

CDC *Vital Signs* Town Hall Teleconference
Q&A

Colorectal Cancer Screening Saves Lives
November 12, 2013
2:00–3:00 pm EST

Dr. Dan Baden: All right thank you very much for those excellent presentations. I'd like to remind everyone that you can get in queue to ask a question by pressing Star 1. Say your name when prompted and you'll be announced into the conference by the operator when it's your turn to ask a question.

I encourage you all to take advantage of this opportunity to share strategies, lessons learned, challenges, and success stories that you've had with each other on the call. To start us off -- listening to your presentation I'm reminded of patients I saw. And I remember the fear and anger they saw at being diagnosed with colon cancer.

I even remember one patient who expressed relief because she finally had something to validate her aches and pains and her husband would believe that she actually had something wrong with her. Regardless, all of them very clearly would have preferred not to have had cancer.

I'm wondering about why people aren't getting tested. Can you remind us or tell us some of the fears or reasons that patients give for not getting tested? Can you talk about that at all for a minute?

Dr. Djenaba Joseph: When you look at the literature, the most common (unintelligible) is I didn't know I needed to be tested or my doctor didn't tell me. So that's usually the number one reason you get.

The second reason tends to be just the whole “ick factor.” They just don't want to have anything to do with it basically. When you look at, sort of, test specifically then -- so for colonoscopy one big obstacle tends to be you have to take a day off from work and you have to do that for (unintelligible) -- which people don't particularly care for.

It's also a little cumbersome that you have to have someone to take you if you get sedation. So that's two people who have to take time off from work. So that can actually be a big obstacle -- particularly for people who work on hourly wages and they may not get paid for that time they get - take off.

Evidently sometimes people are just - have a fear of complications -- particularly with colonoscopy. There's albeit very (unintelligible) risk of perforation or poking a hole in their colon -- which can cause a leak. And then there are other side effects, certainly, you can have -- cardiovascular events during the procedure that are unanticipated.

It's very rare to have a serious complication during a colonoscopy, but the possibilities certainly (unintelligible). But for the fecal occult test, most people just don't like that, you know, just having to get anywhere near their own stool. So I usually push back a little bit and try to remind people -- if you have kids or you have a pet, certainly can't be any worse than that.

And then other more causes of common reasons people give with fecal occult blood tests is you give them the kit, they take it home and, quite frankly, they just forget about it. It goes on some shelf somewhere and it never sees the light of day again -- which is why it's important to have providers or somebody who will call the patient to remind them you need to send your kit back in.

Dr. Dan Baden: Great. I loved your comment about kids and pets. Do you have any other more personalized advice that you give people about some of these other issues -- the time off of work, the prep, whether they need drivers or not -- any other advice you can give clinicians that they could give to their patients?

Dr. Djenaba Joseph: Well, I think that's why it's important to offer people a choice of tests. I mean if taking time off work and doing the prep and all of that is just truly a barrier for you, then by all means do the fecal occult blood test. It's certainly easier. You can take it home. You don't have to take any time off. It doesn't require any sedation. You just do it at home and send it back in.

You know, if you really want a colonoscopy I certainly wouldn't let those things slow you down. They can be an obstacle, but if it's - if you get it done and it's normal and they don't see any polyps, you won't need another test for ten years. That's a long time.

So if you think about, you know, having -- if you're a female -- going and getting a pap smear every three years. You'll probably spend less time in the sum total of it all getting a colonoscopy for one day out of ten years. So (unintelligible) remember that it's - as one advertisement that I saw, "It's better not to die from embarrassment." Just get it over with so you can prevent yourself from getting cancer because certainly that's the worst outcome.

Dr. Dan Baden: Okay. Thank you. And let me remind people, if you have a question that you'd like to submit, just press Star 1 and you'll get into queue and we'll get to your question.

Along that line, I personally have never done a FIT or a fecal immunochemical test. I've done plenty of the Guaiac's and those types of things, but can you describe the difference between the two tests?

Dr. Djenaba Joseph: So you may or may not actually see much of a difference to yourself. So with the old Guaiac test you certainly have to have three stool samples. So you have to have three separate bowel movements. You have to take a sample from each of those bowel movements.

Some of the newer FIT tests, some of them need only one sample. So you can just do one bowel movement and take one sample. With the old test you use, like, a little wooden stick that looked kind of like a tongue depressor or a popsicle stick. Some of them used tubes. Some of them used - the newer ones you use tubes or brushes or other things that make it a little easier to get the stool sample.

Not quite as much wrestling. You just take the little stick and stick in the stool and you take it and you stick it in the tube instead of having to smear it on anything. So they are a little easier to do. You don't have to do any dietary modification with the FIT test. With the old Guaiac test you can't eat radishes -- and since I know so many people who radishes -- and red meat and things like that because they can give you a false positive.

With the newer tests there aren't any dietary or medication restrictions. You can just carry on business as usual.

Dr. Dan Baden: Great. Thank you. We have another question.

(Paula Staley): Hi. This is (Paula Staley). I'm one of the healthcare advisors here at CDC. And I have a question for either of the presenters. And that is once you're out and you - I would assume you're encouraging the uninsured also to be tested. And the test results end up positive. What kind of programs are in place for treatment for folks that are uninsured?

Dr. Djenaba Joseph: So for our Colorectal Cancer Control Program we certainly pay for the screening test for the under or uninsured. The treatment is kind of - it's a been a little piecemeal. So with our other program -- which is the National Breast and Cervical Cancer Control Program -- they have a treatment act -- and so it's through Congress where Medicaid can actually pick up treatment for those women, but we don't have that equivalent for the colorectal cancer yet.

So we are relying on our programs to, sort of, barter and negotiate with local hospitals and providers to provide treatment for free for these folks that we diagnose. Now if you're not enrolled in your program and you're just sort of out there and you need to get screened and you're not insured, then you get tested and you have a positive - say a positive FIT test and you need a colonoscopy or if you have a colonoscopy and you find cancer and you need treatment, it's a little more difficult, but there are certainly hospitals out there that offer charity care for people who are uninsured because it can get extremely expensive if you need cancer care.

Dr. Felisha Dickey: Yes. This is Felisha. I kind of have the same sentiment. The experience that we've had, for instance, with the project that we funded with the federally qualified health centers. Our program supported the reminder aspect and the foundation supported the screenings. But there was no dollars provided for diagnostic colonoscopies for positives nor treatment if there was cancer found.

And the feedback that we received is that, of course, it was extremely challenging for the federally qualified health centers to get those follow-up colonoscopies provided to the patient. At last report -- for one specific site -- they had one patient that was eligible for Medicaid and ended up receiving their colonoscopy.

They were - are looking for services through what we have here in Florida -- volunteer health services. And those are some of those volunteer care services that Dr. Joseph was just speaking of.

And then staff in our program has called providers to negotiate bundled rates for colonoscopies and so they're limited on number of colonoscopies that have been bundled -- somewhere in the neighborhood of \$800 to \$1000, which is still quite pricey. So it is definitely a challenge.

Dr. Dan Baden: All right. Thank you very much. Good answers.

(Paula Staley): I have one more question. This is (Paula) again. And this is to Felisha. Can you talk a little bit about the impact of your program as far as number of - or percent of increase of effectiveness of the program -- increase in screening? Do you monitor that over the years? I'm not sure how long your program has been in operation.

Dr. Felisha Dickey: We're at the beginning of the fifth year of our five year grant cycle. We started with a rate of approximately 56%. And the most recent data is that our current rate is 61%.

(Paula Staley): Also I noticed that a lot of the work that you do is for some of the health plans -- some of the employers. So how is that work funded? Is that under the CDC grant or is that something that they've gotten you to do?

Dr. Felisha Dickey: That's correct. It's all a part of the funding that received. We engage in screening - limited screening provision and primarily screening promotion activities. And those groups are entities that we are encouraged to work with in order to increase the screening rate.

And so we reach out to those partners specifically to develop initiatives that will result in system improvements to - we need to increase screening adherence.

(Paula Staley): Under the CDC grant, right? Yes. Okay. I see. Thank you.

Dr. Felisha Dickey: You're welcome.

Dr. Dan Baden: All right. Thank you. And (Debbie) do we have any questions in the queue?

Coordinator: At this time I'm showing no questions.

Dr. Dan Baden: Okay. Then I think we'll go ahead and wrap up. But before we do, it would be very helpful to us if you let us know how we can improve these teleconferences. Please email your suggestions to ostltsfeedback@cdc.gov. That's O-S-T-L-T-S feedback -- one word -- at cdc.gov. And I want to thank you - thank the presenters once again as well as everyone else who participated. That ends today's call. Good bye.

Coordinator: Thank you. This concludes today's presentation. You may disconnect at this time.