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2023 **ACG HEPATOLOGY
SCHOOL & WESTERN**
REGIONAL POSTGRADUATE COURSE

JANUARY 27-29, 2023 | CAESARS PALACE
LAS VEGAS, NEVADA

 Register online: meetings.gi.org

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FEBRUARY 24-26, 2023
HILTON RIVERSIDE HOTEL
NEW ORLEANS, LOUISIANA

2023 → *ACG is coming to a city near you!*
**ACG / LGS REGIONAL
POSTGRADUATE COURSE**

EARN UP TO **11.5 CME CREDITS** | EARN UP TO **11.5 MOC POINTS**

ACG | LGS LOUISIANA GASTROENTEROLOGY SOCIETY



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2023 **ACG / FGS ANNUAL
SPRING SYMPOSIUM**

MARCH 10-12, 2023 | HYATT REGENCY COCONUT POINT
NAPLES, FLORIDA

→ Register online: meetings.gi.org



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ACG
2023

OCTOBER
20-25, 2023
VANCOUVER, CANADA

VANCOUVER

Save the Date!

Be sure your passport is up to date!

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Participating in the Webinar

All attendees will be muted and will remain in Listen Only Mode.

Type your questions here so that the moderator can see them. Not all questions will be answered but we will get to as many as possible.

Meridith Test
Webinar ID: 998-221-123
This session is being recorded.
GoToWebinar

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How to Receive CME and MOC Points

LIVE VIRTUAL GRAND ROUNDS WEBINAR

ACG will send a link to a CME & MOC evaluation to all attendees on the live webinar.

ABIM Board Certified physicians need to complete their MOC activities by December 31, 2022 in order for the MOC points to count toward any MOC requirements that are due by the end of the year. No MOC credit may be awarded after March 1, 2023 for this activity.

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MOC QUESTION

If you plan to claim MOC Points for this activity, you will be asked to: Please list specific changes you will make in your practice as a result of the information you received from this activity.

Include specific strategies or changes that you plan to implement.
THESE ANSWERS WILL BE REVIEWED.

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ACG Virtual Grand Rounds

Join us for upcoming Virtual Grand Rounds!




Week 3 –Thursday, January 19, 2023
Cannabis for Gastrointestinal Disorders: Everything You Wanted to Know, But Were Afraid to Ask
 Faculty: Linda Anh Nguyen, MD
 Moderator: Steven Carpenter, MD, FACG
At Noon and 8pm Eastern





Week 4 – Thursday, January 26, 2023
Managing IBD: Technology Enabled, Resilience-Based Self-Management Solutions (sponsored by GI OnDEMAND)
 Faculty: David T. Rubin, MD, FACG; Laurie A. Keefer, PhD, and Megan Riehl, PsyD
At Noon and 8pm Eastern

Visit gi.org/ACGVGR to Register

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Disclosures



Renee L. Williams, MD, MHPE, FACG
Stock owner Boston Scientific and Advisory Board - Janssen




Loren G. Rabinowitz, MD
Dr. Rabinowitz has no relevant relationships with ineligible companies.

**All of the relevant financial relationships listed for these individuals have been mitigated*

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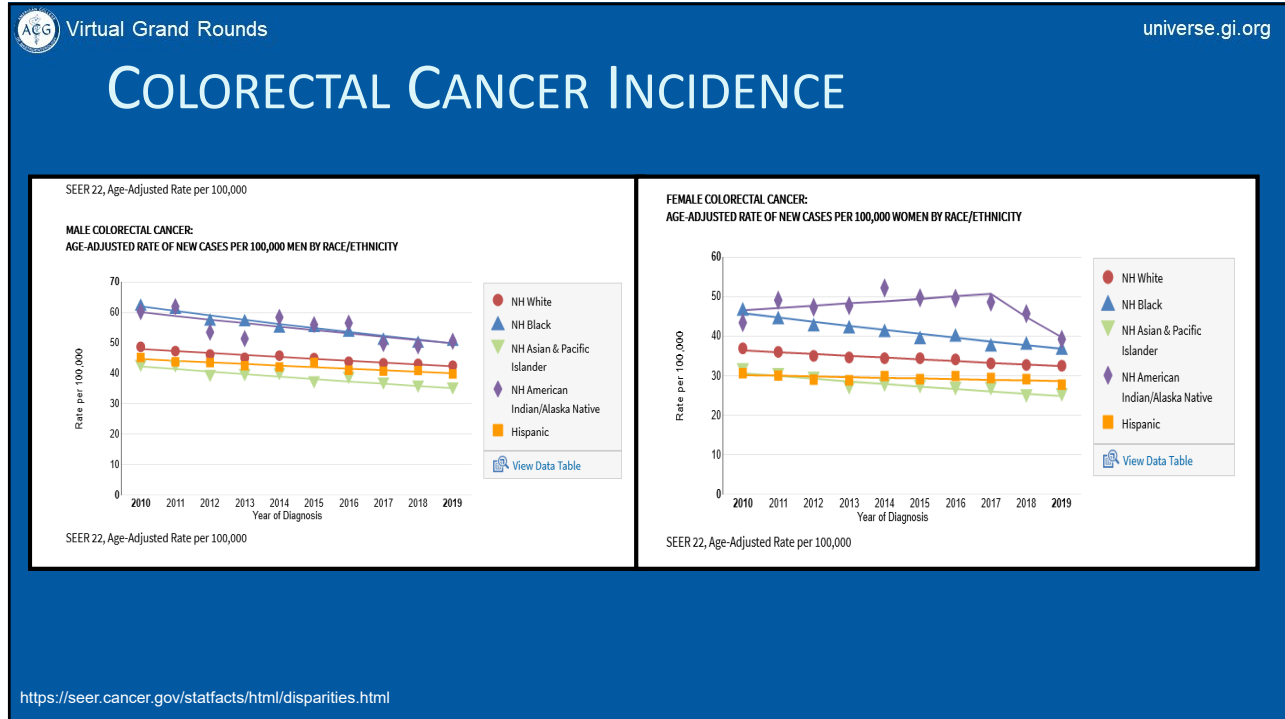
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HOW CAN WE CLOSE THE SCREENING DISPARITY GAPS IN OUR POPULATION?

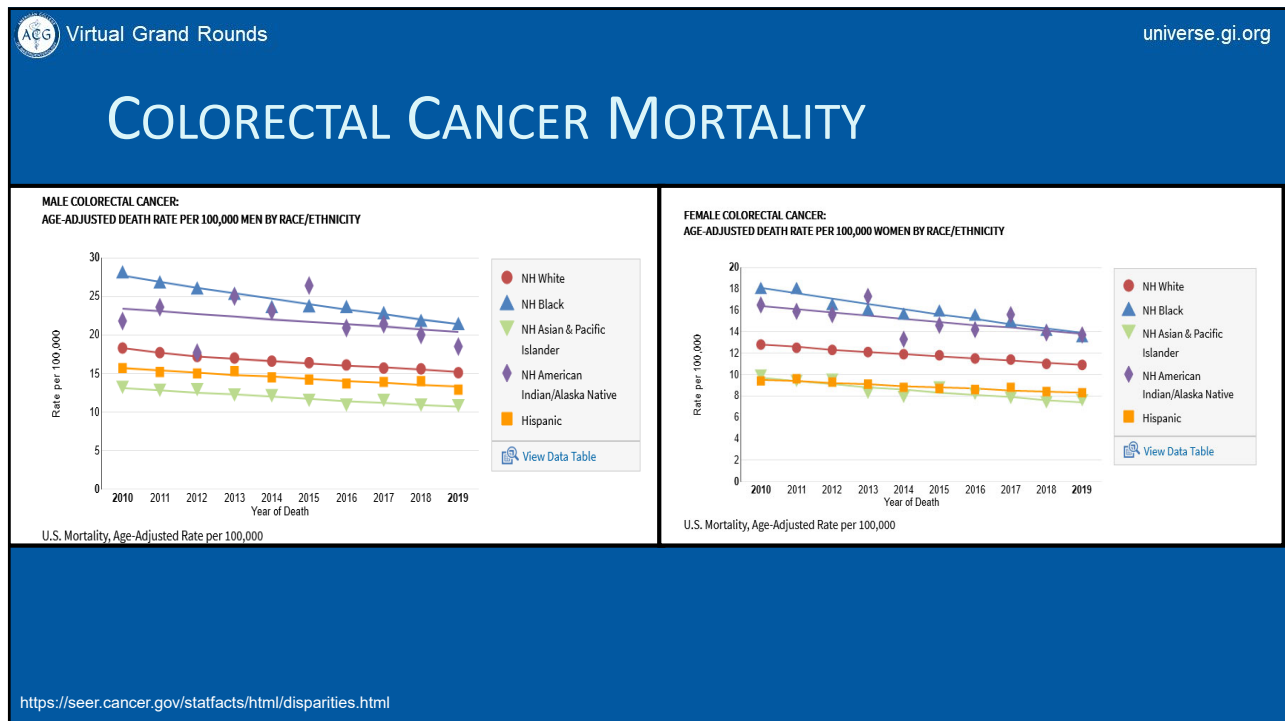


Renee Williams, MD, MHPE, FACG
Associate Professor of Medicine
Associate Chair, Diversity Equity & Inclusion
Director, Saul J Farber Program in Health Equity
NYU Grossman school of Medicine

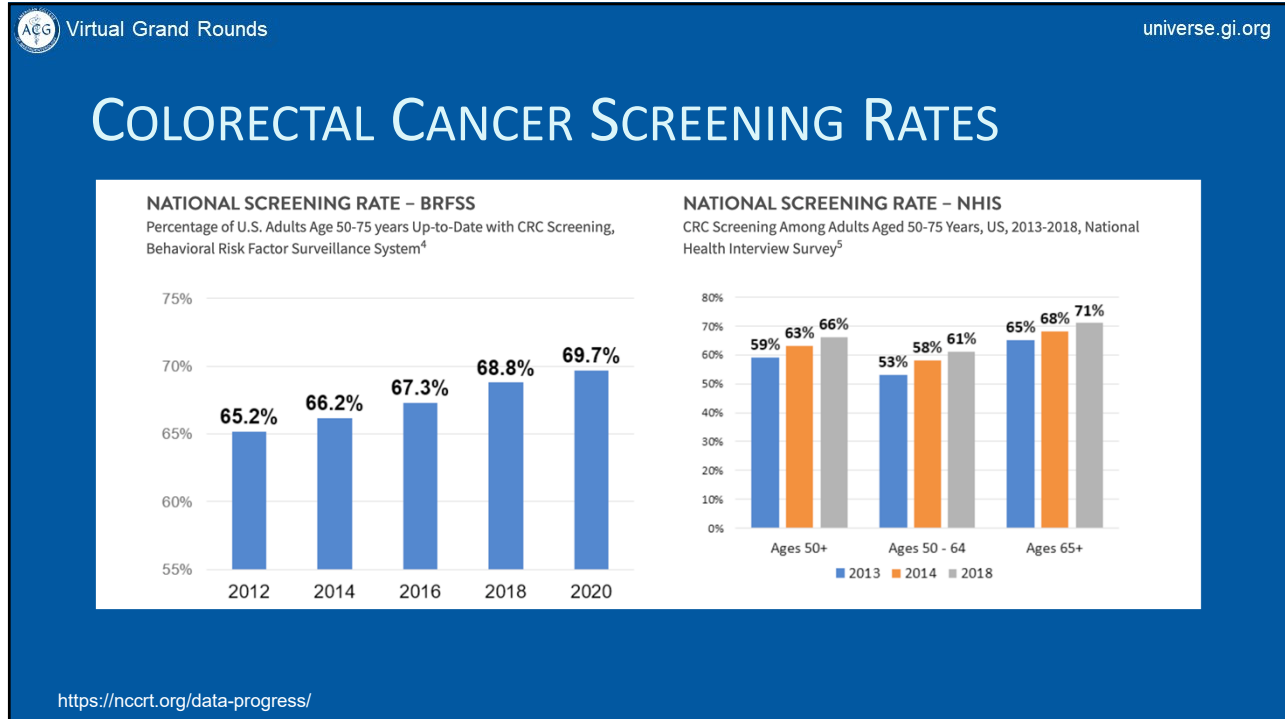
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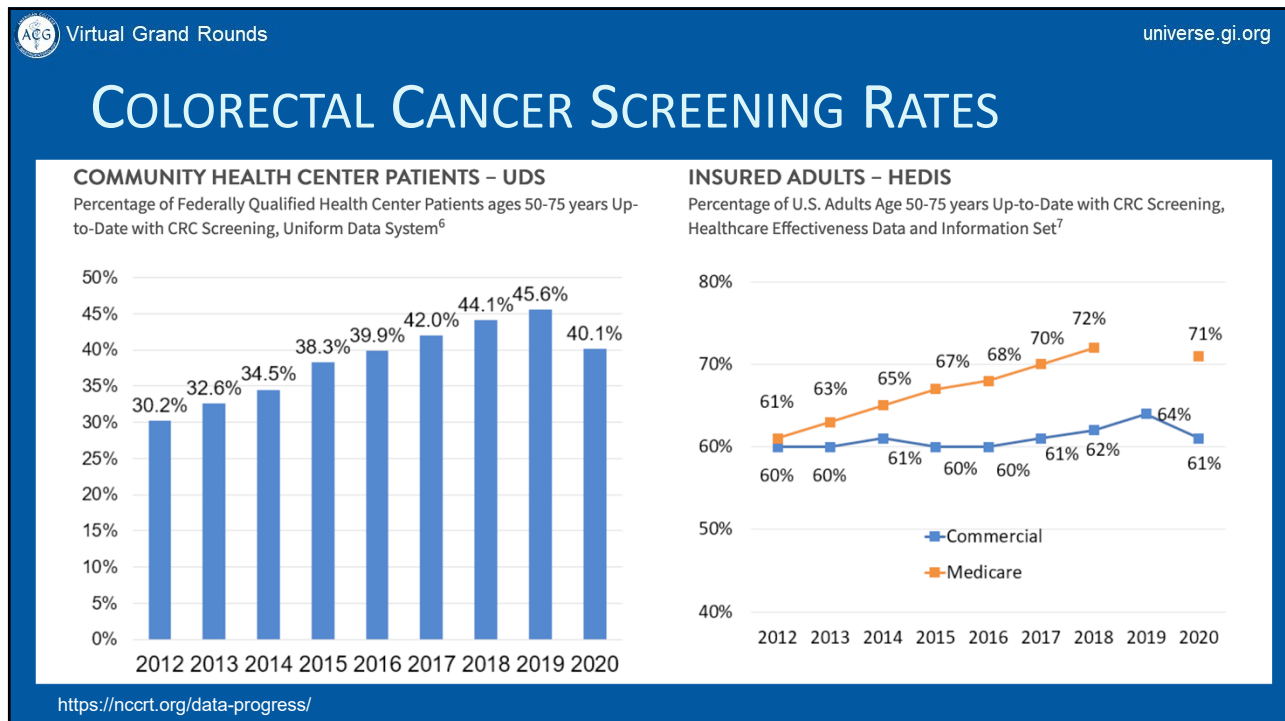
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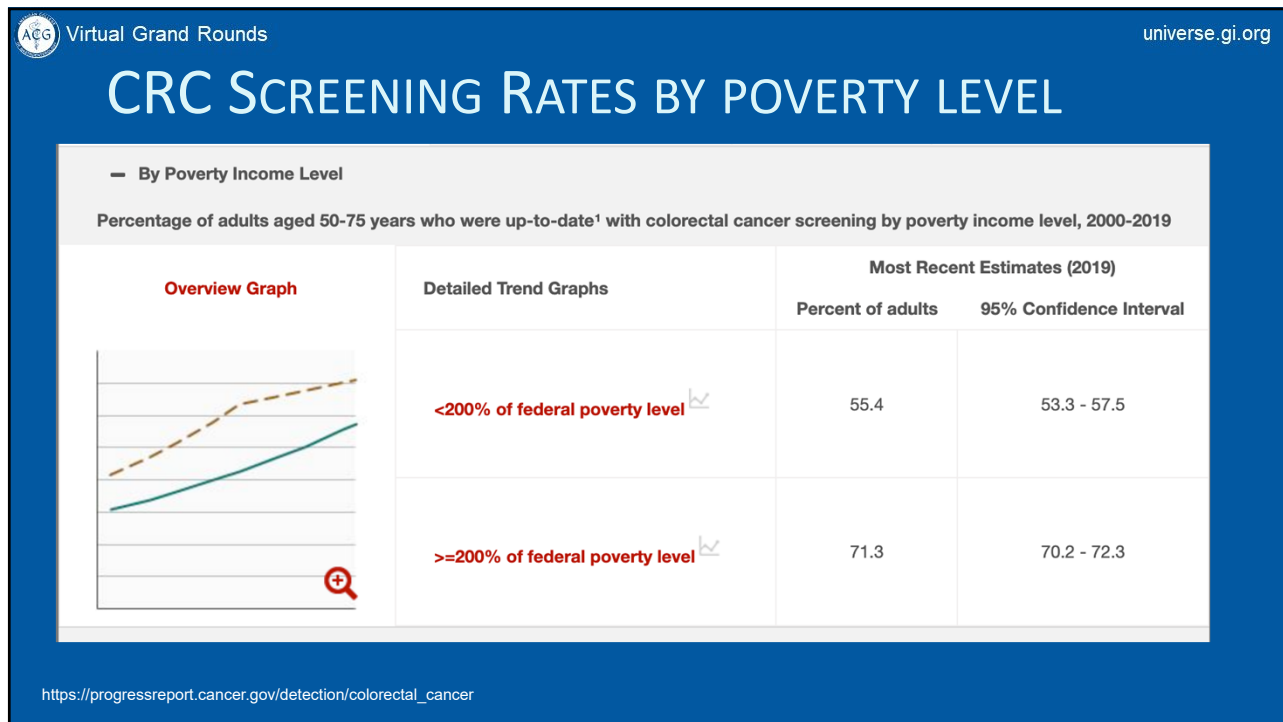
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STRATIFICATIONS OF DISPARITIES IN SCREENING OUTCOMES

- Race/Ethnicity
- Occupation
- Sex
- Educational level
- Socioeconomic status
- Insurance coverage
- Geographic location
- Age
- Neighborhoods, county, state, rural vs urban etc
- English proficiency/language
- Immigrant Status
- Income
- Behavioral risk factors

Doubeni, Chyke A, Kevin Selby, and Samir Gupta. "Annual Review of Medicine 72 (2021): 383.

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CAUSATION IS COMPLEX

- Differences in access
 - Preventative services
 - Screening services
- Social risk factors
 - Lack of culturally aligned services
 - Driven by SDOH
- Inadvertent creation of structural barriers

Doubeni, Chyke A, Kevin Selby, and Samir Gupta. "Annual Review of Medicine 72 (2021): 383.

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HOW DO WE CLOSE THE GAP?

- Equitable access
- Quality access
- Health equity framework
 - Social determinants of health
 - Policy
 - Community engagement
 - Individual
 - Screening processes
- **Stratify barriers and facilitators to CRC screening**

Doubeni, Chyke A, Kevin Selby, and Samir Gupta. "Annual Review of Medicine 72 (2021): 383.

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ACCESS TO HEALTHCARE IS NOT EQUITABLE

- Caring for the **whole person**, and **understanding their lived environment** must inform strategies for health care delivery.
- Providers need to **recognize** underlying **social determinants of health** in the populations we serve, and **tailor care** accordingly.
- High-quality care should be **accessible** to our patients where they live, work and play.

Precision Population Health

Slide Credit – Olugbenga Ogedegbe, MD, MPH

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SOCIAL DETERMINANTS OF HEALTH

Socioeconomic Factors

Education

Job Status

Family/
Social Support

Income

Community Safety

Physical Environment

Health Behaviors

Diet &
Exercise

Alcohol
Use

Sexual
Activity

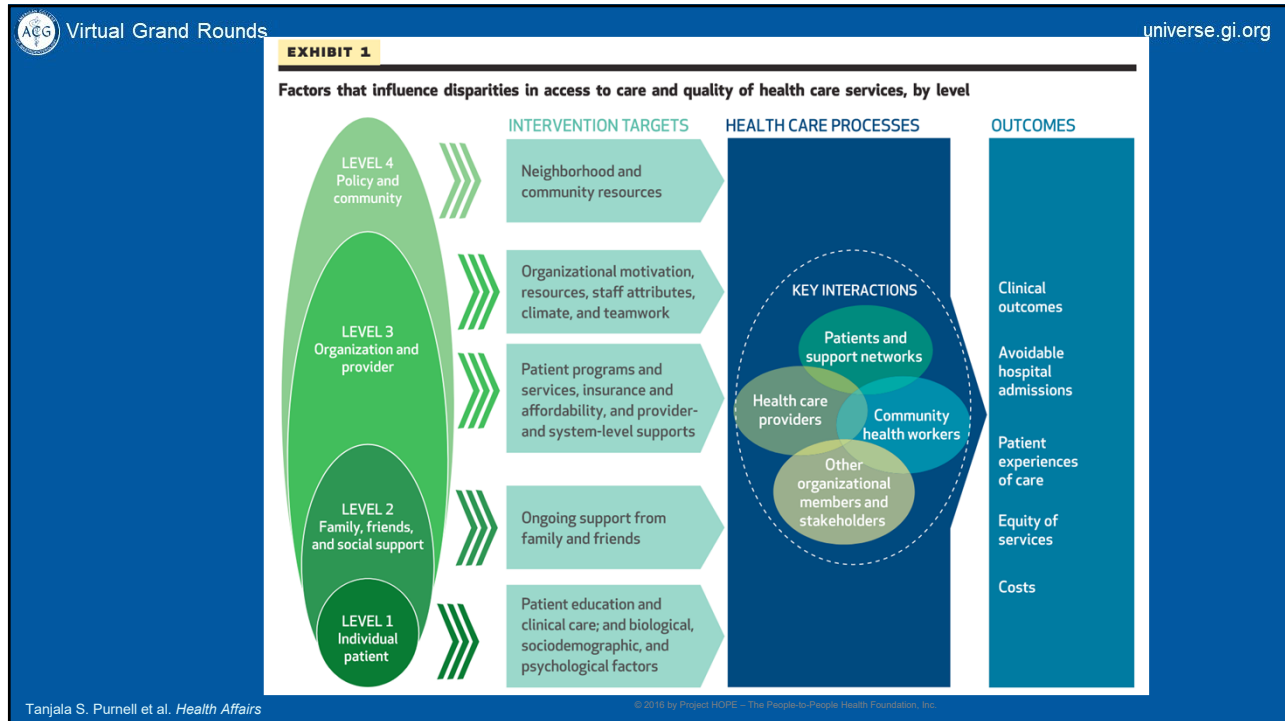
Health Care

Access to Care
Quality of Care

→ **Root causes of health inequities**

National Academies of Sciences, Engineering, and Medicine. 2017. Communities in Action: Pathways to Health Equity. Washington, DC: The National Academies Press.

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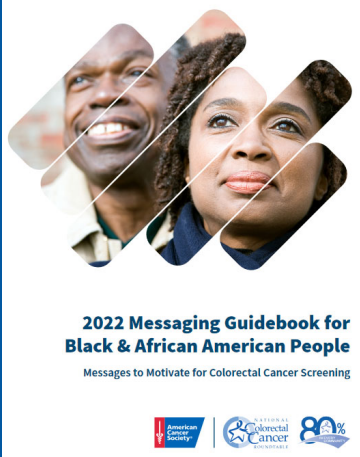
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INTERVENTIONS

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LEVEL 1: PATIENT EDUCATION



- 1. NCCRT 2022 Messaging Guidebook for Black or African American People
- 2. ACG CRC Community education toolkit
- 3. CDC What should I know about CRC screening
- 4. Multilingual resources should be utilized

file:///C:/Users/willir02/AppData/Local/Temp/2022-CRC-African-Americans-Messaging-Companion-Guide_1.pdf

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LEVEL 2: FAMILY, FRIENDS AND SOCIAL SUPPORT

LEVEL 3: PROVIDER AND ORGANIZATIONS

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CULTURALLY COMPETENT CARE - INDIVIDUAL

Linguistic and/or cultural matching

Bilingual/bicultural medical professionals
 Medical represent the target community

Incorporation of culturally specific concepts into individual contacts

Perception of access barriers to care
 Use of specific culturally competent communication
 Use culturally specific language patterns

Use of culturally and linguistically adapted/appropriate written or visual material

Consent forms
 Screening instruments
 Videos

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CULTURALLY COMPETENT CARE - INDIVIDUAL

- Involvement of families
 - Families are involved in the treatment process
- Continuity of care
 - Follow up clinic visits
 - Home visits
 - Telephone calls

Handtke, O., Schilgen, B., & Mösko, M. (2019). *PloS one*, 14(7), e0219971.

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CULTURALLY COMPETENT CARE - ORGANIZATION

- Cultural competence training for healthcare providers
- Human resources development
 - Recruitment of bilingual staff
- Integration of interpreter services
- Adaption of facility's social and physical environment

Handtke, O., Schilgen, B., & Mösko, M. (2019). *PLoS one*, 14(7), e0219971.

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LEVEL 4: POLICY AND COMMUNITY

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PROVIDING ACCESS TO CULTURALLY COMPETENT CARE

- Integration of community health workers (CHW)
 - Help patients navigate the system
- User engagement and networking
 - Strategies to assure cultural appropriateness of healthcare interventions
- Telemedicine
 - Overcome limited access to healthcare
- Creating community health networks

Handtke, O., Schilgen, B., & Möske, M. (2019). *PLoS one*, 14(7), e0219971.

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PRINCIPLES OF COMMUNITY ENGAGEMENT

- ✓ Have a shared goals with the community
- ✓ Understand the community and history of engagement
- ✓ Build trust and see come in from stakeholders
- ✓ Respect diverse perspectives within a community
- ✓ Identifying mobilize community assets
- ✓ Partner with the community
- ✓ Assure community ownership and control of actions
- ✓ Long-term commitment

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DELAWARE CANCER CONSORTIUM

- **Establishment of the Delaware Cancer Advisory Council in 2001**
 - Develop a statewide cancer control program
 - Increase CRC screening
 - Target quality treatment
 - Utilize patient navigation to promote access to screening and proper care
 - “Turning Commitment into Action”
- **Fully funded by the Delaware State Legislature in 2003**
 - CRC screening program
 - Provided reimbursement to uninsured Delaware residents
 - Coverage via Medicaid and Medicare
 - Cancer treatment program for the uninsured (2004)
 - Coverage for 2 years of therapy for the uninsured
 - Emphasis on African-American cancer disparity reduction
 - Nurse navigators
 - Underserved community organizations

Grubbs et. al Journal of Clinical Oncology 2013;31(16):1928-1930

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Table 1. Trends in CRC Screening, Incidence, and Mortality Rates by Race in Delaware: 2001 and 2009

Trend	2001*		2009		Change From 2001 to 2009 (%)	
	Black	White	Black	White	Black	White
Ever had screening colonoscopy, %	47.8	58.0	73.5	74.7	54	29
CRC incidence rate per 100,000†	66.9	58.2	44.3	43.2	-34	-26
Total No. of cases‡	205	1,206	235	1,149		
CRC mortality rate per 100,000†	31.2	19.5	18.0	16.9	-42	-13
Total No. of cases§	88	398	75	420		

Data adapted.²⁸

Abbreviation: CRC, colorectal cancer.

*Program started in 2002.

†3-year average, age adjusted.

‡Black and white differences in incidence significant at $P < .001$.§Black differences in mortality significant at $P < .001$; white, $P = .002$.

- **Cost Analysis**
 - CRC incidence across USA: **\$14 billion** annually
 - Delaware screening program : **\$1 million** annually
 - Increased screening: \$8.5 million saved from reduced incidence and stage shift

Grubbs et. al Journal of Clinical Oncology 2013;31(16):1928-1930

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C5 MISSION STATEMENT

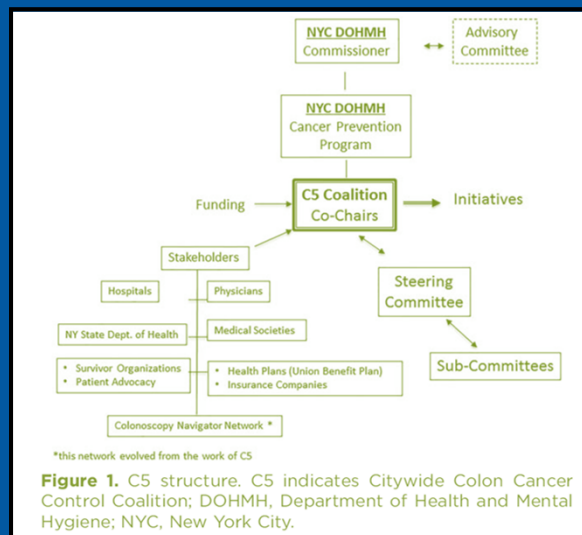
To partner with the NYC DOHMH to increase awareness and screening for colorectal cancer and adenomatous polyps in NYC men and women in order to reduce the incidence and mortality of this highly prevalent and preventable disease

Itzkowitz, S et. al Cancer 122.2 (2016): 269-277.

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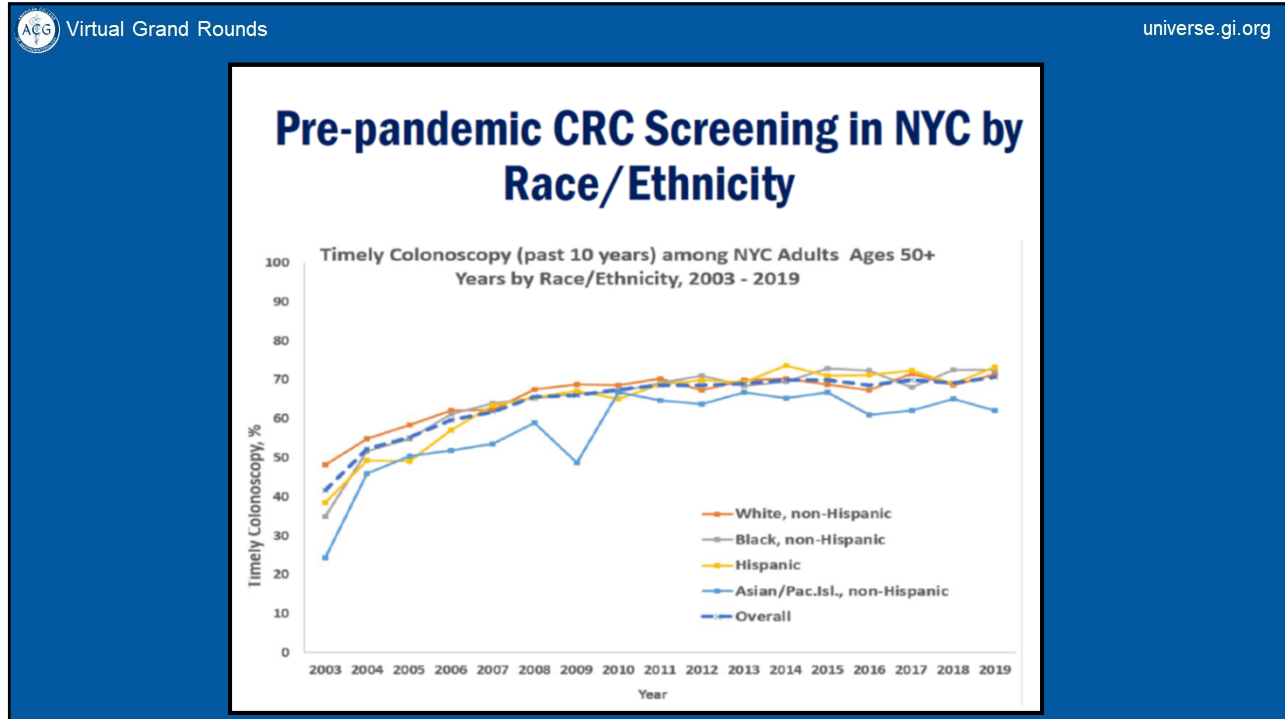
NYC COLORECTAL CANCER CONTROL COALITION (C5)

- 1500 CRC deaths per year in NYC
- 42% screening rate in 2003

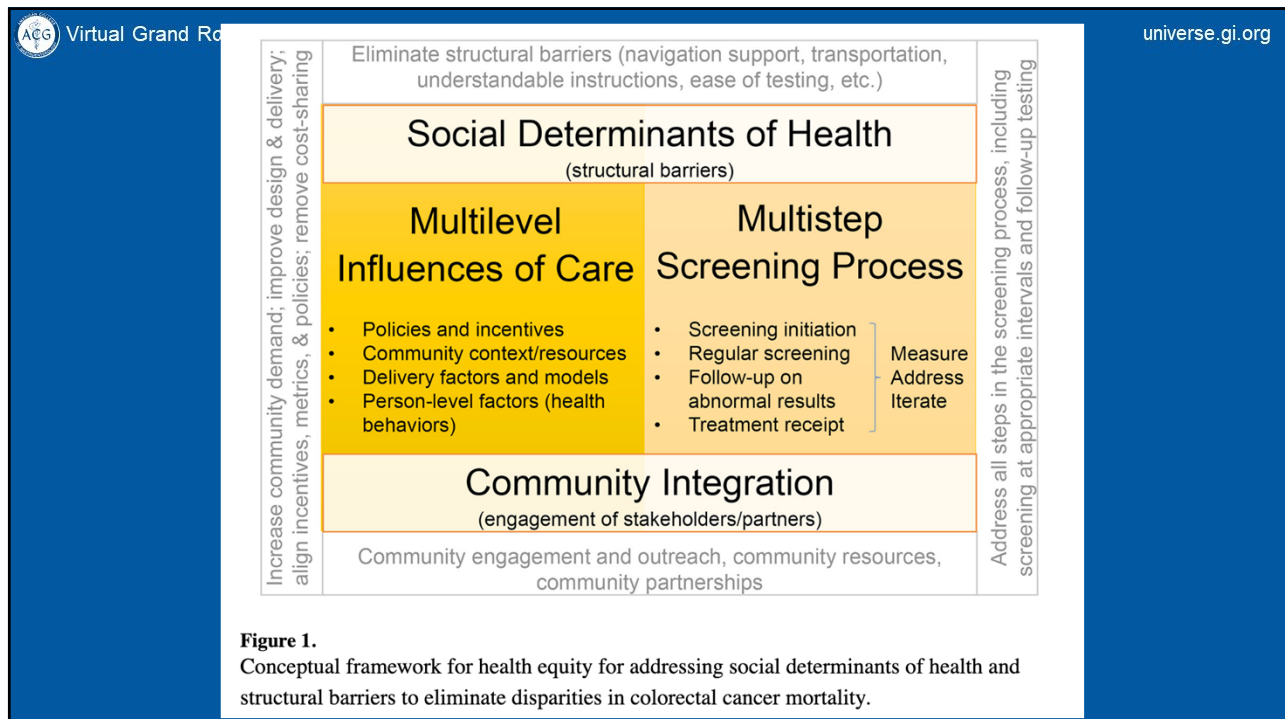


Itzkowitz, S et. al Cancer 122.2 (2016): 269-277.

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THANK YOU

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Questions



Renee L. Williams, MD, MHPE, FACG



Loren G. Rabinowitz, MD

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CONNECT AND COLLABORATE IN GI



ACG & CCF IBD Circle



ACG Hepatology Circle



ACG Functional GI
Health and Nutrition Circle



GI

ACG GI Circle

Connect and collaborate within GI



ACG Women in GI Circle

ACG's Online Professional Networking Communities
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