INNOVATIVE WAYS TO INCREASE COLORECTAL CANCER SCREENING AMONG THE UNDERSERVED

FEBRUARY 20TH, 2018
3:00 PM ET
Purpose of Today’s Webinar

• Learn how to move beyond describing the challenges of reaching the underserved to implementing innovative solutions.

• Hear from three experts who are leading strategies that are seeing success in priority communities.

• Q&A
Presenters

Joseph Ravenell, MD, MS (Presenter/Moderator)
NYU School of Medicine

Karen E. Kim, MD
University of Chicago Medicine
Comprehensive Cancer Center

Jenna Hatcher, RN, PhD, MPH
University of Kentucky, College of Nursing
Searchable Resource Center

nccrt.org/resource-center
Partnership between an Academic Medical Centers And Local Health Departments: The New York City Experience

Joseph E. Ravenell, MD, MS
Associate Professor of Medicine & Population Health
Associate Dean of Diversity Affairs and Inclusion
Director, Center for the Elimination of Cancer Disparities
Perlmutter Cancer Center
New York University School of Medicine
CRC Mortality Disparity

Death Rate from Colon Cancer

Deaths per 100,000

Black Men: 32
White Men: 22
CRC Mortality in Black Men: Contributing Factors

- Black men less likely to have screening colonoscopy before age 65 (NYC DOH, 2008)

- Blacks less likely to have diagnostic colonoscopy after abnormal screen (Laiyemo et al. 2010)
Barriers to Colon Cancer Prevention

CRC-screening eligible Black Men

CRC-screened Black Men

Cost/Access Fear

Lack of Navigation

Colonoscopy Referral

Healthcare-Seeking Behavior

Healthcare System

Regular MD

Therapeutic Inertia
Black men are less likely to have a primary care provider

Arch Intern Med. 2008;168(12):1285-1293
How can we reach Black Men?
Place-based Interventions
Why Barbershops?

• “The Black man’s Country Club”
• Relaxed non-medical atmosphere
• Frequent follow up (q 1-4 weeks)
• Tradition of “Barber Surgeons”
• Barbers as key opinion leaders (“important others”; set social norms)

“shops are and always have been places where black men could feel free to discuss anything and everything – without the interference and censorship found in other public forums”
– NPR radio, Pittsburgh
Can we identify unscreened men and ‘navigate’ them from the community?

CRC-screening eligible Black Men

CRC-screened Black Men

Cost/Access
Fear

Lack of Navigation

Physician Inertia

Colonoscopy Referral
The NYU Men’s Health Initiative

BARBERSHOP
Know more about the study

BARBERSHOP
Looking for more information about how to get involved with the study

CHURCH OR MOSQUE REP.
Learn how to get your community involved with the study.

BLACK MAN AGED 50+
Find out where to go to participate in the study.
NYU Men’s Health Initiative Research Program

Church-based Study (R01HL096946, NHLBI)

24 Churches in Central Harlem

Randomize CHURCHES within pairs (stratify by size and number of paid clergy)

12 Matched Church Pairs

HTN Intervention CRC Usual Care (n=240 men)

12 more Churches

CRC Intervention HTN Usual Care (n=240 men)

12 more Churches

HTN Intervention PLUS CRC Intervention (n=240 men)

6 more Church Pairs

Baseline Assessment

HTN Intervention PLUS CRC Intervention (n=240 men)

Barbershop-based Study (P60MD003421, NCMHD)

Men from 24 Barbershops referred to mobile van

Enroll eligible men for study (Age ≥ 50, black, male, BP uncontrolled)

Randomize consenting eligible men

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CRC Intervention (n=240 men)

Baseline Assessment

6 Month Assessment of Primary Outcomes (Within-person BP Change and Completed colonoscopy)

NYU PRC Comparative Effectiveness Research Program

NYU Men’s Health Initiative Research Program

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Baseline Assessment

6 Month Assessment of Primary Outcomes (Within-person BP Change and Completed colonoscopy)

NYU PRC Comparative Effectiveness Research Program
**Patient Navigation Intervention**

**Session 1:**
- Education on CRC and need for screening
- Elicit barriers
- Assess readiness

**Follow-up Sessions:**
- Revisit barriers
- Assist with scheduling
- Navigate to appropriate screening facility
- Check in prior to screening
- Check-in after screening to debrief

**Session 1**
Within 2 weeks of baseline interview

**Follow-up Sessions**
As needed for duration of study period (~3)
MAP OF SITE LOCATIONS

- Barbershop
- Church Site
- Social Services Organization
- Mosque
- Food Pantry/Soup Kitchen
- Community Health Fair/Festival
### Characteristics of Unscreened Men

<table>
<thead>
<tr>
<th>Demographics</th>
<th>Mister B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (Mean in years)</td>
<td>55.1</td>
</tr>
<tr>
<td>Highest Grade or Year of School</td>
<td></td>
</tr>
<tr>
<td>Less than HS</td>
<td>29.4</td>
</tr>
<tr>
<td>HS Grad or GED</td>
<td>40.3</td>
</tr>
<tr>
<td>Some college or more</td>
<td>30.3</td>
</tr>
<tr>
<td>Born in the United States</td>
<td>72.5</td>
</tr>
<tr>
<td>Generally speaks English at home</td>
<td>90.9</td>
</tr>
<tr>
<td>Marital Status</td>
<td></td>
</tr>
<tr>
<td>Married or living with a partner</td>
<td>25.2</td>
</tr>
<tr>
<td>Divorced</td>
<td>17.9</td>
</tr>
<tr>
<td>Widowed</td>
<td>6.7</td>
</tr>
<tr>
<td>Separated</td>
<td>10.4</td>
</tr>
<tr>
<td>Never Married</td>
<td>39.6</td>
</tr>
</tbody>
</table>
### Characteristics of Unscreened Men

<table>
<thead>
<tr>
<th>Demographics</th>
<th>Mister B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employment</td>
<td></td>
</tr>
<tr>
<td>Employed for wages</td>
<td>21.1</td>
</tr>
<tr>
<td>Out of work less than 1 year</td>
<td>10.8</td>
</tr>
<tr>
<td>Out of work for 1 year or longer</td>
<td>34.8</td>
</tr>
<tr>
<td>Retired</td>
<td>12.1</td>
</tr>
<tr>
<td>Unable to work</td>
<td>11.5</td>
</tr>
<tr>
<td>Annual household income (sd)</td>
<td>17,003 (18,883)</td>
</tr>
<tr>
<td>Currently uses tobacco products</td>
<td>45.1</td>
</tr>
</tbody>
</table>
**Difference remains significant after adjusting for education, health literacy, insurance status, having a personal doctor, neighborhood poverty and neighborhood segregation**
• Participants who received the Patient Navigation Intervention were **more than twice as likely** to get screened as those who didn’t get navigation.

• Screening rates were similar to those in past studies.

• Intervention was equally effective for those with no insurance and those with inadequate health literacy.
Community-Based, Preclinical Patient Navigation for Colorectal Cancer Screening Among Older Black Men Recruited From Barbershops: The MISTER B Trial

Helen Cole, DrPH, Hayley S. Thompson, PhD, Marilyn White, MD, Ruth Browne, PhD, Chau Tinh-Shevin, DrPH, Scott Braithwaite, MD, MS, Kevin Ficella, MD, MPH, Carla Boutin-Foster, MD, MS, and Joseph Ravenell, MD, MS

Objectives. To test the effectiveness of a preclinical, telephone-based patient navigation intervention to encourage colorectal cancer (CRC) screening among older Black men.

Methods. We conducted a 3-parallel-arm, randomized trial among 731 self-identified Black men recruited at barbershops between 2010 and 2013 in New York City. Participants had to be aged 50 years or older, not be up-to-date on CRC screening, have uncontrolled high blood pressure, and have a working telephone. We randomized participants to 1 of 3 groups: (1) patient navigation by a community health worker for CRC screening (PN), (2) motivational interviewing for blood pressure control by a trained counselor (MINT), or (3) both interventions (PLUS). We assessed CRC screening completion at 6-month follow-up.

Results. Intent-to-treat analysis revealed that participants in the navigation interventions were significantly more likely than those in the MINT-only group to be screened for CRC during the 6-month study period (17.5% of participants in PN, 17.8% in PLUS, 8.4% in MINT; P<.01).

Conclusions. Telephone-based preclinical patient navigation has the potential to be effective for older Black men. Our results indicate the importance of community-based health interventions for improving health among minority men. (Am J Public Health. Published online ahead of print July 20, 2017: e1–e8. doi:10.2105/AJPH.2017.303885)
Welcome to the

Communities Partnering in Navigation in New York City Program

We partner with patients to help navigate colorectal and breast cancer screening resources in New York City communities.

The Communities Partnering in Navigation in New York City Program at NYU Langone’s Perlmutter Cancer Center helps people in medically underserved areas of New York City access screening for colorectal cancer and breast cancer, regardless of their income or insurance status.
Additional Funding— NYC DOHMH

• Funded by New York City Department of Health & Mental Hygiene (NYC DOHMH)

• Project Title: *Communities Partnering in Navigation in New York City*

• Three year grant; $1,350,000 annually

• Expands work of the Men’s Health Initiative

• Aims to refer 10,000 medically underserved individuals to breast and colorectal cancer screenings

• Funds five NYU navigators and two navigators from community partner organizations
ACKNOWLEDGEMENTS

• Men’s Health Initiative team
• 200+ community partners
• 7000+ participants in the Initiative
• CCSG Pilot Funding (P30CA016087-35)
• NIH/NIMHD (P60MD003421)
• NIH/NHLBI (R01HL096946)
• Centers for Disease Control and Prevention (1U48DP002671)
• Center for the Elimination of Cancer Disparities
• New York City Department of Health and Mental Health
• Beatrice W. Welters Breast Health Outreach Program
Utilizing HIT to increase CRC screening and reduce health disparities among vulnerable populations

Karen E. Kim, MD
Professor of Medicine
Associate Director, UC Comprehensive Cancer Center
PI, Cook County CARES
University of Chicago
THE BURDEN OF COLORECTAL CANCER IS UNNECESSARY

16 EACH HOUR

44/MIN NOT BEING SCREENED

2MM IN ILLINOIS
Illinois Facts

Colorectal Cancer
Incidence Rates* by State, 2014†

Illinois ranks in the last quartile (42.1% to 49%) for CRC screening rates across the nation.

Chicago Demographics
- 37% African American
- 27% Hispanic
- 6% Asian

* Rates are per 100,000 and are age-adjusted to the 2000 U.S. standard population.
† Rates are not shown if the state did not meet USCS publication criteria or if the state did not submit data to CDC.
University of Chicago Medicine Center (UCMC)

- The UCMC is located on the Southside of Chicago is one of two NCI-designated Comprehensive Cancer Centers in Illinois.
- This area is one of the nation's largest contiguous urban African American communities (72% of 1.1 million people).
- Seven of the 8 poorest communities in Chicago are found on the Southside; 5 of these border the University campus.
Illinois CRCCP Program: Snapshot

Year 1 Clinic Partners Demographics: Multi Ethnic Sites

University of Chicago Medicine
- 10,974 CRC patients at baseline
- 66% Baseline screening rate

Clinic A
- 3,570 CRC patients at baseline
- 29% Baseline screening rate

Clinic B
- ~1400 CRC patients at baseline
- 16% Baseline screening rate

Clinic C
- 2,750 CRC patients at baseline
- TBD - Baseline screening rate

Current
- 66%
Current
- 51.4%
Current
- 49.6%
Current-NA

2 New Sites Added
Screening rates vary by community

BRFSS: Colorectal Cancer Ever Tested Screening Rate

Source: Small Area Estimates for Cancer-Related Measures (NIH), State Cancer Profiles (CDC, National Cancer Institute), American Community Survey, 2011-15 (US Census), CAHE/AHC data, ReferenceUSA (business database)
Source: Small Area Estimates for Cancer-Related Measures (NIH), State Cancer Profiles (CDC, National Cancer Institute), American Community Survey, 2011-15 (US Census), CAHE/AHC data, Reference USA (business database)
What are key health system barriers that need to be addressed to increase screening and optimize quality services?

<table>
<thead>
<tr>
<th>Providers</th>
<th>Patients</th>
<th>Hospitals</th>
<th>Society</th>
</tr>
</thead>
<tbody>
<tr>
<td>Variable connections between systems</td>
<td>No point of service Specialty scheduling</td>
<td>Unfilled capacity</td>
<td>Lack of Screening</td>
</tr>
<tr>
<td>Inefficiency and inadequate communication</td>
<td>50% referrals fail to result in a procedure</td>
<td>Uncaptured revenue</td>
<td>COLON CANCER</td>
</tr>
</tbody>
</table>
Failed Information Transfer is the Blame Game

- > 50% of referring providers had no communication with the specialist
- 45% of specialists do not send information back to the referring provider
- 25% of information from specialist arrive too late for medical decision making
What are key health system barriers that need to be addressed to **increase** screening and **optimize** quality services?

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<tr>
<td>Variable connections between systems</td>
<td>No point of service</td>
<td>Unfilled capacity-up to 24%</td>
<td>Lack of Screening</td>
</tr>
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<td>Inefficiency and inadequate communication</td>
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</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>COLON CANCER</td>
</tr>
</tbody>
</table>
A typical day in the procedure Unit?

<table>
<thead>
<tr>
<th>Time</th>
<th>Room</th>
<th>Procedure</th>
<th>Anesthesia</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:15</td>
<td>OPD</td>
<td>Gi Colonoscopy</td>
<td>NO ANES</td>
<td>N/A</td>
</tr>
<tr>
<td>9</td>
<td>LE</td>
<td>Gi Colonoscopy</td>
<td>NO ANES</td>
<td>N/A</td>
</tr>
<tr>
<td>9:30</td>
<td></td>
<td>Gi Colonoscopy</td>
<td>NO ANES</td>
<td>N/A</td>
</tr>
<tr>
<td>11:15</td>
<td></td>
<td>Gi Colonoscopy</td>
<td>NO ANES</td>
<td>N/A</td>
</tr>
<tr>
<td>12:30</td>
<td>C5-26</td>
<td>Gi Upper GI Endoscopy</td>
<td>NO ANES</td>
<td>N/A</td>
</tr>
<tr>
<td>13:30</td>
<td></td>
<td>Gi Colonoscopy</td>
<td>NO ANES</td>
<td>CCD-A</td>
</tr>
<tr>
<td>14:30</td>
<td></td>
<td>Gi Colonoscopy</td>
<td>NO ANES</td>
<td>CCD-A</td>
</tr>
<tr>
<td>15:15</td>
<td></td>
<td>Gi Colonoscopy</td>
<td>NO ANES</td>
<td>N/A</td>
</tr>
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On average - 10 cases/room/day
What are key health system barriers that need to be addressed to increase screening and optimize quality services?

Providers
- Variable connections between systems
- Inefficiency and inadequate communication

Patients
- No point of service
- Specialty scheduling
- 50% referrals fail to result in a procedure

Hospitals
- Unfilled capacity
- Uncaptured revenue

Society
- Lack of Screening
- COLON CANCER
The problem
1 year delay in screening increases cancer risk twofold

Complete Diagnostic Exam

47%

Miglioretti et al. Med Care, 2008
Specialty Care: Broken System

The System was never broken. It was built this way.
Cloud based portal (Gaps in Service-Specialty) is an end-to-end solution for linkage to specialty care services

Innovative web-based HIPAA-compliant software:

- Connects out-of-network (decentralized) healthcare systems
- Provides physician-to-physician communication
- Linkage to specialty care services with follow-up reporting
Here’s how it works?

Hospital allocates procedure slots ➔ Clinic schedules appointment ➔ Patient completes colonoscopy ➔ Clinic receives Results and quality benchmarks

To fill capacity ➔ Before patient leaves clinic ➔ Reducing colorectal cancer risk ➔ Closing the information loop
Illinois Colon Cares: Concept

- Patient Needs Colonoscopy
- Hospital has open/unfilled Slots
- Hospital Donates slots

Center for Asian Health Equity
Asian Health Coalition
University of Chicago Medicine

Gaps In Service
CRCCP Sites

1. The University of Chicago Medicine
2. Swedish Covenant Hospital
3. Rush University Medical Center
4. Friend Family Health Center
5. Heartland Health Centers
6. Serving the Uninsured Community Health
Acknowledgements

➢ Matt Johnson, MPH - Program Director, Cook County CARES
➢ Fornessa Randal, MCRP - Project Manager, Cook County CARES, Project Lead, ILColonCares.org
➢ Sachin Shah, MD, Informatics Director, EHR Specialist
➢ Mike Quinn, PhD - Evaluation Specialist, Behaviorist
➢ Chieko Maene, MS - Data Analyst, GIS Specialist

Funding by Center for Disease Control grant number: 5 NU58DP006079-03-0
Promoting Colorectal Cancer Screening in Rural Emergency Departments

Jennifer Hatcher, RN, MPH, PhD
Associate Professor
Director of Diversity & Inclusivity
College of Nursing
University of Kentucky
Why the Emergency Department?

- 100 million ED visits per year in the U.S.
- 1 in 5 Americans visit at least once a year (20%)
  - African Americans and other minorities more likely to visit
  - As income decreases likelihood of one or more visits increases
- Wait times for non urgent care are often more than 3 hours
- Teachable moment (heightened attention to health care enhancing receptivity to medical recommendations)
Why a Rural Emergency Department?

- Residents of rural Appalachia have a higher incidence and mortality rate from CRC than residents of other regions of the country.
- A primary barrier to screening is limited access to the health care system resulting in infrequent recommendations for screening and inadequate screening education.
- More than half of all rural ED visits are low severity cases.
- More than half of all rural ED low severity cases occur during business hours.
Establishing Feasibility

• Pilot survey of interest at Academic Medical Center Emergency Department
  • 197 women convenience sample of women seated in the ED
    • 15% had never had a mammogram
    • >50% out of compliance with current guidelines
    • ¾ were somewhat to very interested in receiving information while they waited

• SEEDS (Sisters Educated in Emergency Departments)

Specific Aims

❖ Adapt and pilot a tailored intervention to promote CRC screening in a rural Appalachian Kentucky ED in order to
  ❖ A) evaluate feasibility of providing a cancer screening promotion intervention in an ED that serves a rural community
  ❖ B) assess the effects of the intervention on barriers to CRC screening, stage of readiness to screen and CRC engagement.

❖ Long term goal of the project is to eliminate the inequitable burden of CRC experienced by rural Appalachian residents by increasing screening
Setting

- Rural Appalachian KY Emergency Department
- St. Clair Hospital Morehead KY
  - Largest rural hospital in Northeastern Kentucky
  - Serves 11 rural counties and 160,000 persons
  - 23 bed ED (serving more than 30K per year)
- Hazard Appalachian Regional Hospital
  - Largest provider of care in Southeastern Kentucky
  - 24 Bed ED (25-35K patients per year)
Intervention protocol

• Establish eligibility
• Randomize to control or intervention
• Control: Brochure on CRC
• Intervention: Motivational Interview (MI) with resource assistance
• One week follow up: MI reinforcement and resource assistance
• Three month follow-up call
• Six month follow-up call
Protocol

Establish eligibility
Baseline interview
Randomization
Intervention
One week telephone follow up MI

- 50+ years old
- No history of CRC
- No cognitive impairment
- English speaking
- Has not had CRC screening according to guidelines
<table>
<thead>
<tr>
<th>Variable</th>
<th>Treatment Mean (±SD) or N (%)</th>
<th>Control Mean (±SD) or N (%)</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td>57.25 (±8.40); range 50-84</td>
<td>58.44 (±9.17); range 50-84</td>
<td>.60</td>
</tr>
<tr>
<td><strong>Race/ethnicity</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White or Caucasian</td>
<td>93 (96.9)</td>
<td>94 (98.9)</td>
<td></td>
</tr>
<tr>
<td>Hispanic</td>
<td>2 (2.1)</td>
<td>1 (1.1)</td>
<td></td>
</tr>
<tr>
<td>African American</td>
<td>1 (1.0)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>62 (64.6)</td>
<td>50 (52.6)</td>
<td>.08</td>
</tr>
<tr>
<td>Male</td>
<td>34 (35.4)</td>
<td>45 (47.4)</td>
<td></td>
</tr>
<tr>
<td><strong>Relationship Status</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single, never married</td>
<td>11 (11.5)</td>
<td>7 (7.4)</td>
<td>.66</td>
</tr>
<tr>
<td>Married/living with significant other</td>
<td>45 (46.9)</td>
<td>52 (54.7)</td>
<td></td>
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<tr>
<td>Divorced/Separated/Widowed</td>
<td>36 (37.5)</td>
<td>35 (36.8)</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>4 (4.16)</td>
<td>1 (1.1)</td>
<td></td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than high school</td>
<td>27 (28.1)</td>
<td>28 (29.5)</td>
<td>.46</td>
</tr>
<tr>
<td>Completed high school or GED</td>
<td>42 (43.8)</td>
<td>41 (43.2)</td>
<td></td>
</tr>
<tr>
<td>Some College</td>
<td>21 (21.9)</td>
<td>18 (18.9)</td>
<td></td>
</tr>
<tr>
<td>Completed College Degree or Post Graduate</td>
<td>4 (4.2)</td>
<td>8 (8.4)</td>
<td></td>
</tr>
<tr>
<td><strong>Income</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>≤ $19,999</td>
<td>28 (29.1)</td>
<td>35 (36.8)</td>
<td>.46</td>
</tr>
<tr>
<td>$20,000 - $39,999</td>
<td>18 (18.8)</td>
<td>16 (16.8)</td>
<td></td>
</tr>
<tr>
<td>≥ $40,000</td>
<td>9 (9.4)</td>
<td>7 (7.4)</td>
<td>.87</td>
</tr>
<tr>
<td>Other</td>
<td>41 (42.7)</td>
<td>37 (38.9)</td>
<td></td>
</tr>
<tr>
<td><strong>Health Insurance</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No Insurance</td>
<td>24 (25.0)</td>
<td>21 (22.1)</td>
<td>.73</td>
</tr>
<tr>
<td>Government Insurance</td>
<td>72 (75.0)</td>
<td>74 (77.9)</td>
<td></td>
</tr>
</tbody>
</table>
Baseline results

Barriers to Screening

- Fear (50.8%) of the test result & fear of pain (50.3%)
- Cost (48.7%) regardless of insurance status

Baseline CRC Screening Status

<table>
<thead>
<tr>
<th>Ever screened</th>
<th>Treatment</th>
<th>Control</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>4 (4.2%)</td>
<td>6 (6.3%)</td>
</tr>
<tr>
<td>No</td>
<td>92 (95.8%)</td>
<td>88 (92.6%)</td>
</tr>
</tbody>
</table>
Conclusions

- Non-urgent ED users are not being screened regularly
- Using ED to conduct this intervention is feasible
- LHWs are effective in this setting
- There are both benefits and challenges to CRC screening promotion in the ED
Challenges

- Transient population
- Fidelity to the protocol
- Contamination
- Privacy
Benefits

- Reaching hardest to reach
- Emergency Department Staff
- Community Health Workers
Discussion & Questions
Please submit your questions in the chat box.
Join Us for the Following Upcoming Event:

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Thank You!

- Joseph Ravenell, MD, MS
- Karen E. Kim, MD
- Jenna Hatcher, RN, PhD, MPH