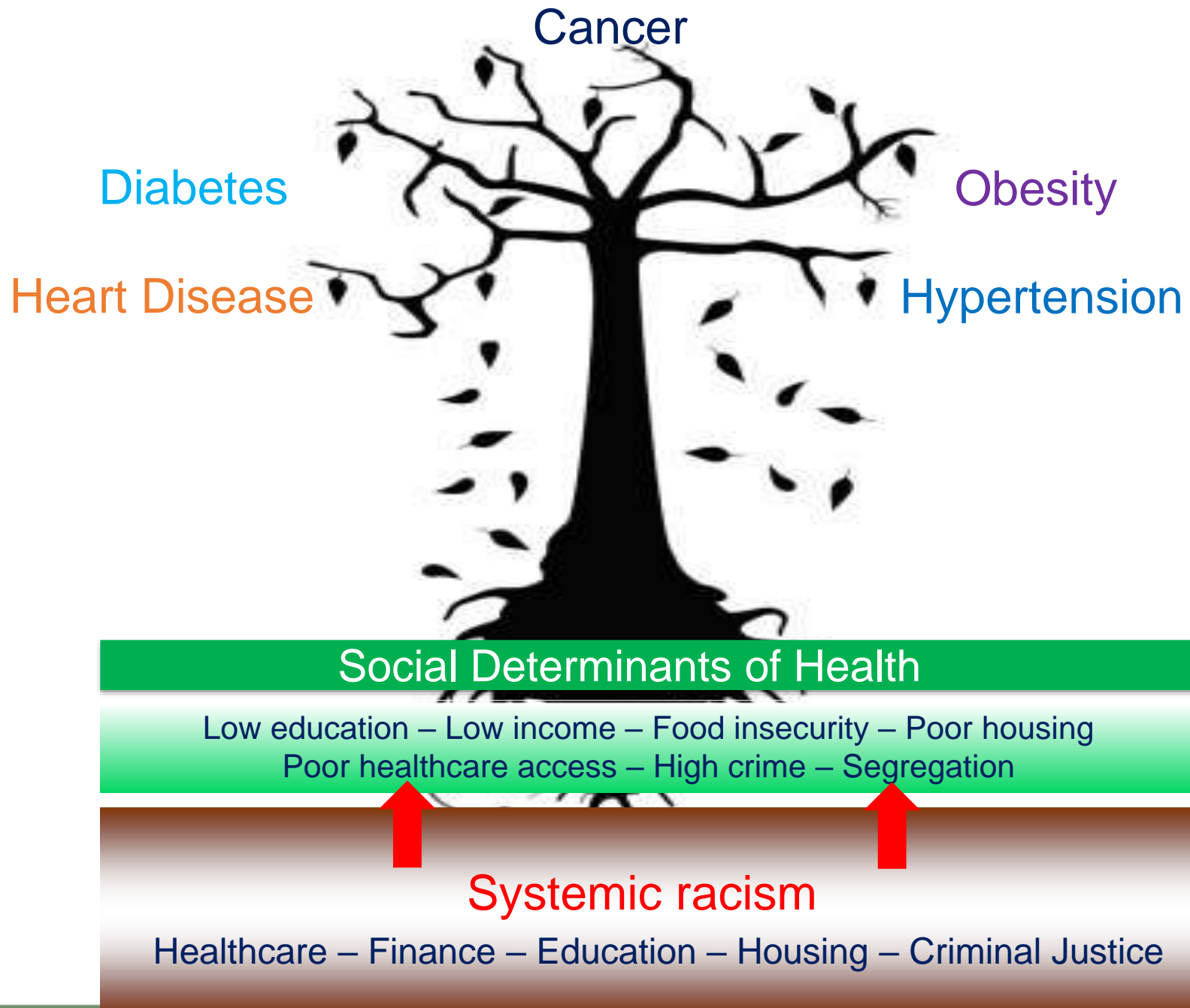
The increase in the screening rate between 2012 and 2018 represents an additional 9.3 million adults screened for colorectal cancer.⁴

COMMUNITY HEALTH CENTER PATIENTS – UDS

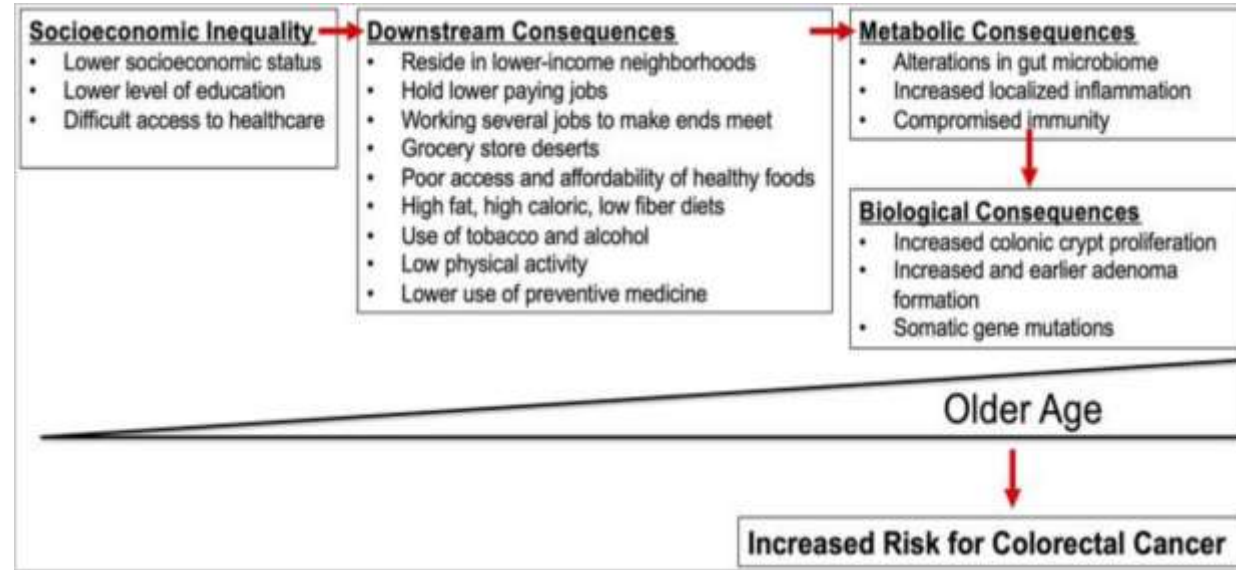
Percentage of Federally Qualified Health Center Patients ages 50-75 years Up-to-Date with CRC Screening, Uniform Data System⁶



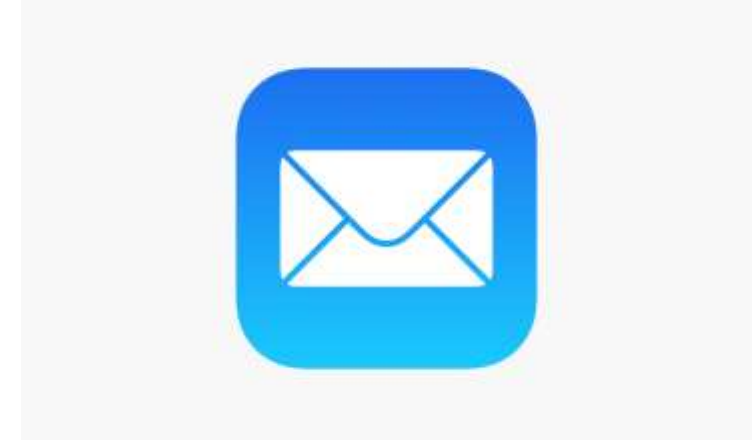
The UDS CRC screening rate was 40.1% in 2020, which amounts to 2,448,976 patients screened in 2020 alone. In 2020, 11 health centers reached or exceeded an 80% screening rate.















Consequences of Socioeconomic Disparities



How ABGH Started...



Co-Founders/Board of Directors of ABGH

 <p>Adjoa Anyane-Yeboah, MD, MPH</p>	 <p>Valerie Antoine-Gustave, MD, MPH Treasurer</p>	 <p>Sophie Balzora, MD President</p>	 <p>Rotonya Carr, MD</p>
 <p>Darrell M. Gray II, MD, MPH</p>	 <p>Alexandra Guillaume, MD</p>	 <p>Ugo Iroku, MD, MHS, PCEO Secretary</p>	 <p>Rachel Issaka, MD, MAS</p>
 <p>Fola May, MD, PhD, MPhil</p>	 <p>Pascale White, MD</p>	 <p>Renee Williams, MD, MS Vice President</p>	

Community Outreach

FIGHT **ABGH**

**LET'S BEAT COLORECTAL CANCER:
AN UPDATE FOR THE BLACK
COMMUNITY**

AN ABGH VIRTUAL ROUNDTABLE

DR. PASCALE WHITE
Moderator, ABGH
Co-founder

DR. EDWIN McDONALD
Physician Expert, ABGH
Member

WENORA JOHNSON
CRC Survivor, Research/Patient
Advocate

WALTER HICKMAN
CRC Survivor, Community
Advocacy Award

KENTISHA MATEKE
CRC Advocate,
Founder, Faith's Love

JOIN US LIVE AND ENGAGE WITH PHYSICIAN EXPERTS,
COLORECTAL CANCER SURVIVORS, AND CAREGIVERS

MARCH 10, 2022, 8-9PM EST | REGISTER: WWW.LETSBEATCRC.EVENTBRITE.COM

**good
downthere**
Columbia

ASK A DOCTOR VIRTUAL

**RACISM AND
COLORECTAL CANCER**

A discussion on the intersection between
race, racism, and health inequities in colorectal
cancer outcomes for Black Americans.

A B G H **ELK
HLTH** **Cottonelle** **colorectal
cancer
alliance**

Tuesday, May 18th | 7 - 8:30 PM EST
Register here: bit.ly/3t3m0vz

PANEL **FIGHT**

Colorectal Cancer In The COVID-19 Era

Dr. Fola May, MD, PhD, Mphil
Assistant Professor of Medicine,
The Vetche and Tamer Maroukian
Division of Digestive Diseases at
UCLA
Director of Quality Improvement,
UCLA

Norma Yvette Davis-Atkins
Colorectal cancer caregiver
Advocate
Mount Juliet, TN

Diane Nathaniel M.S., Ed
Colorectal cancer survivor
Advocate
Co-Founder of Real Stage 3, Inc
Ambassador, American Cancer Society
Cancer Action Network
New York, NY

Walter Hickman, Jr
Colorectal cancer survivor
Advocate
2020 recipient of FightCRC
Community Advocacy Award
Stone Mountain, Georgia

MISTER - B Trial

- **M**ulti-intervention study to **I**mprove colorectal cancer **S**creening and **T**o **E**nhance **R**isk reduction in **B**lack men trial
- RCT with 731 self-identified Black men recruited at barbershops between 2010 and 2013 in New York City.
- Participants: 50 years or older, not be up-to-date on CRC screening, have uncontrolled high blood pressure, and have a working telephone.
- Assessed completion of colorectal cancer screening at 6 months.



MISTER - B Trial

Group 1:
Patient navigator

17.5%

Group 2:
Motivational
interviewing

8.4%

Group 3:
Patient navigator
and Motivational
interviewing

17.8%

- Telephone-based PN was effective for older Black men
- Trusted community settings reach patients who aren't seen in the clinic.

Approaches to **Increase** Screening

- Multiple strategies should be employed to deliver the intervention
 - Tailor the specific intervention to address identified barriers
 - Personalize the education materials, culturally sensitive approach
 - Recruitment in familiar community settings
 - Educate the healthcare providers

Summary

- Colorectal cancer disparities in incidence, mortality and survival persist in the African American community
- We must acknowledge and address patient, physician, and healthcare system barriers including lack of knowledge, misperceptions and access issues.
- CRC Screening champions are working harder than ever to break down barriers in access and health inequities in our healthcare system on a local and national level.

Top 3 Things to Optimize Quality in Closing Disparities in CRC Screening

- #1 – Discuss CRC screening with your patients and include choices for screening options, whenever possible.
- #2 – Aim to recognize and address barriers to CRC screening among patients and providers as well as within your health system.
- #3 – Advocate and prioritize CRC screening for patients from underserved communities.