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. 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.
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 lab’s research spans several areas from the epidemiology of disease and these risk factors to implementation science to improve disease outcomes. As Director of the Melvin and Brendan Simon Gastroenterology
Quality Improvement Program,

Doctor May also overseas 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 to improve healthcare delivery.

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
for the invitation to be here.

It's an absolute honor to be here at the Yale Cancer Center today and to speak with all of you.

And I'm actually really excited to see so many people live in the audience on a Friday morning.

So thank you for weathering the weather and for coming to meet in person.

And thank you as well for those of you online who I know are listening in,

I am going to try and keep my eye on the chat and the Q&A. So if you do have questions, please add those there.

Also, if you're here live in the audience,
00:02:27.600 --> 00:02:29.280 please interrupt me if anything’s unclear.

00:02:29.280 --> 00:02:31.200 If you have any questions.

00:02:31.200 --> 00:02:33.520 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.

00:02:39.360 --> 00:02:42.630 I’ll start by here just providing my disclosures.

00:02:42.630 --> 00:02:45.796 And since we are at Yale, I have to start with a few stories.

00:02:45.800 --> 00:02:47.880 So I was very honored to receive this invitation to come here today. I was thank you.

00:02:52.080 --> 00:02:55.654 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 to do that. So with that context, where am I now? 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 California. My husband’s from Northern California, I’m from Southern California, and I did my GI fellowship at UCLA. This amazing opportunity. I know there’s a similar program here. It’s called the STAR program.
that gives fellows.

So these are people who have finished their internal medicine training.

I had left MGH after my internals medicine training,

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 publish a lot of that work and then I do about 20% patient care. I am involved in running the
STAR program now.

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So that’s my way of giving back.

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

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In the lab, it’s largely health services research.

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There is a heavy lean towards cancer.

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We’re going to talk today about one of these cancers and HealthEquity, but we also do a lot of clinical EPI.

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As mentioned,

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

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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. 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, to the uptake of screening and those who’ve participated,

but also partially into some improvements that we’ve had in treatment and reduction in risk factors.

We do think that some of the reduction in smoking has contributed to some
00:08:09.420 --> 00:08:11.430 of the reduction in the number
00:08:11.498 --> 00:08:13.976 of polyps that we see and polyp
00:08:13.976 --> 00:08:15.600 progression to colorectal cancers.
00:08:15.600 --> 00:08:17.608 But I do want to mention that it’s
00:08:17.608 --> 00:08:19.319 a success story with a caveat,
00:08:19.320 --> 00:08:20.409 a couple caveats.
00:08:20.409 --> 00:08:22.950 The first being that there were massive
00:08:23.017 --> 00:08:25.117 disparities in colorectal cancer.
00:08:25.120 --> 00:08:27.626 The group that has the highest incidence
00:08:27.626 --> 00:08:30.119 of colorectal cancer is our American Indian,
00:08:30.120 --> 00:08:31.215 Alaska Native population.
00:08:31.215 --> 00:08:33.040 Those two groups are often
00:08:33.040 --> 00:08:34.920 combined in national databases,
00:08:34.920 --> 00:08:36.800 including SERE because they’re small,
00:08:36.800 --> 00:08:38.249 But I want to highlight that they
are very distinct populations.
And actually, if you separate it, it's the Alaska Native group that's largely driving this epiphenomena that we see. And then after that, we have black individuals in the United States having the second highest rates of colorectal cancer, then white Americans, then our Latino population, followed by our Asian and Pacific Islander population. So even though in the Asian, Pacific Islander population it’s 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 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% or lower. So we do pay a lot of attention to stage at diagnosis. And when you look at distance, 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 25
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 six percent of cases were non Hispanic white individuals. That is dropped to fifty eight percent of cases in 2019, probably even lower if we actually had 2023 data and that is attributed to an increase in the number of cases in Latino Hispanic individuals and non Hispanic American Indian 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

00:13:31.158 --> 00:13:32.959 little bit about what’s going on in the

00:13:32.959 --> 00:13:34.494 screening world and some of the work

00:13:34.494 --> 00:13:36.260 that we’re doing to help close some

00:13:36.260 --> 00:13:39.185 of these gaps just to make sure that

00:13:39.185 --> 00:13:41.358 we are all starting on the same page.

00:13:41.360 --> 00:13:43.502 Colorectal cancer is very unique and that

00:13:43.502 --> 00:13:46.400 we have a precursor lesion called a polyp.

00:13:46.400 --> 00:13:48.297 So when I am doing a procedure

00:13:48.297 --> 00:13:50.717 see if I can use my mouse here.

00:13:50.720 --> 00:13:52.480 This is what a colon,

00:13:52.480 --> 00:13:53.960 this is what a normal colon looks like.

00:13:53.960 --> 00:13:55.840 When I’m in the colon with a scope,

00:13:55.840 --> 00:13:59.277 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 the normal colon picture.

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 have 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.

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 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 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

And these are data that were released

And actually the report that

Cancer Society just last month

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suggests 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 USPSTF 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 40 to 49 year olds.

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

If there’s a family history of polyposis for average risk individuals.
syndrome or hereditary syndrome,
we’re actually going to screen much earlier.
These are the USPFTF recommended screening modalities.
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 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,

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despite the fact that we have evidence

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despite the fact that screening works and the fact

NOTE Confidence: 0.919895606315789
that everyone should be screened,

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we still have a problem with

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only about 6067% of people being

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screened even when we have all of

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these options for our patients.

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So we still are trying to find ways to

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have more people participate in screening.

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When you participate in one of the

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screening tests that is not a colonoscopy,

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we don’t have the opportunity to

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go in and grab those polyps or

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or biopsy those early cancers.

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So we do call those two step
NOTE Confidence: 0.919895606315789
00:19:43.645 --> 00:19:44.515 screening processes.
NOTE Confidence: 0.919895606315789
00:19:44.520 --> 00:19:45.996 So whether you’re talking about FIT,
NOTE Confidence: 0.919895606315789
00:19:46.000 --> 00:19:49.120 Cologuard, FOBT or CT colonography,
NOTE Confidence: 0.919895606315789
00:19:49.120 --> 00:19:51.560 if a polyp is found or abnormal abnormality
NOTE Confidence: 0.919895606315789
00:19:51.560 --> 00:19:53.758 is found during one of these tests,
NOTE Confidence: 0.919895606315789
00:19:53.760 --> 00:19:55.422 it’s actually required that you have
NOTE Confidence: 0.919895606315789
00:19:55.422 --> 00:19:57.247 the second step which is colonoscopy
NOTE Confidence: 0.919895606315789
00:19:57.247 --> 00:20:00.552 to complete the screening process.
NOTE Confidence: 0.919895606315789
00:20:00.552 --> 00:20:00.960 Now this seems obvious,
NOTE Confidence: 0.919895606315789
00:20:00.960 --> 00:20:02.955 but I work in settings where only
NOTE Confidence: 0.919895606315789
00:20:02.960 --> 00:20:06.215 18% of patients have that throughput from
NOTE Confidence: 0.919895606315789
00:20:06.215 --> 00:20:09.505 abnormal fit or abnormal stool based
NOTE Confidence: 0.919895606315789
00:20:09.505 --> 00:20:12.515 testing to the completion colonoscopy.
NOTE Confidence: 0.919895606315789
00:20:12.520 --> 00:20:15.300 Participation and screening varies
NOTE Confidence: 0.919895606315789
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. So overall, we’re not doing very well at the top of the chart at 59%. You’ll see the differences by age. Of course just because we’ve just started screening our 45 to 49 year olds,
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.
there’s still more than a 1% difference, but it does signal that we’ve done a good job of closing that gap. But look at the other non white racial ethnic groups again. When we’re looking at our native populations, Asian and Hispanic individuals, we do. We have a lot of work to do. So this is where a lot of our work focuses on in the underserved, not just our black community but our other groups that are have low rates as well. I think I also hear put a lie where where you’re born matters. So our immigrant populations
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 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. There are conditions about your life that make it more or less likely for you to participate in your healthcare. 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 test for a cancer or disease they don’t have is off the table. But the more specific reasons for screening 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 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 that’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 go with a multi component intervention.

A couple things I do want to highlight. So policy because we talk a lot about patient provider system, but 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 --> 00:26:34.330 So we finally convinced Congress that that didn’t make any sense and they removed those co-pays.

00:26:34.330 --> 00:26:36.000 This is work that’s been championed for years, but that law went through I think 2 1/2 years ago.

00:26:37.100 --> 00:26:38.965 So there are also policy things that have to be addressed for us to close these gaps.

00:26:40.440 --> 00:26:43.040 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 field of implementation science,
which is,

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is,

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is kind of what we could we consider where

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health service the research is going to.

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So in health services research,

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we’re trying to understand

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how to get the best care,

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the best quality of care to all people

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equitably and through health systems or

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other sources of healthcare delivery.

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And a lot of that leads up to

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effective implementation science.

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In implementation science,

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especially related to disparities,

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our first goal is to understand the

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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 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
how you design your intervention. You want it to target multiple levels. As I mentioned, you want to address barriers at all those levels which leads to a multi component intervention. You want them to be culturally tailored. Particularly interventions that involve patient education where all of the individuals on the pamphlet are are appear white or a pure male are not going to appeal to people who come from brown or black populations or underserved populations for example. So culturally tailoring the language,
the examples, the settings, the people, and then also you want to work closely with the stakeholders. I think we come from unfortunately a history since probably the beginning of time where we've come into places and decided what's best for the people there. When we develop interventions, we sit down with our community 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
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primary care providers by automating
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screening for them and and prompting
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them to do things and taking
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steps and the number of of touches
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on the EHR away from them.
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We also have interventions that are
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focused mainly on the provider or
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her provider components and also as
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I mentioned communities and patients.
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So when we’re building intervention,
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a lot of times we’re looking at lists
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like these and we’re saying OK where
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do we want to pull from each of
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these levels as we build our multi
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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.
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.
I'm also interested in which completion of screening. They even when they do get screened, if that screening is abnormal like they 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 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
00:32:42.904 --> 00:32:44.872 in FQHCS just in our county.
NOTE Confidence: 0.902135681428572
00:32:44.880 --> 00:32:45.480 And then I just go,
NOTE Confidence: 0.902135681428572
00:32:45.480 --> 00:32:47.112 I gotta drive 2 hours South to meet
NOTE Confidence: 0.902135681428572
00:32:47.112 --> 00:32:49.005 up with Samir Gupta and I've got the
NOTE Confidence: 0.902135681428572
00:32:49.005 --> 00:32:50.959 San Diego counties at my disposal as well.
NOTE Confidence: 0.902135681428572
00:32:50.960 --> 00:32:52.304 And we do a lot of partnership
NOTE Confidence: 0.902135681428572
00:32:52.304 --> 00:32:52.880 with San Diego.
NOTE Confidence: 0.902135681428572
00:32:52.880 --> 00:32:55.360 Our populations are similar.
NOTE Confidence: 0.902135681428572
00:32:55.360 --> 00:32:57.608 So at the Center for HealthEquity,
NOTE Confidence: 0.902135681428572
00:32:57.608 --> 00:32:59.560 which is at UCLA,
NOTE Confidence: 0.902135681428572
00:32:59.560 --> 00:33:01.240 in the UCLA Cancer Center,
NOTE Confidence: 0.902135681428572
00:33:01.240 --> 00:33:03.200 where I am one of the associate directors,
NOTE Confidence: 0.902135681428572
00:33:03.200 --> 00:33:04.776 we collaborate with federally
NOTE Confidence: 0.902135681428572
00:33:04.776 --> 00:33:05.958 qualified health centers.
NOTE Confidence: 0.902135681428572
00:33:05.960 --> 00:33:08.036 We develop advisory committees with them.
NOTE Confidence: 0.902135681428572
00:33:08.040 --> 00:33:09.840 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,
84% and largely uninsured 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 Valley 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
patients and this was a multi level intervention mostly about their workflow is how can we help them reestablish their workflow in the clinic.

We offloaded the primary care providers.

We got different levels non-MD providers in the clinic involved and explaining the kit following up with patients and that was very effective in increasing their overall screening rate.

Then we had a post doc who said OK that’s great.
The patient got screened once in 2018, they 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.
NOTE Confidence: 0.882475737333333
00:36:59.016 --> 00:37:00.636 again who does the colonoscopy.

NOTE Confidence: 0.882475737333333
00:37:00.640 --> 00:37:02.224 So I want to make sure all these

NOTE Confidence: 0.882475737333333
00:37:02.224 --> 00:37:03.261 patients who have abnormal

NOTE Confidence: 0.882475737333333
00:37:03.261 --> 00:37:04.437 results get a colonoscopy.

NOTE Confidence: 0.882475737333333
00:37:04.440 --> 00:37:06.222 And that work started with an

NOTE Confidence: 0.882475737333333
00:37:06.222 --> 00:37:08.088 NCIRO 3 where we proposed that

NOTE Confidence: 0.882475737333333
00:37:08.088 --> 00:37:10.520 we were going to look at the why,

NOTE Confidence: 0.882475737333333
00:37:10.520 --> 00:37:12.128 And we,

NOTE Confidence: 0.882475737333333
00:37:12.128 --> 00:37:13.720 we quantified the fallout or the

NOTE Confidence: 0.882475737333333
00:37:13.720 --> 00:37:15.688 why is it that patients are

NOTE Confidence: 0.882475737333333
00:37:15.688 --> 00:37:17.880 falling out in this process.

NOTE Confidence: 0.882475737333333
00:37:17.880 --> 00:37:19.798 And we created this conceptual framework

NOTE Confidence: 0.882475737333333
00:37:19.798 --> 00:37:22.119 where we showed that there were nine

NOTE Confidence: 0.882475737333333
00:37:22.119 --> 00:37:24.712 things that needed to happen for an

NOTE Confidence: 0.882475737333333
00:37:24.712 --> 00:37:26.328 abnormal FIT patient to get a colonoscopy.

NOTE Confidence: 0.882475737333333
00:37:26.328 --> 00:37:27.968 And we,

NOTE Confidence: 0.882475737333333
00:37:27.968 --> 00:37:29.076 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 which is kind of crazy the first time. 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 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

79
NOTE Confidence: 0.9167681663333333
00:38:51.869 --> 00:38:53.727 LA community to make sure that those
NOTE Confidence: 0.9167681663333333
00:38:53.727 --> 00:38:55.838 patients are connected to the GI clinics
NOTE Confidence: 0.9167681663333333
00:38:55.838 --> 00:38:58.232 and make sure that those colonoscopies
NOTE Confidence: 0.9167681663333333
00:38:58.232 --> 00:39:00.556 are completed and make sure that the
NOTE Confidence: 0.9167681663333333
00:39:00.556 --> 00:39:02.835 reports get back to the FQHC, right.
NOTE Confidence: 0.9167681663333333
00:39:02.835 --> 00:39:05.880 Because if it’s not documented in the
NOTE Confidence: 0.9167681663333333
00:39:05.880 --> 00:39:07.840 FQHCSEHR, it’s as though it never happened.
NOTE Confidence: 0.9167681663333333
00:39:07.840 --> 00:39:10.424 So part of it was a measurement problem
NOTE Confidence: 0.9167681663333333
00:39:10.424 --> 00:39:13.030 to you and we just got the word that
NOTE Confidence: 0.9167681663333333
00:39:13.030 --> 00:39:14.955 this was scored very well and we’re
NOTE Confidence: 0.9167681663333333
00:39:14.955 --> 00:39:16.881 doing all the paperwork and hopefully
NOTE Confidence: 0.9167681663333333
00:39:16.881 --> 00:39:19.070 we’ll get this work started very shortly
NOTE Confidence: 0.9167681663333333
00:39:19.070 --> 00:39:20.840 and we’re very excited about that.
NOTE Confidence: 0.9167681663333333
00:39:20.840 --> 00:39:22.480 So for me, you know,
NOTE Confidence: 0.9167681663333333
00:39:22.480 --> 00:39:24.804 the this work that we’ve done at
NOTE Confidence: 0.9167681663333333
Northeast Valley has been really
because I think even as a PhD student,
I understood community partnership,
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
00:40:09.348 --> 00:40:11.152 get those patients into liver care
NOTE Confidence: 0.916768166333333
00:40:11.152 --> 00:40:12.440 or into transplant evaluation.
NOTE Confidence: 0.916768166333333
00:40:12.440 --> 00:40:13.964 So it is replicating that model
NOTE Confidence: 0.916768166333333
00:40:13.964 --> 00:40:15.476 once you’ve figured out how to
NOTE Confidence: 0.916768166333333
00:40:15.476 --> 00:40:16.596 do it well and effectively.
NOTE Confidence: 0.841944484545455
00:40:18.640 --> 00:40:21.454 This work also dovetailed because we I
NOTE Confidence: 0.841944484545455
00:40:21.454 --> 00:40:24.284 started this work in 2016 seventeen and
NOTE Confidence: 0.841944484545455
00:40:24.284 --> 00:40:27.560 it’s been going on my entire career.
NOTE Confidence: 0.841944484545455
00:40:27.560 --> 00:40:32.240 It’s lent opportunities into other settings.
NOTE Confidence: 0.841944484545455
00:40:32.240 --> 00:40:33.738 So one of the things that came
NOTE Confidence: 0.841944484545455
00:40:33.738 --> 00:40:35.508 up about four years ago was this
NOTE Confidence: 0.841944484545455
00:40:35.508 --> 00:40:37.116 opportunity from Stand Up to Cancer,
NOTE Confidence: 0.841944484545455
00:40:37.120 --> 00:40:39.615 which is a nonprofit organization
NOTE Confidence: 0.841944484545455
00:40:39.615 --> 00:40:42.567 that is about cancer awareness and
NOTE Confidence: 0.841944484545455
00:40:42.567 --> 00:40:44.972 also works with AACR to fund research.
NOTE Confidence: 0.841944484545455
00:40:44.972 --> 00:40:46.910 They made 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 kind of just made sense for us to go in. 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.
So we picked FQHCS in three cities, Los Angeles, Boston and in South Dakota. Now why South Dakota? Because of the Tribal Nations. So we have this incredible opportunity to in a very careful way engage with two FQHCS and tribal nations of South Dakota. And we are doing the same thing. We’re helping them improve their clinic infrastructure to improve their screening. We’re helping them improve the repeat screening. And the part that is we’re doing right now we’re in the last year of the study 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 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. 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 agree, I agree with that.
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, 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, but it’s on.
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 want you to leave understanding how common this disease is, but how preventable it is. I want you to understand that young adults need to be aware of getting screened and also symptoms and not ignore them. I want you to be aware that the screening guidelines changed and 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 that 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
is from the system’s perspective

00:48:43.416 --> 00:48:45.756 that is causing a challenge?

I, there’s a chance I have a slide.

So I’m just going to, I have all these extra slides just in case.

But I don’t think that’s one of them.

So OK, what it is, it’s not that there are 8 barriers

because that’s how I used to think

of things as like whole barriers.

What we did is we there are eight sets, OK.

What we did is we went into

the clinic and we said

when a patient has an abnormal fit,

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. 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 after that is that the referral has to be processed and that was a step we didn’t really acknowledge before because we just thought it, it just happens. But we realized that a lot of
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.

And then this is what was 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.

I talked to my colleagues in Boston and New York. Everyone was just taking those patients and putting them into Open Access and scoping 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.

So in LA, particularly with
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 get rid of this,

you’ll fix this problem.

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, And they found, I think, 13 interventions and all the body of literature, 8 of them were manuscripts, five were abstract conference abstracts, one involved the Navigator. So there there is really in these settings in particular,
there's something about patient interaction and coaching that's effective and important. Did I answer your question?

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.

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
certain days or I've gotten a call that my project coordinator came in talking like she knows everything. You know, like you have to be, you have to be very careful. I mean, I hate to say it, but even like the way we dress or the jewelry we wear, you can be very careful when you go into these settings and you have to be very aware of that. And then, and you have to understand, this takes time.
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, thank 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, is 42%. I think the, the one point O, so those two newer test 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 the blood ones that do not 13 percent, 13%. 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 surgery, chemotherapy, radiation, particularly radiation for rectal cancer, the use of guideline appropriate treatment as laid out in the guidelines was lower in black individuals. So that it’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, '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 like 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 I'll stand here for a few
minutes in case there are more.
Thank you so much.