Moderator Rachel Breidster: Hello and welcome to the public health live the third Thursday breakfast broadcast. I'm Rachel Breidster and I'll be your moderator. Before we get started I would ask that you fill out your online evaluation at the end of the webcast, continuing education credits are available after you take our short posttest your feedback is helpful in planning future programs I also want to let you know that planners presenters of public health live do not have any financial arrangements or affiliations with any commercial entities whose products research or services may be discussed in this activity and no commercial funding has been accepted for this activity. As for today's program we will be taking your questions throughout the hour by phone at 1-518-880-3516 or via email at phlive.ny@gmail.com. Today's program is “Saving Lives: How New York State is Increasing Colorectal Cancer Screening Rates” and our guests are Dr. Daniel Napolitano, who is the Deputy Chief Medical Officer and the Director of Primary Care at the Community Healthcare Network, and Dr. Heather Dacus who is the Director of the Bureau of Cancer Prevention and Control at the New York State Department of Health Thank you both very much for being here.

Doctors Heather Dacus & Daniel Napolitano: Thanks for having us.

RB: Heather, you can tell us about the main objectives for today's discussion.

Dr. Heather Dacus, DO, MPH: Yes, we have three main objectives today. First define the need for improving colorectal screening rates here in New York State; to describe the role multiple sectors to play in helping us achieve our goals; and identify innovative approaches to improving our rates.

RB: Now that we know what we hope to accomplish today can we talk about why is it important to talk about colorectal cancer screening.

HD: This is incredibly important topic to be discussing. First of all cancer is second leading cause of death in our nation and here in New York State. And colorectal cancer specifically is second leading cause of cancer in men and women. When we look at mortality rates for cancer, for men and women combined we see colorectal cancer is second leading cause of cancer related deaths. This is sobering information but through screening and early detection we have chance to find materially when treatment is best and chance for a cure is best, and also to prevent colorectal from happening in the first place through the identification and removal of precancerous polyps. It's important as well to discuss this topic because there's a lot of evidence around what works and doesn't work to increase rates. And we also
need multiple organization attentive to this issue if we make any headway—this is not just a drop for medical colleagues.

RB: And now, is it a statewide goal to increase colorectal screening rates.

HD: It's a statewide goal in both the state Prevention Agenda, which is the state blueprint for action to improve the health of New Yorkers, as well as New York State Comprehensive Cancer Control Plan which outlines focus areas, and goals specific to cancer. And both of these guiding documents outline target for increasing screening rates here in the state.

RB: Now, looking beyond New York State I understand there are national goal as well and I heard about the goal of 80% by 2018. Can you tell me more about that?

HD: Yes, definitely. 80% by 2018 is call to action established by the National Colorectal Cancer Roundtable, which is an organization led by American Cancer Society and Centers for Disease Control and Prevention. 80% by 2018 is challenge goal for achieving 80% colon cancer screening rate among men and women ages 50 to 75 by 2018. And the stretch goal acknowledges benefits of screening, and the gains that we can see here in New York State if we can come together to raise awareness about the importance of screening, remove obstacles and barriers that are getting in the way of people obtaining screening, and to improve work flow around preventative care over man and woman at average risk for colorectal cancer is recommended to be screening and receives that screening and receives any necessary follow up testing.

RB: Excellent. How would an individual public health agency, or perhaps organization, take part in the 80% by 2018 initiative.

HD: Well the first step is in joining initiative is to take 80% by 2018 pledge and taking this pledge means you're committed to investing more energy than ever before and focusing on colorectal screening. Nationally—and this slide is actually just a few months outdated—over 700 organization around the country signed on this this pledge. It's a large number. It's a very big initiative with a lot of momentum behind it. I'm happy to say New York State Department of Health signed this pledge but each more excited to say, that we have numerous other partners around the state that are signing on to this pledge especially just in the last month. And I want to main a few.

RB: Sure, please do.
HD: City Wide City Colorectal Coalition, C5, which is a very large organization of different partners down in New York City; Hudson Headwaters Health Network; Saratoga Hospital; Upstate Medical University; Mount Sinai; The New York State Association Of County Health Officials; multiple local health departments around the state; the majority of our cancer services program contractors here in the state; the New York State Academy Of Family Physicians; Roswell Park Cancer Institute; and recently the cities of Syracuse and Buffalo have both had their mayors sign on to the pledge. I want to highlight Buffalo because Buffalo is the first major city in the country to bring together its local health department all of its competing hospitals and insurance plans behind the 80% by 2018 initiative and it's very exciting.

RB: Excellent. And so it's good to see it's not just us talking about it but there's action and movement happening on the ground as well. What would the public health impact be if we achieved 80% colorectal screening rate?

HD: This is a great question and important one. We wonder what is the impact going to be of the things we try to do. And we're lucky that this is actually been looked at by researcher and last year was published in the Journal of Cancer using simulation modeling. It is estimated nationally we could avert approximately 280,000 new colorectal cancer cases, and prevent 200,000 colorectal cancer death if we achieve the rate by 2018. New York State it's estimated we need to reach about 1 million men and women ages 50 to 75 if we achieve that goal. So it's a daunting number, and it's really the reason why it's so great we have momentum that we have. But that we need more organizations to get behind what we're doing.

RB: Now you mentioned that that one million of folks age 50 to 75, as a state, how are we doing in getting that population of adults ages 50 to 75 screened for colorectal cancer?

HD: We have a lot of different data sources to look at both statewide and individually in private practices they can look at their own screening rates. But here in the state what we're going to be tracking to monitor our progress around this goal, comes from New York State Behavioral Risk Factor Surveillance System. Which is a telephone—landline and cellphone—survey that reaches out to New York State and asks them various questions about health behaviors. The question for colorectal cancer assesses whether men and women are up to date with screening, according to most recent screening guidelines, and we can see here on the slide in terms of screening a lot of progress has been made in the last 15 years.
And however, we're reaching a point we are really leveling off in the improvements and even for 2014 the slide goes to 2013 even when we look at data 2014 we are about the same place. We need to put a little more “umph” into our efforts if we will get over this leveling off that we're at.

**RB:** Okay. And now when we look at it in terms of across the state, what are the rates looking like?

**HD:** Yeah, so, it's great here in New York State that we have the ability every few years to look at rates at county level. And with we look at that type of things, we see there's a lot of variation. And you can see here in the slide that some counties, the ones here depicted in yellow—such as Steuben, Chautauqua and Oneida counties—they have rates that appear to be above the state average. Some counties in light green, such as Ulster Franklin and Wayne, raised between 64 and 68%. And then we have other counties in blue where rates are less than 64%. Rates vary as well when we look at colorectal screening in the New York City metro area using New York EpiQuery system. That data system measures percentage of adults receiving colonoscopy in the last ten years. And you can see here around the state there's variation. Some areas ever city have rates above 73% and others range somewhere between 57 and 78. The main point here is whether below the state average or above it everyone has room for progress and we need to do things to get us collectively to that 80% rate.

**RB:** It's a very timely conversation that we're having here today. Now, are there opportunities for success would you say here in New York State?

**HD:** There are a lot. I think it's one of the biggest reasons there is so much momentum happening across the state. New Yorkers have greater access to affordable healthcare. That's a huge factor.

**RB:** Absolutely.

**HD:** We also know screening tests are covered health benefits. So, tests are covered and the worry around insurance coverage should be a lot less now. We also have evidence-based for what exists and we'll hear about that a lot today throughout the presentation. There's also tools and resources available. We often hear from partners, “Do you have any promotional materials?” There are so many things that have been created now with tested messaging, that I'll talk about a little later, so people don't have to reinvent the wheel. The resource link attached to the Webinar today has a lot of those pieces of information. And finally as I mentioned,
there's momentum and so we're really at a place where more partners coming together create an opportunity for great improvement.

**RB:** Excellent. So it sounds like people have insurance access than would be covered for those that would like to have the screening, what does that tell us?

**HD:** So this gets another great opportunity. As I mentioned Affordable Care and screening tests that are covered. And when we look at colon cancer screening rates we see that people without health insurance and people that are not seeing a regular healthcare provider, that's where screening rates are lowest. When we look at individuals tell us they have never been screened it's interesting and this slide shows, that a lot of those individuals actually are saying they have insurance, that they have seen a regular healthcare provider and they have one, and they've been to the doctor's office. And so, what this tells us is there are many people not currently getting screened already engaged with the healthcare system. So, right at that point of care there's a lot of opportunity.

**RB:** Excellent. So Dr. Dacus you made compelling arguments here why we need a greater focus on increasing colorectal cancer screening rates. I want to turn to you, Dr. Napolitano, and ask you to give more specifics and what can you give me about the different tests used to screen for colorectal cancer and is there one option what are we looking at here?

**Dr. Daniel Napolitano, MD:** There's are a lot of options particularly three important in our sort of sanctioned by American Cancer Society and United States Preventative Task Force, that is a colonoscopy, some kind of stool-based testing—high sensitivity guaiac or fit testing—or sigmoidoscopy.

**RB:** And is one type of test performed over the others?

**DN:** Really, no. There's no really one best test. And I think that's really important message people have to hear is that there are many different test and different patients may accept different types of tests, and it may be the right test for them.

**RB:** Now, given the information that you shared, you can talk about the differences in terms of mortality or benefits of one test versus the other?

**DN:** Yeah, I mean specifically I would like to talk about colonoscopy and stool-based testing—either fit testing or guaiac-based testing. The mortality benefit, and this slide shows, really are the same for either test. So you can count
that you're going to save the same amount of lives whether you use either test. And that's sort of important message for us all to kind of hear and think about.

RB: So when you consider this information, would you say is it better for practices to offer one type of test or the other or to offer multiple tests?

DN: Well, there's lots of evidence that shows that it's bet to give options. And you know to engage your patients in care and give them a chance to make shared decision making with you really produces better results. This slide shows a study done in 2012 where people were either offered colonoscopy only, guaiac stool-based or both. If you only offer colonoscopy you get 30% of patients screened. A lot of people don't find that test acceptable they're afraid of it and the costs or barriers are too high. They will accept a stool-based test. So it's significantly jumps when you offer options to your patients.

RB: Sure. And now the differences are interesting. You can talk about what patients say they prefer across the different types of testing?

DN: Well, so, different patients are different. And every office has its own set of patients and part of what you need to do when you're looking in, and I'll talk about it more later, but is to see what your patients in your office are interested in. This slide shows that really a lot of patients will not accept a colonoscopy but would accept a test they can do in home or return to office or mail in.

RB: Let me ask you how do you have that conversation with your patients? Do you have strategies or things you think of?

DN: Yeah I think you know, what I try to do is sort of sit down with patients and say, we need to find a way to screen you for colon cancer it's an important test and test that can save your life. You can prevent cancer from ever happening or catch at early stage that it's very curable and there's different ways to get that test done. You know I always offer both colonoscopy and stool-based testing—we use in our office the FIT test which is even easier than the guaiac-based test. I'll talk about that too.

RB: The differences are interesting. Can you talk about the different fecal tests that are available, and the FIT test and how they are different than the traditional stool tests you mentioned?

DN: The traditional stool test is guaiac-based test indirectly looks for blood there
stool. FIT test is immune-chemical test looks for antibodies it has antibodies that look for human blood in your stool. The guaiac-based test, the high sensitivity test, although it can be really useful and are appropriate to use in office, can have a lot of false positives—depending what you eat and what medications you may find out you have a positive even though it's not actually true. FIT test gets rid of a lot of that. It specifically looks for blood coming from lower GI tract and it will not get confused by medications you're on or food you're eating.

RB: So in your practice you would say the FIT test may be a more accurate, positive response?

DN: I think it definitely does. And there's evidence it's more sensitive that the guaiac-based testing. It’s also easier to do. A lot of FIT tests, and there's many out there, only require one sample. The guaiac test require three. That's a barrier for some patients.

RB: There's a reason when you talk to physician about why patients are not getting screened what are physicians telling you are the reasons?

DN: A lot of studies show and a lot of us have the experience, you know, I offered this to my patient, but they just don't want to do. It a lot of people they say it's for fear. Patients are afraid of what will happen to them, and what the colonoscopy will be like, what the bowel prep will be like or financial barriers or systematic barriers—taking a day off from work and will my insurance cover it? There were issues in the past I think have been sort service straightened out around whether anesthesia aspect was covered. So people are afraid of those things and they don't want to incur costs.

RB: Now, in contrast to that, how do those barriers—this is what we're hearing from physicians—how does that compare when we talk to men and women and ask them why aren't you being screened? How do answers different?

DN: What's interesting is we think we are doing such a good job offering this test to our patients and we're trying so hard to do that. Over and over again when we poll patients they say I don't know I went to the doctor they never recommended this test to me. And so somehow there's disconnect between what we think we're doing and what patients are hearing.

RB: And that's definitely interesting information. So when you consider that, what information do patients want to receive about the test that might help facilitate the
process and increase the screening rates?

**DN:** Right. This is a really interesting slide, right. It shows some of the things patients most want to hear. They want to hear about why you're having the test—most importantly—what's it for. And I think a lot of my patients when I bring up that test they say well I don't have any pain or symptoms and I don't see blood why should I have the test. They really want to understand what the test is for and what it is good for. They also want to know, how accurate the test is and what options they have if they have options they want to hear them. And what you can see on right-hand side of the slide we do a really good job telling people how to do the test when we offer it but don't do a great job of explaining other things patients want to hear.

**RB:** All right. Now I think tying right into that the idea of maybe we're not telling patients everything they want to hear. One of the reasons it may come back to doctors are so busy with so many things they need to address this practices. So, are there strategies that you would recommend that would help make sure that we're translating or getting that information to patients and getting them the information they need to make that decision about getting screened?

**DN:** Yeah, there's a lot of evidence-based strategies to get that message across to the patients and then help close the loop for patients after you make that recommendation and ensure the test is getting done and I think the starting point is making a clear policy. You know, your office has to commit the entire office from top to bottom to a policy of colorectal cancer screening, and making it a priority. We have lots of competing priorities there's lots of good things we need do this is important one. If you have a clear policy and entire network is aware of the policy and how important it is to everyone you can pull together as a team and really help get this done.

**RB:** So talk to me about what would you say the essential elements you know if you were to develop office wide policy what are things you want to make sure are included in that policy?

**DN:** Well, so the policy should be very tangible. It should is very clear what goals are, and hopefully your goal is to have 80% screening by 2018 and it should be very laid out very clearly and methodically for your whole staff. So a flow sheet that allows you to know algorithm this is what we do, this is how we do it, and this is how we follow up on it and how to track those tests that you order and how to attract those patients who need more screening who are due for screening and those
are the sort of essential elements.

**RB:** Now once policy is established to fit the needs of a patient are there other proven interests as I practice can take to help increase screening rates within the office or practice?

**DN:** Yeah, there's two here you can see on the slide. Screening interventions that are around using small media and reminders for patient and postcards, evidence-based postcards that send a message that has been proven and is effective for the patient population you serve. Using those methods are important and also physician-based reminders. We have to sort—in the busy fast-paced office life we need our team to remind us who is due and have the entire team help us make that recommendation to the patient and keep track of them once we made the recommendation and make sure that the tests are getting completed

**RB:** Now it sounds like a lot of work for the physicians and their colleagues to put all this into place and still provide the care to their patients, right? We're continually asking people to do more work and in limited time. What do you say to somebody that presents that argument or perspective to you?

**DN:** It's valid argument right something and it's team-base add approach, it has to start from top to bottom. This has to start before your patient comes into the door with mailings and outreach and tracking. And then it has to take place in the front office where you're giving reminders, and flyers and then you need nursing staff to sort of prompt your patients, and remind them, and educate them. And then we have to sort of make that recommendation as physicians and then there has to be follow up at the end. It has to happen front to back of the office.

**RB:** If we go back to one of first slides we had beginning of show your last bullet it takes a team approach. Really that's the message you're both sending here. Let's see example of how this works in busy clinic in Rochester, New York.

<<CLIP STARTS>>

**Doctor Kevin Fiscella, MD, MPH:** So we take a team approach. Which is a very much systems approach that each person has designated role which includes medical records and it includes LPN who works with me, and of course, it includes myself. So for example, we have huddles every morning before each session and the LPN reviews the chart and looks at the chart and looks at who the needs colorectal rectal screening and then brings you up during the
huddle. And then when I see the person, I raise the question of colorectal screening. I think options are really important. I think that I found that when patients have options they are much more likely to get screened then if I give them one. Well, particularly for people who decline the colonoscopy many are willing to do the FIT. When we talk about colonoscopy and they say, “I’m not sure I’m there.” I say let's talk about the FIT. And even if you get the FIT this the year you can have a colonoscopy next year. Let's get you screened right now. The majority of people in those circumstance agree to the FIT, and get it done. The biggest barrier I think for cancer screening, and that certainly applies to colorectal cancer screening, is the need to be able to track who had the screening, and then to put that information in a place in medical record that is easily retrievable. In other words we can look at what our population wide rates are and our rates since we've implemented this team-base add approach have doubled.

At the same time we need to be reporting out how we're doing as a practice. In terms of these different measures, including colorectal cancer screening. And most of us including myself, always think that we're doing better than we are, and then when we see the data we go, “that can't be right. I know I'm doing better.” Outreach to patients is a critical part of improving rates of colorectal cancer screening. We'll never hit the 80% just by discussing colorectal cancer screening with the patients who come in to see us. What we do in own practice is have office staff call patients. We look at services patients need based on electronic medical record and preventive services including colorectal cancer screening and we can look at who is past due and who turned 50 so they aged into needing colorectal cancer screening. And then they actually call patients and say I'm calling on behalf of Dr. Fiscella and we see that are you in need of an office visit including colorectal cancer screening—would you like to make an appointment now?

<<CLIP ENDS>>

RB: So that’s a clear example of a clinic that is getting some really great work done, and getting more men and women screened for colorectal cancer, which is what we're looking for. Now, Dr. Dacus, are healthcare providers and practices alone in this endeavor in trying get this work done.

HD: They're absolutely not alone and shouldn't be alone. We spoke a little while ago about the importance of the entire clinical care team within a practice being part of the process. And for all preventative care and all care in general. Similarly when we step outside of the clinic, clinics should be support the by community
organizations that surround it and various types of organizations. On this slide we see a list of stakeholders, local documents, community organizations, academic institutions, employers. There’s a role for all of these entities to play as it relates to the colorectal cancer screening. Whether it's researching more people to educate them and promote cancer screening. Whether it’s an employer choosing to adopt a policy instead of charging for time to get screened for colorectal cancer, they may allow employees to take time to get colorectal screening test. You may be in health insurance plan and may work with your staff or some key entity to directly research—make a personal connection to the people that appear to not be getting screened. Try to assess their barriers and reduce them—maybe its transportation, maybe fear, maybe embarrassment, who knows—but making a personal connection can help. And bringing them into the medical facility. Everyone has a role to play and there's lots of resources we'll talk about them late to give some ideas to people.

**RB:** And let me ask you as follow up are some interventions those things you're seeing happening with their employers creating policies allowing people to get screenings done without charging time? Do you see health insurance providers reaching out to people? Or are these things we like to see happen?

**HD:** We do see them happening we just need them on a grander scale. We have a number of counties around the state that have taken existing public health law, and have expanded it to individuals that work in municipalities cannot only take time off to get screened for breast cancer, but to also get screened for colorectal cancer and that's a great opportunity. We have a number of cancer services, program contractor around the state engaging with employers to talk to them about the benefit of offering this kind of paid time off policy. As it relates to other question you mentioned possible insurance providers reaching out to those with barriers. We know insurance plans are doing a lot of things. They are not necessarily able to do them on a grand scale, perhaps, but making commitment and getting behind it; doing client target reminders and messages to proven top resonate with individuals to get them in.

**RB:** Now, you can talk about what you talk about barriers. You can talk in more details about the barriers we're seeing for folks getting screened.

**HD:** So Dr. Napolitano talked about what we hear from physician and patients saying the doctor never told me I need to be screened. We do know of other barriers and this is another reason why everybody on board to help address these barriers is so important. We hear from patients the fear and they don't want to
know if they have cancer, or what if they do and they can't afford treatment? The fear about cost, and now the opportunity around Affordable Care Act and health insurance benefits covering screening. That's a message to get out to the public to say, “this is a covered benefit.” And the cost issue should not be a barrier and if it is and someone doesn't have health insurance, we have the program here which provides men and women with free access to colorectal cancer screening as well as breast and cervical cancer screening. Another barrier we hear about quite often, people say, “I don't need to get tested because I don't have any problems.” Right? “I don't see a problem, so why would I go?” There's education around you know this is cancer that may not ever show symptoms unless you know, God forbid it ends up getting a later stage. And embarrassment—especially men. This is a body part people don't want it talk about, they don’t want to think about somebody examining, and they don't want to go into the bathroom and do a stool test. It’s embarrassing, so that's a factor. And then finally, people don't feel like they have a personal connection. Whether it's because they don't know anybody that ever had it, or they themselves never had it. And let's be honest here, this is not something busy people with big families are worrying about on day-to-day basis.

RB: Sure. Sound like we have significant barriers to overcome. Are there ways or strategies to address those barriers?

HD: There are a number of strategies and you know we've been talking about some of them, whether it's in clip call practice or whether it's out in the community setting, and what we know is that certain messages really work. Through focus group testing the American Cancer Society has done, and this slide here lists out messages. These are brief to the point statements that can be used either in clinical setting, or they can be used by employer to develop material or to encourage employees to talk to doctors about getting tested. It could be something that a local health department uses to build its materials, and I talked before about a lot of resources being available. I cannot understate that. People don't have to reinvent the wheel. These things exist whether on Department of Health website or National Colorectal Cancer Roundtable website, and through this webinar we have condensed resources so that people can access them quickly.

RB: Excellent, thank you. In addition to patient barriers there may be physician barriers as well and we talked about the different types that exist colonoscopy vs. the FIT test. I understand some physicians are skeptical about the accuracy or about using the fit test? Can you talk a little about that?

DN: Yeah, you know, I think that the perception has been colonoscopy is “gold
standard test” for colorectal screening, and certainly people think that's the best test 
that's what I order for my patient I will not offer a substandard version of the test. 
But there's study after study that shows that really both test save lives at the same 
rate. Colonoscopy has advantages. It can detect precancerous lesions, and if you 
have a good screening ten years later you can wait ten years for another screening; 
whereas the FIT test happens every year and doesn't really catch precancerous 
screenings, it's looking to detect early cancer—and you need to follow up with any 
positive screening FIT tests with a colonoscopy. You still have to have access. But 
you know, what people really need to hear is the message that if a patient does not 
get a test done, then there's no benefit to them. So if they're going to refuse time 
and time again instead of beating your head against the wall and saying yes to 
something they're cot comfortable you have effective test to offer them.

HD: I want to add to that, that as a state we're a big state. 
And we're a big state with variance different amounts of resources so access may 
not be available, say like in a big metro area. And that's another factor. If every 
single person that was due for colorectal cancer screening in your community, all 
got sent for colonoscopy all at once, we would overwhelm the system quite a bit. 
But acknowledging that's not a test that resonate with a lot of people, it is good we 
very options to offer them. 
And yes a positive test has to be followed up on. 
But it's a test that has been proven to reduce mortality to colorectal cancer.

RB: I think I heard the expression the best test is the test that gets done.

HD: Right, and we won't achieve rates or get out of the lull that we’re in if we 
don't have both tests being offered and both tests being provided.

RB: Thank you that's very important information. And so, let's now take a look at 
a successful program where healthcare providers are teaming up with barber shops 
to get more men screened for colorectal cancer.

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Dr. Joseph E. Ravenell, MD, MS: Back in 2011 we started the Men's Health 
Initiative. It's really focusing on increasing colorectal cancer screening in black 
men. The reason we focused on black men is because they have highest incidence 
and mortality rates for colorectal cancer. Part of that is due to the fact that black 
men are less engaged with the primary healthcare system. There's a host for 
reasons for that including access, and in many parts of the country a lack of health
insurance, but also historically there has been a lot of medical mistrust between black men and the medical community.

**Theodore Hickman, Community Health Worker:** Well, not too many people are enthused about talking about their rectum and colorectal cancer, period. We find in barbershops its environment where lots of conversations are going on. And health is one of them. What we try to do is to integrate ourselves until it the natural conversations of barbershop from health to family to community. We find that health has a wonderful fit or niche in barber shops.

**Dennis Mitchell, Barbershop Owner:** And I think the men that come in the barbershop would be willing to hear about colon cancer screening from someone they trust. And I think their barbers are a trusted factor in their life.

**JER:** Way it works we partner with barber shops and we basically come up with a time for a day or time that works best for our team to come in and do basic health promotion and patient navigation around colon cancer screening.

**TH:** The number one reason why men don't get screened for colorectal cancer is fear. Fear of the unknown. Fear of someone touching a very sensitive part of their body. That fear can paralyze someone from having a conversation and definitely going to a hospital or clinic to be screened. We found that non-clinical settings, men can be very on to talking about things they would not necessarily talk about in a hospital setting. So, non-clinical settings work to have health conversations.

**DM:** Me as a barber, how I get people to talk about certain things, believe it or not I share. Once I talk to them about certain things they'll on up about their situations. That's going on with health, relationships, everything you know? So you basically got to be a can opener man, and open them up you know and you have to know how to do that.

**JER:** We actually recently complete aid randomized control trial of the patient navigation that we do where we essentially randomized barbershop customers to usual care, or to be connected with one of our patient navigators. And we found that in the customers who received the patient navigation intervention from our navigators, they're screening at the end of six months was twice as high as those with user repair. We think that part of the success of our program has been our willingness to get out into the community to go where the target population is and also our navigators who are very skilled at clear communication. If we let people know exactly what we want them to do and why we want them to do it, I think we
can be much more successful at spreading our public health records.

<<CLIP ENDS>>

RB: And I think that was a really great example of a community and hospital partnership to really get the work done and get increase in screening rates. And what I think really strikes me about it is that it seems like a fairly innovative approach, and I wonder are there other examples you can think of to step outside traditional approach or things we usually think of?

HD: Right, we think that these kind of conversations need to happen behind a door with a physician or with a nurse—when in reality, it may be these types of non-healthcare settings where these conversations take place between real people dealing with real issues and where the decision gets made to take action on something like being screened or colorectal cancer. This was a fantastic example and Dr. Ravenell and what he's doing is amazing. We do know in other cases across the state with breast cancer, there's a lot of models in peer education where similarly people from the community go out and talk about breast cancer. And we know that some of these programs are starting to change and talk also about colorectal cancer. So for example the She Matters program out of the Upstate Medical University-area, that program is beginning to expand to accepted people out to the community to talk about colorectal cancer just like we see here. Culturally sensitive, meaningful conversations, it can really make a difference.

RB: Excellent. Now are there any resources that—and I know there are resources you mentioned it several times throughout the show—but are there resources you would like to share that you would recommend that people into to become a partner and get involved in the effort?

HD: Well, if there's anybody watching that just doesn't know where to get started there's really excellent resources from the National Colorectal Cancer Roundtable. You can see here on the slide examples of three and four pages long and target particular audiences and we see here hospitals, primary care physicians, insurers. Each goes into detail around what people can do to get started. When we look at the next slide, and the example for communities just bringing people together to take the 80 by 18 pledge is a way to get started. Knowing what your regional or county level data is. And saying, “Okay, 80% is a long way off. Maybe we're starting at 40%. We'll make efforts to reach 50%.” That's going to help no matter what. It's not about reaching 80% number it's about getting behind the effort and making improvements wherever you can. Community-based organization or local
health department can designate spokesperson and identify people who survived colorectal cancer that's powerful person to talk about colorectal cancer and that kind of organization can make headway. For employers, we talked a bit before about what they can do with the paid time off policy. But even going so far as to educate employees about wellness in general, and colorectal cancer screening, and making it the kind of environment we're talking about that kind of thing is not taboo—making it comfortable conversation—these are really important aspects.

**RB:** Now it's great to know these types of resources exists and you mentioned earlier not having to reinvent the wheel. Given everyone being so busy and pressed for time it's great to know resources already exist. Dr. Napolitano, you work in a city with the New York City Community Cares Project. You can tell me about that project and how it is example of a team effort that is working to help ensure people get screened.

**DN:** Yeah so, my office system is a community health network. So it's FQHC the most underserved populations of New York City—we're one of those organizations. Our patients have particular par years. We're seeing patients who are uninsured or undocumented or really have major cost barriers as well as socioeconomic barriers. So the Community Cares Project is great linkup funded by state and national government by ACS to bring us together with endoscopists that will perform colonoscopies for free, for those not insured. It’s an amazing project where bridge are made and a lot of facilitation happens to help them get to appointment, keep appointment. It's been successful. I think there's room to grow with it.

**RB:** That's excellent to hear about everybody coming together and seeing increase in the payoff and the efforts. Now, are there other resources that wow recommend to clinical colleagues?

**DN:** I would. You know, there are also tool kits specifically designed for community health centers. As I said, we have a different set of barriers that really can be spoken to specifically, so, the American Cancer Society created a tool kit specifically for community health centers with similar messages that helps you get started, how to do tracking and recall, and how to just boost those numbers.

**RB:** And before we turn to audience for questions let me ask you both for parting words you may have or key messages you may ensure at the end of today's webcast, our viewers are taking away. I'll start with you Dr. Napolitano.
DN: The 80 by 2018 initiative is a very ambitious one, but it can be done. Our colleague from the American Cancer Society goes around nationally and talks about. Together if we believe we can do it and we all do it we can see great results from it!

HD: I would add to that and say, clearly, the care team, community team, we all need to work together to reach that goal. And then this issue around offering options to individuals around what tests that are available. Again, we're not going to achieve any improvements if we don't have both tests being actively recommend

RB: Excellent. Thank you both for the information you shared. We have quite a few questions from our audience. Let's start taking some of those. First question, have presenters heard of any barriers arising with insurance coverage for colorectal cancer screening that occurs outside ever the recommendations of the USPSTS? For example, what happens if someone is African-American and has a family history of colorectal cancer but is only 45? Given that USPSTF recommendations cover ramming under ACA, would the test still be covered?

DN: I can feel a little bit of that and Dr. Dacus could as well. When we're talking about screening we're talking about average risk, no personal history or family history of colon cancer and fit test and colonoscopy between 50 and 75 is sort of that subject. But there are people at high risk. They do need colonoscopies and usually that's better test rather than offering FIT test and sometimes they need to be seen earlier…Specifically if coverage I have not personally had coverage issues, I don't know in Dr. Dacus knows anything about policy, but risk strategies and ensuring it can usually assure that the test gets done.

HD: I have not heard of any specific issued of coverage not applying when issues of risk is involved. Clearly as Dr. Napolitano said you can be at average risk, low risk or high wrist. What we want to do is get people to the right point of care. And USPSTF guidelines are being used to inform what health insurance should cover as far as preventative care is concerned. But the task force itself is not the body to decide what insurance should pay for or not. You know, that's really a conversation for health benefits group as a health insurance plan and if people are worried about specific plans, they should reach out to them and see what information they can get. And if there's issues or concerns, then maybe bring them to our attention at the health department so we could look into them.

RB: Next question we have, can you talk a bit more about patient navigation and how it works?
**DN:** Yes, patient navigator right is a great evidence-based approach to helping patients get the test done you want to have done for them. So there are some grants available for community health centers to have patient navigators in their offices and you know the navigator can really guide patients throughout process. You can make the recommendation, but a lot of times people leave the door without help to overcome those barriers and test won't get done. So navigators can spend extra 45 minute sitting with a patient educating them further and answer answering more questions you didn't have time to address in full detail. And also figuring out barriers in helping people overcome them. There can be official navigators and health home agents that contact help people do that and nurse can help be navigators if you have the funding to do it.

**RB:** Great. Next question we have, what do you think can be done about the situation where a screening colonoscopy, a covered procedure, turns into diagnostic colonoscopy where a patient will be required to pay towards deductible? For example, the more polyps found in the procedure, the more the patient will have to pay. This is becoming significant barrier.

**HD:** There's different ways this is being handled whether Medicare or private insurance. It's one of those situations nationally we're really trying to promote that screening is continuum. If you go for screening test you should not wake up with a bill in your hand when you went in thinking it was a covered benefit. And so in some cases this barrier has been addressed in others that have not. Nationally there are efforts to help address it and change it, and here in New York we are having those conversations to see what we can do about it.

**RB:** Great. The next question we have are patients aware they're at risk each if there is no family history?

**DN:** Well I think that's a good question. I think you know it depends on the patient. I think there's lots of risks that patient don't you know besides family history that patients might not know about. People with inflammatory bowel disease increased risk from people who don't have inflammatory bowel disease. Sometimes people don't know their family history. Some are adopted or didn't get information from one side of family and that gets to be difficult. That's part of the sort of art of medicine is to get that information from your patient and help them find out that information and take more interest and ask their family.

**HD:** And also, actually, this raises another point for me that is interesting. There's
concerns about individuals diagnosed with colorectal cancer before age of 50 where there was not a history or risk factors like inflammatory bowel disease. That's an issue looked at by the National Colorectal Cancer Roundtable. We have experts here in New York City looking at it. If somebody is experiencing symptoms and bleeding and darker stools, etc. that's something they should bring to attention of doctor sooner rather than later. I had a friend diagnosed at age of 34. No family history. She went in and had symptoms and the doctor looked into it right away. There's that factor and people should be aware symptoms are important to be attentive to.

RB: Absolutely. Another question, within 50 to 75 gear age group are their populations more at risk than others? You spoke a little about that.

DN: The African-American, especially the male population, is at a higher risk for detection colorectal cancer and late detection due it access of care. So there are risk factors besides that and taking place and you have to be aware of them.

RB: Can FIT tests be completed in the medical office while the patient is there?

DN: It's a good question. No is the short answer. Back in the day there was thought of doing rectal exam in office as a screening test, which is sort of similar to I think what this question is asking. Here where do you rectal scam and put the stool on the card yourself that's proven not to be effective method for screening. You do need to send people home with the kit.

HD: We're hearing about interesting project that are being researched with these “one sample FIT tests” where practices are—you know, again, you have to depend on somebody needing to use bathroom then and there in your office and to actually have the test be completed. Being able to promote that we would need to see more evidence for what project are finding and at this point I agree with Dr. Napolitano in office testing is not colorectal cancer screening.

RB: Okay, thank you. What new tests are on the horizon, and are they covered by insurance?

DN: I mean I think we were expecting that question because there's a lot of excitement around stool DNA testing—I think that's the one people are excited about. There are insurance barriers, I believe it's been accepted by Medicare and some private insurances depending. It's very expensive test, and promising test. But currently we just don't all the evidence there to sort put it on the list of three
accepted screening methods that are the most effective to reduce mortality but it looks promising.

**RB:** Excellent.

Let's see, where we should start about we want our organization to take 80% by 2018 pledge?

**HD:** Thank you that's a great question.

If individuals were to go and Google or look at the National Colorectal Cancer Roundtable, I think it's NCCRT.org, they can go on that organization's website and find the link—it's prominent—where they can click to sign the pledge. They can download a form and complete the form and submit the form. We would love the health department to know whether someone in the state has taken the pledge, just so we can keep track and be aware and even give a shout-out to congratulate organizations for taking the pledge. That's where I would start the National Colorectal Roundtable.

**RB:** Few more…now, Dr. Dacus you can talk more about what paid time off for cancer screening means in employer setting, doesn't sick time offer cover that?

**HD:** I said this previously before but I think I said it rather fast. The difference here for paid time off for cancer screening or any preventative screening would be rather than charging sick time or vacation time, people may be more encouraged to go get colorectal cancer screening test in this case, if they knew they didn't have to charge their otherwise potentially limited or valuable vacation and stick time. So it's added benefit and organizations are doing it, people are taking advantage of it, and it really is a nice way to remove another barrier.

**RB:** Great. We have just a couple more here. Is there anything that can be done to prevent colorectal cancer other than screening?...That's a big question.

**DN:** Diet seems to play some role. So diets heavy in meats may have a role to increase chances of colorectal cancer. I mean almost always the answer is quit smoking. If you're smoker for almost any cancer. Regular, daily exercise has proven benefits, too.

**HD:** We know obesity is a risk factor for many cancers including colorectal cancer that issue of eating well and being active is really a way to help add some protective factors—maybe not a guarantee, but certainly a way to reduce risk.
**RB:** I believe that might be our last question. So, thank you both very much for all of the information you have shared. Is there any other information you'd like to share before we close out the show?

**DN:** I want to thank you for having us here today. It's really my pleasure.

**HD:** It's a great opportunity thanks for having us.

**RB:** It was a great time to have this conversation we had a trend rate were going up and plateaued and hopefully this conversation will jump start folks to seeing numbers increase hit that 80% goal. And thank you very much for joining us today. Please remember to fill out your evaluations online. Your feedback is always help full to the development of our programs and continuing education credits are available. To obtain nurse continuing education hours, CME and CHES credits, learners must visit www.phlive.org and complete an evaluation and post-test for today's offers. And additional information on upcoming web casts and relevant public health topics can be found on our Facebook page—don’t forget to like us on Facebook to stay up to date! This webcast will be available on demand in our web site two weeks from today's show. I'm Rachel Breidster, thanks for joining us on Public Health Live!