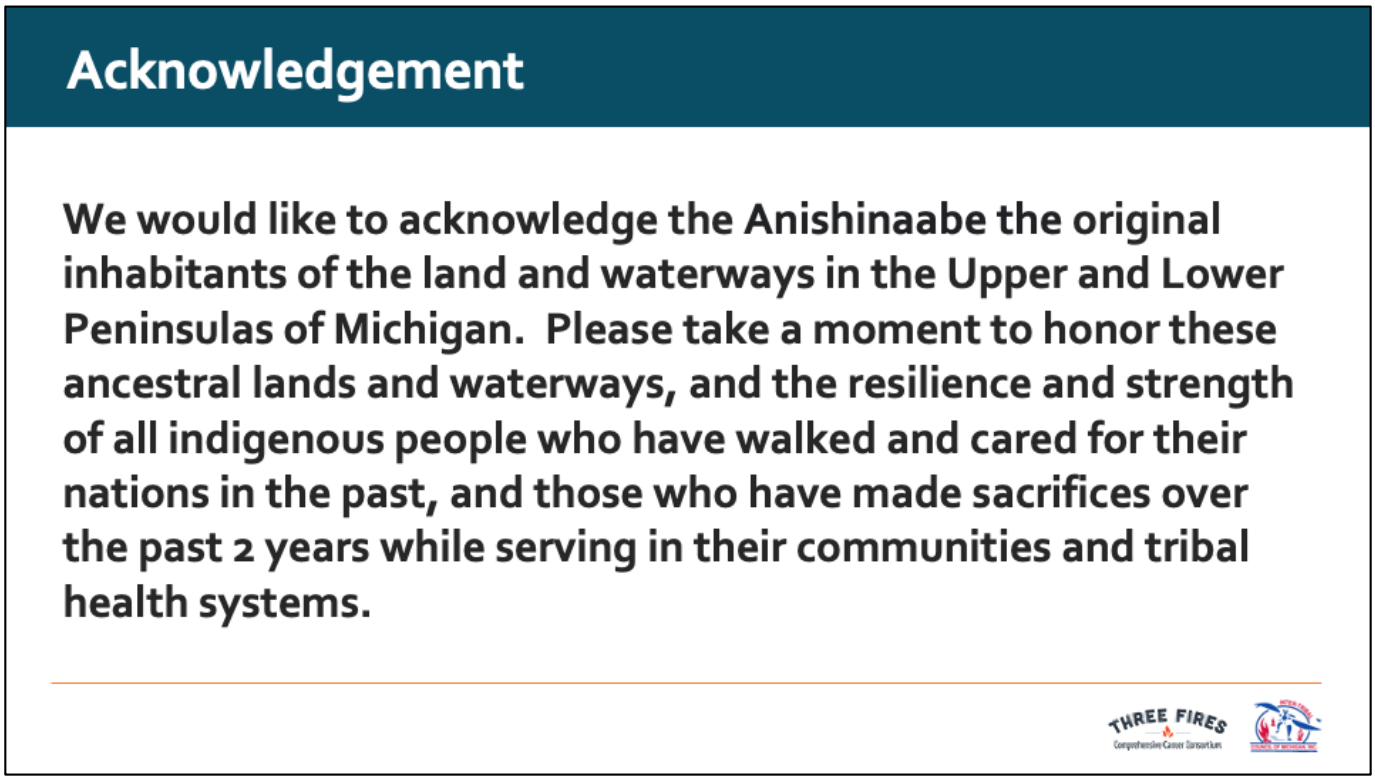
This presentation is a collaboration with Beth Sieloff, MPH (Inter-Tribal Council of Michigan) and Alyssa Allen, MPH Candidate (Grand Valley State University)

The Inter-Tribal Council of Michigan, Inc. (ITCM) is a 501©(3) non-profit corporation duly organized under a State Charter filed April 16, 1968. The Inter-Tribal Council of Michigan, Inc. is located in Sault Ste. Marie, Michigan. It represents twelve federally recognized tribes in Michigan.

Mission Statement

1. To act as a forum for member tribes
2. To advocate for member tribes in the development of programs and policies which will improve the economy, education, and quality of life for Michigan's American Indians; and

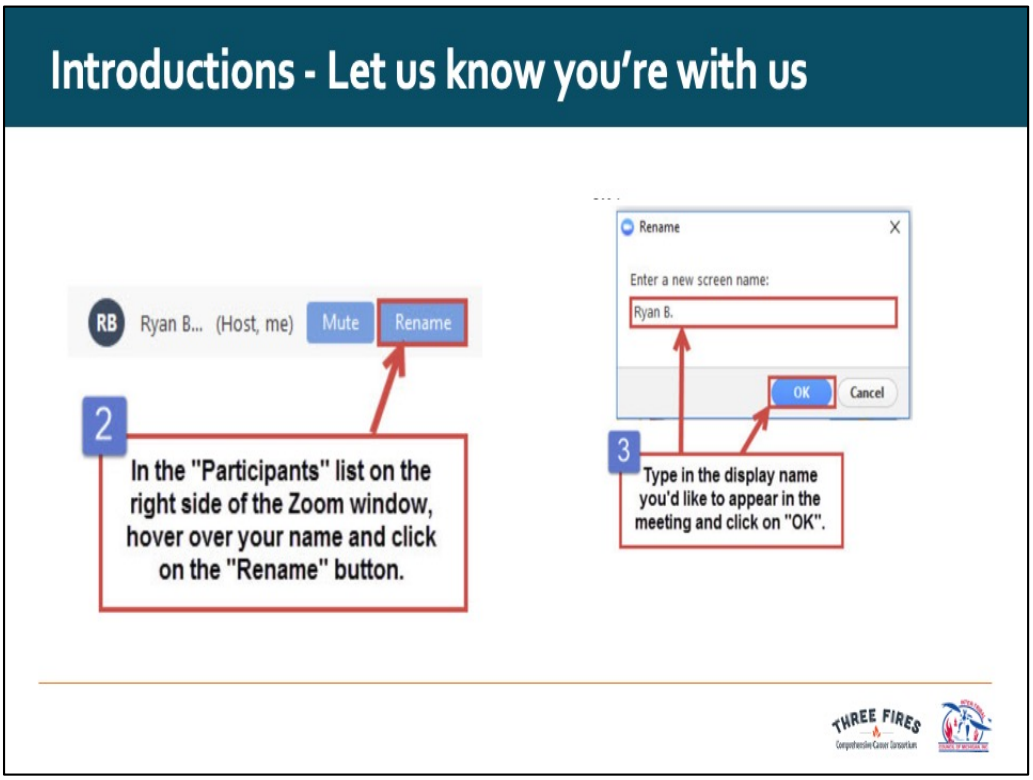
3. To provide technical assistance to member tribes, assisting in the development of tribal regulations, ordinances, and policies applicable to health and human services.



Ainni everyone, thank you for joining us today. I am Beth Sieloff, a cancer prevention and control specialist serving Michigan tribal communities at the Inter-Tribal Council of Michigan. As we come together today, **we would like to acknowledge the Anishinaabe the original inhabitants of the land and waterways in the Upper and Lower Peninsulas of Michigan. Please take a moment to honor these ancestral lands and waterways, and the resilience and strength of all indigenous people who have walked and cared for their nation's in the past, and those who have sacrificed over the past 2 years while serving in their communities and tribal health systems.**

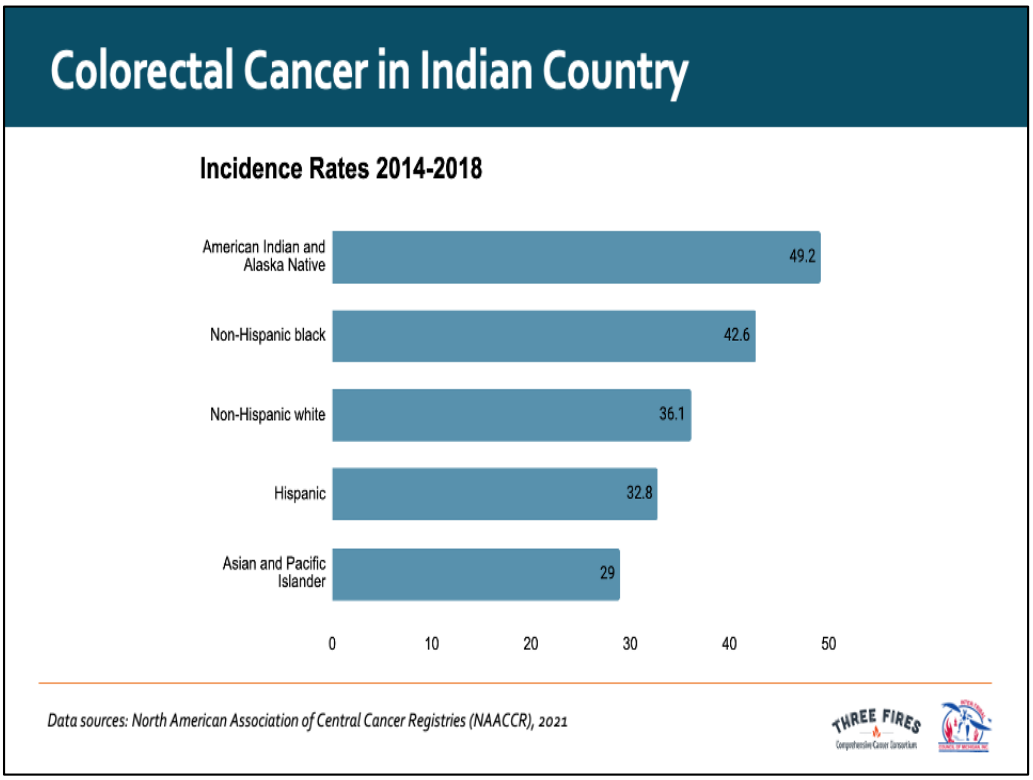
I would like to introduce you to Alyssa Allen. Alyssa is a master of public health candidate who is dedicating her graduate course work to ending colorectal cancer disparities

in indigenous populations.



Annii, my name is Alyssa Allen and I am a Master of Public Health Candidate at Grand Valley State University in Michigan. I am honored to be with you today. I am a graduate student working with the Inter-Tribal Council of Michigan, and supporting the 3 Fires Cancer Consortium to improve colorectal cancer screening rates in our tribal communities. We have a big group with us today, so please take time to ensure your name and organization are present for others to acknowledge, and feel free to introduce yourself in the chat.

We will have a moderator for questions, so if at anytime you would like to share a comment or question please raise your hand or let us know in the chat, so we can pause and make this an open discussion.



As professionals serving our indigenous populations across the United States, you are all aware of the Colorectal Cancer Disparities in Indian Country. In honor of those who are colorectal cancer survivors, and those who walked on early due to colorectal cancer, we are taking time today to address CRC disparities, and most importantly screening refusals. While the Community Guide provides guidance to evidence based interventions such as patient reminders, provider reminders and provider assessments, we often overlook strategies to address patient refusals.

As you can see in this slide comparatively from 2014 - 2018 the incidence rates are higher among American Indians and Alaska Natives, and recent data for the period of the pandemic is indicating that CRC screen rates have declined further.

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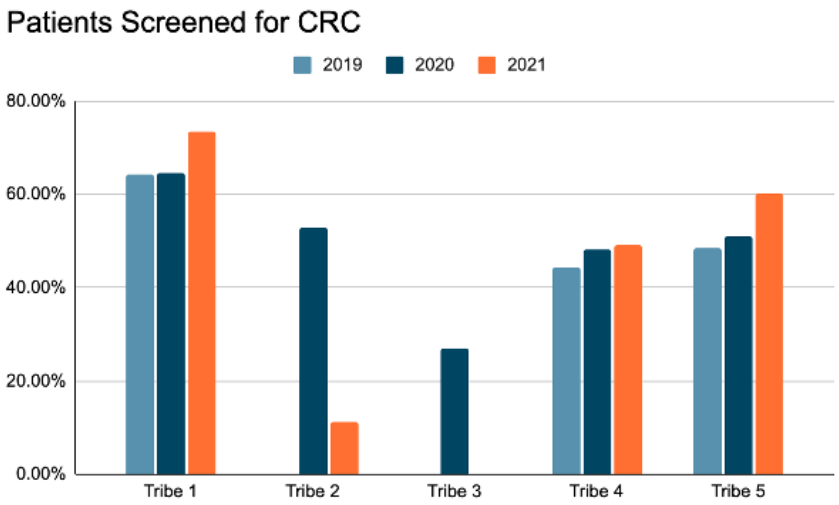
*Colorectal Cancer average annual rate per 100,000

American Cancer Society. (n.d.). *Colorectum*. Retrieved March 2022, from https://cancerstatisticscenter.cancer.org/?_ga=2.196635054.384246894.1645146211-389603593.1645146210#!/cancer-site/Colorectum

Screening Rates in Michigan Tribal Communities



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In addition to the national data, here we can see some state data across 5 tribal health centers in Michigan. As you can see here, CRC screening rates can vary greatly among tribal health centers. These variations in rates can be attributed to the evidence based interventions being implemented, other factors such as the pandemic, or often the case is incorrect documentation or the corruption of data in the clinic's EHR systems. It is also important to note race misclassification, American Indians are misclassified about 45% of the time, this means incidence, mortality, and screening rates are underestimated.

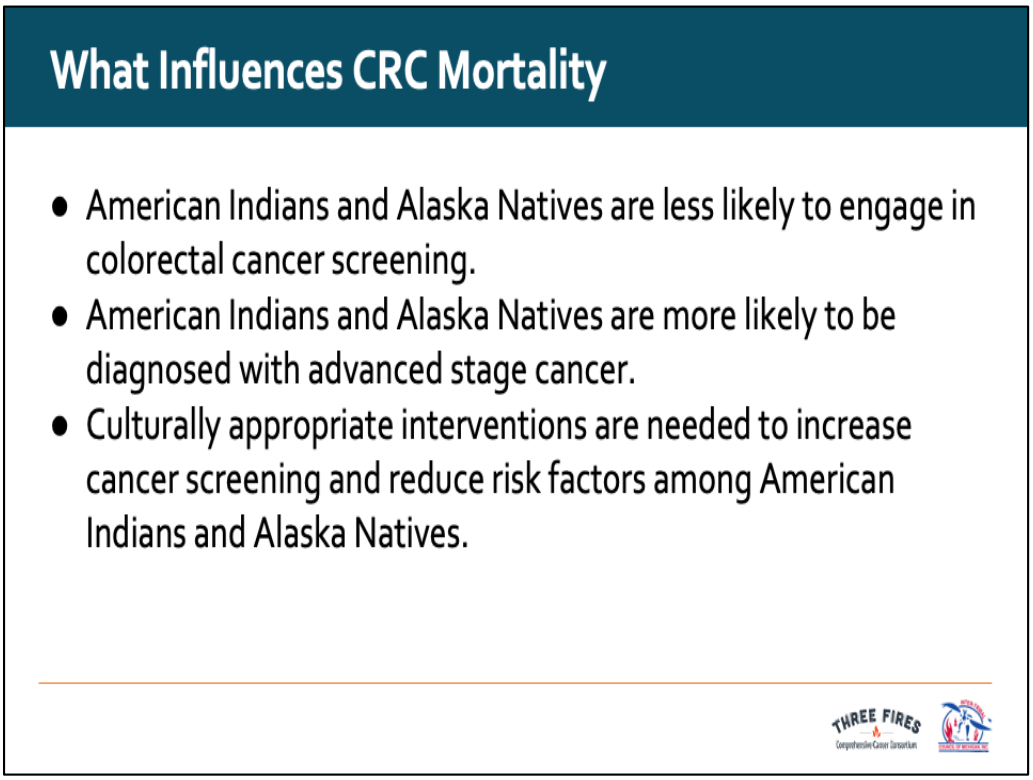
Remarkably, while the national data is showing screening rates have declined you can see here with sustained evidence based intervention efforts we are showing an increase in CRC screening rates across the state of Michigan.

And as you know low screening rates generally lead to increased mortality rates.

Questions?

Ref: Three Fires Cancer Consortium

Perdue, D. G., Perkins, C., Jackson-Thompson, J., Coughlin, S. S., Ahmed, F., Haverkamp, D. S., & Jim, M. A. (2008). Regional differences in colorectal cancer incidence, stage, and subsite among American Indians and Alaska Natives, 1999–2004. *Cancer*, *113*(S5), 1179–1190. https://doi.org/10.1002/cncr.23726

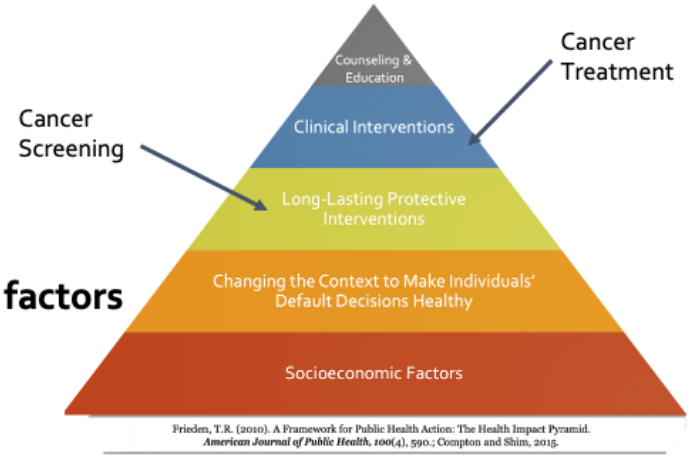


When our screening rates are low our mortality rates are higher. Culturally appropriate interventions are needed to increase cancer screening and reduce risk factors among American Indians and Alaska Natives.

Batai, K., Gachupin, F. C., Estrada, A. L., Garcia, D. O., Gomez, J., & Kittles, R. A. (2019). Patterns of Cancer Related Health Disparities in Arizona. *Cancer health disparities*, *3*, e1–e20.

Disparities of Refusing CRC Screening andTreatment

- **Patient related factors**
  - Socioeconomic status
  - Cultural differences
  - Limited health care literacy
  - Mistrust
  - Dissatisfaction
- **Physician and health care related factors**
  - Lack of cultural competency
  - Unique health care system
  - Funding status



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Here are some disparities that influence individuals refusing cancer screening and cancer treatment. Disparities include both the patient and practitioner level. Some patient level factors are limited health literacy, cultural differences, socio economic factors and mistrust.

Looking at Frieden's Health Impact pyramid Interventions at the top tiers are designed to help individuals rather than entire populations, but they could theoretically have a large population impact if universally and effectively applied. In practice, however, even the best programs at the pyramid's higher levels achieve limited public health impact, largely because of their dependence on long-term individual behavior change.

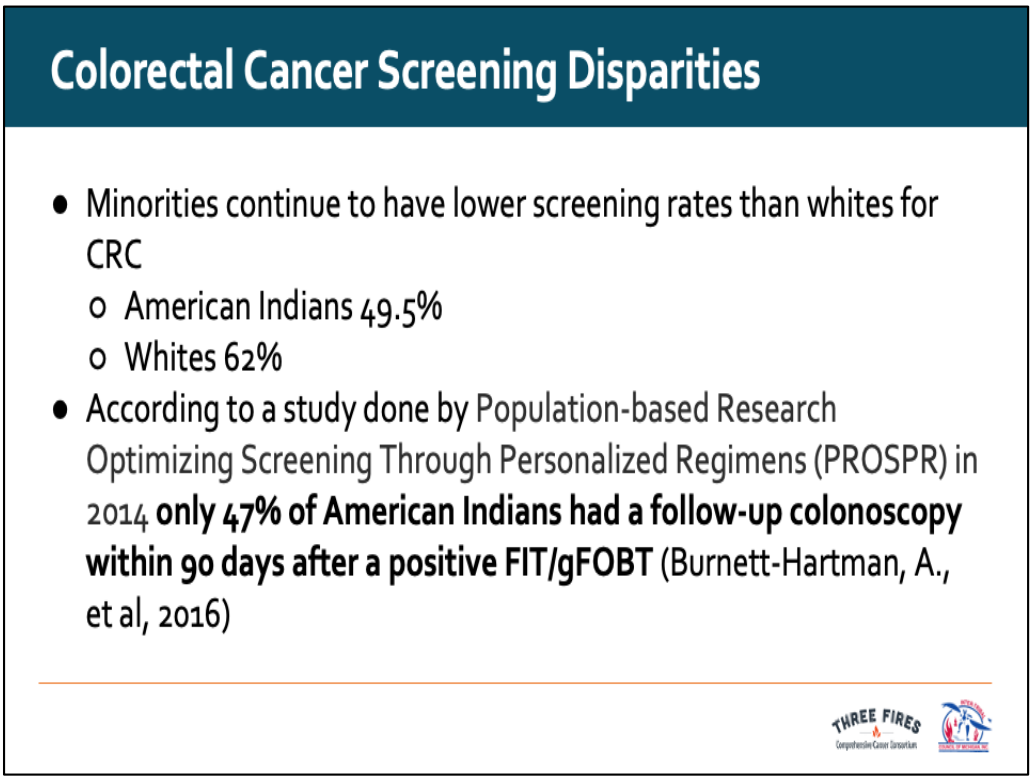
The third level of the pyramid represents 1-time or infrequent protective interventions that do not require ongoing clinical care; these generally have less impact than interventions represented by the bottom 2 tiers because they necessitate reaching people as individuals rather than collectively.

Elders, parents, aunts, and uncles have a large influence in our tribal communities, don't you think that addressing the patient and provider related factors in our tribal communities can influence behaviors toward long lasting protective interventions, trust in clinical interventions?

Questions?

Frieden T. R. (2010). A framework for public health action: the health impact pyramid. *American journal of public health*, *100*(4), 590–595. https://doi.org/10.2105/AJPH.2009.185652

Ashleigh Guadagnolo, Kristin Cina, Petra Helbig, Kevin Molloy, Mary Reiner, E. Francis Cook, & Daniel G. Petereit. (2008). Medical Mistrust and Less Satisfaction With Health Care Among American Indians Presenting for Cancer Treatment. *Journal of Health Care for the Poor and Underserved*, *20*(1), 210–226. https://doi.org/10.1353/hpu.0.0108



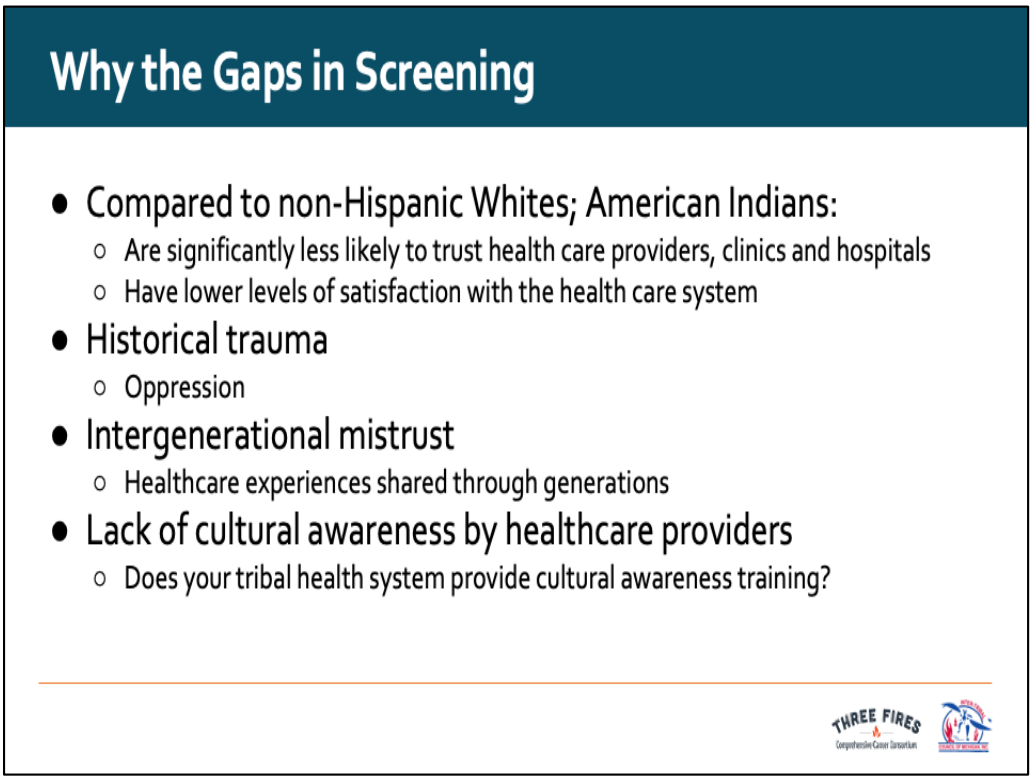
- According to Behavioral Risk Factor Surveillance System data from 2010, self reported CRC screening was 49.5% for American Indians while 62% of whites reported CRC screening.
    - American Indians were behind Black, Native Hawaiian/Pacific Islander, and Hispanic-English.

Burnett-Hartman, A. N., Mehta, S. J., Zheng, Y., Ghai, N. R., McLerran, D. F., Chubak, J., Quinn, V. P., Skinner, C. S., Corley, D. A., Inadomi, J. M., & Doubeni, C. A. (2016). Racial/Ethnic Disparities in Colorectal Cancer Screening Across Healthcare Systems. *American Journal of Preventive Medicine*, *51*(4), e107–e115. https://doi.org/10.1016/j.amepre.2016.02.025

Batai, K., Gachupin, F. C., Estrada, A. L., Garcia, D. O., Gomez, J., & Kittles, R. A. (2019). Patterns of Cancer Related Health Disparities in Arizona. *Cancer health disparities*, *3*, e1–e20.

Liss, D. T., & Baker, D. W. (2014). Understanding Current Racial/Ethnic

Disparities in Colorectal Cancer Screening in the United States. *American Journal of Preventive Medicine*, *46*(3), 228–236. https://doi.org/10.1016/j.amepre.2013.10.023



Absence of culturally based interventions can lead to distrust of the healthcare system and loss to follow-up. As discussed on the previous slide, less than 50% of American Indians who have a positive FIT/FOBT test had a diagnostic colonoscopy, this data supports the rates of late stage diagnosis for CRC.

- Examples of historical trauma include oppression
- Personal experiences with healthcare practitioners and the healthcare system shared over the years through generations.
- Healthcare professionals lacking the cultural understanding and the patient's beliefs

Canales, M. K., Weiner, D., Samos, M., Wampler, N. S., Cunha, A., & Geer, B. (2011). Multi-generational Perspectives on Health, Cancer, and Biomedicine: Northeastern Native American Perspectives Shaped by Mistrust. *Journal of Health Care for the Poor and Underserved*, *22*(3), 894–911. https://doi.org/10.1353/hpu.2011.0096

B. Ashleigh Guadagnolo, Kristin Cina, Petra Helbig, Kevin Molloy, Mary Reiner, E. Francis Cook, & Daniel G. Petereit. (2008). Medical Mistrust and Less Satisfaction With Health Care Among American Indians Presenting for Cancer Treatment. *Journal of Health Care for the Poor and Underserved*, *20*(1), 210–226. https://doi.org/10.1353/hpu.0.0108

Cancer Screening Refusals vs Cancer Treatment

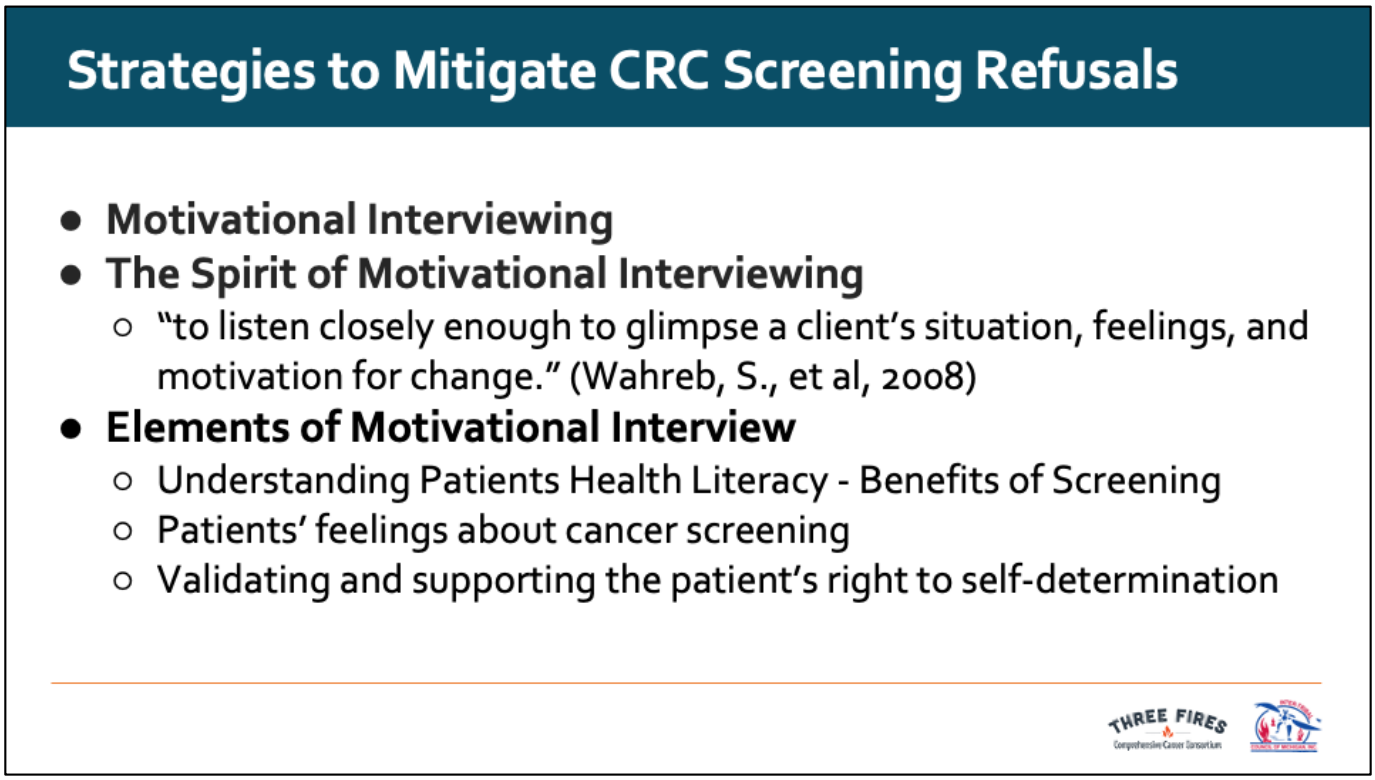
In research assessing cancer screening disparities among American Indians there were significant differences by race/ethnicity about the impact of a cancer diagnosis and treatment. (Guadagnolo et al., 2009)

- 64% of American Indians compared to 41% of whites agreed that cancer treatment "always takes many weeks of daily treatment."
- 29% agreed cancer treatments "always make people so sick that they are unable to go about their daily lives," compared to only 1% of whites.
- American Indians also agreed that a diagnosis of cancer can result in being treated in a way that makes them uncomfortable compared to whites.

Overall, American Indians often have less knowledge about the benefits of cancer screening. As you are aware, CRC is preventable with early screening. As you see in this slide, American Indians have higher rates of negative attitudes on cancer treatment and are often less likely to engage in treatment, so today we are going to address cancer screening refusals to improve early diagnosis and preventable screenings.

Questions?

Guadagnolo, B. A., Cina, K., Helbig, P., Molloy, K., Reiner, M., Cook, E. F., & Petereit, D. G. (2009). Assessing Cancer Stage and Screening Disparities among Native American Cancer Patients. *Public Health Reports*, *124*(1), 79–89. https://doi.org/10.1177/003335490912400111



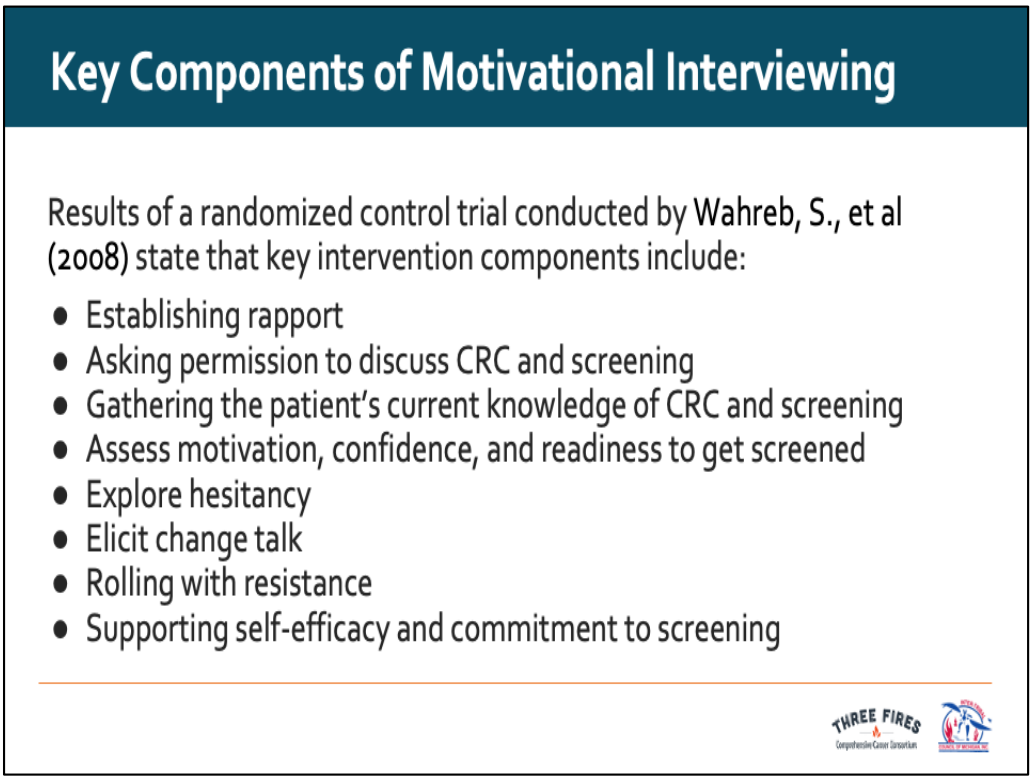
Motivational Interviewing is a skill, but more importantly a technique for enhancing the motivation to change by resolving the patients hesitancy.

The Spirit of Motivational Interviewing is they style in which practitioners "take time to listen closely enough to glimpse a client's situation, feelings, and motivation for change," or in this specific example; completing their cancer screening.

Elements of MI

- Practitioners should promote an environment that is conducive rather than coercive to change. Rather than telling the patient what to do the practitioner should work with the patient to understand what they do and don't know about colorectal cancer and screening.
- Capturing the client's intrinsic motivations for change by using the patient's own perceptions, goals and values.
- Validates and supports the patient's right to self-determination.

Canales, M. K., Weiner, D., Samos, M., Wampler, N. S., Cunha, A., & Geer, B. (2011). Multi-generational Perspectives on Health, Cancer, and Biomedicine: Northeastern Native American Perspectives Shaped by Mistrust. *Journal of Health Care for the Poor and Underserved*, *22*(3), 894–911. https://doi.org/10.1353/hpu.2011.0096



Wahab, S., Menon, U., & Szalacha, L. (2008). Motivational interviewing and colorectal cancer screening: A peek from the inside out. *Patient Education and Counseling*, *72*(2), 210–217. https://doi.org/10.1016/j.pec.2008.03.023

Rolling with Resistance

Types of reflections:

- Simple - reflects what is heard
- Amplified - amplifies the resistance that is heard
- Double sided - reflects points on both sides
- Shifting focus - shifting attention away from what is blocking progress
- Emphasizing personal choice - emphasizes the choice is entirely up to the patient
- Reframing - places a different meaning on what patient says so they do not seem so resistant

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The patient: "I really do not want to get screened, it scares me." The Practitioner: "I am hearing that CRC screening scares you and you do not want to do it."

The Patient: "I fear they will find something if I get screened." The Practitioner: "It sounds like you are scared your screening result will be something you do not want to hear."

The Patient: "I understand screening is important but I do not have any known family history or symptoms." The Practitioner: "From what I am hearing, you know that screening is important but you are also saying that your lack of family history and lack of symptoms means you do not need to be screened."

The Patient: "You are probably telling me I need to be screened because

you know I do not eat healthy." The Practitioner: "It sounds like you think I am here to tell you everything you are doing wrong, I apologize if that is your impression. I am here to have a discussion with you about your thoughts about screening and answer any questions you may have."

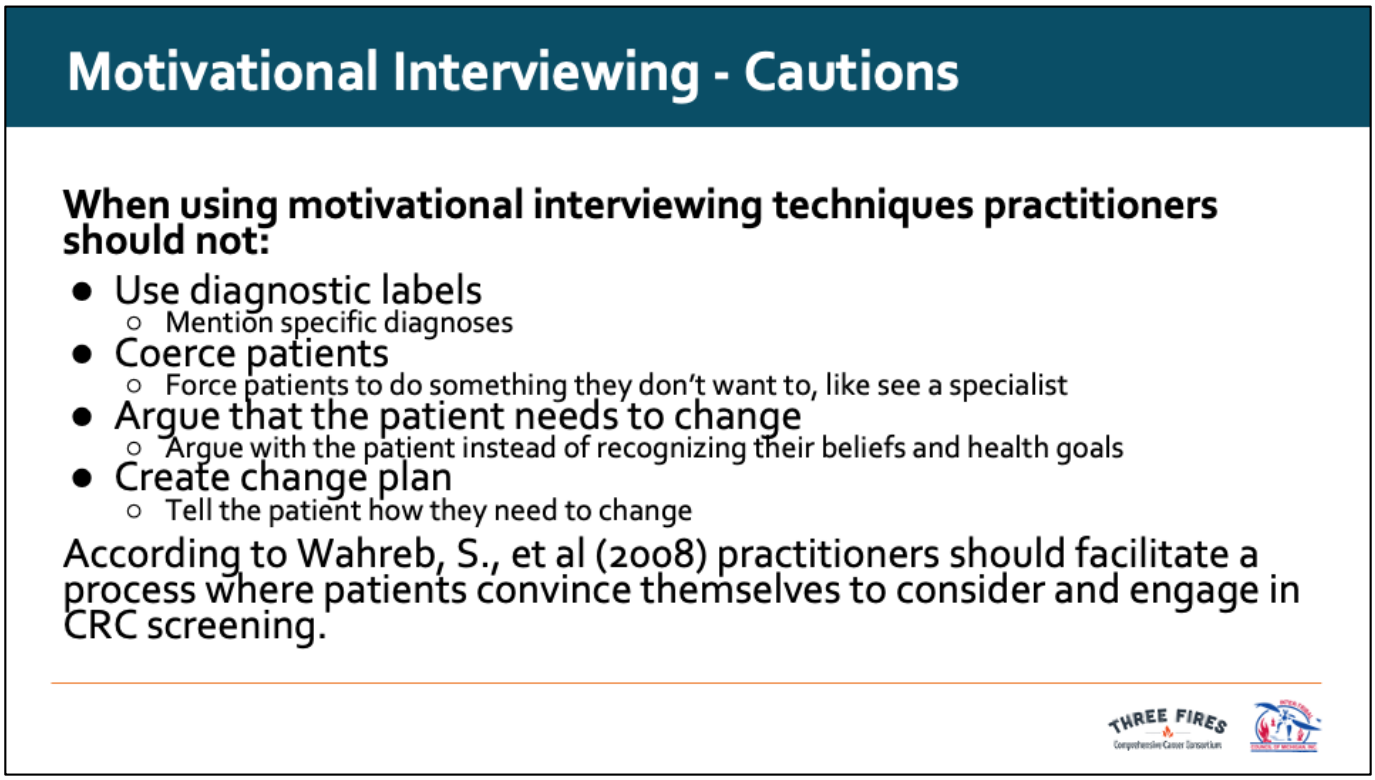
The Patient: "I am upset that everyone thinks they know what is best for me." The Practitioner: "I am sorry you are feeling that way, no one can force you to get screened, it is your personal choice."

The Patient: "My daughter keeps telling me I need to talk to my doctor and get screened, I know it is important but I know it will make me uncomfortable." The Practitioner: "It sounds like you feel that your daughter is telling you what to do, but her concern makes sense to you and you'd consider getting screened if you could talk to the doctor about it. How does that sound?"

Again, these are just some examples of how to support a discussion when you receive resistance from your patient. It is important to note this is just one component of Motivational Interviewing.

Questions or comments?

Wahab, S., Menon, U., & Szalacha, L. (2008). Motivational interviewing and colorectal cancer screening: A peek from the inside out. *Patient Education and Counseling*, *72*(2), 210–217. https://doi.org/10.1016/j.pec.2008.03.023



Here we have some cautions to mention related to MI. When using motivational interviewing techniques practitioners should not:

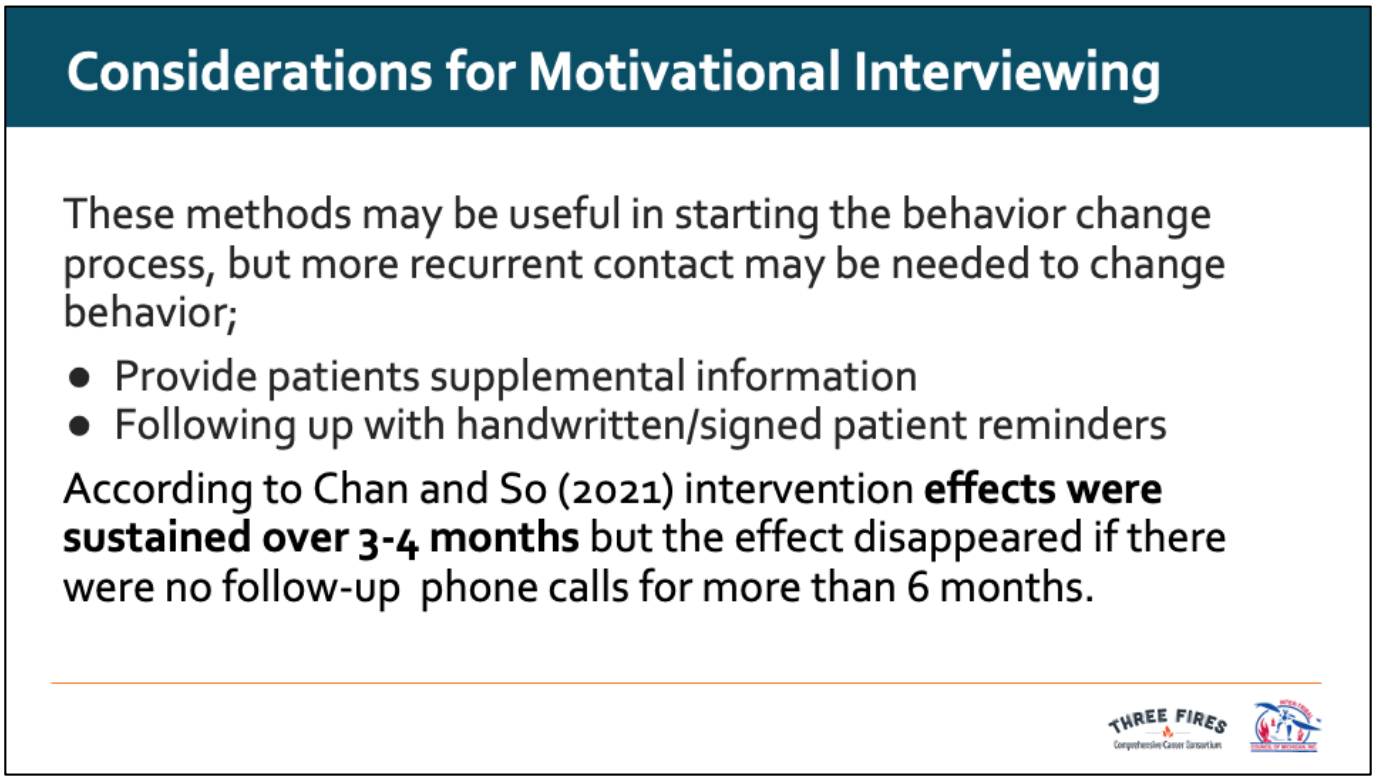
- Mention specific diagnoses
- Force patients to do something they don't want to, like see a specialist
- Argue with the patient instead of recognizing their beliefs and health goals
- Tell the patient how they need to change

Practitioners should facilitate a process where patients convince themselves to consider and engage in CRC screening.

When we use the word practitioner, regardless of our education level, or letters behind our last name, we are all practitioners in our efforts to support cancer screenings.

Wahab, S., Menon, U., & Szalacha, L. (2008). Motivational interviewing and colorectal cancer screening: A peek from the inside out.

Patient Education and Counseling, *72*(2), 210–217. https://doi.org/10.1016/j.pec.2008.03.023



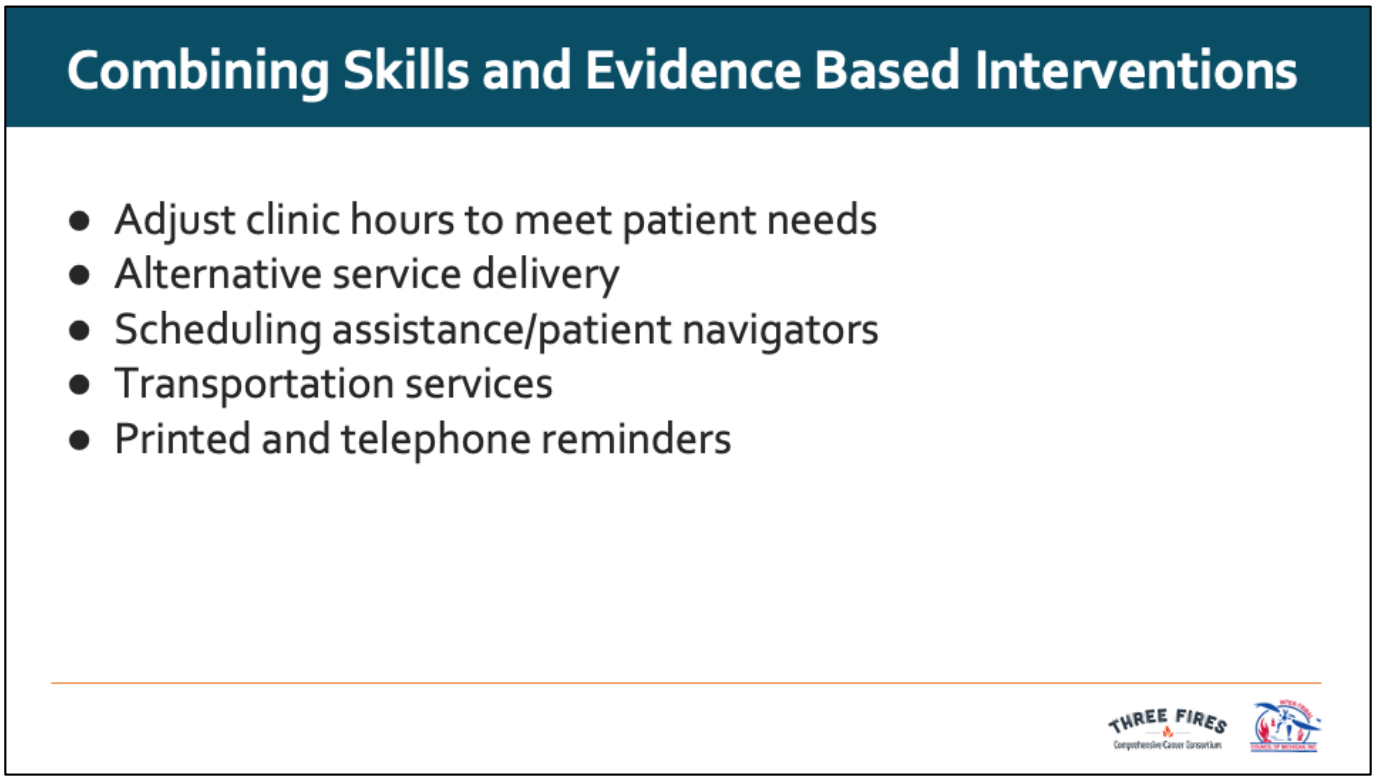
The methods we have discussed today can be useful in starting behavior change but it is important to know that more follow-up will be needed to elicit behavior change. Providing patients with supplemental information, like education materials about colorectal cancer and screening is useful, but also following up with your patients with personalized reminders is another method.

As you can see here on the slide, data shows that the effectiveness of intervention disappears if there is no follow-up for more than 6 months.

Emmons, K. (2001). Motivational interviewing in health care settings Opportunities and limitations. *American Journal of Preventive Medicine*, *20*(1), 68–74.https://doi.org/10.1016/s0749-3797(00)00254-3

Chan, D. N., & So, W. K. (2021). Effectiveness of motivational interviewing in enhancing cancer screening uptake amongst average-

risk
individuals: A systematic review. *International Journal of Nursing Studies*, *113*, 103786. https://doi.org/10.1016/j.ijnurstu.2020.103786



As you all know, using multiple interventions provides the best support for your communities in addressing cancer screening disparities. Motivational Interviewing competency is just one of many tools to support the efforts of your health system. The suggestions by the Community Preventive Services Task Force "Community Guide" can address the disparities influenced by the social determinants of health.

The Community Preventive Services Task Force "Community Guide" suggests the use of interventions to reduce structural barriers to increase screening for CRC. Examples of these structural barriers include:

- Adjust clinic hours to meet patient needs
- Alternative service delivery
- Scheduling assistance/patient navigators
- Transportation services
- Printed and telephone reminders

What are your current strategies?

- What is working?
- What is not working?

Questions?

If you are interested in receiving more information on gaining skills for motivational interviewing please e-mail info@itcmi.org

Chee Miigwetch for your time and support.

Cancer Screening: Reducing Structural Barriers for Clients –. (2021, December 22). The Guide to Community Preventive Services (The Community Guide). https://www.thecommunityguide.org/findings/cancer-screening-reducing-structural-barriers-clients-colorectal-cancer

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