



Colorectal Cancer Screening in American Indian & Alaska Native Communities

Additional Questions & Answers November 28th, 2017

Presenters: Kris Rhodes, MPH; Laura Makaroff, DO; Jessica Deaton, RN, BSN;
and Richard Mousseau, MS

Webinar replay: <http://nccrt.org/webinars/>

- 1. Q: Have any panelists done any Quality Improvement (QI) surveys with their patients? If so, any significant outcomes to share?**

Jessica Deaton (OKCIC): While we do utilize a CRC Quality Improvement Committee, we have not done surveys with our patients. We primarily utilize evidence based practice initiatives and modify our efforts based on results. Surveying these patients is a great idea and something we will discuss at our next CRC QI Committee meeting.

Richard Mousseau (GPTCHB): We have done some Quality Improvement (QI) surveys in collaboration with Great Plains Quality Innovation Network (GP-QIN) for some of the facilities that we work with. We will be conducting the community readiness model with some of the facilities that will include patients as key stakeholders to examine barriers closer.

- 2. Q: What is the caseload for the grant funded CRC screening navigators? Alternatively, without grant funding what would it cost per screening to increase the rate of screening in the community?**

Richard Mousseau (GPTCHB): The caseload varies for patient navigators and it varies between community and facility. A cancer awareness month such as colorectal in March can increase a workload for a patient navigator. Our patient navigators typically have a caseload of 25 patients to 100 patients a week and the amount of navigation can depend on the type of test, treatment, etc. It depends on the cost per screening based on the facility and the test. Stool tests can vary in price and I would recommend on having a return rate between 30% to 45%.

- 3. Q: I work in Hawaii with many diverse populations and was wondering if we could have access to the small media shared and also more detail on what was done to address financial and transportation barriers.**

Jessica Deaton (OKCIC): The majority of our small media comes from our partnership with the American Cancer Society. If you are not already working with them, I would highly encourage you to develop a partnership. ACS has an abundance of resources and options for you to utilize in your screening efforts. As far as addressing our financial and transportation barriers, we unfortunately have not been able to address these other than utilizing a CHR to transport patients to consult visits and screening our patients for insurance so that they can utilize closer facilities that help reduce the transportation and financial barrier.

Richard Mousseau (GPTCHB): Yes. A lot of our small media is available on our organizational website www.gptchb.org. I would also recommend looking the Make It Your Own (MIYO) website (<http://www.miyoworks.org>) to assist in creating your small media.

- 4. Q: Do you find issues of trust by the tribe members of outside programs like those provided by ACS? Sometimes just making the connection and getting in the doctor can be difficult. Any suggestions?**

Laura Makaroff (ACS): Building trust with partners has been an important focus for ACS. It has been helpful to work with an AI/AN advisory group to develop our work nationally. Building relationships at the local level has been most successful when a community champion is identified and when time is spent learning about a tribe's culture and beliefs and allowing for a phased approach to the work as trust is established.

- 5. Q: Keep those incentives coming! Natives love those. Why not develop punch cards of some sort? Get the flu shot-get a punch-get an A1C-get a punch-get a mammogram-get a punch etc., etc.**

Jessica Deaton (OKCIC): This is a great idea! We do utilize a similar "punch card" at our health fair events. When patients complete their punch card at the health fair, they get to enter it into a drawing for prizes. This would be a good program to look into at the beginning of our next screening year and determine if it is feasible and what kind of prizes we can offer.

- 6. Q: I am very interested in telemedicine for screening colonoscopy, where I can FaceTime or something with a patient who is sitting with the provider in another clinic far away. If he/she agrees after I answer all the questions, we can schedule a date.**

Jessica Deaton (OKCIC): I believe this is in regards to scheduling a colonoscopy to prevent an additional consult visit and help eliminate transportation barriers. I think this would be a great option that would be helpful to our patient population. If this could help us eliminate our patients going for a consult visit prior to the colonoscopy, I think this would be great to implement.

Richard Mousseau (GPTCHB): I would have your hospital or organization look into ZOOM because it is a great tool for telemedicine across the world and can be beneficial at eliminating the consult visit time prior to the colonoscopy.

7. Q: Please email me reference lists for statistics and studies mentioned. I'm working on a project that all this information can be quite useful.

Most data and statistics cited in this presentation are also found in the Background section of the ACS/NCCRT April 2016 AI/AN and CRC post meeting report: <http://nccrt.org/resource/meeting-report-aian-crc-april2016/>. Sources and original slides prepared by Don Haverkamp, MPH, CPH, Epidemiologist, Division of Cancer Prevention and Control, CDC, are linked in the report, found here: <http://nccrt.org/wp-content/uploads/CRC-meeting-presentation-Haverkamp-4-25-16-shorter-version.pdf>