Good morning, everyone.

We'll go ahead and get the festivities started.

So we are just absolutely delighted to welcome Doctor Folasade May back to Yale. So Doctor May graduated cum laude from Yale University with a degree in molecular, cellular and developmental biology. She attended the University of Cambridge to study epidemiology and International health, earning a Master’s of Philosophy in Epidemiology, and attended Harvard Medical School. During her Gastroenterology fellowship at UCLA, she earned a PHD.
00:00:31.428 --> 00:00:34.000 in Health Policy and Management from the
UCLA Fielding School of Public Health.

Her doctoral dissertation addressed Black
white disparities in colorectal cancer
incidents, screening and outcomes. Dr.
May’s lab engages in health services,
research and quality improvement
related to population health,
preventive medicine, and health disparities.
The labs research spans several areas
from the epidemiology of disease and these
risk factors to implementation
these risk factors to implementation
science to improve disease outcomes.
As Director of the Melvin and
Brendan Simon Gastroenterology

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Quality Improvement Program,

Doctor May also oversees the portfolio of quality improvement projects at UCLA Health to improve the quality of care for UCLA Health patients with gastrointestinal and liver conditions.

Doctor May is passionate about improving awareness about preventive health and Health Equity and is involved in advocacy at the state and national level to develop and encourage policy.

So we’re going to do a quick photo with the presentation of the plaque.

So again, we are so delighted to have Doctor May and welcome her back to Yale.
Thank you so much for that introduction.
Yeah, absolutely.
And here we go.
I’m happy to be in that photo. Thank you so much.
I’ll have to get the picture.
Thank you. Thank you so much.
We will mail this to you.
So beautiful. Yeah.
Thank you already.
You don’t need my eyes.
These doors are your glasses too.
Fantastic. OK.
Well, thank you very much for that wonderful introduction and
00:01:59.627 --> 00:02:01.919 for the invitation to be here.
NOTE Confidence: 0.518014178333333
00:02:01.920 --> 00:02:03.453 It’s an absolute honor to be here
NOTE Confidence: 0.518014178333333
00:02:03.453 --> 00:02:04.884 at the Yale Cancer Center today
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00:02:04.884 --> 00:02:06.557 and to speak with all of you.
NOTE Confidence: 0.518014178333333
00:02:06.560 --> 00:02:07.850 And I’m actually really excited
NOTE Confidence: 0.518014178333333
00:02:07.850 --> 00:02:09.947 to see so many people live in the
NOTE Confidence: 0.518014178333333
00:02:09.947 --> 00:02:11.197 audience on a Friday morning.
NOTE Confidence: 0.518014178333333
00:02:11.200 --> 00:02:13.678 So thank you for weathering the weather
NOTE Confidence: 0.518014178333333
00:02:13.680 --> 00:02:15.997 and for coming to meet in person.
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00:02:16.000 --> 00:02:17.899 And thank you as well for those of you
NOTE Confidence: 0.518014178333333
00:02:17.899 --> 00:02:19.477 online who I know are listening in,
NOTE Confidence: 0.518014178333333
00:02:19.480 --> 00:02:20.952 I am going to try and keep my
NOTE Confidence: 0.518014178333333
00:02:20.952 --> 00:02:22.462 eye on the chat and the Q&amp;A.
NOTE Confidence: 0.518014178333333
00:02:22.462 --> 00:02:24.034 So if you do have questions,
NOTE Confidence: 0.518014178333333
00:02:24.040 --> 00:02:25.608 please add those there.
NOTE Confidence: 0.518014178333333
00:02:25.608 --> 00:02:27.596 Also, if you’re here live in the audience,
please interrupt me if anything’s unclear.
If you have any questions.
Today, I’m going to be talking about inequities and colorectal cancer screening and outcomes,
which is what a large majority of the work is in my lab.
I’ll start by here just providing my disclosures.
And since we are at Yale, I have to start with a few stories. So I was very honored to receive this invitation to come here today. But I was excited to share
about the work that we’re doing.

And it also gave me a time to some opportunity to reflect because it’s actually been 20 years since I’ve been on this campus.

I graduated from Yale undergrad in 2002. I came back two years after that for a conference and then that for a conference and then I haven’t been back since.

This is actually a picture of my parents who trusted me leaving Los Angeles to come to the East Coast for the very first time. I’ve never even visited to become an undergrad here at Yale.

That young man is my brother.
who's now much taller than me.
So this is them dropping me off at old campus in August of 1998.
I had an extraordinary 4 years here.
I say that they were the years that helped me become who I am.
That's me studying rigorously in my dorm room here in Farnham Hall.
I played on the JV volleyball team here, wasn’t tall enough to play varsity.
And then there’s some pictures as well from my last week at Yale when I went through graduation.
So I really think of Yale as kind of the beginning.
I think, as many of us do think of college as the beginning of your adulthood, your opportunity to think independently. This is where I became impassioned about global health, social justice, medicine and research. And for me this is kind of a full circle moment to be back here. I was got in a little early yesterday and got to walk around campus. So I also want to thank you for the opportunity. So as mentioned, I work at UCLA Health.
After my time at Yale, I spent some time in the UK and then I was in Boston for a long time, maybe a little too long. And then it got very cold and we had our first child and we said, you know what, California’s looking pretty good right now. So we went back to to California.

My husband’s from Northern California, I’m from Southern California, and I did my GI fellowship at UCLA. I know there’s a similar program here. It’s called the STAR program.
that gives fellows.

So these are people who have finished

I had left MGH after my

thinking I wanted to do research,

but I hadn’t had a chance to do

an MDPHD program and kind of

regretted that I never did that PhD.

So when I got to UCLA,

we had this STAR program where you

can actually do a PhD at the same

time as your clinical fellowship.

So as I did my GI fellowship,

I received a PhD in Health

Policy and Management,
which is really a health services degree and really from that point did never look back from doing research. I was able to start the May lab in 2015 and I became the director of quality for our health systems in GI in 2016. So right now this is kind of how I split my time. I do spend a lot of time running a research program. I do include the quality improvement in the research bucket 'cause we do publish a lot of that work and then I do about 20% patient care. I am involved in running the
ST AR program now.

So that’s my way of giving back.

And I also have some small involvement in global Health at our Global Health program at the David Geppen School of Medicine.

In the lab, it’s largely health services research. We’re going to talk today about one of these cancers and HealthEquity, we also do a lot of clinical EPI.

As mentioned, I did an EPI degree before I even went to medical school.

We run clinical trials including
some of the big national GI clinical trials that are going on right now and have a lot of foothold in population health and how you roll out interventions across the health system which ties into the Qi work today. However, we’re going to talk about one specific disease that I would say is the majority of my research, and that’s in colorectal cancer. I’m going to start by talking about national trends in this disease, focusing on 2 areas that are high interest to me. Disparity is an early onset disease.
And then we’ll also talk about colorectal cancer screening, screening disparities, including the challenges that we have and barriers to screening and potential solutions.

And then I’ll end with a couple things that I think are important as we move forward in this area. So I’m going to assume that everyone in here is not going to be too shocked by this slide, but many people are surprised to hear about the large burden of colorectal cancer in the United States and globally. It is the third most common cause
00:07:09.808 --> 00:07:11.782 of cancer for men and women in

00:07:11.782 --> 00:07:13.468 the United States and second most

00:07:13.524 --> 00:07:15.179 common cause of cancer related

00:07:15.179 --> 00:07:16.834 deaths in the United States.

00:07:16.840 --> 00:07:18.982 And even though we have very

00:07:18.982 --> 00:07:20.762 effective screening modalities and a

00:07:20.762 --> 00:07:22.496 national call for everyone at some

00:07:22.496 --> 00:07:24.557 point in their life to be screened,

00:07:24.560 --> 00:07:26.756 one in three adults in the US do not

00:07:26.756 --> 00:07:28.958 get screened for colorectal cancer,

00:07:28.960 --> 00:07:31.822 which is a problem that many of us have

00:07:31.822 --> 00:07:34.596 been trying to tackle since the 1990s.

00:07:34.600 --> 00:07:36.856 Some of us do consider colorectal

00:07:36.856 --> 00:07:38.360 cancer a success story.

00:07:38.360 --> 00:07:39.336 Since the mid 1980s,
we have had a decline in incidence
and mortality from this disease
and you can see that on the figure
that’s up here on this slide for men,
women and overall.
We’ve had a drop in overall numbers
looking at all age groups in this
disease and we attribute that to
the introduction of screening,
looking at all age groups in this
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NOTE Confidence: 0.9028446505
00:08:09.420 --> 00:08:11.430 of the reduction in the number
NOTE Confidence: 0.9028446505
00:08:11.498 --> 00:08:13.976 of polyps that we see and polyp
NOTE Confidence: 0.9028446505
00:08:13.976 --> 00:08:15.600 progression to colorectal cancers.
NOTE Confidence: 0.9028446505
00:08:15.600 --> 00:08:17.608 But I do want to mention that it’s
NOTE Confidence: 0.9028446505
00:08:17.608 --> 00:08:19.319 a success story with a caveat,
NOTE Confidence: 0.9028446505
00:08:19.320 --> 00:08:20.409 a couple caveats.
NOTE Confidence: 0.9028446505
00:08:20.409 --> 00:08:22.950 The first being that there were massive
NOTE Confidence: 0.9028446505
00:08:23.017 --> 00:08:25.117 disparities in colorectal cancer.
NOTE Confidence: 0.9028446505
00:08:25.120 --> 00:08:27.626 The group that has the highest incidence
NOTE Confidence: 0.9028446505
00:08:27.626 --> 00:08:30.119 of colorectal cancer is our American Indian,
NOTE Confidence: 0.9028446505
00:08:30.120 --> 00:08:31.215 Alaska Native population.
NOTE Confidence: 0.9028446505
00:08:31.215 --> 00:08:33.040 Those two groups are often
NOTE Confidence: 0.9028446505
00:08:33.040 --> 00:08:34.920 combined in national databases,
NOTE Confidence: 0.9028446505
00:08:34.920 --> 00:08:36.800 including SERE because they’re small,
NOTE Confidence: 0.9028446505
00:08:36.800 --> 00:08:38.249 But I want to highlight that they
NOTE Confidence: 0.9028446505
00:08:38.249 --> 00:08:39.400 are very distinct populations.
NOTE Confidence: 0.9028446505
00:08:39.400 --> 00:08:39.892 And actually,
NOTE Confidence: 0.9028446505
00:08:39.892 --> 00:08:40.876 if you separate it,
NOTE Confidence: 0.9028446505
00:08:40.880 --> 00:08:44.408 it's the Alaska Native group that's largely
NOTE Confidence: 0.9028446505
00:08:44.408 --> 00:08:46.878 driving this epiphenomena that we see.
NOTE Confidence: 0.9028446505
00:08:46.880 --> 00:08:49.700 And then after that,
NOTE Confidence: 0.9028446505
00:08:48.008 --> 00:08:49.700 we have black individuals in the
NOTE Confidence: 0.9028446505
00:08:49.754 --> 00:08:51.534 United States having the second
NOTE Confidence: 0.9028446505
00:08:51.534 --> 00:08:54.964 highest rates of colorectal cancer,
NOTE Confidence: 0.9028446505
00:08:53.320 --> 00:08:54.964 then white Americans,
NOTE Confidence: 0.9028446505
00:08:54.964 --> 00:08:57.156 then our Latino population,
NOTE Confidence: 0.9028446505
00:08:57.160 --> 00:08:59.685 followed by our Asian and
NOTE Confidence: 0.9028446505
00:08:59.685 --> 00:09:01.200 Pacific Islander population.
NOTE Confidence: 0.9028446505
00:09:01.200 --> 00:09:02.676 So even though in the Asian,
NOTE Confidence: 0.9028446505
00:09:02.680 --> 00:09:04.372 Pacific Islander population it's
NOTE Confidence: 0.9028446505
00:09:04.372 --> 00:09:06.064 a relatively lower incidence
and mortality than in white, black or Native Americans. I do want to say and highlight that for our Asian individuals, it’s still the number 2 cause of cancer related mortality. So in all of these groups there’s significant burden. We also know that we have similar trends for mortality of colorectal cancer. Now the bars here are going to be lower because we have fewer deaths than we have cases. But again we’re going to see that the largest number of deaths are
going to be in our native communities
followed by black individuals, white individuals, Latinos and then Asians.
We also carry about state.
We also care a lot about stage because for colorectal cancer,
we know that if we can diagnose this disease at stage 1,
the survival is over 90%. Survival at stage 4 is 13 percent or lower.
So we do pay a lot of attention to stage at diagnosis.
And when you look at distance,
stage at the time of diagnosis, we have the worst case for black
individuals where 25% of cases
are being diagnosed at a late stage five year survival. Similar disparities and trends where you have worse outcomes for black individuals and Alaska Native American Indian populations than you do in the other subgroups. The other caveat to the success story is the recent trend that we’ve seen at the for the age of onset of disease which we call early age onset disease. These are individuals who are diagnosed with colorectal cancer under the age of 50. Now, I’ll tell you,
it wasn’t too long ago that I was an internal medicine resident and I was taught that colorectal cancer is the disease that you look for for people in their sixties, 70s or 80s. I no longer teach that to my residents and fellows. This is the disease that we need to be aware of in people in their thirties, 40s and 50s. And that’s because of these different trends that we’ve seen. So if you look at individuals age 0 to 49, which is the first graph, we have increasing rates.
or incidents over time.

We have some plateauing as well and individuals that are 50 to 64.

This was a slope that 10 years ago was clearly downward and now we are seeing that even in middle-aged adults in their 50s and early 60s that we don’t see the huge of impact that we did up screening and treatment before.

And the group that we’re still seeing a big benefit is individuals over age 65,

which again we attribute to higher uptake of screening and greater penetrance over time of screening programs.

Mortality, we’re seeing the same thing.
Unfortunately, we’re not seeing this downward slope and mortality, particularly with the under fifty group, we’re seeing an upward swing and mortality. And even when you look at individuals over 65, there’s some concern for plateauing. So this big success story that we’ve been touting is now at risk not only because the disparities that we see, but because of early onset disease. This is actually a publication that my Co wrote with some incredible colleagues led by Samir Gupta at UCSD, where we did an overview of
early onset colorectal cancer.

And we were able to show using CR data that when you look from 1992 to 2019, there’s actually a notable shift in the proportion of individuals who are diagnosed with disease. I’ll highlight first the group that is age 40 to 49, that’s this darker red 5% of cases in 1992. And then in 2019 where we have the most complete SEER data, that population increased to 9%. Again looking at individuals 50 to 59, that population was about 12% in 1992 and now is 21%.
So these are profound changes in the epidemiology of disease. I’m also including here a slide on the demographic profile by race and ethnicity using the same data. As you can see in 1992 seventy 6% of cases were non Hispanic white individuals. That is dropped to 58% of cases in 2019, probably even lower now if we actually had 2023 data and that is attributed to an increase in the number of cases in Latino Hispanic individuals and also non Hispanic American Indian individuals and also Alaska Native individuals.
00:13:25.330 --> 00:13:27.480 in non Hispanic black individuals.

00:13:29.520 --> 00:13:31.158 So in that context I want to talk a little bit about what’s going on in the screening world and some of the work we’re doing to help close some of these gaps just to make sure that we are all starting on the same page.

00:13:34.494 --> 00:13:36.260 Colorectal cancer is very unique and that we have a precursor lesion called a polyp.

00:13:39.185 --> 00:13:41.358 When I am doing a procedure obviously it’s can you see my pointer? This is what a colon looks like. When I’m in the colon with a scope, obviously it’s can you see my pointer?
No, you can’t see my opponent.

Let’s see it.

Does this work?

I should have checked this technology before I tried using the mouse.

It’s not right. But I'll describe So the normal colon picture, that is a nice looking colon.

As Doctor Lane knows, that’s what we want to see when we’re doing a colonoscopy. It’s sparkly, it’s pink, there’s no polyps and about 50% of people, however, we’re gonna see a polyp and in about 25% of people those polyps are pre malignant.

Now when we’re looking at a polyp, we often cannot tell which one of
those has the opportunity or the likelihood to progress into cancer. So we typically take out all the polyps that we see during a screening colonoscopy. Unfortunately though, if these polyps are left to themselves after years and years and years, they can develop into colorectal cancer. And this is the progression that we’re trying to stop when we do screening for colorectal cancer. So we have two opportunities with colorectal cancer, which is very different from many other cancers.
We can find the polyps and take them out before they transition to cancer. What that means is that’s less people hearing the words you have cancer, right, because they never had cancer. But we also have the opportunity of finding a cancer early enough that you have that 90% cure rate that the words are more you have stage 1 cancer, we likely can cure you hopefully. So again, there’s the prevention and an early detection benefit of screening. We know that screening is effective. We actually have RCT data that supports mostly Gwyac FOBT and
flexible sigmoidoscopy and that’s been extrapolated to assume that there’s RCT evidence to support studies like FIT and colonoscopy, which are similar methodologies. Right now the most common screening test in the United States is colonoscopy and some health systems. It’s up to 85% of screening, but we’re about 70% national. And then of the stool based screening modalities, FIT or fecal immunochemical testing is the most common. Those are supported mostly by...
a large observational studies. And also this really, I think, amazing figure that was produced by Anne Zauber, an epidemiologist and her group that showed that over time, the red line is the incidence the blue line is the incidence of colorectal cancer. The blue line is the incidence of colonoscopy uptake. And as you can see in the United States, as we’ve been using more colonoscopy, that incidence line is coming down South, another kind of observational piece of data that shows this early success story.
we don’t see this in our young adults
because we don’t screen our young adults.
And these are data that were released
and JAMA Network open where they
did a projection or a modeling
study that showed that because of
this 51% increase in young onset
colorectal cancer since 1994,
colorectal cancer is actually
predicted to be the leading cause
of cancer related deaths for
individuals aged 20 to 49 by 2030.
And actually the report that
was released by the American
Cancer Society just last month
suggesst that we're quite, we're actually there where we're seeing it and particularly in men that colorectal cancer aged 20 to 49 is the number one cause of cancer related deaths in women, it's #2 by 2030 will probably be there for both groups. This change in epidemiology is largely what prompted the change in the United States Preventive Service Task Force recommendations in 2021. These are looked at every few years and every year.
A to start screening at age 50.

We now have a grade B recommendation that people fit 49 to 49 should also be screened by for colorectal cancer.

This matters because everything that’s grade A or B by USPFTF is mandated insurance coverage.

And This is why, even though the American Cancer Society said this back in 2018, it’s just now that we’re starting to screen all of our 40 to 4049 year olds.

I’ll highlight that this is for average risk individuals.

If there’s a family history of polyposis.
syndrome or hereditary syndrome,

we’re actually going to screen much earlier.

These are the USPFTF recommended

As I alluded to before,

we’ve got stool based strategies

and then we’ve got what we call

direct visualization techniques.

Among the stool based strategy

there is high sensitivity FOBT

which is mostly out of favor.

We have fit which is the number one

stool based strategy and then stool

dNA otherwise known as Cologuard.

You’ve probably seen the commercial

with the cartoon in the little white
box which is a growing in use and actually we just saw last month in the New England Journal the release of the data for the Cologuard version 2.0, which is a newer version of their test that performs slightly better. The direct variation techniques are also listed here. These are all acceptable ways to screen for colon, not for colorectal cancer. And I think what’s most shocking is that despite the fact that this is a rising burden of disease, a concerning disease that
is highly impactful, despite the fact that we have evidence that screening works and the fact that everyone should be screened, we still have a problem with only about 60.67% of people being screened even when we have all of these options for our patients. So we still are trying to find ways to have more people participate in screening. When you participate in one of the screening tests that is not a colonoscopy, we don’t have the opportunity to go in and grab those polyps or biopsy those early cancers. So we do call those two step
00:19:43.645 --> 00:19:44.515 screening processes.

00:19:44.520 --> 00:19:45.996 So whether you’re talking about FIT, Cologuard, FOBT or CT colonography,

00:19:46.000 --> 00:19:49.120 if a polyp is found or abnormal abnormality is found during one of these tests,

00:19:49.120 --> 00:19:51.560 it’s actually required that you have the second step which is colonoscopy to complete the screening process.

00:19:51.560 --> 00:19:53.758 Now this seems obvious,

00:19:53.760 --> 00:19:55.422 Participation and screening varies

00:19:55.422 --> 00:19:57.247 in settings where only 18% of patients have that throughput from abnormal fit or abnormal stool based testing to the completion colonoscopy.

00:19:57.247 --> 00:20:00.552 Participation and screening varies

00:20:00.552 --> 00:20:00.960 in settings where only

00:20:00.960 --> 00:20:02.955 but I work in settings where only

00:20:02.960 --> 00:20:06.215 18% of patients have that throughput from abnormal fit or abnormal stool based

00:20:06.215 --> 00:20:09.505 testing to the completion colonoscopy.

00:20:09.505 --> 00:20:12.515 Participation and screening varies

00:20:12.520 --> 00:20:15.300 Participation and screening varies
broadly across patient demographics. These are data from the National Health Interview Survey. So the caveat here is that these are patient reported data. And if anything, we've found that when you look at EHR data versus patient reported data, the patient reported data actually is maybe a little higher. Patients like to report that they've done things that maybe they haven't. So we're going to take this with a caveat that that 59% at the top, we're probably even lower than that in these patients.
And there's also a lot of misremembering. I mean, I can't tell you how many times I've asked a patient when did you have your colonoscopy and they said, oh, it was last year and then we look in the chart and it was six years ago and nowhere close, right. And it happens with the stool based test as well. Of course just because we’ve just started screening our 45 to 49 year olds, you'll see the differences by age.
we’re going to have the lowest uptake in that group.

But we also haven’t been very well at screening our 50 to 54 year olds.

And prior to the release of the new guidance, a lot of us are focusing on those 50 year old patients because those people were under screened as well.

Males and females do pretty well, but we have seen, as I mentioned, big differences by race, ethnicity.

I will highlight that in the last 10 years, the black white screening gap has narrowed.

I don’t believe these data completely because when you look at EHR data,
00:21:37.560 --> 00:21:39.857 there’s still more than a 1% difference,
NOTE Confidence: 0.906923790555555

00:21:39.857 --> 00:21:42.496 but it does signal that we’ve done
NOTE Confidence: 0.906923790555555

00:21:42.496 --> 00:21:45.039 a good job of closing that gap.
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00:21:45.040 --> 00:21:47.306 But look at the other non white
NOTE Confidence: 0.906923790555555

00:21:47.306 --> 00:21:48.798 racial ethnic groups again.
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00:21:48.800 --> 00:21:50.914 When we’re looking at our native populations,
NOTE Confidence: 0.906923790555555

00:21:50.920 --> 00:21:53.116 Asian and Hispanic individuals, we do.
NOTE Confidence: 0.906923790555555

00:21:53.120 --> 00:21:54.560 We have a lot of work to do.
NOTE Confidence: 0.906923790555555

00:21:54.560 --> 00:21:56.207 So this is where a lot of our work
NOTE Confidence: 0.906923790555555

00:21:56.207 --> 00:21:57.399 focuses on in the underserved,
NOTE Confidence: 0.906923790555555

00:21:57.400 --> 00:21:59.570 not just our black community but our
NOTE Confidence: 0.906923790555555

00:21:59.570 --> 00:22:02.120 other groups that are have low rates as well.
NOTE Confidence: 0.906923790555555

00:22:02.120 --> 00:22:03.808 I think I also hear a lie
NOTE Confidence: 0.906923790555555

00:22:03.808 --> 00:22:05.320 where where you’re born matters.
NOTE Confidence: 0.906923790555555

00:22:05.320 --> 00:22:06.616 So our immigrant populations
NOTE Confidence: 0.906923790555555
have very low screening rates.
And then also what how your insurance type is going to be a large predator for screening.
So when I talk about inequities and when I talk about underserved, yes, for me it did start with black, white, and that's what my dissertation was on for my PhD. But it really has expanded to include Latinos, which is a group that we're seeing the highest rise and early onset. It also includes individuals who are Native American.
I'll talk about one of the products that I have in the Tribal Nations and it also gives people who are foreign born and also who have insurance types that are barriers to them getting screened.

The why. This is complicated and I could spend an hour talking about the why, but I've tried to just distill it into a quick slide here on social determinants of health. You can boil it down to competing demands.
I tend to find that a lot of our underserved populations have so many health and non health competing demands that getting screened for a preventive screening test for a cancer or disease they don’t have is off the table. But the more specific reasons have been populated through a myriad of studies. This, I thought, was really interesting. This is Kaiser Family Foundation data, which I love all the data that they release online. They looked at the number of adverse social determinants of health by race and ethnicity,
and they found that at the first bar, if you’re a black individual, you have 16 worse, on average social determinants of health than a white individual. And you can see for Latinos it’s similar, but even Asian, our native populations and our native Hawaiian populations as well. So this is this was I think a nice way to quantify these competing demands that happen in life and to kind of at baseline try to understand why it is that when you have four children at home and
00:24:07.569 --> 00:24:09.557 elderly parent to take care of four
NOTE Confidence: 0.894020198
00:24:09.557 --> 00:24:11.719 jobs trying to put food on the table,
NOTE Confidence: 0.894020198
00:24:11.720 --> 00:24:13.358 don’t even have a primary care provider.
NOTE Confidence: 0.894020198
00:24:13.360 --> 00:24:15.376 The idea of getting screened for
NOTE Confidence: 0.894020198
00:24:15.376 --> 00:24:17.327 colorectal cancer is not even on
NOTE Confidence: 0.894020198
00:24:17.327 --> 00:24:18.953 on the list of priorities for
NOTE Confidence: 0.894020198
00:24:18.953 --> 00:24:20.800 you that day or year or month.
NOTE Confidence: 0.894020198
00:24:20.800 --> 00:24:22.195 We’ve done a lot of work in this area.
NOTE Confidence: 0.894020198
00:24:22.200 --> 00:24:24.318 I’m going to populate this slide
NOTE Confidence: 0.894020198
00:24:24.320 --> 00:24:26.126 and this also combines work from
NOTE Confidence: 0.894020198
00:24:26.126 --> 00:24:27.669 colleagues in this area where
NOTE Confidence: 0.894020198
00:24:27.669 --> 00:24:29.379 we’ve tried to look at barriers
NOTE Confidence: 0.894020198
00:24:29.379 --> 00:24:31.040 to screening on a multi level.
NOTE Confidence: 0.894020198
00:24:31.040 --> 00:24:33.000 I like to look at it as patient
NOTE Confidence: 0.894020198
00:24:33.000 --> 00:24:34.478 provider health system and policy.
NOTE Confidence: 0.894020198
00:24:34.480 --> 00:24:36.328 What struck me most about this work when
I started doing it was that everyone wanted to talk about the patient problems, right. The patient being the problem. The patient won’t get screened because the patient has this and that and these barriers. But let’s also highlight that there are provider factors. So that second box here, there are data that show that when you survey primary care providers, they don’t know that there are disparities in colorectal cancer or they don’t get the screening guidance right. They don’t know that we’ve
lowered the screening age.

We know that your practice setting matters.

The number one predictor, in fact, for whether a person is to get screened for colorectal cancer is whether or not their primary care doctor talked to them about a director directly. This is one of the first papers that I published with Brandon Spiegel. And when you look at ethnic and racial minorities, that odds ratio is even higher. So a, a trusted provider telling a patient to get screened is one of the most important predictors and that’s
not happening more in those groups. And again I could spend an hour just
on the slide because we know that there’s so many barriers and This is why a lot of the work that we do
in this area is about multi level interventions where we’re trying to pick at many of these barriers in one
policy because we talk a lot and I also throw policy in there because I think for a long time there were policy barriers to getting screened.
So the ACA, which I am a fan of, actually eliminated issues like copay and mandated coverage for preventive services that had a huge effect on disparities, not just for colorectal cancer but other cancers as well. And then we’ve been done some work on the state and national level. We had a law that we got past two years ago about removing barriers to colorectal cancer screening, which removed copay. Believe it or not, if you had a colonoscopy for screening and I took out a polyp,
00:26:26.160 --> 00:26:28.440 you would get a charge.
00:26:28.440 --> 00:26:30.800 It’s like that’s the purpose of the test.
00:26:30.800 --> 00:26:32.370 So we finally convinced Congress
00:26:32.370 --> 00:26:34.330 that that didn’t make any sense
00:26:34.330 --> 00:26:36.000 and they removed those co-pays.
00:26:36.000 --> 00:26:37.100 This is work that’s been
00:26:37.100 --> 00:26:37.760 championed for years,
00:26:37.760 --> 00:26:38.965 but that law went through
00:26:38.965 --> 00:26:40.440 I think 2 1/2 years ago.
00:26:40.440 --> 00:26:43.040 So there are also policy things that have
00:26:43.040 --> 00:26:46.315 to be addressed for us to close these gaps.
00:26:46.320 --> 00:26:48.168 I’ll talk about those strategies next
00:26:48.168 --> 00:26:50.279 and how we address these barriers.
00:26:50.280 --> 00:26:52.044 And this really pulls us into the
00:26:52.044 --> 00:26:53.200 field of implementation science,
which is, 
NOTE Confidence: 0.879430191666667
00:26:54.132 --> 00:26:54.598 is, 
NOTE Confidence: 0.879430191666667
00:26:54.598 --> 00:26:57.632 is kind of what we could we consider where 
NOTE Confidence: 0.879430191666667
00:26:57.632 --> 00:26:59.319 health service the research is going to. 
NOTE Confidence: 0.879430191666667
00:26:59.320 --> 00:27:01.280 So in health services research, 
NOTE Confidence: 0.879430191666667
00:27:01.280 --> 00:27:02.160 we’re trying to understand 
NOTE Confidence: 0.879430191666667
00:27:02.160 --> 00:27:03.480 how to get the best care, 
NOTE Confidence: 0.879430191666667
00:27:03.480 --> 00:27:05.888 the best quality of care to all people 
NOTE Confidence: 0.879430191666667
00:27:05.888 --> 00:27:08.170 equitably and through health systems or 
NOTE Confidence: 0.879430191666667
00:27:08.170 --> 00:27:10.195 other sources of healthcare delivery. 
NOTE Confidence: 0.879430191666667
00:27:10.200 --> 00:27:12.968 And a lot of that leads up to 
NOTE Confidence: 0.879430191666667
00:27:12.968 --> 00:27:14.240 effective implementation science. 
NOTE Confidence: 0.879430191666667
00:27:14.240 --> 00:27:15.626 In implementation science, 
NOTE Confidence: 0.879430191666667
00:27:15.626 --> 00:27:17.474 especially related to disparities, 
NOTE Confidence: 0.879430191666667
00:27:17.480 --> 00:27:19.391 our first goal is to understand the 
NOTE Confidence: 0.879430191666667
00:27:19.391 --> 00:27:21.474 extent of the disparities which we’ve
talked about mechanisms and barriers, why we have the disparity and particularly for screening. We just looked at that slide and then we want to come up with evidence based solutions to those disparities and then we want to disseminate and scale them so that everyone has access and everyone has improvement in those outcomes. So that’s what leads us towards these interventions that are multi level at the individual provider, health system and policy level. And more recently,
we’ve had interventions that
are also queued into community.
And that’s another level of the work
that we do now because I came along
at a fortunate time where the giants
have been working in this field for a
long time. We’ve learned a lot.
And now we’re at a place where we
actually know pretty much what works.
It’s just trying to tailor it for the
appropriate population and scale it.
And we know, for example,
that when we look at effective interventions,
did it light up?
Yes, there are certain goals that you want and
00:28:13.848 --> 00:28:15.438 how you design your intervention.

00:28:15.440 --> 00:28:17.757 You want it to target multiple levels.

00:28:17.760 --> 00:28:18.642 As I mentioned,

00:28:18.642 --> 00:28:20.406 you want to address barriers at

00:28:20.406 --> 00:28:22.648 all those levels which leads to


00:28:24.160 --> 00:28:26.120 You want them to be culturally tailored.

00:28:26.120 --> 00:28:27.888 Particularly interventions that involve

00:28:27.888 --> 00:28:30.540 patient education where all of the

00:28:30.603 --> 00:28:32.499 individuals on the pamphlet are are

00:28:32.499 --> 00:28:34.951 appear white or a pure male are not

00:28:34.951 --> 00:28:37.006 going to appeal to people who come

00:28:37.006 --> 00:28:39.202 from brown or black populations or

00:28:39.202 --> 00:28:40.800 underserved populations for example.

00:28:40.800 --> 00:28:43.240 So culturally tailoring the language,
the examples, the settings,
NOTE Confidence: 0.900698878181818
the people,
NOTE Confidence: 0.900698878181818
and then also you want to work
NOTE Confidence: 0.900698878181818
closely with the stakeholders.
NOTE Confidence: 0.900698878181818
I think we come from unfortunately a
NOTE Confidence: 0.900698878181818
history since probably the beginning of
NOTE Confidence: 0.900698878181818
time where we’ve come into places and
NOTE Confidence: 0.900698878181818
decided what’s best for the people there.
NOTE Confidence: 0.900698878181818
And this is more around coming into
NOTE Confidence: 0.900698878181818
a place acknowledging that you’re
NOTE Confidence: 0.900698878181818
coming within with expertise,
NOTE Confidence: 0.900698878181818
but that those people understand
NOTE Confidence: 0.900698878181818
the community best.
NOTE Confidence: 0.900698878181818
So when we develop interventions,
NOTE Confidence: 0.900698878181818
we sit down with our community
NOTE Confidence: 0.900698878181818
leaders and we say,
what do you see as the problem and how would you fix it?
And then we try to adapt our science to those potential solutions. And I think that’s what makes the most exciting brainstorming.
That has led to a slew of interventions and we have, as I mentioned, policy interventions that have been very effective. There’s been interventions at the healthcare, healthcare system level. A lot of those have to do with automation. So a lot of the work that I do
with my Qi hat is about offloading primary care providers by automating screening for them and prompting them to do things and taking steps and the number of of touches on the EHR away from them. We also have interventions that are focused mainly on the provider or her provider components and also as I mentioned communities and patients. So when we’re building intervention, a lot of times we’re looking at lists like these and we’re saying OK where do we want to pull from each of these levels as we build our multi level intervention to address the
specific barriers in that community.

I’m going to adopt that thinking to the work we’ve done in federally qualified health centers.

So just to make sure that everyone understands what these clinical settings are,

These are community based.

They provide only primary care or that’s how the government has structured them.

They get funding and resources to provide primary and preventive care.

They take care of 30 million Americans in the United States.

And although they have offerings for screening or cancer diagnostics,
they won’t typically have a specialist on site. And so those patients often have to leave the FQHC when they need specialty services, which makes it very tricky for those patients who need that level of care. When you look at screening rates for colorectal cancer in federally qualified health centers, which we really only have for the age group of 50 to 75 at this time, the screening rates are much lower than national screening rates. So yes, we’ve had some improvements over time in federally qualified health centers. The blue line’s going up,
but look how far below the national screening rate we are. And the national screening rate isn’t that great, so that’s not even our goal. So in these settings, we have underserved individuals, often brown and black, often uninsured, often low SES, and very often poorly screened, not just for colorectal cancer, but for pretty much any measure. And that’s the challenge of the primary care providers in this setting. Going back to that problem that
I’m also interested in which
is completion of screening.
They even when they do get screened,
if that screening is abnormal like
they use a lot of stool based
screening in these settings because
it’s easier for them to give out.
Sometimes there’s no opportunity
to get a colonoscopy.
So in some of the series we’ve done
as low as 18% of the patients who have
an abnormal fit get a colonoscopy,
which as a fellow when I started
looking into the problem drove me
crazy and I said this is definitely
where I’m going to do my research and
we’re going to talk about that today.

So we I do this work in LA County which is a very interesting place to do work in underserved.

Our county has 10 million people, we are majority minority.

So 72% of Los Angelinos identify as being a person of color.

And just in our county we have 49 FQHCS and someone told me there was a new one, so it might be 50 now.

So this is an incredible setting to do this work.

It’s an incredible playground.

We have 1.1 million people
in FQHCS just in our county.
And then I just go,
I gotta drive 2 hours South to meet
up with Samir Gupta and I've got the
San Diego counties at my disposal as well.
And we do a lot of partnership
with San Diego.
Our populations are similar.
So at the Center for HealthEquity,
which is at UCLA,
in the UCLA Cancer Center,
where I am one of the associate directors,
where we collaborate with federally
qualified health centers.
We develop advisory committees with them.
We have ongoing clinic engagement.
I have staff that literally just sit in an FQHC clinic for a week and just observe how care is administered.

We perform key informant interviews. We sit in a conference room with the clinic leadership with a couple of their providers and we bring in a couple patients and an interpreter often. And we just talk about what’s working, what’s not working and this is how we help them develop multi-level interventions.

Again, focusing on their system workflow, focusing on their provider and staff and how to maximize...
efficiency and also how to educate and best inform their patients.

I’m going to lean into one example with one of our main partners. This is the Northeast Valley. I’m going to call them Northeast Valley from here on out, but it’s a large FQHC. They actually have 15 sites throughout Los Angeles. It would take me an hour and a half to drive from one site to another. That’s how spread out this one FQHC is and they’ve got a lot of patients from different backgrounds. It is largely Latino,
and largely uninsured with 84% and largely uninsured with a with
about 90% living below the 200% FPL we've.
I haven't,
but my center has been working
with this FQHC for 13 years.
The partnership was started by
Doctor Rashan Bastani who was
one of my mentors doing my PhD.
They've done work in breast cervical
HPV vaccination for kids in the clinic
and then now with colorectal cancer.
So beginning in 2018,
which is when I started working
with this clinic, I said,
well, you know,
I’m a gastroenterologist, I’m going to come into the setting and of course I’m going to look at colorectal cancer screening and their screening rate was about 51%. Then it actually dropped to 39% during COVID and 9% of their fits were abnormal, but only 20% were getting that colonoscopy for completion. They had no screening program and no abnormal screening follow up program. So this was an incredible opportunity for me to come in with Doctor Bastani and talk to him about the work that they’re doing.
And over the last six years, now we've done a slew of work. I know this slide's very busy, but I did want to summarize and try to explain the trajectory here because with colorectal cancer screening, it's a process of care for which you need all the components you need to screen more people, but then you need to recognize that those people need to be screened at intervals and so that's what we call repeat screening. And then you also need to recognize that those people who have
abnormal screening need a certain
line of care as well.
So our three buckets of work at Northeast
have been in those three lines.
We’ve done work in the blue box about increasing the screening rate.
That first work, that work was first funded by TRDRP
which is a tobacco related disease program that does funding but
they were very interested because obviously tobacco relationship with
colorectal cancer risk and that
grant allowed us to do a cluster randomized trial greater than I
think it ended up being 12,000
00:36:03.776 --> 00:36:06.105 patients and this was a multi level
NOTE Confidence: 0.934958678095238
00:36:06.105 --> 00:36:07.413 intervention mostly about their
NOTE Confidence: 0.934958678095238
00:36:07.471 --> 00:36:09.795 workflow is how can we help them
NOTE Confidence: 0.934958678095238
00:36:09.795 --> 00:36:11.691 reestablish their workflow in the clinic.
NOTE Confidence: 0.934958678095238
00:36:11.691 --> 00:36:13.473 We offloaded the primary care providers.
NOTE Confidence: 0.934958678095238
00:36:13.480 --> 00:36:15.790 We got the M as involved in
NOTE Confidence: 0.934958678095238
00:36:15.790 --> 00:36:17.240 handing out FIT kits.
NOTE Confidence: 0.934958678095238
00:36:17.240 --> 00:36:18.705 We got different levels non
NOTE Confidence: 0.934958678095238
00:36:18.705 --> 00:36:20.170 MD providers in the clinic
NOTE Confidence: 0.882475737333333
00:36:20.225 --> 00:36:21.905 involved and explaining the kit
NOTE Confidence: 0.882475737333333
00:36:21.905 --> 00:36:24.007 following up with patients and that
NOTE Confidence: 0.882475737333333
00:36:24.007 --> 00:36:25.822 was very effective in increasing
NOTE Confidence: 0.882475737333333
00:36:25.822 --> 00:36:27.274 their overall screening rate.
NOTE Confidence: 0.882475737333333
00:36:27.280 --> 00:36:28.510 Then we had a post doc
NOTE Confidence: 0.882475737333333
00:36:28.510 --> 00:36:29.680 who said OK that’s great.
NOTE Confidence: 0.882475737333333
The patient got screened once in 2018, and had to get screened again 9 to 12 months later. What do we make sure that happens? So she did RO three or she started the RO 3:00 and also had an internal seed grant to help us work on repeat screening. And with nurses work we were able to make sure the clinic was doing recall of the patients. Ends up being about every nine months. So they have a mental alarm that they’re going to be due for screening every year. And then of course I came along and I said OK, well I’m the gastroenterologist.
again who does the colonoscopy.

So I want to make sure all these patients who have abnormal results get a colonoscopy.

And that work started with an NCIRO 3 where we proposed that we were going to look at the why, why is it that patients are falling out in this process.

And we created this conceptual framework where we showed that there were nine things that needed to happen for an abnormal FIT patient to get a colonoscopy.

we quantified the fallout or the
attrition at each step and we were able to assess that these primary care doctors were doing very good at seeing that there was an abnormal fit in the chart. They’re actually doing very good at ordering the referral to GI. About 85 to 90% of referrals were going in and then everything was a disaster after that. The patients just they were either getting to GI and not doing the colonoscopy or they never got to GI or they would get to GI have an appointment and then the colonoscopy was not scheduled.
So we knew that we had to focus not only just on the internal processes at the FQHC, but that kind of there was another level of this multi level at the GI practice level where we had to work on that connectedness. And we actually Beth Glenn and I wrote an RO one where we said OK, we’re going to do a multi level intervention in an FQHC. The review did not go well. NIH is like what are you talking about because we proposed doing a multi level intervention in an FQHC.
at the same time as doing a multi level intervention in several GI practices that see their patients.

But guess what we got?

Note, we got news 2 weeks ago that it got funded.

So this is a very excited exciting multi level intervention.

We're at Northeast Valley.

We've done a really good job of improving care at the clinic within the FQHC.

But now we're going to be working very closely with GI providers in the LA and the larger
LA community to make sure that those patients are connected to the GI clinics and make sure that those colonoscopies are completed and make sure that the reports get back to the FQHC, right. Because if it’s not documented in the FQHCSEHR, it’s as though it never happened. So part of it was a measurement problem to you and we just got the word that this was scored very well and we’re doing all the paperwork and hopefully we’ll get this work started very shortly and we’re very excited about that.

So for me, you know, the this work that we’ve done at
Northeast Valley has been really
because I think even as a PhD student,
I understood community partnership,
I understood what it was.
I was starting to understand what
it was like to effectively go
into community settings and listen
and learn and then intervene.
But now I've had about 5 projects
with them where I've been able
to not only see that process,
but see the trajectory across
the screening spectrum,
which has been an incredibly
rewarding experience.
And you can do this in anything, right?
You can do this in breast cerebral cancer screening, the FQHC.

You know, we asked them, what are your priorities? And they actually recently told us liver disease. And I was like, OK, that’s not me, but we’ll find someone who’s got this expertise because they have the similar problem with chronic liver disease. As we know, it’s become increasing burden in the United States particularly. In these populations and they can’t
get those patients into liver care

or into transplant evaluation.

So it is replicating that model once you’ve figured out how to do it well and effectively.

This work also dovetailed because we started this work in 2016 seventeen and it’s been going on my entire career.

It’s lent opportunities into other settings.

So one of the things that came up about four years ago was this opportunity from Stand Up to Cancer, which is a nonprofit organization that is about cancer awareness and also works with AACR to fund research.

They made an announcement a
few years ago. I’ll never forget, ‘cause I was sitting in my office and it said Stand up to Cancer, Colorectal, Cancer Equity Dream Team. And I said, well, that sounds like me. It sounds like someone wrote a grant for me, but I’m way too junior and there’s no way I’m going to get this, you know, $8 million grant. So I just kind of deleted the e-mail. And I think a few weeks later, Andy Chan at MGH reached out and said we’re thinking about applying for this grant. And I said that’s great. And I said, yeah, I’ll consult, I’ll help.
And he said, no, no, we want you to run it. And I said no.

So what are you talking about, Andy?

But again, another incredible opportunity where I started meeting with him and Jennifer Haas, we pulled the team together and it it kind of just made sense for for us to go in. And we were very fortunate to get awarded this grant. It’s $8 million. It’s the same work that I just described to you in Northeast Valley, but it’s across the nation.
00:41:50.280 --> 00:41:52.954 So we picked FQHCS in three cities,
00:41:52.960 --> 00:41:55.557 Los Angeles, Boston and in South Dakota.
00:41:55.560 --> 00:41:57.140 Now why South Dakota?
00:41:57.140 --> 00:41:59.115 Because of the Tribal Nations.
00:41:59.120 --> 00:42:01.784 So we have this incredible opportunity
00:42:01.784 --> 00:42:05.999 to in a very careful way engage with two
00:42:06.000 --> 00:42:08.597 FQHCS and tribal nations of South Dakota.
00:42:08.600 --> 00:42:10.280 And we are doing the same thing.
00:42:10.280 --> 00:42:12.584 We’re helping them improve their clinic
00:42:12.584 --> 00:42:14.720 infrastructure to improve their screening.
00:42:14.720 --> 00:42:15.952 We’re helping them improve
00:42:15.952 --> 00:42:16.876 the repeat screening.
00:42:16.880 --> 00:42:19.304 And the part that is we’re doing right
00:42:19.304 --> 00:42:21.695 now we’re in the last year of the study
00:42:21.695 --> 00:42:24.123 is we are improving their follow up
after Abnormal Fit and Cologuard testing.

Those are the tests that are most commonly used in these settings.

So this has been an incredible opportunity to kind of spread the work that we’ve learned in local FQHCS in Los Angeles to other parts of the country and to work with incredible investigators like Doctor Hawes and Doctor Chan.

This work is wrapping up. So we’re kind of hoping that Stand Up to Cancer will give us an opportunity to do more of it moving forward.

I think I just have two more slides and then I’ll have time for questions.
that I think are important to think about as we think about this field moving forward.

I do think that we’re just at the beginning of implementation science around colorectal cancer, equity. And there are groups all over the country that are doing work, even much better work than what I just described to you. And I’m so excited because it’s wonderful to come together at conferences and to be collegial with these individuals. And there’s a couple things that we’re noticing that make this work
even more relevant to everybody.

The demographics in the United States are changing.

I don’t think anyone in this room is surprised by that, but unfortunately a lot of others are.

And where we look at our demographics in 1980 compared to data from 2020, we know that the proportion of individuals who identify as white, non-Latino is smaller and we’ve got a larger proportion of Latinos, black individuals and Asian Americans. And in certain parts of the country, it’s a different proportion increase. This means that addressing disparities,
addressing inequities,
understanding what gets different
groups to get screened or get
testing is even more critically
important because we think that this
demographic shift will continue.
So I I try to remind people that
even though this is starting as
equity or disparities in a small
group of investigators,
we all need to learn how to do
this work if we really want to
address this problem on a national
level and similar problems.
The other thing that’s going to rock
our world in colorectal cancer is non invasive screening tests that are on the verge of driving me crazy. So we are going to have an emergence of stool based testing and blood based testing that we hope will be helpful towards screening more individuals but have potential downsides as well. So why are we having so many more tests? It’s because we’re still stuck at less than 70% of Americans getting screened for colorectal cancer. There is a huge market to make tests to get more people screened and I I agree, I agree with that. I think that certain test types are going
to appeal to different population groups.

The other thing that is critical to note is that there’s a big movement towards ease of testing. So that is why we’re seeing the emergence of liquid biopsy and said the idea that when I send a patient to get a Chem 7 or ACBC every year, I can just check off a box for their colorectal cancer screening and they don’t need to manipulate their stool or do a prep and take two days off for a colonoscopy, right. So there’s amazing potential in these blood based tests.
We saw the garden data that was released in New England Journal last month and raised a lot of excitement. I was quoted in the New York Times as saying that a prep for a colonoscopy was a horrible experience and this potentially could get rid of that, which isn’t what I said. What I said was that patients feel that way, but we have to recognize that these tests are different strategy, right. So I started this whole presentation by saying that the amazing power we have in colorectal is that we can prevent an early detect.
These blood based tests are mostly early detecting and they’re not even early detecting stage 1.

So we just have to recognize that this motto that Brendan Spiegel taught me when I was a fellow that the best test is a screening test that gets done. I’m not sure I’m going to be saying that anymore, right? Because to me it’s kind of apples to oranges.

We have tests that prevent and early detect and now we have tests that early detect. My biggest fear and why I get to the slide and bite my lip is that I’m
excited about the technology and the
emergence of people in our field.
But I’m nervous about the interpretation of
these tests because I’ve run into harmony,
lay people, but also researchers and clinicians
who don’t even understand that
we’re shifting fundamentally from
prevention to early detection.
That potentially changes again the number
of people that we say you have cancer too,
right, which is what I started
this presentation with.
So I am excited.
These are not yet recommended by USPFTF,
I think that our whole field is going to change as those become more and more popular. I'm going to close out here. I think I'm going to just put this up here for a couple minutes, but I'm pretty sure I made all these points. I want you to be aware that the screening guidelines changed and now we're screening at 45 and that now we're screening at 45 and that...
Despite all the work in this area, we still have profound disparities. What we’re doing some work in those areas, but a lot more has to be done and it really has to do with very sensitive, culturally tailored and targeted interventions. I’m going to end there and I’ll just put my thank you slide up. And I’m putting this up because that QR code is to my lab if you want to learn more. And then also I want obviously want to thank my partners and our funders.
So thank you very much.
Thank you so much.
And what a fantastic talk.
Happy to take questions.
Now there's something in the chat too.
So that was so fantastic.
Thank you. Thank you.
I have a question about the the research you're doing from the FQHC to the the clinics and you mentioned eight factors you have found that are the barriers to getting the 2nd screening.
Can you just say like what is the primary barrier that you would think
00:48:41.682 --> 00:48:43.416 is from the system’s perspective
NOTE Confidence: 0.950363401111111
00:48:43.416 --> 00:48:45.756 that is causing a challenge?
NOTE Confidence: 0.950363401111111
00:48:45.760 --> 00:48:47.640 I, there’s a chance I have a slide.
NOTE Confidence: 0.950363401111111
00:48:47.640 --> 00:48:49.680 So I’m just going to,
NOTE Confidence: 0.950363401111111
00:48:49.680 --> 00:48:51.678 I have all these extra slides just in case.
NOTE Confidence: 0.950363401111111
00:48:51.680 --> 00:48:53.760 But I don’t think that’s one of them.
NOTE Confidence: 0.950363401111111
00:48:53.760 --> 00:49:00.555 So OK, what it is,
NOTE Confidence: 0.950363401111111
00:49:00.560 --> 00:49:02.803 what we did is we there are eight sets, OK.
NOTE Confidence: 0.950363401111111
00:49:02.803 --> 00:49:06.278 So what we did is we went into
NOTE Confidence: 0.950363401111111
00:49:04.747 --> 00:49:06.277 the clinic and we said,
NOTE Confidence: 0.950363401111111
00:49:06.280 --> 00:49:08.640 we went into the clinic and we said
NOTE Confidence: 0.950363401111111
00:49:08.640 --> 00:49:11.278 when a patient has an abnormal fit,
NOTE Confidence: 0.950363401111111
00:49:11.280 --> 00:49:13.400 what’s the first thing that has to happen.
And the first thing that has to happen is that the doctor has to see the results, right. And believe it or not, there are cases where it’s just sitting in the EHR and no one ever noticed it, right. So that’s step one. Then the second step is the provider has to contact the patient and communicate the results. And then the second step is the provider has to contact the patient and communicate the results. The third step is the provider and the patient have to come to a patient provider decision that a colonoscopy should be pursued and by
the multi society task force Full
disclosure and part of that task force.

But our guideline says that 80% of patients at least who have an abnormal fit should be appropriate for colonoscopy.

So the answer to that third step should be yes.

Then the next step is the provider needs to place a referral.

Then the next step after that is that the referral has to be processed that was a step we didn’t really acknowledge before because we just thought it, it just happens.
these referrals, they would call the insurer and the insurer would say no and then no one else would follow up. And so things were getting stuck there. Really interesting in LA, the GI consultants were requiring the patients to have an in office visit and then a second visit for the colonoscopy. Everyone was just taking those patients and putting them into Open Access and spacing them.
But when we did our qualitative interviews, which a part of the NIH grant I didn’t go to with, the first aim was qualitative interviews. All of the private practitioners in LA were saying it’s a disaster when we do that. These patients are coming from a setting where they haven’t had procedures, they don’t understand the prep, we have language barriers, they have comorbidities they’re showing up with in a FIB. We can’t do the procedure. It’s getting cancelled day of so they.
this underserved population, it became very clear to me that I wasn’t going to be able to get rid of that step because all of my colleagues were saying oh, if you get rid of that step, you’ll fix this problem. But we have not. We’ve just tried to streamline that step by doing better medical documentation and preprocedural work. Yes. So Rachel Osaka,
who’s a colleague at University of Washington, she has a systematic review that’s just about to come out that looked at effective interventions for fit, follow up and underserved. And they found, I think, 13 interventions and all of them involved the Navigator. So there is really in these settings in particular,
there’s something about patient interaction and coaching someone through these eight or nine steps that’s effective and important. Did I answer your question? Yes.

I want to also thank you for an amazing talk and thank you for really eloquently outlining how complex it is to develop interventions across all these levels. So thank you for being here.

One of the things that I’m a huge fan of your work,
but what I'm really sort of fanning over right now is your relationship with the Federally qualified health centers and acknowledging that, you know, a large majority of our at risk populations are being served in those settings, but yet we’re not able to engage them in research regularly. So you outlined a sort of program that sort of has a longitudinal relationship with these centers. And I wonder if you can just help us understand what it really takes to maintain that relationship.
and engage those community, because I think that’s where we miss the mark a lot. I think we miss the mark a lot. And I’m not going to sit here and say that I do this perfectly. I’ve had missteps, I would say that in everyone. But one of the FQHCS that I’ve worked in, the hardest part was trust building. So a lot of these settings I walked into, they had had experience with, with academic institutions, with investigators.
They felt almost raped of their data in some situations. So a lot of that first year or so is like courting them like just showing up like we’re here to. I said I have coordinators that just sit there and just watch and bring in breakfast and you know, just listen and learn. We are very pushy. Like I think as academics we don’t realize and it probably is very efficient and effective people. You just were like in five states in the last two days. We are very efficient people.
and we like things like this and you go into those settings and you realize if you act like that it does not work. They just see you as a pushy person who needs to watch your agenda. So a lot of it is the trust building and the relationship building. The other, the second part that I would say answering your question is you have to have a really strong like stakeholder in the setting. For us it tends to at least start with the Qi director or someone who has that equivalent role and sometimes will migrate to someone else.
We have one of the FQHTS that we're working with for the Stand Up to Cancer grant. It's actually a primary care provider. She just really decided that she loves this work. But you have to have buy in because that person helps change the culture of the institution and almost gives you cred among all the other providers there. So that's been really important as well. But it's hard. I mean, we've gotten feedback from some of these settings that we were rude on.
00:54:34.456 --> 00:54:35.919 certain days or I've gotten a call
NOTE Confidence: 0.8634098875
00:54:35.971 --> 00:54:37.519 that my project coordinator came in
NOTE Confidence: 0.8634098875
00:54:37.519 --> 00:54:38.968 there talking like she knows everything.
NOTE Confidence: 0.8634098875
00:54:38.968 --> 00:54:40.396 You know, like you have to be,
NOTE Confidence: 0.8634098875
00:54:40.400 --> 00:54:41.720 you have to be very careful.
NOTE Confidence: 0.8634098875
00:54:41.720 --> 00:54:43.080 I mean, I mean,
NOTE Confidence: 0.8634098875
00:54:43.080 --> 00:54:45.152 I hate to say it,
NOTE Confidence: 0.8634098875
00:54:45.152 --> 00:54:46.239 but even like the way we dress
NOTE Confidence: 0.8634098875
00:54:46.240 --> 00:54:47.969 or the jewelry we wear,
NOTE Confidence: 0.8634098875
00:54:47.969 --> 00:54:49.510 you can be very careful when you
NOTE Confidence: 0.8634098875
00:54:49.510 --> 00:54:50.595 go into these settings and you
NOTE Confidence: 0.8634098875
00:54:50.600 --> 00:54:53.440 And then, and you have to understand,
NOTE Confidence: 0.8634098875
00:54:51.840 --> 00:54:52.800 this takes time.
NOTE Confidence: 0.8634098875
00:54:52.800 --> 00:54:53.440 I mean,
I started doing this work and Gary Gitnick was the chief of my division. And I told him I want to do this work. No one does this work. But I’m going to need like five years to figure this out. And can you just pay me? Well, figure this out. And he was like, sure, yeah, we’ll, we’ll figure it out. We’ll just pay you. And now it’s paying off. But I mean, you have to have some. You have to be at an institution that’s going to invest in people. And the time, I hope the answers, I can go on forever,
but hope that answers.

Hi, It's good to see you.

Good,

thanks you. But with the stool based test, if you pick out polyps in you actually can with the fit. So the sensitivity for fit, for FIT, for advanced adenoma which is the polyps we care about is about 40%, it's for the. Yeah. So the sensitive is even higher for stage one through 4:00. So we actually think fit does a pretty good job of both the prevention, early detection, the Gwyak, the FOPG does not, it's like 12%.
So though that’s why those have come out of favor. Cologuard is 42%. I think the one point O, so those two newer tests and then the Cologuard 2 point O, the one that they just released the Journal, the in New England Journal 3 weeks ago, that also has good sensitivity for Vance Adenovus. But it’s just the liquid, the blood ones that do not 13 percent. Yeah. I mean, I, like you don’t really believe that screening is being done as frequently as black Americans.
as white Americans.

But, you know, that’s the idea you have.

But clearly, you know,

mortality is higher in black individuals.

Yeah. So there’s there’s a problem

after diagnosing and there’s no

question about that. Absolutely.

You have thoughts about that? Yeah.

So you know that I do have a slide.

Do I have, do I have a minute?

I have a minute to it.

I have a minute. OK.

So this, I’m glad you brought

that up because we only talked

about a piece of the problem.
Right. So, oh gosh, no, I’m not.

I’m using my minute to like scroll through slides.

But this is the bigger problem, right,

is that you have disparities at every box.

So I’ve decided to focus on this box.

But you could have,

you could focus on any of those boxes.

And recently we had a paper that came out in JAMA that showed differences but black,

white differences in treatment.

So when you look at guideline directed treatment for colon and rectal cancer,

black individuals are less likely to get the NCCN guideline recommended treatment than white Americans.
And that’s after we controlled for everything that was national data adherence. So when you look at the use of guideline appropriate treatment as laid out in the guidelines was lower in black individuals. So that’s the accumulation of disparities at every one of these boxes that’s at 40% mortality difference that you’re referring to. Yeah. And I this, this alone is a talk, right, ’cause I mean you could I’m
we just talked about screening today,

but there's differences in risk factors and lifestyle and also survivorship as well.

When you look at things like sexual dysfunction, Gu dysfunction,
those are all different by race as well.

I'd like to thank Doctor May again time and presentation today.

Thank you so much and thank you for the questions.

And I'll stand here for a few minutes in case there are more.

Thank you so much.