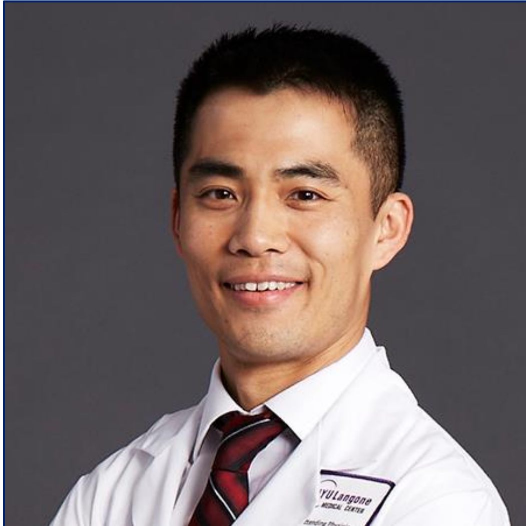
Armchair Conversation on Colorectal Cancer Health Equity: Barriers and Solutions to Reaching Asian American Communities for Colorectal Cancer Screening

2:20 PM – 3:30 PM

Armchair Conversation on Colorectal Cancer Health Equity



Moderator
Peter Liang, MD, MPH
NYU Langone Health

Christina Wang, MD
Icahn School of Medicine at Mount Sinai

Samar Aslam, MD
Advocate Primary Care

Esther Hyun
Colorectal Cancer Survivor

American Cancer Society | National Colorectal Cancer Roundtable

The Challenge of Discussing Asian Americans

Peter Liang, MD, MPH
NYU Langone Health

The challenge of discussing Asian Americans

Ancestry

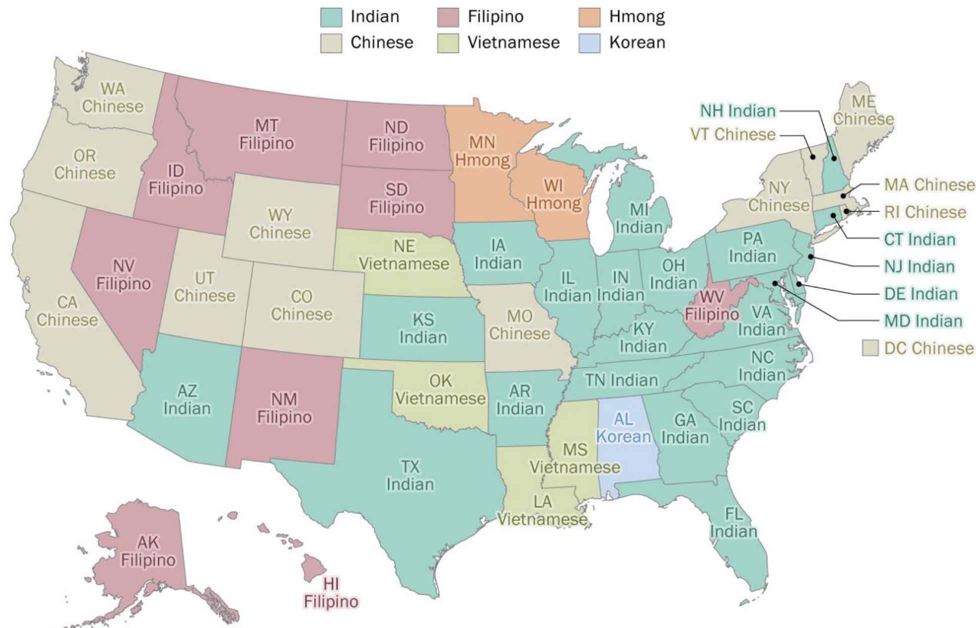
49 countries, which account for 60% of world population

Hundreds of languages

Source: Wikipedia

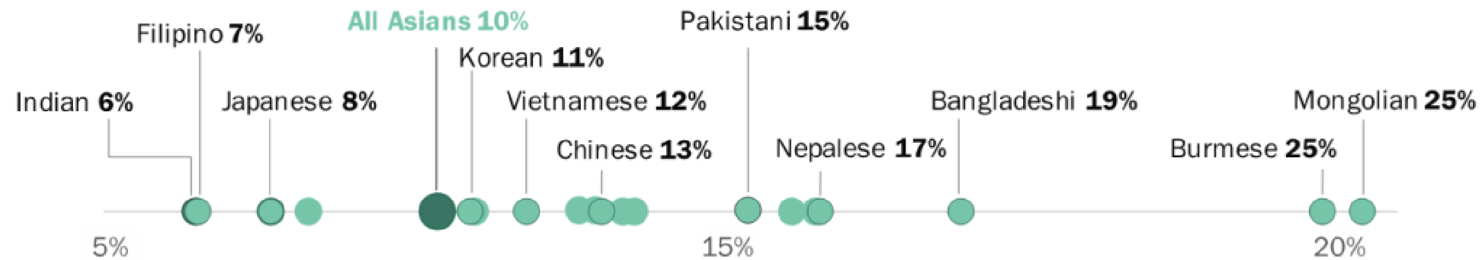
25.9 million Asian Americans = 7.2% of US population

Includes groups with >4 million (Chinese, Indian, Filipino) & groups with <40K (Mongolian, Bhutanese, Kazakh)



57% foreign born

Wide disparities in English proficiency, education, and income



Sources: Wikipedia, Pew Research Center

Thank You

Barriers and Solutions to Reaching Asian American Communities: NCCRT 2024

Christina Wang, MD
Assistant Professor of Medicine
Division of Gastroenterology
Co-Chair, Education and Research Committee
Center for Asian Equity and Professional Development
Icahn School of Medicine at Mount Sinai

Disclosures

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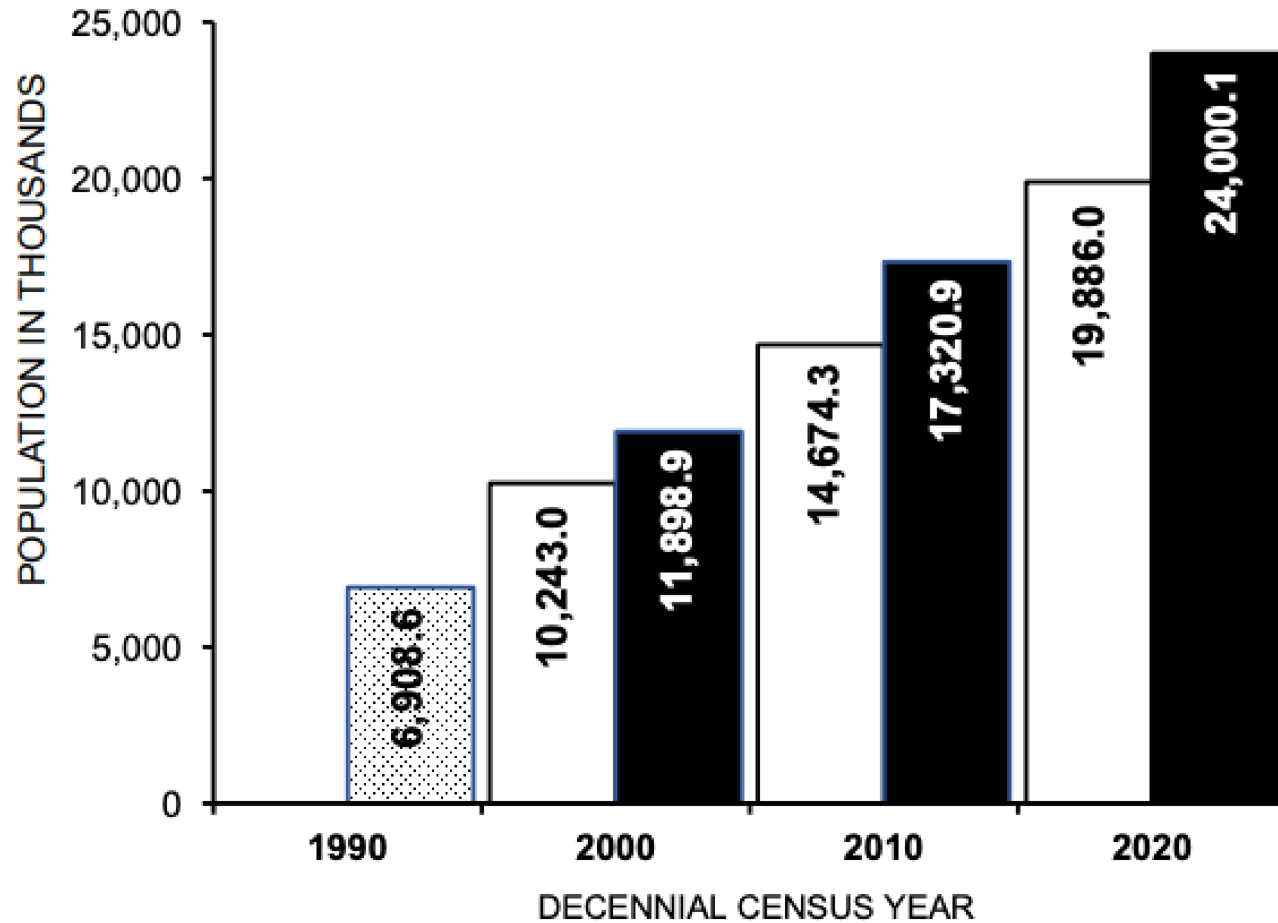
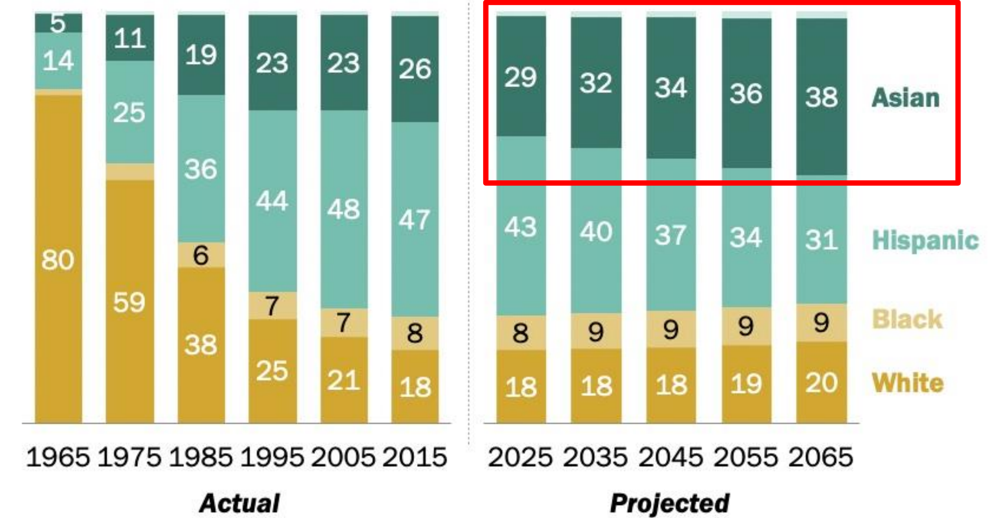
The Asian American Population





Chen, MS, et al; *J Natl Cancer Inst*. 2022 Jun 13;114(6):792-799.
Budiman A. and Ruiz NG. Pew Research Center. 2021.

A Call for Data Disaggregation

DIVERSITY, EQUITY, AND INCLUSION IN GI

Disaggregating Racial and Ethnic Data: A Step Toward Diversity, Equity, and Inclusion

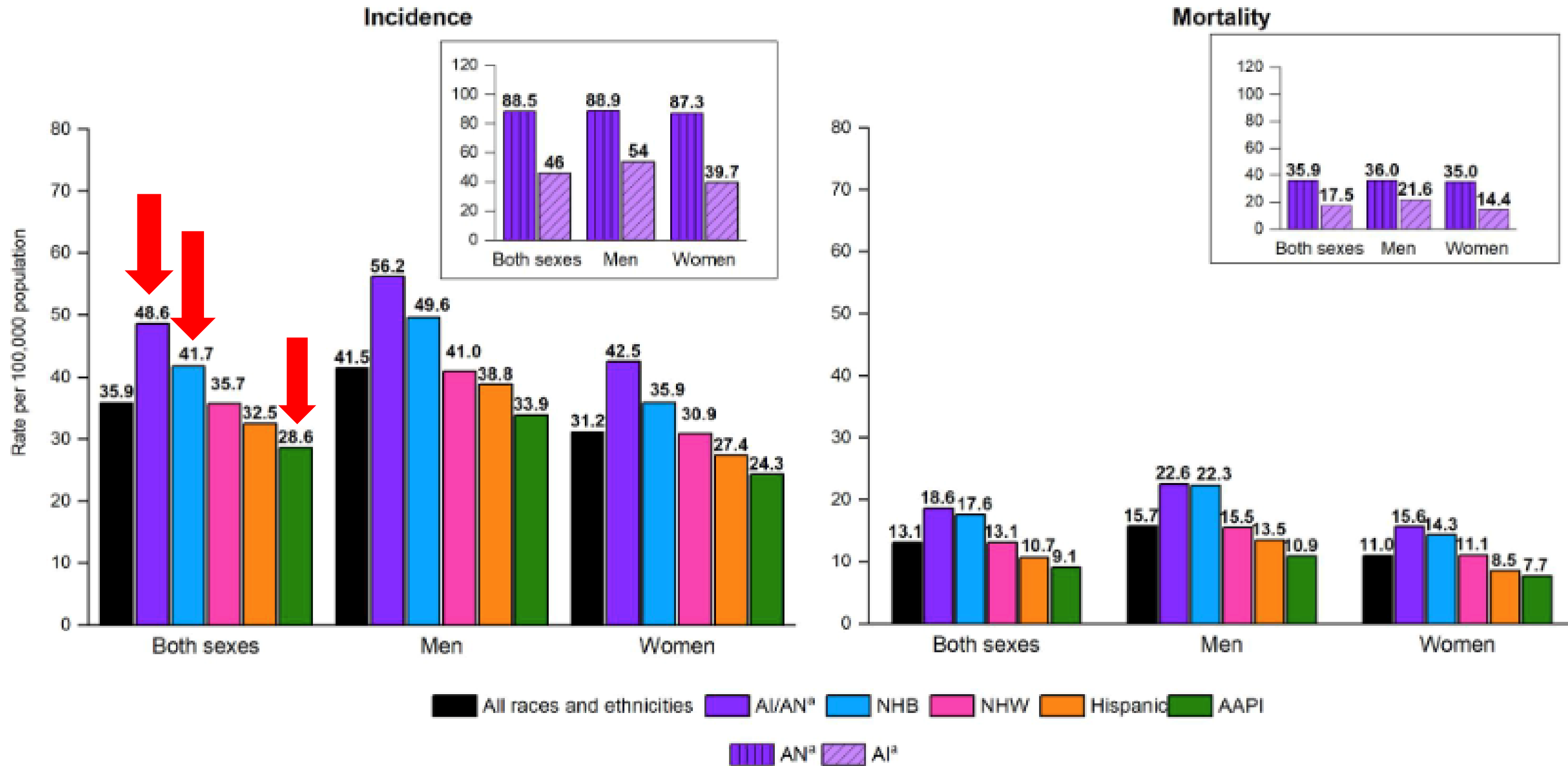
Table 1. OMB Racial and Ethnic Categories and Alternative Disaggregated Categories

OMB	HHS	New York State[a]
American Indian or Alaska Native		
Asian	7 subgroups: Asian Indian, Chinese, Filipino, Japanese, Korean, Vietnamese, and Other Asian	20 subgroups: 7 HHS subgroups, Laotian, Cambodian, Bangladeshi, Hmong, Indonesian, Malaysian, Pakistani, Sri Lankan, Taiwanese, Nepalese, Burmese, Tibetan, and Thai
Black or African American		
Hispanic or Latino	4 subgroups: Mexican/Mexican American/ Chicano/a, Puerto Rican, Cuban, and Another Hispanic/Latino/Spanish origin	
Native Hawaiian or Other Pacific Islander	4 subgroups: Native Hawaiian, Guamanian or Chamorro, Samoan, and Other Pacific Islander	6 subgroups: 4 HHS subgroups, Fijian, and Tongan
White		

HHS, Department of Health and Human Services; OMB, Office of Management and Budget.
[a]These categories are required by NY S.6639-A/A.6896-A,[17] which specifically addressed the Asian, Native Hawaiian, and Pacific Islander populations.

Liang, PS, et al; *Gastroenterology*. 2023 Mar;164(3):320-324.

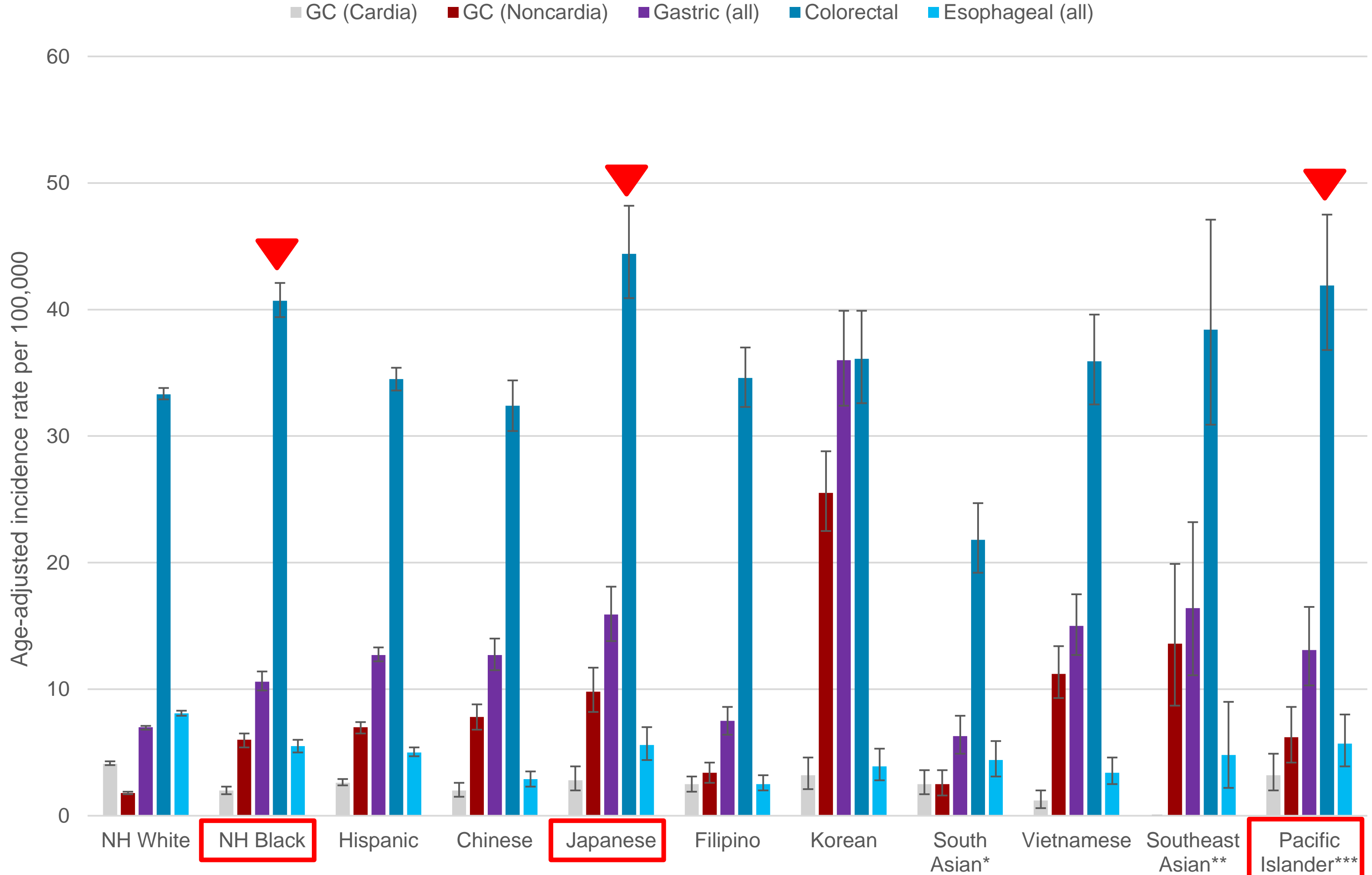
Colorectal Cancer Statistics, 2015-2020



- In aggregate, Asian Americans and Pacific Islanders experience the lowest colorectal cancer (CRC) incidence.

Siegel RL, et al.; *CA Cancer J Clin*. 2023 May-Jun;73(3):233-254.

The Burden of Endoscopically Screenable Cancers: A Push for Disaggregation



- CRC incidence in Japanese American and Pacific Islander men exceeds the CRC burden in Black men.

Wang, CP; et al; Gastro Hep Adv. 2024 Jan 18;3(4):482-490.

TABLE 6 Colorectal cancer screening (%), adults aged 45 years and older, 2021, United States.

	Stool test[a]	Colonoscopy[b]	Up to date[c]	
	≥45 years	≥45 years	≥45 years	45–75
Overall	10	54	59	58
Race/ethnicity				
Hispanic	14	46	52	51
White only	9	57	61	60
Black only	11	57	61	59
Asian only	10	45	50	48
AIAN only or multiple	10	48	52	52
Immigration status				
Born in United States/US Territory	9	57	61	60
In United States <10 years	9	25	29	30
In United States ≥10 years	12	48	53	52
Education				
Less than high school	11	43	48	47
High school diploma	9	51	55	54
Some college	11	56	61	59
College graduate	9	60	64	63
Income level				
<100% FPL	11	42	47	46
100% to <200% FPL	12	47	52	51
≥200% FPL	9	58	62	61
Insurance status				
Uninsured	4	18	21	22
Private	9	59	63	64
Medicaid/Public/dual eligible	11	48	52	53
Medicare (ages ≥65 years)	15	69	75	82
Other	15	68	73	74

- National CRC screening rate, as of 2021: **59%**

US Department of Health and Human Services. Healthy People 2030.
Siegel RL, et al.; *CA Cancer J Clin*. 2023 May-Jun;73(3):233-254.

Elimination of CRC Screening Disparities for Most…But Not All

Timely Colonoscopy (past 10 years) among NYC adults ages 50+ years by race/ethnicity, 2003-2023

Timely Colonoscopy, %

100
90
80
70
60
50
40
30
20
10
0

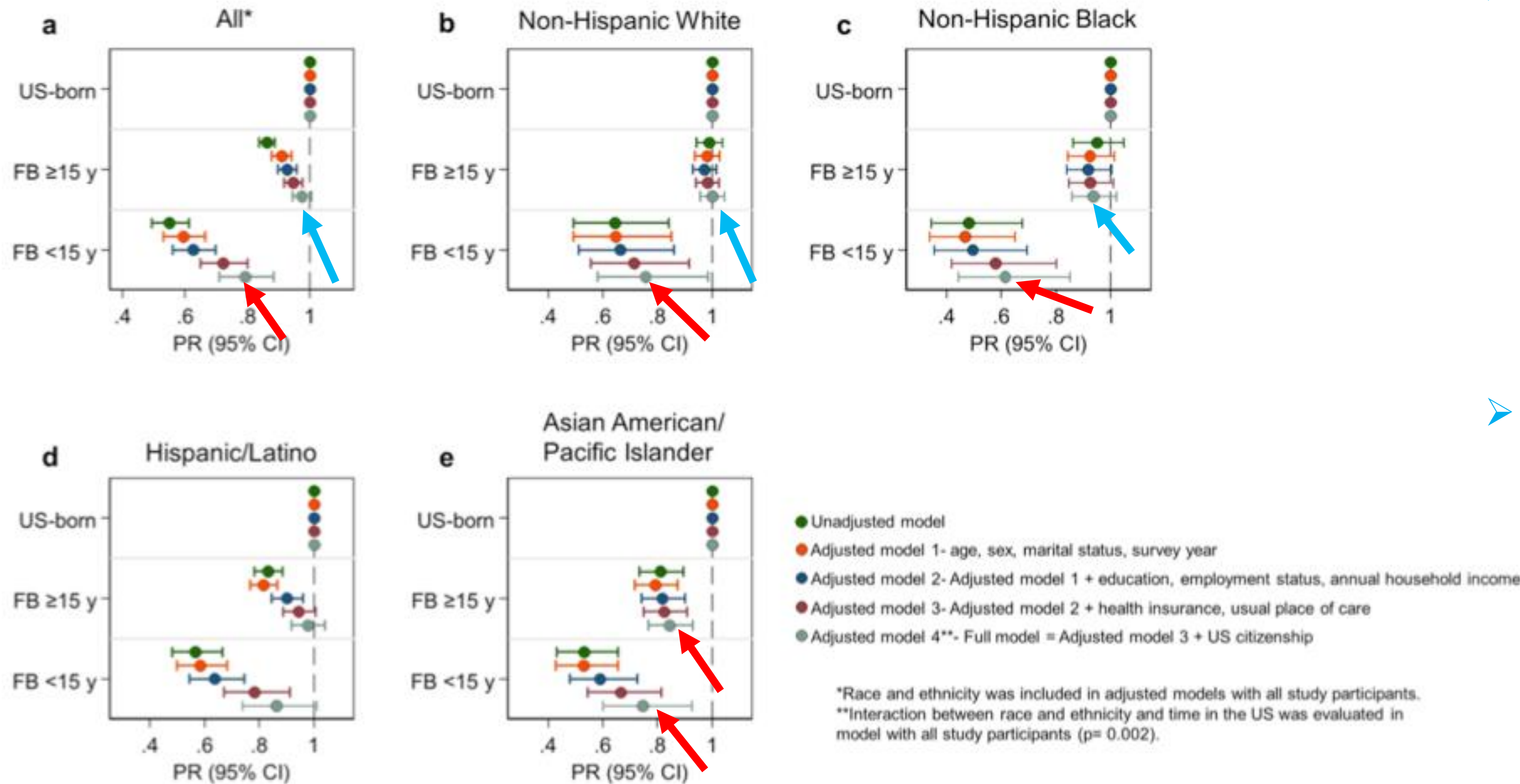
White, non-Hispanic
Black, non-Hispanic
Hispanic
Asian/PI, non-Hispanic
NYC Overall

2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2014 2015 2016 2017 2018 2019 2020 2021 2022 2023

Survey Year

Source: NYC Community Health Survey, Data are age-adjusted
Note: In 2021, CHS transition to new survey methodology and data should not be compared to prior years

CRC screening uptake by time in the U.S. and race and ethnicity, NHIS 2010–2018.



- Recently immigrated, foreign-born (FB) individuals (<15 years in the US) have lower CRC screening rates than US born individuals.
- ALL FB Asian Americans/Pacific Islanders, regardless of time lived in the US, had lower CRC screening than their US-born counterparts.

Santiago-Rodríguez EJ, et al; *Am J Prev Med*. 2023 Jul;65(1):74-82.

Follow-up Colonoscopy After a Positive Stool-Based Screening Test Among Health Care Organizations in the US, 2017-2020, Cox Model

Characteristic at index date	HR (95% CI)
Age, y	
50-59	1 [Reference]
60-69	0.97 (0.94-1.01)
70-75	0.97 (0.93-1.01)
Sex	
Female	1 [Reference]
Male	0.99 (0.96-1.02)
Race	
Asian	0.79 (0.69-0.91)
Black	0.85 (0.80-0.91)
White	1 [Reference]
Unknown	0.93 (0.86-1.02)
Ethnicity	
Hispanic	0.94 (0.84-1.04)
Non-Hispanic	1 [Reference]
Unknown	0.96 (0.88-1.04)
Insurance type	
Commercial	1 [Reference]
Medicaid	0.79 (0.73-0.85)
Medicare	0.95 (0.91-0.99)
Other	0.87 (0.76-0.99)
Unknown	0.67 (0.58-0.77)
Prior SBT use	
No	1 [Reference]
Yes	1.12 (1.08-1.16)
Index year	
2017	1 [Reference]
2018	1.00 (0.96-1.05)
2019	0.90 (0.86-0.93)
2020	0.72 (0.68-0.77)
SBT type	
FIT	1 [Reference]
mt-sDNA	1.63 (1.57-1.68)
CCI levels	
0	1 [Reference]
1-2	0.89 (0.87-0.92)
3-4	0.72 (0.68-0.77)
5+	0.64 (0.59-0.71)

- Overall follow-up colonoscopy rate after positive stool-based test remains sub-optimal:
  - within 6 months: 51%
  - within 1 year: 56%

- Follow-up colonoscopy was lower in Asian and Black patients than White patients.

Mohl, JT, et al; *JAMA Netw Open*. 2023;6(1):e2251384.
Escaron, AL, et al; *Journal of Primary Care & Community Health*. 2022;13.

Chi gung: CHinese Immigrant Women Get Up-to-date on CaNcer ScreeninG

- Chinese immigrant women (CIW) are a particularly disadvantaged group who are adversely impacted by the social determinants of health.
  - CRC is a leading cause of preventable cancer death in CIW.
  - Up-to-date CRC in CIW (52%) remain well below Healthy People 2030 and NCCRT benchmarks (74% and 80%, respectively).
  - Multi-level barriers to cancer screening exist at the *system*-, *provider*-, and *patient*-level.

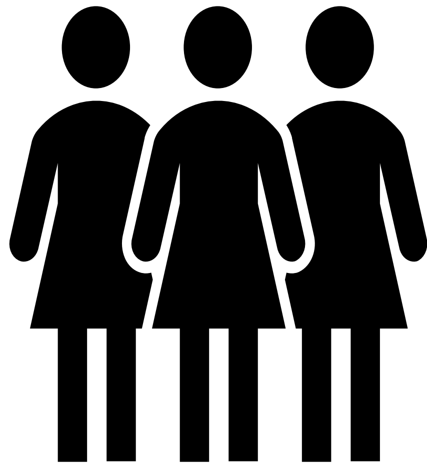
Asian American Federation. Profile of New York City's Chinese Americans. New York, NY. 2019.
New York City DoH. Health of Asians and Pacific Islander in New York City. New York, NY. 2021.
Kim K, et al. J Racial Ethn Health Disparities. Dec 2018;5(6):1346-1353.
US Centers for Disease Control and Prevention. Cancer screening - United States, 2010. Morbidity and Mortality Weekly Report. 2012.
American Cancer Society. Cancer Facts & Figures for Asian American, Native Hawaiian, & Other Pacific Islander People 2024-2026. Atlanta: American Cancer Society, Inc. 2024.
Shah I, et al. Clin Gastroenterol Hepatol. 2024 Apr;22(4):679-683.

Role for Community Partnerships

- The perspectives of CIW and community stakeholders are essential to designing a culturally-tailored and meaningful intervention to improve CRC screening rates.
  - Focus groups of stakeholders – gather information about community concerns related to CRC screening
    - Explore understanding of structural barriers to care and methods to effectively engage CIW in cancer screening programs
  - One-on-one interviews with CIW – allows for a safe forum to encourage participants to openly share views on sensitive topics
    - Explore illness beliefs, emotional responses, and self-efficacy related to CRC screening

Table 1. Participant characteristics

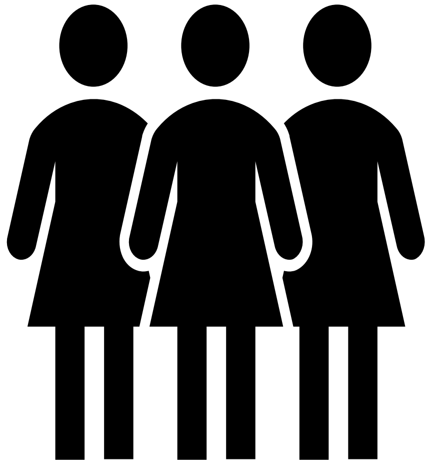
Characteristics	Stakeholders (n=22)
Age group, n (%)	
25-40	13 (59)
41-60	7 (32)
Female, n (%)	19 (86)
Race/Ethnicity, n (%)	
Asian	22 (100)
Non-Hispanic	21 (95)
Other Languages, n (%)	
Mandarin	4 (18)
Cantonese	6 (27)
>1 Chinese dialect	9 (41)
Chinese	3 (14)
Birthplace, n (%)	
United States (US)	3 (14)
Outside of the US	19 (86)
Occupation, n (%)	
Case manager	6 (27)
Social worker	5 (23)
Program manager	1 (5)
Outreach coordinator	2 (9)
Nurse	1 (5)
Other (e.g., program director, resident service coordinator)	7 (32)



Focus Groups of Community Stakeholders

Focus Group Findings: Health Beliefs

Theme 1:
Underperception of cancer risk/ Avoidance of finding cancer

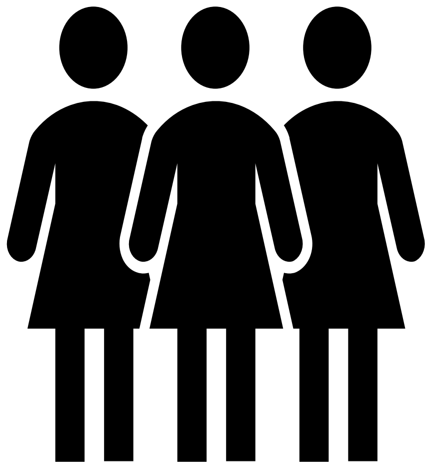


If there is no symptoms, don't touch it, especially cancer…if I don't do the screening, I don't have cancer.

They don't have time for prevention, they don't even have medical insurance…they will wait until there are [symptoms], then they will maybe try to find out [more].

Focus Group Findings: Health Beliefs

Theme 2:
Differing healthcare approaches
(East vs West)

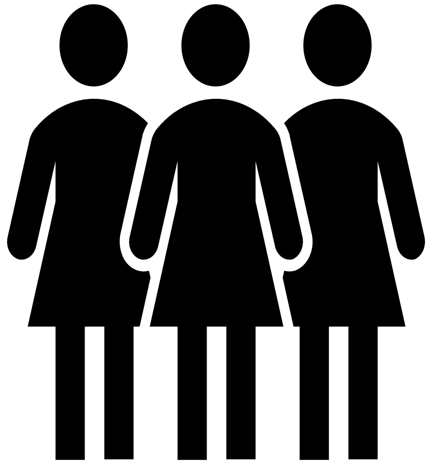


Culture is very important…Cuz they do believe [in] Chinese alternative medicine…so before they physically show up in front of Western doctors, they will turn to Chinese way of treatment.

That is why I have to train the doctor, cuz they will give the patient options, option 1, 2, 3. And then the patient looks very helpless. And then I have to pull the doctor aside. I explain to them, in the Chinese population, they treat the doctor as an authority figure. So if you want to give options, that's fine, but you have to be more directive. For example, some [doctors] say 'if you are my parents, I would have you do this,' then [the patient] knows how to follow.

Focus Group Findings: Health Beliefs

Theme 3:
Social influences



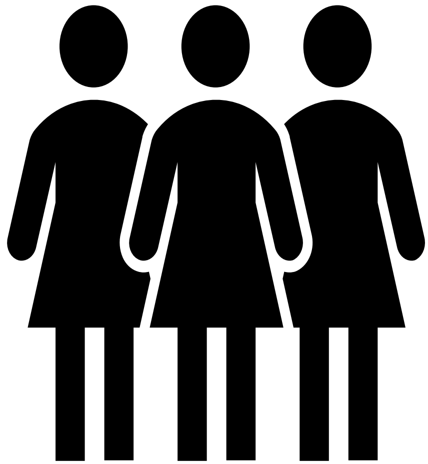
They will agree with the doctor, but they have to ask people who speak their language and their friends. Then they make a decision.

[If a friend] sees me go on the mobile [mammography] van, she may think 'oh she must have some problem, that's why she needs to do the screening.' It's not for prevention, it's because she has a problem. So I will feel bad, 'I don't want people to think I have a problem.' I don't have a problem, but [people] will think that way...

...like if I know she does a [screening] test, I'm like 'are you ok?' And if you say 'no [its] just for prevention,' people don't understand. Once you get on the van, that means you have something. And then the rumors the next day…

Focus Group Findings: Barriers

Theme 1:
Medical mistrust

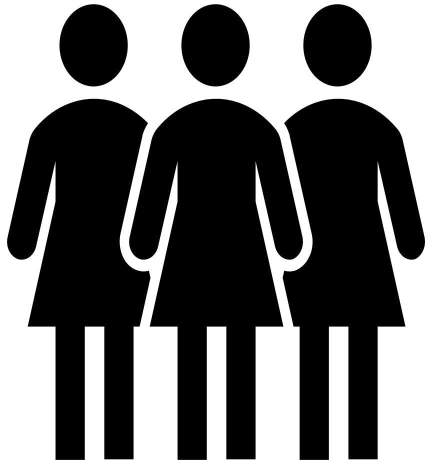


They are concerned with ‘is this [test] necessary?’ or ‘is the doctor trying to make money?’

They have a van system that takes [patients] to [the hospital], but sometimes, they don’t bring them back and they don’t know how to come back…They’ve heard bad stories about Access-a-ride and how clients got stranded or the driver didn’t pick up the phone, so they’re scared to get on any kind of transportation provided by the insurance company.

Focus Group Findings: Barriers

Theme 2:
Consequences of detecting cancer

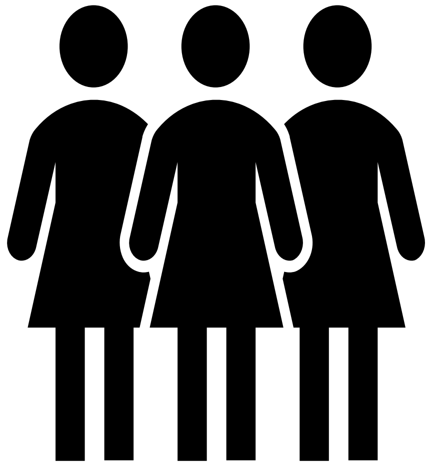


I could tell there is a financial strain…next thing you know if [the cancer] is officially diagnosed, the money keeps growing. Let's just say they have to stay in the hospital, next thing you know it's like $20,000 and you're giving all of this money, and then it doesn't work…so pretty much the idea of the finances, it's like they don't want to go through with it. They'd rather just [have the mindset] 'I don't care to know.'

If you have cancer, that means you are a burden of the family and the patient themselves feel so bad to give extra work to the family. Also the family member will get tired, like 'oh you get cancer, what am I gonna do? I'm gonna lose my life to take care of that family member.'

Focus Group Findings: Barriers

Theme 3:
Language
(interpreter issues and
misunderstandings)



Even if you speak the same language, it doesn't mean you understand the situation. You translate just the words, not the [meaning] behind them, so I think that is the big problem…[interpreters] never say something to make them feel comfortable. They just interpret what the doctor will say. They won't say any extra words.

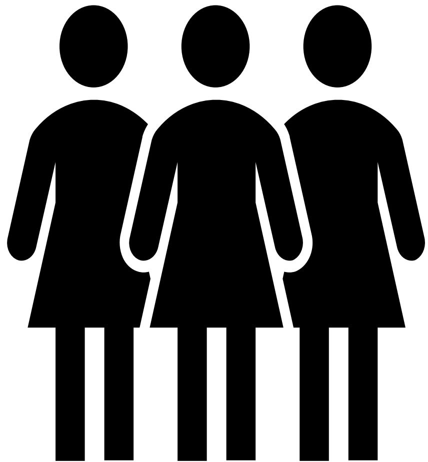
We do have clients [who had bad experiences with the dentist]. This is where I'm hurting but the dentist works on the other side. Even though I mentioned it many times. And then that costs them. Or the original problem is not fixed. So with the bad experiences [piling up]. I'm already poor. Rather than do [screening], I'll stay where I am.

Focus Group Findings: Barriers

Theme 4:
Terminology issues

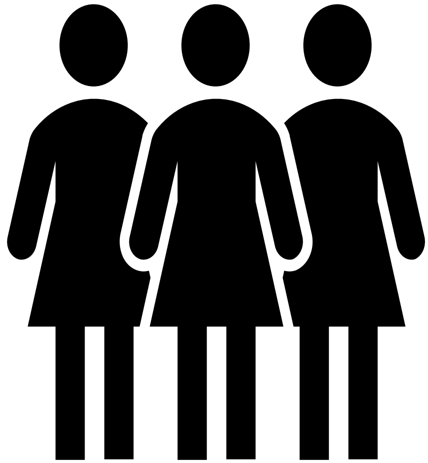
The word screening is a mouthful. It's a concept. It's more of advanced language, it's not a day to day thing where 'oh I have to eat, I have to sleep.' I think screening in Chinese is not a widely used word.

Breast, you know in Chinese, is easy to understand. But colon, some people may not know where my colon is. I think they know hemorrhoids more than they know colon.



Focus Group Findings: Barriers

Theme 5:
Perceptions about CRC screening



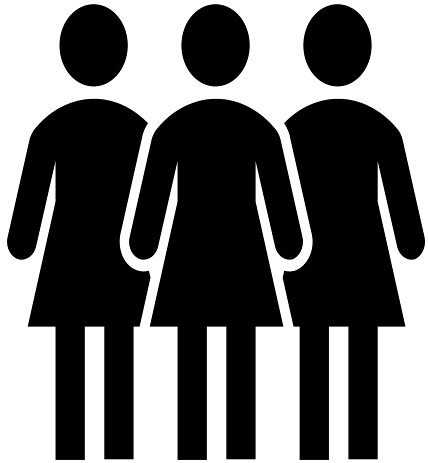
The time you have to spend on it. This is definitely a big barrier for people who work. Even for me, I want to do it but I know that I have to prepare like 3 days before, I just hesitate to make the move.

So everyone hears the word 'colonoscopy,' they're like 'oh my god I am going to have to do this, I really don't want to do it.' It's really word of mouth that colonoscopy has been one of the more evil tests.

This goes back to the stool tests. I don't think that needs a lot of preparation, but we're not aware of that as an option. So when I think about colon screening, I immediately jump to colonoscopy. I wouldn't even ask 'what are you talking about when you talk about screening?' I would assume [it's a colonoscopy] and make the decision to say no.

Focus Group Findings: Facilitators

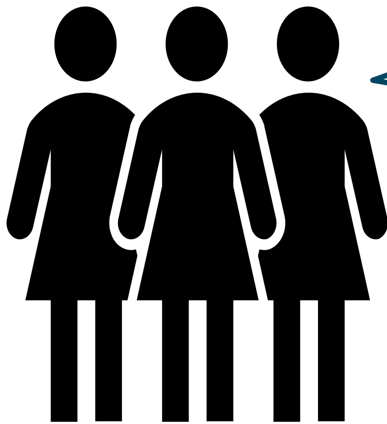
Theme 1:
Education



I think education is very important, about the treatments or survival rates. If you catch it early, what's the survival rate, so they know the benefit of screening not just finding out that you have cancer [but] what's next. But then you have to tell them why it's important. You catch it early and your survival rate is 10 or 20 years. But if you catch it end stage, then you may not have time to get treatment. I think lots of time they think 'I got cancer then I'm done so then why do I have to find out?'

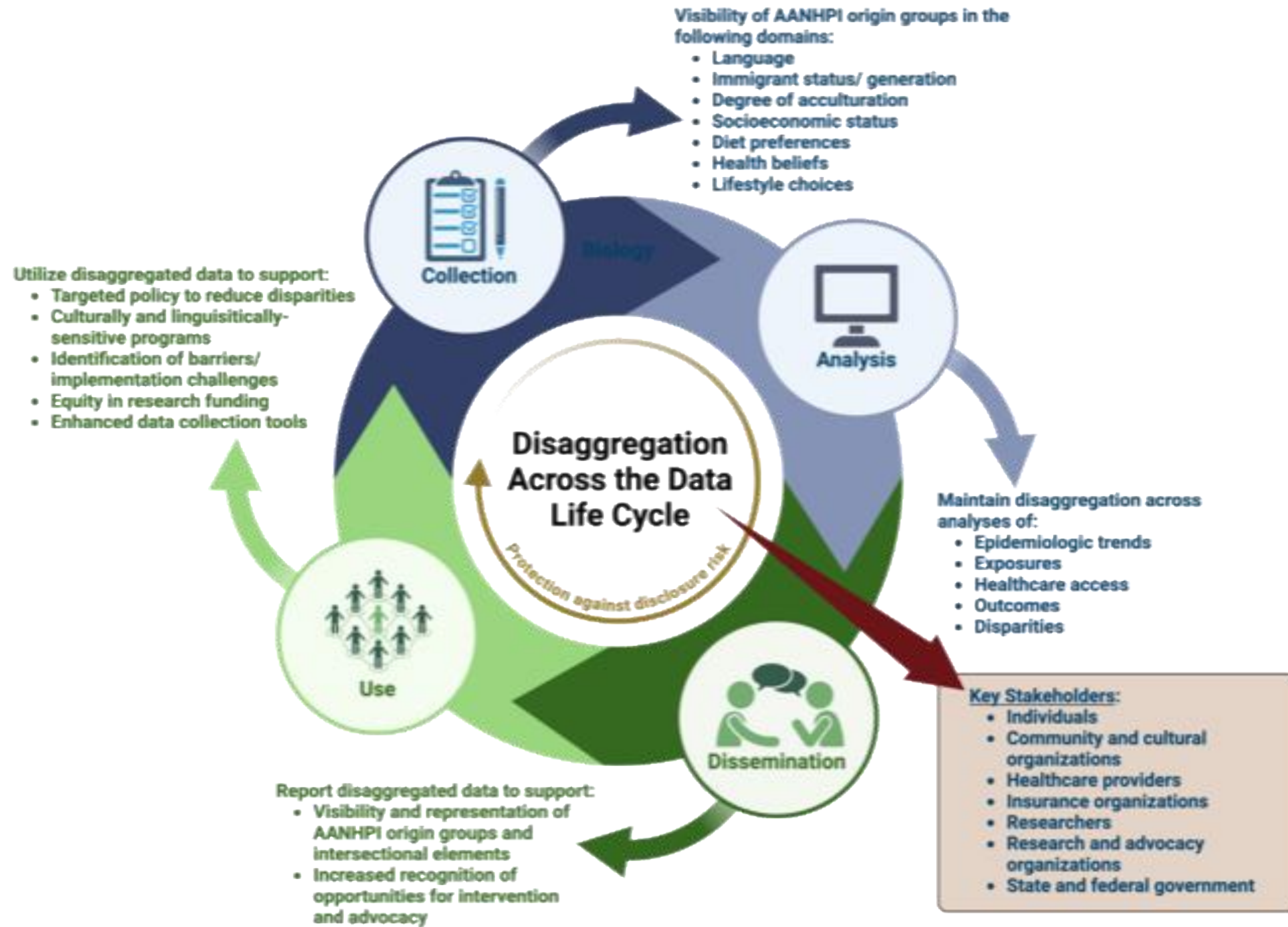
Focus Group Findings: Facilitators

Theme 2:
Framing



My mom avoids saying 'cancer,' she feel like it means 'death.' However, I'm always talking to her about cancer, and I tell her 'you can do the screening. It's easy, and it doesn't mean death.' Because my coworkers are cancer survivors and my mom sees them and she says 'oh they look healthy,' and then she prefers to do the screening…I think because I always [talk about screening] in a positive way. Cancer doesn't mean death, it doesn't mean you will go away, it means it's a challenge in your life. You will get better! And she feels much better.

Just like a long time ago, Diabetes, Hypertension, all is not a good disease. But now its very common. Everybody has Hypertension. Everybody has Diabetes. And it's ok, get the treatment. But now cancer, it's the same thing because there are so many cures. So it's not a bad disease, it's not taboo, it's not a curse. So talk more, so people think it's common.


Visibility of AANHPI origin groups in the following domains:
Language
Immigrant status/ generation
Degree of acculturation
Socioeconomic status
Diet preferences
Health beliefs
Lifestyle choices
Collection
Analysis
Utilize disaggregated data to support:
Targeted policy to reduce disparities
Culturally and linguisitically-sensitive programs
Identification of barriers/ implementation challenges
Equity in research funding
Enhanced data collection tools
Disaggregation Across the Data Life Cycle
Protection against disclosure risk
Maintain disaggregation across analyses of:
Epidemiologic trends
Exposures
Healthcare access
Outcomes
Disparities
Use
Dissemination
Key Stakeholders:
Individuals
Community and cultural organizations
Healthcare providers
Insurance organizations
Researchers
Research and advocacy organizations
State and federal government
Report disaggregated data to support:
Visibility and representation of AANHPI origin groups and intersectional elements
Increased recognition of opportunities for intervention and advocacy

Acknowledgements

CHARLES B. WANG
COMMUNITY HEALTH CENTER

UNIVERSITY
SETTLEMENT

ST. MARGARET'S
HOUSE

Mount Sinai Team:

- Lili Liang, Clinical research coordinator
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- Jenny Lin, MD, MPH, Division of General Internal Medicine
- Steve Itzkowitz, MD, Division of Gastroenterology
- Lina Jandorf, MA, Department of Population Health Sciences and Policy
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Thank You