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**ReachMD**
www.reachmd.com
info@reachmd.com
(866) 423-7849

Assessing Racial Disparities in Colorectal Cancer Screening

Dr. Nandi:
Welcome to *GI insights* on ReachMD. I'm Dr. Neil Nandi. Even with technological advances in medicine, we are still striving to push for higher colorectal cancer screening rates. While stigma continues to play a role, it is racial and ethnic bias that still contribute to greater inequities. African Americans have a higher increased rate of colorectal cancer, especially compared to other populations, and yet access and screening rates are still poor. The 2020 coronavirus pandemic has only magnified this issue.

Now joining me today to shed light on how you, as a clinician, or you, as a healthcare administrator, can make a difference and prevent colorectal cancer in your community is Dr. Fola May. Dr. Fola May is an Assistant Professor of Medicine at UCLA and her research focuses and health disparities inequities in gastroenterology. She is the director of the Melvin and Bren Simon Gastroenterology Quality Improvement Program and holds many titles, and yet she is a committed advocate for colorectal cancer screening amongst all populations.

Now, notably, she is an MD, a PhD, and holds a master's in philosophy to boot. But moreover, she is very dedicated and humble. Welcome to *GI Insights*, Dr. May.

Dr. May:
Thank you, so much for having me. I'm so thrilled to be here, today.

Dr. Nandi:
We're pleased to have you, indeed.

Now, we have known for many years that African Americans and Native Americans have higher in colorectal cancer incidences than other populations, and yet we observe that African Americans have higher colorectal cancer death rates. Notably, Hispanics have colorectal cancer screening rates that are even lower than African Americans. Dr. May, can you please help us understand what are the differences in colorectal cancer incidence, prevalence, and access to screening amongst different populations?

Dr. May:
Yes, as you mentioned, the healthcare disparities that we see in colorectal cancer incidence, screening, mortality, are very different across each racial and ethnic group. So, as you mentioned, there are disparities across, what we call, the cancer care continuum. So, that's everything from risk factors, to screening, to early prevention of disease, to treatment. And in every one of those buckets or categories, we have disparities. But those disparities differ for each racial and ethnic group. So, for example, African Americans have lower colorectal screening rates than white Americans but actually that screening rate gap has closed quite significantly in the last ten years. However, the biggest differences we're seeing in African Americans, right now are in incidence and mortality. So, African Americans are 20% more likely to be diagnosed with colorectal cancer in a lifetime, and they're 40% more likely to die, as a result of colorectal cancer. So, those reflect inequities that include problems with screening in the African American community, but also beyond that. We think that it actually implies differences in treatment and in care that impact survivorship.

There was a really incredible study that was done a couple of years ago that did a microsimulation model to estimate the differences in screening and the impact and the differences in screening on incidence and mortality. And what they found were that differences in screening between Blacks and whites account for only about 40% of the incidence disparity and only about 19% of the mortality disparity between Blacks and whites. So, again, there are other factors beyond screening, which likely include stage at diagnosis, access to treatments, types of treatment, treatment success that are contributing to Black/white disparities.

I'll continue to say that it's different when you look, for example, at Latinos. For Latinos in the United States, there are also disparities,

but the pattern is different. Their screening rates are a lot lower than white Americans, about 20% lower than white Americans. But incidence and mortality of colorectal cancer in Latinos is lower than white Americans. So, while we still need to bring up screening rates in Latinos, to optimize their outcomes from disease, we don't have those profound differences in incidence and mortality that we see when we look at Black Americans compared to white Americans.

Dr. Nandi:
Like you're saying, there are differences in terms of mortality and incidence, and certain populations are more urgent to act upon now, such as African Americans, but every demographic still has a reasonable incidence or prevalence of colorectal cancer that we can impact upon. Now, you mentioned the study that shows that there's this great disparity in access and screening rates. Can you elaborate a little bit more what those factors are and what's modifiable?

Dr. May:
I sure can. And I'm really happy about your statement because it's true, I mean, overall, colon cancer is just killing too many Americans, so even when we look at white Americans, this disease that is largely preventable is impacting way too many of us. It's the second most common cancer killer in America, just after lung cancer and it's largely preventable by screening, so it shouldn't be that high on the list.

When we look specifically at disparities, we know that there are many reasons or factors that are contributing to the differences by race and ethnicity. I remember when I was going through my training, a lot of the teaching was that it must be biologic or genetic differences that are driving these disparities and we've actually moved really far away from thinking that way now.

So, rather than biologic or genetic differences, by race and ethnicity, we know that the major contributors to these disparities are environmental, social, and healthcare-related factors. And this is really where social determinants of health come in. Social determinants of health are the context in which we live our lives. And they are the root causes of disparities by race and ethnicity. Social determinants of health include government policies, they also include the environment; whether that's the social, physical, economic, or living environment factors, all of these things can impact your health. We like to say in public health that much of your health is dictated by where you were born. So, people are literally lived into the surrounding influences that can impact their health outcomes. And those make them more or less likely to develop things like colorectal cancer.

Dr. Nandi:
That was a great segue to my next question to be hyper-focused on solutions. You kind of mentioned some of the social determinants of health at the patient-level. What are the provider-level factors? Physicians who are listening to this podcast, they have an opportunity to practice very effective preventative health. They can advocate for their patients in their own community which they live in. What are the provider-level factors that a physician listening to this can advocate for, for their patients, or modify, to help increase risk?

Dr. May:
I'm so excited that you're bringing this up because for so long, we have been phrasing poor uptake in preventive measures as a patient problem. We, in medicine, unfortunately often blame the patient, and we say that the reason why they haven't assumed care is because they didn't know, or they didn't follow-up on the advice, or they didn't take action, but the reality is that there are a lot of data that show that it's multi-component, multi-factorial, and that there is a significant role of the provider.

So, there have been studies that have been done by our group and others that show that whether a provider recommends screening, is highly variable. And not only that, patients report in many studies now that the number one factor or reason why they participate in colorectal cancer screening is because the doctor, their trusted doctor, told them to do it.

So, this really speaks to the importance at the provider level of talking to patients and talking to patients early about the importance of colorectal cancer screening. We can't wait 'til people are 51 and start bringing this up as something that is past due and barely talking about the importance of screening. We need to start engaging in these conversations with people well before their screening age. We need to start planning ahead to find out which screening modality patients are going to be more interested in, whether that's something like a colonoscopy or a stool-based screening modality, or CT scan, so that when patient's hit screening eligibility, whether that's 45 or 50, which is highly debatable right now, that we are ready to go and that patients understand that this is an important healthcare measure.

So, I certainly think there's a lot that we can do at the provider level. And part of it is being vocal about this as a public health problem. Part of this is being involved in national campaigns like we all are in every year when we hit March for colorectal cancer screening. But part of it is just one-to-one at the clinic level and making sure that no patient is left behind.

Dr. Nandi:
For those just tuning in, you're listening to *GI Insights* on ReachMD. I'm Dr. Neil Nandi and today I'm speaking with Dr. Fola May about the different factors that lead to racial and ethnic disparity in colorectal cancer screening in the United States.

Fola, let me ask you, what kinds of factors are at play and are modifiable at the policy level and at the organizational level, a hospital within its community, in order to create better screening for colorectal cancer and access?

Dr. May:
Absolutely, thank you for that question as well. There are actually many things that can be done, I would say, at the patient level, the provider level, but also the healthcare system and the policy level. And I'm excited to talk about the hospital level because one of the hats that I'm so fortunate to wear here at UCLA Health is that I'm the Director of Quality for Gastroenterology. And one of the main pillars within our quality improvement program is to improve the colon health of our UCLA Health patients, which we do through a robust colorectal cancer screening program.

There is a lot that hospitals can do to optimize how they offer and track screening for colorectal cancer among their patients. I would say the first challenge for hospitals is measuring it in the first place, right? So, a lot of hospitals don't even know what their colorectal screening rate is. And that's because it's hard to define what patients you want to include in the denominator; it's hard to figure out how to optimize your EHR so that you're measuring all types of screening modalities in your numerator. Nonetheless, the first step is to make sure that in every health system, we are actually measuring colorectal screening rates and that we are looking at them regularly, and by race, ethnicity, age, and gender. So, once we have those data, we can become rather scientific about our approach. And we can think about those particular groups or subgroups that need further attention.

The policy level-- I mean, it's hard right? I mean, the ideal is that we have policies in place that help improve access to everyone. I will say that the Affordable Care Act, the ACA was a huge step forward for us. We were able to improve a lot of preventive care measures, especially among low-income and ethnic and racial minority groups with the passage of the ACA, which, not only improved insurance coverage, it also improved supports to services like federally-qualified health centers, so that they can provide more preventive health services to low-income Americans. So, that policy was groundbreaking in that it certainly helped. We have studies that now show that it certainly helped with colorectal cancer screening. It didn't solve the problem, though. So, that really points the reality that you can build policies all day, but unless you're doing things on the ground like some of these hospital level interventions, you're not gonna really move the needle with the screening rates.

Dr. Nandi:
Before we conclude, I want to ask: are there any last take-home points that you want our listeners to take home and practice to increase rates?

Dr. May:
I really wanna emphasize that there's something that all of us can do. So, whether you are a public health expert, a physician, whether you are a patient or a survivor, you can spread awareness about colorectal cancer screening and the importance of screening. You can preach and teach that everyone in this country, at some point, is due for screening. This is not like some other cancers that we screen for, where it's only certain populations that are eligible, or certain populations that are high risk that we screen for. Everyone needs to be screened for colorectal cancer. Really the only thing that varies is the age that we start and that depends on whether you have a family history and also if you're African American. But I think that we all can be contributing to solving this problem by talking about this disease more. And there's so much stigma around colorectal cancer and we need to get over that.

I'll add that especially now, we've got a couple of things that are working against us. We've got the COVID crisis and that has plummeted screening utilization in the United States upwards of an 80 to 90% drop in colonoscopy rates in health centers across the country in large. Now, we've had some recovery, but we know by predictor models that there are many cancers that we have missed during COVID-19. So, especially now, the messaging needs to be that there are still safe ways to screen during COVID. Health centers have implemented safe policies so you can come and get your procedure, be socially distanced, have a mask, get pre-testing and still get your colonoscopy. But even if that's not for you and you still don't feel comfortable with that, we can do stool-based testing in your home and you can mail that to a lab where we can get the screening process started. So, I think those are messages that are really important, too.

Dr. Nandi:
Well, that's all the time we have for today, but I want to sincerely thank Dr. Fola May for giving us her time and giving us great practical insights on what we can do to increase colorectal cancer screening in all populations, especially in our different ethnic minorities that require better access and screening rates for colorectal cancer prevention. Dr. May, thank you so much for your time.

Dr. May:
Thank you for doing this. Thank you for having me.

Dr. Nandi:

For ReachMD, I'm Dr. Neil Nandi. To access this episode and others from GI Insights, please visit ReachMD.com/GIInsights, where you can be part of the knowledge.