- You know, I'm bringing us home to talk about your point about the importance of partners. There was a male with his partner that went through the inflatable colon, we call it the Super Colon, and he went through the Super Colon, and he comes out and he's like, "Doc, Doc, thank you so much for this. You know, because of this exhibit, I'm going to set my appointment next week to get screened." So his partner like punches him in the shoulder, and she's like, "I've been on you for this for months, and you haven't been to the doctor, and said you weren't gonna get this. And you had to go through some blow up colon, the bigger, you know, like a size of a tiny house to get screened?" And that's when I even started to think differently too, that like how something like that could be so powerful for someone versus what the research says. The research says that if someone close to you is for a behavior, the more likely you'll get a behavior. So, you know, like you wanna lose weight, you have a higher probability of continuously working out if you have a partner to work out with.

- [Announcer] You're listening to Further Together: The ORAU Podcast. Join Michael Holtz and his guests for conversations about all things ORAU. They'll talk about ORAU's storied history, our impact on an ever-changing world, our innovative scientific and technical solutions for our customers, and our commitment to the communities where we do business. Welcome to "Further Together," the ORAU podcast.

- Welcome to Further together: The ORAU Podcast. As ever, it's me, your host, Michael Holtz in the Communications and Marketing Department at ORAU, and we are having another of our continuing series of conversations about life in the cancer space, cancer advocacy, oncology, all of the things that we've been talking about for the last few months, and I have a special guest co-host for this episode, my friend and colleague, Brenda Blunt. Brenda is the Senior Director of Health Policy here at ORAU and knows a lot about healthcare and health equity. She's a former nurse, she's done health policy work. She's done lots of things in the health space, and I'm thrilled to have her as my co-host for this conversation. Brenda, welcome back to Further Together.

- Thank you, Michael. I am excited to be here. Always a very deep topic, but I'm so excited that the advocacy work and we have come so far in cancer care. We still have a long way to go, but I'm always excited to discuss the topic with you and share expertise from across the nation.

- And I am really excited to introduce our guest for this episode. Our guest is Dr. Charles R. Rogers. Dr. Rogers is the founder of the Colorectal Cancer Equity Foundation, and his background is deep. He's done some great work. He's a behavioral scientist and a master certified health education specialist. He has done men's health inequities research. He is part of the University of Michigan Mixed Methods Program. He has prioritized addressing health disparities among various underserved and socially vulnerable groups, and is a tireless advocate for Native Hawaiian and Pacific Islanders, older adults, African Americans, the unhoused, Somalis, adolescents, young adults, Hispanics, rural residents, Indigenous peoples, and sexual minorities. He has made a huge impact in the equity space, and in 2021, he founded the Colorectal Cancer Equity Foundation, which aims to address obstacles to colorectal cancer equity among African-American men and other underserved populations by increasing awareness about colorectal cancer, which is preventable, treatable, and beatable, and is a disease that no one should die from. And we wanna talk about that work with Charles today. Charles, I am so glad that you're here and so glad that we are having this conversation. Welcome to "Further Together."

- Awesome, awesome. Thank you and Dr. Brenda for having me.

- So glad to have you. So I know I talked a little bit about your background. Talk about what it is that led you to create the Colorectal Cancer Equity Foundation.

- Awesome, awesome. Great question. So I've been in this space for, you know, well over a decade, and, you know, as it relates to Black men, that's where I initially started. You know, I learned earlier in my career that Black men had the highest incidence of mortality or the chances of being diagnosed with CRC and dying from it compared to everybody, males and females, for way too long. When I say way too long, I mean like over 25 years. And so even when I first started, for me, I had a 52% higher chance of dying from colorectal cancer or CRC than you. And so, you know, it's been my mission to try to, you know, do something in regards of reducing this disparity substantially. And so in the summer of 2020, 2020 is a year we all remember due to the good old, this little virus that came around. And so during that year is also when I put out this pivotal paper with some colleagues where I identified these hotspots where individuals well below 50 were dying from colorectal cancer, specifically men across the country. And so this was roughly June and July. It didn't get as much attention as it should, but then August, something else happens that's pretty big. We unfortunately lose Chadwick Boseman, best known for his key role in the "Black Panther." And so that article started to get a lot of more attention at that time because where he was born in South Carolina is actually one of the hot spots we found. And so that made people have more conversation and et cetera, but what really bothered me about Chadwick's passing was him being diagnosed, like many others, yourself included, at a, you know, not okay younger age, well below 50. And so on socials, everyone was tagging, saying like, you know, "Who knows is there any foundations or nonprofits that are doing something new with this work so we can honor him?" I mean, everybody was tagging me saying like, "If there is, Dr. Rogers is the best, you know, person to know, and it relates to African Americans specifically." It didn't exist. And so for several years people have to say to me that I start a foundation. And I'm like, "Who got time to start a foundation?" I had a wife, you know, now I have a son, he'll be two in a month. You know, I'm getting older, so I gotta stay active physically myself. But the loss of Brother Chadwick Boseman, it really bothered me, and so I set a goal to by March of 2021, and you and I both know that March is Colorectal Cancer Awareness Month. I set a goal, okay, by March of next year I'll launch a foundation. And to even give myself a strong deadline, I ended up co-writing and co-hosting a PBS town hall special that was also in March. So I said, "Okay, when I come on this show, I'm gonna say, 'Hey, I'm Dr. Charles Rogers, the founder and president of the, you know, CRC Equity or the Colorectal Cancer Equity Foundation.'" And that's how we started.

- Wow. What an amazing story. That's awesome. And I know you and I have met. We met through colorectal cancer advocacy with Fight Colorectal Cancer and being part of going to Capitol Hill to, you know, push for legislation for increased research and really to talk about the equity issues. So I just wanna say congratulations for starting the foundation. You're doing great work. And I know, as someone who's been in the advocacy space both professionally and as a volunteer for 22 years now, I know how important equity is, and I'm glad to be, you know, part of your organization and to be helping you, you know, to the extent that I can, to help with the work of making screening, making colorectal cancer something that people are talking about and getting their early detection screenings to prevent them from dying from this disease.

- Awesome, awesome.

- I would love to ask a question, and you probably know, Michael, where I'm gonna go, because you know my passion, and Michael and I talk a lot about nutrition, and I think when we talk about health equity, that is part of our disparities in a lot of the groups that Michael mentioned in your opening, right? So it's the African American communities, it's the rural communities, it's the urban communities. Food deserts in a lot of places, as well as knowledge gaps about nutrition. And the knowledge gaps really span not just the populations we're treating, right, but they also span into the healthcare community and the provider community because it's not something that's readily taught, but it impacts both your susceptibility to cancers but also your cancer journey and navigating and how well you do through chemo and radiation and surgery. So I would love to hear kind of your take when you look at disparities, what you see in those nutrition gaps and what are some of the ways that you see that as a nation we can help to address some of those things and really being able to support, especially cancers like colorectal cancer.

- Awesome, awesome. You know, great question. So I haven't been in the nutrition space as closely as I would like. In the hotspot piece that I mentioned earlier, we didn't mention that some of these areas that were hotspots are like clustered areas where a lot of people were dying from colorectal cancer were really under 50, we talked about how a lot of those places were places that more than likely have food deserts. And so if we think about those areas versus like Minnesota, like when I lived in Minnesota years ago, they actually had legislation that would require fresh fruits and vegetables, eight to 10 of those in your gas station or at your Dollar General, versus like in those hotspots areas, more than likely it's super processed things that we know, you know, when we think about what contributes to early onset colorectal cancer being defined as colorectal cancer before age 50, we don't know, but we think there may be some contributors. You know, it's like the consumption of high fructose corn syrup, which is in sodas, that's gonna be available in those food deserts for sure. Processed foods, for sure those are definitely there, you know, plenty of those. And even if we think about other risk factors outside of nutrition that contribute to CRC, you know, we have smoking. You know, in those hotspots we also saw that a lot of people were smoking, you know, well over 100 packs of cigarettes at a time. Little fruit, vegetable, fiber consumption, being overweight and obese, lack of physical activity, heavy alcohol use, diabetes, a diet high in red meat such as beef, pork, or lamb, and then, of course, you know, a family history as well. And so when you look at all these things together and consider those for specifically Black and brown populations, we unfortunately usually have the worst behaviors that increase our risk every day.

- And Charles, that's a lot to, you know, educate people about, you know, in terms of knowledge gaps about nutrition and then knowledge gaps about how nutrition impacts cancer risk. And then, you know, you have a higher risk of cancer and you need to get tested. So you have all of these high-level, all of these knowledge gaps. From your foundation's perspective, where do your priorities lie? Is it all of that and more? Is it...?

- Yeah, so with the foundation itself, our priorities have really focused on four areas. So one, you know, how you and I got closer connected is through, you know, aiming to intentionally influence policy change. You know, even with me, you know, I have too much education, some may say. And so specifically I have a Master's of Public Health focused on public administration and policy, 'cause I knew I was doing great work. I was like, "No one can hear what I'm saying." And so that degree taught me how to write op-eds or newspaper articles a great-grandma can read and how to write policy briefs, and, you know, made more prepared to do work with Fight CRC even though they prepare you very well from scratch if you go to any of their things every March. And so, you know, even with that, when I was in Minnesota, speaking a little bit further on the smoking piece, back then, African Americans, 75% of African Americans smoked menthol cigarettes. And so you think about smoking being a risk factor for CRC, partnered with some legislators trying to include legislation that had more individuals focused on decreasing that, lowered the screening age to 45 back then, as well as providing more funding for community organizations to do disparities work. Those first two items unfortunately, you know, didn't move forward, but, you know, that work is, yeah, that's just an example of the power of actually influencing policy change where you can learn how to speak the language and connect with the right people. Another priority is actually funding innovative and critical research. This has also been expanded a little bit in terms of actually providing opportunities to support people. Like, you know, we provided two travel awards for two bright individuals to attend Call-on Congress with Fight CRC this year, some travel awards for some research presentations, et cetera. Another priority is actually highlighting leaders in organizations. And so we like to strategically partner with people that are doing great work, whether it be the National Colorectal Cancer Roundtable, Fight CRC, Colorectal Alliance, even you all in the future, because we feel something that I do in my lab, one of my mottoes is "Team stands for together everyone achieves more." And last but not least, you know, which is one of the focuses of our talk today, is removing barriers to equity. And in order to do that, it's not an easy piece if you were to just focus on the policy piece as well. You know, policy advocacy can impact CRC equity by helping to create fair and just healthcare systems. And so, like I mentioned earlier, the importance of working together, when we work together we can change laws and policies and we can even ensure that ultimately everyone has the same access to good healthcare regardless of their background or income.

- So I was just gonna say, so you touched kind of on the research piece. How did you come to doing research in this space?

- Yes, so in the summer of 2009, my family was having a family reunion doing several things that I mentioned earlier to increase your risk for colorectal cancer. There was smoking, there was the food and alcohol, but there was definitely consumption of processed foods like hot dogs, not just straight beef, but even people may say a beef hotdog is processed as well. But also doing some things to decrease our risk, such as being physically active. So we're big on like dance, line dances and things like that. And so we had noticed that my aunt had lost a lot of weight but she was out there dancing fine, laughing and talking as she usually does, talking junk, et cetera. You fast forward about two months later, and this is again the fall of 2009 or so now, and my aunt gets really, really ill. And so she goes to two major healthcare systems in North Carolina to be misdiagnosed five to six times with stage 4 CRC at 52 years of age. And so, you know, with colorectal cancer, you don't just wake up and you have stage 4. It develops over time. And so more than likely she, you know, started, you know, developing it well before she was even 50. And so, you know, shortly after that, you know, I did a research experience in Michigan with Chief Colorectal Surgeon Arden Morris. She's now at Stanford, but she was trying to figure out why Black people would get surgery but not chemo for CRC. And so then I saw like if you had a poor white male and a poor Black male, the poor white male would move forward with getting chemo 'cause he wanted to make sure that all the cancer, you know, was removed and taken away as much as possible, whereas a poor Black male would stay at home and work, 'cause he felt that when the doctor said they got it all through surgery, that was enough and he needed to stay and focus on his family. And so then I saw other studies that said if you had a Black male who was well off in terms of his socioeconomic status, he would go and get four or five opinions before he would move forward with getting chemo. And so that's where I started to see the social determinants of health coming into play in terms of how they would contribute to disparities. But even more so when my aunt was misdiagnosed, I had never ever heard about colon or rectal or colorectal cancer in my life, and I was very, very educated. And so in the Black community, I only heard about prostate cancer for Black men and breast cancer for Black women. And, you know, so I'm starting to think then, like if I'm super educated and I don't know about this, then I know a lot of others don't. And so then other things that started to percolate during my training and my doctorate at A&M in Texas is I would see guys do a lot of joking about the exam. You know, they would mix it up with prostate and thinking it was a finger up the butt. Even that's changed nowadays. And then I really started to think about like this masculinity piece is a major barrier as well, and so that's where I started in terms of looking at how masculinity keeps guys from getting screened for colorectal cancer and even going to the doctor in the first place. And so you fast forward to now, and my goal is being if you Google Black men and colon cancer, my face pops up. And so that's definitely happened. But even more so too, you know, when I first started this work and I saw that the screening age recommended to be lowered to 45 for African Americans in 2009, I also started to see how colorectal cancer among younger people has been on the rise at about 2 or 3% every year since the mid-nineties. And so, you know, I'm more into the space now, but early in my career I was trying to get funding to do research as it relates to early onset and no one was listening to me. They were like, "Oh, it's nothing," you know, and then in 2018 or so, this "New York Times" article comes out, and , the board who's on the front, I partnered with in Minnesota, and so like I'm giving you a lot, so hopefully you can receive it as you need to, but it's like I already saw in the literature the problem was bad, and then I already was impacted personally with it badly with my aunt. She did fight it for like eight years or so, and I learned a lot, you know, from her fighting herself. But I just kept seeing and meeting so many people that I was like, "This is not okay." And so there was even times when I did my own work. Like that hotspot work, I funded it myself. And, you know, it's very important, but people were saying like, "Oh no, it's not a hot topic," and you fast forward it now, and it's, you know, definitely something that contributes a lot to the literature. So in brief, personally, that's where it started for me.

- I was just gonna say, it's interesting how the concern about early onset has changed, because when I was diagnosed in 2012 at age 43, which was considered young onset because the screening age was 50, and it still is, although, you know, more people are being diagnosed in their, you know, thirties and early forties today. Like that topic has totally, you know, wasn't even really an issue in 2012, and now it's like the big issue in the colon space. And we talk about stigma. You know, people don't like to talk about, you know, their butts and poop and, you know, toilet habits and all that, but then you add, you know, for Black men the masculinity piece that, you know, you don't touch that part of the body, you know, right? If you're a guy, there's not a finger going up there, nevermind a hose, right, to do a scope. I mean, stigma's huge. It's a huge issue.

- Right. I don't disagree.

- Yeah.

- Yeah.

- How do you overcome that?

- It's huge. Yeesh. So how do you overcome masculinity barriers?

- It's not just even talking about it?

- I think it just varies on the individual. So for some people, like they need some like negative framing, and by negative framing, they need to like have bad things talked about in order for them to change their behavior. And so for instance, like I say, "You know, we don't wanna lose you, we don't want you to die so you can't be there for your..." Let's say it's a Latino male. "We don't want you to die early from this preventable disease so you won't be there for your daughter's quinceanera. That's maybe something that may make a trigger for them to say like, "Okay, I need to consider screening." Or even, you know, for a lot of men, unfortunately, they don't want to take those next steps until they can't move anymore. And so even as I think about that, you know, Somalis, it relates to Somalis, Minnesota has the largest Somali community in the country, so I did my master's, my MPH thesis on looking at barriers to colorectal cancer screening among Somalis, because Somalis had, like... So, you know, with the Roundtable, we used to have a goal of 80% by 2018, and so what that meant is that we were trying to have statewide screening rates of 80% by 2018. Well, back then in Minnesota, I think their screening average was about 71, but no one met that rate except whites at like 70. You know, it was like 70, and then Blacks were like 55%, American Indians was like 53, but Somalis was like 27. And so I'm like, for this to be a large community, like, you know, what are things that are keeping them from getting screened? And so when I actually did some qualitative work with this population, you know, and I try to go similar ways in terms that I've done work with Black men, you know, because of their religion they pray several times a day, so make sure if I had focus groups, they didn't occur to disrespect the times that they needed to pray; have food that was respectful of their culture as well, 'cause they don't eat pork; have people there that could be fluent in their language, blah blah, blah. I go to do these focus groups, Michael, and it's supposed to be just like an hour and a half, an hour, you know, 30 minutes to check in. The first hour is my trainees actually walking through the consent form because these men who were 50 plus and 50 and older couldn't read or write in English or Somali.

- Oh my goodness.

- You know, so, I mean, I'm thinking I'mma get to the conversations and the masculinity part's gonna come out. I was like, "There is a problem right here, right now, with this in terms of how it can, you know, contribute to disparities that persist in that populations." And then when I started doing the focus groups it was supposed to be like how we're doing today, you're asking me questions and I talk, I'm asking questions, expecting them to talk and they're asking me questions, because so many of their friends and family were dying from CRC. And so, but some of the things that we ended up finding from that study is that prevention is not something that's really stressed in their culture. Like you don't go to the doctor for a preventive screen like a colonoscopy. You go to doctor when your eyeball is fell out or like you broke your leg, like when you have to get something urgently. Another thing that was a barrier is that they felt that cancer was something that happened from you being being disobedient to their God, which is Allah, so if you were sinning a certain way, that's how you were that with cancer. Another thing is that they couldn't distinguish between the different types of cancer. So they didn't know how colorectal cancer was different from prostate cancer, or even, you know, male breast cancer, et cetera. And so if you even just think about those different things in addition to the masculinity, you have to do different things to target... You have to target your work a certain way to reach those different people. So say, you know, there's a whole group of men, specifically Somali, that won't go get screened for colorectal cancer unless they feel they're being disobedient to Allah, then that means that we have to go to the mosque and make sure that their religious leaders are the ones that are changing that narrative to encourage them to ultimately get screened. You see what I'm saying? And so also what I'm saying is that masculinity, I feel like that it's definitely complex. You know, I even have a scale that I've developed, masculinity barriers, medical care scale. But I feel that it's so complex that it also ties with other knowledge and beliefs and attitudes that males have, such that you have to strategically tailor your work to reach these individuals to ultimately get them screened.

- So you have to get to the upstream of all of that to change perception.

- Right.

- Wow. That's a lot of work for sure.

- And kind of on that same thread, one of the questions that I had for you is, you know, and I can't empathize with it 'cause I'm female, right, but in the screening part of it, now there's all these other screening tests, that it's not the finger, nobody's going near the unmentionables, you don't have to go in for a procedure right away. But there's other screening tests now, and I won't name all the brand names, but the screening tests now that you can mail in samples and kind of get... It's a pre-screening, and I know they're not 100%, but have you found in any of your work that those help some of this stigma in getting people to start to get screened?

- Yes. So stool-based exams have definitely been more receptive to men in regards to them getting screened for several reasons. You know, they're less invasive, as you mentioned. You can do this in the privacy of your own home. If you think about the cost of a FIT kit versus a colonoscopy, they're substantially cheaper, well under $50 versus thousands of bucks. If you think about that masculinity piece, we're overcoming that as well, because it's, again, less invasive. But something that I do wanna mention, and I will disclose that I do have a working relationship with Exact Sciences that makes Cologuard, but my comments, they do not represent them in any kind of way. I did some focus groups in a barbershop in Ohio several years ago, before the pandemic, and we're wrapping up and a guy goes, "I don't trust the box." And so I say, you know, "What box are you referring to?" He said, "Yeah, you know, that little box on TV with the blue arms that be talking and dancing, talking about colorectal cancer?" And everybody's like, "Cologuard?" and all. And he's like, "Yeah." He said, "I don't trust what they would do with my poop." And that was the first time in my entire career where I had ever slowed down to look at stool-based exam differently, because I hadn't taken the time to think about how medical mistrust runs so deep in Black and brown communities that even with something such as your stool, people may be thinking that, you know, samples are being kept to be used for reasons that they haven't provided their own consent to do so.

- And so that's really interesting. And I think you also touched then on, so my other question on, you know, when you talked about poor Black men don't go through with the chemo because they're gonna go back to work and they're gonna take care of their families, and, you know, if they're wealthy they're getting four and five consults and getting lots of opinions before they do something. Does that also have to do with the medical mistrust or is there another issue that you found that kind of prevents them from following through with the treatments? And then my second part of that is kind of a research question. As we look at how different ethnicities respond differently to treatment, is there research being done to say this is kind of the treatment path that seems to work best in these different ethnic groups?

- Awesome, awesome. Okay, so with the first question, you know, I'd like to note that with that work, that was work that was already done, that I was, you know, first started my career in seeing that those disparities were there in terms of Black men, you know, poor Black men not seeking chemo after surgery, whereas the white males would. And so as it relates to my own work, other things that I contributed to Black men in regards to not getting screened, 'cause with me, like, you know, I'm from rural North Carolina originally, and how I have my mom describe me to friends and family is, you know, Charles is the type of doctor who tries to not help you go to the doctor in the first place, or when you do, you're not in as bad of shape. So I really don't focus on the treatment side at all. I have done a little work in terms of survivorship, and I even have people just like Michael on my projects to get that patient perspective on my work. But a lot of my work is, again, really focused on like awareness, advocacy as Michael has mentioned, and looking at things that have actually kept men from getting screened from CRC, and more recently trying to intervene in terms of increasing awareness and also trying to ultimately get people screened. But on the treatment side, I can't speak to that directly, but I would imagine that the barriers to getting treatment for Black and brown populations are similar to the barriers that are there for going to the doctor in the first place and/or getting screened for colorectal cancer specifically like a colonoscopy, and those things, for my own work, have been, you know, a lack of knowledge, medical mistrust, lack of social support. Plenty of research shows that, you know, if Michael was my partner and he's going for colorectal cancer screening, there's a higher chance that I'll get screened because he's for it. That's why we even see so much in terms of like why married people live longer, especially as it relates to guys, you know, et cetera. Other things that I've looked at in my work is, you know, racism not race, you know, race is a social construct, and so, you know, that's something that's contributed. And even more recently, this is work we have under review where we've looked at colorectal cancer screening among Latino men in New York, Florida, and Texas, 'cause, you know, in theory these are the places that have the most Latino Hispanics in them. When we write our discussion, we had to slow down and think about like, "Hey, some of these guys may not be going to get screening because they don't feel that they're safe in terms of the climate in America, that if they go to the doctor they may get deported." And so there's so many different factors that contribute to disparities that are very, very, very deep, that it ultimately takes a team, a complex multidisciplinary team, rather, to solve these problems. And then with your second question, I can't answer it. I already knew that when you were saying that. I said, "Oh, I can't answer that one." I can't. But if you wanna ask it again, I can try, but I'm pretty sure the second one, I can't answer that.

- No, that's fine.

- 'Cause I don't really do treatment.

- Right.

- That's the only reason.

- Yeah, no, and that's fine. And I think, you know, I last year did a project where we looked at women's experiences, particularly on complementary alternative medicine. And one of the themes that we've identified was they're tired of the conventional medical system and feeling like they're not heard, getting rushed through the door. They don't really have time to explain what's going on. And I wonder, you know, you talk about this connection, married people live longer, especially for men, the influence that the women have over their men. And what we heard from the women was once they went and they found a complementary alternative medicine provider that they were comfortable with and felt like they were being heard, they started making their husbands go. So their husbands would not go to the doctor, conventional doctors, wouldn't seek help unless, you know, bone sticking out, they're dying, and then they go to the ER. But once their wives, partners, found this other trusted provider that gave them time and would listen, they got their male partners to go. So I think it's interesting that you bring up kind of this, how do men perceive this, what are these barriers to them even going in the first place, let alone having the conversation about being screened. 'Cause you have to walk through the door before you can have the conversation about being screened.

- Right. That's so good, Brenda. And that reminds me of some work. The first time I ever did work at a state fair was in Minnesota a long time ago, like over a decade ago. I did some last summer in Minnesota as well as Wisconsin, but it's more so like an intervention. But, you know, over 10 years ago I did some work in the Minnesota State Fair, 'cause it's the second largest in the country, and it's like a big deal. And so many people go, it's, you know, diverse attendance, you know, people that are wealthy, as you mentioned, or people that may not be as well as they would hope to be financially attend the fair. You know, is a big thing to do in the summertime. And so I did some work abroad that year in Eldoret, Kenya where there was this community event that was like a mile and a half from town, there was dirt roads, but people walked to this free event, and in an AR day, they saw 1,000 people. And like it did something to me where I was like, "I'm doing all this stuff, putting all these resources in to do some work, and I'm getting a bunch of pushback like I'm dissecting brains from the Institutional Review Board, and I'm just trying to do some stuff with some surveys." But I said, "Okay, how can I still reach a lot of people?" even though my work for this specific study was focusing on Black men. And that's when I thought about, you know, at the fair, people like to touch stuff, do stuff, and I thought about the inflatable colon. So it's very popular now. Everybody owns one, our foundation included. But I was like, "Man, if we have this inflatable colon, people will lose it in a good way." And we did. You know, we were there about seven days, and there were 24,600 people who went through that inflatable colon in those seven days. And, you know, I'm bringing this home to talk about your point about the importance of partners. There was a male with his partner that went through the inflatable colon. We call it the Super Colon. And he went through the Super Colon, and he comes out and he's like, "Doc, Doc, thank you so much for this. You know, because of this exhibit, I'm going to set my appointment next week to get screened." So his partner like punches him in the shoulder, and she's like, "I've been on you for this for months and you haven't been to the doctor, and said you weren't gonna get this, and you had to go through some blow up colon, the bigger, you know, like the size of a tiny house to get screened?" And that's when I even started thinking differently too, that like how something like that could be so powerful for someone versus what the research says. The research says if someone close to you is for a behavior, the more likely you'll get a behavior. So even though like you wanna lose weight, you have a higher probability of continuously working out if you have a partner to work out with. Like it's consistent for so many different behaviors. So I definitely wanted to to bring it up, 'cause that's something that I thought of when you mentioned that.

- That's amazing. That's a great story. Charles, health equity obviously is a big nut to crack. What can people do as individuals, but then also, you know, "Further Together" as a corporate podcast. What can companies like ORAU do to help make health access more equitable for everybody?

- Great question. So several things. First, they can support their policies. So, you know, advocating for laws and policies that ensure everyone has access to quality healthcare, no matter their background. Income is the first one. Second, we talked about this a little bit today, educating people, so sharing information about health equity and why it's important. This can help more people understand the issues and support positive changes. Three, volunteer; you know, get involved with local organizations that work to provide healthcare and support to underserved and under-resourced communities is another route. Four, you know, this is a lot of things happening right now as of, you know, a lot of big changes this past weekend is vote. You know, we can't improve equity in our country if we don't elect leaders who prioritize it and are committed to creating fair healthcare systems. Five, donate; contribute to organizations and causes that aim to reduce health disparities and support equal access to healthcare. And last but not least, like you all are doing with this podcast, which I really appreciate and I'm thankful to be here, is speak up. You know, we can't raise awareness about health inequities if we don't speak out, do podcasts, do social media, by writing to your local newspaper, or even participate in community meetings. By ultimately taking these steps people can create a healthier and more equitable society for everyone.

- Thank you for that. Brenda?

- So I think, Charles, and my doctorate is health policy and advocacy, so I certainly have had some of those same, how do you write an op-ed, how do you contact your congressman. What are like the top three things you would recommend to the average person in the public if they wanted to advocate, or they wanted to get in touch with their legislators and their elected officials, or write op-eds, what are your recommendations to them or how would you tell them to get started with that?

- Yeah, I would encourage them to partner with organizations that have expertise in that. So my thing is like, you know, just making this up, Michael, you know, based on your background, say Michael has expertise in creating gray cabinets. He's a master at making these things. And I would to create a gray cabinet that rolls, you know, and he's really good at making gray cabinets that are steel, but I'm really good at making wheels. I would partner with him to make sure we have the cabinet part, and I would have the skill part in terms of the wheels, so for us to ultimately create a rolling gray cabinet. So let me make sure I keep you here, because I may have lost you with that weak analogy, is, you know, if I want to learn how to do advocacy as it relates to colorectal cancer, like op-eds, I would partner with organizations that do that. So as Michael already mentioned, Fight CRC has been doing advocacy work for so long, you know, and it takes a long time, unfortunately, for laws and things to change, 'cause it takes a lot of individuals telling people over and over again for years for them to be, unfortunately, convinced. But even that's a loaded word, 'cause it's a lot of politics involved even with that. But in brief, I would recommend that individuals partner organizations that are doing this all the time, 'cause they will literally show you how to do it in a very, very short amount of time in an effective way. So in brief, that applies not only for like colorectal cancer, but for anything that is bothering you. They're there, like as it relates to the Capitol, if you visit the Capitol, you will see people there every day that are advocating for something, because like that's really how a lot of change happens. Like I mentioned earlier, like I knew I was doing great research, but like politicians are not reading my research papers, even if they're freely available on the internet, because they may be too hard to understand. But if I write that as like a newspaper article like that gets a lot of attention, or TikToks, like, you know, Alison Rosen, like she's really good with TikTok. Like that stuff could go viral and our politicians see that and notice the problem. There's these other non-traditional ways that can really create change that we have to welcome with open arms to make a difference, regardless of what disease or issue that we have a passion about making a a difference in.

- And how would... So, and I hear you. People need to find those organizations. How can people assess organizations? I mean, if you go on Google now, cancer organizations, you know, you're gonna get multiple pages of a Google list. So how can people assess which organizations they should engage with or should be a part of?

- So that's a good one. So unfortunately you can't, like, there's not like a Yelp, really, for like organizations. There is like these different groups like CharityStars, that say that like organizations are legit in regards to like a nonprofit space, but some routes that you can take is like talk to people that actually volunteer in the organizations. So like, you know, Michael already several times has talked about good words about my organization, Fight CRC, like those personal testimonies, in my opinion, they matter a lot. But also in that same vein, individuals who have worked with organizations that they may not have necessarily the best of name, these same individuals, like Michael, will also tell you that too. And so with that, I always try to make sure that I'm not in that discussion, and be transparent with my work as much as possible. And even with that, and you think about like the research side, as we mentioned earlier about how people have been taking advantage of research, people are taking advantage extensively in the advocacy space as well. You know, and it's easy to do. You know, like thank God I'm able to see another day, I wanna share my story with everyone, and people will capitalize on that, versus me, I really remind anybody that I'm friends with or collaborate with, if you work with me in any kind of way, I'm gonna compensate you every time you open your mouth, and I think you should do the same when you're out here in these streets, the good streets, trying to make a difference.

- Awesome, thank you for that, Charles. Second to last question, if people want to join your work, how do they find the Colorectal Cancer Equity Foundation?

- Yes, so visit crcequity.org, so that's C as in Charles, R as in rabbit, C as in colorectal, E as in elephant, Q as in quail, U as in umbrella, I as in igloo, T as in Thomas, and Y as in yellow. crcequity.org today, and you can follow us on socials. There's even a form on there where you can let know how you want to be involved. If you wanna just stay in the loop, that's like your one-stop shop to let you know how you can get involved or how you can even rent our inflatable colon, and we call ours the MEGA Colon.

- Awesome. The MEGA Colon is a lot of fun. We had one here at ORUA couple years ago, so.

- Awesome.

- You might need to bring that out again next March.

- Awesome.

- It was a lot of fun. Last question for you, Charles. What brings you joy?

- Man, what brings me joy right now is my son. So he's 20... I gotta change this. I'm used to speaking in months. So he's 23 months old today, which is one month before his 24 months, which is two years, so he'll be two next month, and it's just been truly a joy to watch him and learn from him as much as possible. You know, now he's in Montessori school, and so even with that, that's different because before, you know, we had a nanny at home and so I could see him all time. He'd come knock on my door. Like I'm surprised he has a knocked right now because he's gonna school halftime, but he's probably still asleep, but he wakes up at 3:30 so he'll be up in about six minutes. But it's just so much joy just, you know, spending time with him and having an opportunity, and we talked earlier about masculinity, I'm really big on making sure that he is not your typical male in terms of what masculinity looks like. You know what I'm saying? So let them know that it's okay to cry, let them know that it's okay to show emotion. Like when he has, you know, emotion, you know, we're trying to really focus on the terrific twos instead of the terrible twos. You know, just trying to show him how to be him whole self earlier in life is what I'm really excited about doing. So that's definitely my biggest joy, is raising my son in a world that doesn't necessarily care in terms of valuing quality time as it relates to family.

- I love it. Brenda, how about you? What's bringing you joy this week?

- So, oh, apparently I raised my hand. So this week joy for us is also family. So all of our kids are grown, and we are now seven grand babies with number eight due like any day. So just, you know, watching our adult children be successful individuals in the world and raising their families, like you said, in a world that doesn't necessarily value that family time, but watching our kids value that and raise their children in their ways brings me a lot of joy. And then when they aren't directly with me, Michael, you know my dogs and our farm always bring me joy in the beautiful scenery. But waiting on grandbaby number eight is very much... And grandbaby number seven's only four months old, so watching him develop and squeal and all the noises that start coming out, it's so much fun.

- Awesome. I love that.

- Awesome. Congratulations.

- Well, and for me, what's brought me joy this week is my best friend was in town last weekend for Fight CRC's Climb for a Cure, so we took the Ramsey Cascades Trail and just got to spend a weekend together, and he lives in Denver, so time in person is not something that happens very often, so we got to have a couple of days together and that was awesome, so.

- Awesome, awesome.

- Yep. Just riding that wave of joy from the weekend, so it's been great.

- Awesome.

- Well, Charles, thank you so much for spending this time with me and Brenda today to learn more about you, learn more about the Colorectal Cancer Equity Foundation, and really what we can do as a society and as a company to help make healthcare more equitable. I know it's a big challenge, but there are things we can do at the individual and the corporate level, so I appreciate your insights into all of that. You're doing amazing work.

- Thank you.

- And I hope folks who are listening will join you in that work and be part of the work that you're doing.

- Awesome. Thanks so much for having me.

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