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Identifying Barriers to Colonoscopy Screening for Nonadherent African American Participants in a Patient Navigation Intervention

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Abstract

African Americans have a higher rate of colorectal cancer (CRC) mortality than other racial/ethnic groups. This disparity is alarming given that CRC is largely preventable through the use of endoscopy (screening colonoscopy or sigmoidoscopy), yet rates of CRC screening among African Americans is suboptimal. Only 48.9% of African Americans are screened for CRC through endoscopy or fecal occult blood testing. As such, researchers have focused their efforts on the prevention of CRC through patient navigation (PN) services for colonoscopy screening. Although PN has been successful in increasing colonoscopy screening rates, screening rates of navigated participants could still be improved. Thus, the purpose of this exploratory study was to understand why patients, who received PN services, did not complete a colonoscopy. Sixteen participants were interviewed to identify salient themes related to noncompletion of the colonoscopy procedure. Major themes identified included the following: a lack of knowledge about CRC; fear/anxiety about the procedure, including unknown expectations, fear of pain, and fear of cancer diagnosis; inadequate physician communication about CRC and the colonoscopy exam; and believing that cancer leads to death. Participants felt that greater communication and explanation from their physician might help allay their fears. Our findings also suggest that a universal approach to PN, even within culturally targeted interventions, may not be appropriate for all individuals. Future interventions should consider gender-specific navigation and combining PN with nonmedical interventions to address other identified barriers.

Keywords

African American; cancer prevention and screening; health disparities; patient navigation; qualitative methods; race/ethnicity

Colorectal cancer (CRC) is the second leading cause of cancer mortality in the United States (American Cancer Society [ACS], 2011), but African Americans have higher incidence and mortality rates compared with European Americans. This is cause for concern, especially for African American males, as they have higher rates of CRC incidence and mortality than

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both their female counterparts and all other racial and ethnic groups (ACS, 2011). These disparities are particularly disturbing in light of the fact that CRC has some of the highest survival rates when detected at earlier stages (ACS, 2011).

Currently, recommendations advise that adults 50 years and older and younger adults with increased risk (family history or previous cancer detection) for CRC be screened using tests that are both preventive and diagnostic, namely flexible sigmoidoscopy, or colonoscopy (Levin et al., 2008). Colonoscopy is often promoted as the “gold standard” of screening tests due to its superior sensitivity leading to a reduction in mortality (Levin et al., 2008; Rex et al., 2009) and decreases CRC mortality by 76% to 90%. Yet national adherence to colonoscopy screening continues to be suboptimal (Meissner, Breen, Klabunde, & Vernon, 2006; Smith, Cokkinides, Brooks, Saslow, & Brawley, 2010), especially for African Americans. In 2008, 56% of European Americans 50 years and older were screened either through fecal occult blood testing, sigmoidoscopy, or colonoscopy compared with only 48.9% of African Americans 50 years and older (ACS, 2011).

The identification of perceived barriers, which may decrease the likelihood that an individual will adhere to recommended cancer screening (e.g., colonoscopy), has been one way of increasing screening and early detection. Barriers specific to African Americans include medical mistrust, fatalism, fear of diagnosis and procedure, provider–patient communication, lack of education, and lack of access to care (De Jesus, Puleo, Shelton, McNeill, & Emmons, 2009; Green et al., 2008; Grenier, Born, Nollen, & Ahluwalia, 2005; James, Campbell, & Hudson, 2002; Lasser, Ayanian, Fletcher, & Good, 2008; Lawsin, DuHamel, Weiss, Rakowski, & Jandorf, 2007; Ogedegbe et al., 2005; Palmer, Midgette, & Dankwa, 2008; Ward et al., 2008). African American men also face additional gender-specific barriers to screening such as embarrassment about the procedure and misperceptions about lack of symptoms (Bass et al., 2011; Jernigan, Truath, Neal-Ferguson, & Cartier-Ulrich, 2001; O’Malley, Beaton, Yabroff, Abramson, & Mandelblatt, 2004). These well-established barriers are best approached with interpersonal interventions (see Guidry, Matthews-Juarez, & Copeland, 2003), including patient navigation.

Patient navigation (PN), first introduced by Freeman, Muth, and Kerner (1995), reduces cancer disparities by addressing barriers that medically underserved populations encounter. A patient navigator, then, is a specifically trained person who helps a patient move through the health care system to obtain medical care. PN programs draw from many different social and psychological theories. In general, PN interventions draw theoretical constructs from cognitive behavior theory (i.e., changing the consequences of behavioral adherence to screening or treatment so that adherence is reinforced and financial and personal costs associated with adherence are reduced; Skinner, 1938, 1974) and social cognitive theory (i.e., emphasizing the relationship between behavior, personal factors, and environmental influences; Bandura, 1986, 1998, 2001; Baranowski, Perry, & Parcel, 2002).

Because decisions that people make about engaging in health behaviors are determined by factors at multiple levels, the current study used a social ecological framework (Stokols, 1992, 2000) to conceptualize intrapersonal, interpersonal, and community influences on PN for colonoscopy screening (Baranowski et al., 2002). Using this framework, constructs drawn from cognitive behavior theory (Skinner, 1938, 1974) and social cognitive theory (Bandura, 1986, 1998, 2001; Baranowski et al., 2002) were integrated and operationalized to facilitate colonoscopy screening consistent with the PN intervention. Constructs from these theories include self-efficacy (e.g., confidence in completing laxative preparation for colonoscopy), expectations (e.g., changing anticipation about painful or fatalistic procedure), behavioral capability (e.g., knowledge of colonoscopy screening procedure and skills needed to successfully perform), and emotional coping strategies (e.g., providing

strategies to deal with fear and anxiety about the procedure) and are categorized as intrapersonal influences. Reinforcing beliefs about the importance of screening through social support (i.e., PN) and enhancing the quality of interactions between the patient and their health care provider are conceptualized as interpersonal factors influencing colonoscopy screening. Community-level influences on screening behavior include determining strategies to address dealing with lack of transportation, care-taking responsibilities, and conflicts with work schedules.

PN has proven to be effective at increasing screening for many types of cancer, including colonoscopy screening and fecal occult blood testing (Chen et al., 2008; Christie et al., 2008; Jandorf, Gutierrez, Lopez, Christie, & Itzkowitz, 2005; Lasser et al., 2009; Lebowitz et al., 2011; Myers et al., 2008; Nash, Azeez, Vlahov, & Schori, 2006; Percac-Lima et al., 2009; Turner et al., 2008). However, up to 76% of navigated patients of various PN interventions (Chen et al., 2008; Christie et al., 2008; Jandorf et al., 2005; Percac-Lima et al., 2009) did not complete a screening colonoscopy. There may be critical barriers, especially for African Americans and other vulnerable populations, which PN interventions may be failing to address.

According to a few studies reasons for noncompletion can be attributed to a lack of understanding or miscommunication about the preparations for a colonoscopy (Christie et al., 2008), the need for face-to-face interaction with navigators (Percac-Lima et al., 2009), and greater communication with their primary physician (Chen et al., 2008), though more research is needed. It is unclear which aspects of PN are most critical to obtaining desired patient behaviors/outcomes (Jean-Pierre et al., 2011), especially for PN for CRC screening. Fortunately, efforts are currently under way to formally evaluate the effectiveness of PN (Freund et al., 2008). Nonetheless, it is important to understand the characteristics of noncompleters, as they represent a segment of the population for whom additional interventions may be needed. This study explores the contextual details related to noncompletion among previously navigated patients and why PN was not effective for these individuals.

Method

Background

African American patients nonadherent for colonoscopy screening who had previously participated in a larger intervention aimed at increasing colonoscopy screening for CRC through culturally targeted peer (an African American of similar age who had completed a colonoscopy) and professional patient navigators (an African American health behavior and education professional; Jandorf et al., 2011), were contacted to participate in in-depth individual interviews. In the PN intervention study (Jandorf et al., 2011), patient navigators were extensively trained in various content areas including CRC and colonoscopy facts, navigation responsibilities, and effective communication skills (see Shelton et al., 2011). Eligible participants (i.e., 50 years or older, no previous colonoscopy, no medical comorbidities which would make them ineligible for a colonoscopy) were referred for screening colonoscopy by their primary care provider and were recruited during a routine visit at a primary care clinic. Participants received colonoscopy screening-related navigation services which included scheduling the colonoscopy and detailed information about the procedure and exam preparation. The patient navigator also contacted participants 2 weeks and 3 days prior to the procedure to remind them of their appointment; confirm receipt of mailed information; review bowel preparation instructions; assess transportation needs and make arrangements, if applicable; and provide education and support. Only 25.3% of navigated participants did not complete a colonoscopy (Jandorf et al., 2011), which demonstrates the intervention's success.

Sampling and Recruitment

In the current institutional review board–approved substudy, eligible participants included those who (a) had previously participated in the larger patient navigation intervention study, (b) agreed to be contacted for future studies, (c) had not completed a scheduled colonoscopy, and (d) were able to be contacted. Noncompleters of colonoscopy are typically defined as participants who were able to be contacted by a patient navigator, agreed to participate in navigation, and were scheduled for a colonoscopy but never completed the appointment. Participants ($N = 46$) who did not complete a scheduled colonoscopy and who had agreed to be contacted for future studies were considered for contact to be interviewed about their experience with the PN study. Potential participants were first contacted by phone at least once and if they were unable to be reached, a letter was mailed to those participants ($N = 21$). Letters were mailed to these participants inviting them to participate in the study because they were unable to be contacted via telephone and were never successfully reached. The sample consisted of the remaining 25 participants, 16 (64%) of whom consented and were interviewed. The other nine participants were never interviewed for various reasons (e.g., refused to participate in the interview, were unavailable to participate at the time). Participants were paid \$40.

Data Collection

Interviews were conducted over a 2-month period and took between 30 to 60 minutes to complete. Interviewers were trained on interviewing techniques and provided with a semistructured interview guide that included constructs thought to be associated with barriers to obtaining screening colonoscopy (see Table 1). The conceptual framework was guided by the social ecological model (Stokols, 1992, 2000), which suggests health issues can be understood by examining influencing factors at multiple levels (e.g., intrapersonal, interpersonal, community). Questions were chosen to cover a broad range of topics related to intrapersonal, interpersonal, and larger community influences to CRC screening. Probes were used (e.g., “Can you tell me more?”) to encourage participants to give detailed answers. The questions were also reviewed, prior to the study, by our Community Action Board. Interviews were audio-taped and transcribed. Interviewers also generated summary reports immediately following each interview to capture relevant contextual information or body language.

Analysis Strategy

Using the social ecological model (Baranowski et al., 2002; Stokols, 1992, 2000), as a framework, the thematic content analysis (Krippendorff, 2004; Neuendorf, 2002; Roberts, 1997) approach to qualitative inquiry was used to identify major themes and codes. Interview transcripts and summaries were reviewed using NVivo qualitative data management software (QSR International Pty Ltd, 2010). The researchers met prior to conducting analysis to discuss coding labels and definitions. The first author (JRS) independently coded transcripts and 20% of transcripts were cross-coded by a coauthor (TE) to ensure intercoder reliability (the same text being coded in the same category by different people). Double-coded transcripts achieved 92% agreement between the two reviewers. When there was disagreement between reviewers about coding labels, the two reviewers met to discuss reasons for disagreement and modified coding labels appropriately.

Results

Sociodemographic characteristics of participants are shown in Table 2. There were no significant differences between interviewed and noninterviewed participants. The themes presented below (and in Table 3) represent reasons for noncompletion of a colonoscopy appointment most frequently cited by participants.

Interpersonal-Level Reasons

Lack of knowledge about CRC and colonoscopy screening—Lack of knowledge and/or information about CRC screening was not cited specifically as a reason for not completing a scheduled colonoscopy, but most of the participants did not understand CRC and cancer in general. For example, when asked what they knew about CRC most participants replied that they knew nothing ($N=12$). Participants more familiar with the concept of a colonoscopy recognized that it was a test used to look for cancer or polyps. Some participants mentioned that visual depictions of the colon, polyps, and colonoscopy procedure would help them better understand the procedure and feel more at ease about the exam. One woman said that she would feel more comfortable if providers would “show the pictures of polyps and then show the picture of one that has colon cancer.” After seeing a live colonoscopy procedure performed on a medical television show, another participant said that her previous perception of the exam was different from what she saw on the show. She did not understand what “screening” meant and thought she was going to be put on display to everyone:

I was picturing something absolutely different than what I saw on television. ... I pictured something that was very painful. [Seeing the procedure on television] took the fear of taking it out of me. ... You said screening, I thought ... people just see everything that's going on with you.

Fear/anxiety—When asked specifically why they had not completed the scheduled colonoscopy, half of the participants ($N=8$) said that they were fearful or anxious about the colonoscopy and indicated that this was the primary reason that they did not keep their scheduled appointment. One woman said, “I’m afraid! Plain and simple. I really don’t want to have [a colonoscopy]. I’m trying to push it as far as I can.” Most participants indicated that they were afraid or anxious about the procedure itself and not knowing what to expect during the exam. A man stated: “I just have some pent up fears about it. You know, people digging all in you and stuff.” Participants also mentioned that their fear and anxiety stemmed from a lack of knowledge about the colonoscopy procedure. One woman indicated that her fear was related to not completely understanding what was going to happen to her during the exam: “I guess its fear, maybe some fear. Fear settles there. ... I told you I was thinking about a tube.” She thought that she would be turned upside down on a table while doctors inspected her colon with a tube.

Cancer leads to death—A significant portion of participants ($N=10$) indicated that they associated the word cancer with death. Interestingly, all the male participants associated the word “cancer” with death or dying. A male participant said, “... death is what comes to my mind. I know so many people that died from cancer. As far as I know, they don’t seem to have made too much progress in treating cancer.” Three of the four male participants who associated cancer with death had also known a close relative who died from some form of cancer.

Intrapersonal-Level Reasons

Inadequate physician explanation about CRC—Another theme was lack of thorough physician explanation of the colonoscopy procedure. Many participants ($N=8$) felt that their primary care provider did not provide enough explanation of the recommended tests used to screen for cancer, especially colonoscopy. Although, participants felt that their navigator explained the exam procedure to them very well, many participants still seemed to want their doctor to explain in detail: what the test was used for, any alternative screening tests that were available to them, and what the procedure would entail. For example, one woman said,

[Physicians] never tell you about what the test consist[s] of. They just say we think you should have this test done ... give you the paperwork and ... make the appointment and that's it. You really don't know what the test consists of.

Patient navigation issues—A few participants ($N = 4$) indicated that issues related to patient navigation (e.g., received too many phone calls, never called to be scheduled for an appointment) influenced their decision not to undergo the procedure. For example, one man said he did not “like to be pushed” to do things. Two others felt agitated from the phone calls, which lead them to feel more anxious about the procedure. One woman said, “They kept calling me and discussing [the procedure] and it just freaked me completely out.” Participants ($N = 3$) mentioned having difficulty with the liquid laxative used to flush the colon before the exam (i.e., they got sick or it did not work). A woman stated, “The [laxative] they gave me for the cleaning, the night before, it did not work. I was trying to call ... I didn't get nobody on the phone.”

Community-Level Reasons

Participants ($N = 4$) also stated that personal obligations or more pressing life priorities prompted them to cancel their scheduled appointments. These types of responses were mostly from women who were caretakers of their family members. For example, one woman, who seemed to understand the importance of the colonoscopy screening and initially indicated that her reason for not completing the colonoscopy was because she did not have an escort said that she was putting her grandson's needs before herself.

Discussion

Our findings present important information about the characteristics of nonadherent navigated patients, from a multilevel ecological perspective (Stokols, 1992, 2000), and serve to further our understanding of why PN may not be effective for noncompleters of colonoscopy screening. Overall, intrapersonal-level factors such as fear/anxiety about the colonoscopy procedure, lack of knowledge of CRC, believing that cancer leads to death; interpersonal-level factors, including inadequate physician explanation of colonoscopy and patient navigation issues; and community-level factors such as social burden and life circumstances were identified as major reasons for noncompletion. These areas are of critical importance to the PN model because they provide important details about the social context of navigated participants who did not complete a colonoscopy.

Participants reported that their fear and anxiety about the procedure lead them to not complete the colonoscopy procedure. Fear and anxiety have been well documented in previous studies (Denberg et al., 2005; James et al., 2002; Ogedegbe et al., 2005; Palmer et al., 2008) as intrapersonal barriers to participation in cancer screening and in colonoscopy screening, specifically among participants who had not received navigation. These emotions were also related to unknown expectations which suggest that the way patient navigators explain the colonoscopy procedure could be modified. Changing negative expectations regarding cancer and colonoscopy screening are major components of the PN model. These intrapersonal factors are addressed by enhancing self-efficacy through education and knowledge-building strategies. Thus, it was important to understand why participants were unfamiliar with CRC. Although we were unable to capture reasons for lack of information about CRC explicitly, most participants indicated that they preferred to hear this type of information from their provider. Additionally, participants seemed to associate fatalistic beliefs about cancer diagnosis because of their friends or family members' personal experiences. Surprisingly few participants mentioned the patient navigation intervention as a source of information about CRC and cancer. These participants may benefit from PN

interventional strategies at interpersonal- or community-levels of influence (e.g., inclusion of members of the patient's social support system during the PN interaction) so that contrasting beliefs and opinions can be addressed and corrected.

Interpersonal factors influencing noncompletion of screening included participants' perception of their physicians' explanation of the colonoscopy procedure. Knowledge is an important factor in screening adherence, but the source of information about CRC and the colonoscopy procedure is also important. Other research (Bass et al., 2011; Chen et al., 2008) has confirmed this preference for greater physician involvement. This suggests that the source of messages about CRC screening is important for many patients and that it may be worthwhile to communicate to patients that the delivery of health care is executed as a team approach, with many health care professionals from different disciplines acting on behalf of the patient. Leading with this perspective may enhance the interpersonal relationship between patients and patient navigators.

Social burden was also identified as a broader, community-level barrier, which has previously been identified as a barrier in other studies (Palmer et al., 2008; Vernon, 1997) where nonadherent participants expressed that CRC screening became a lesser concern when other life circumstances arose. These findings call attention to the use of a screening questionnaire, to identify early in the navigation process patients who possess, as described by Jean-Pierre et al. (2011), maladaptive characteristics, which may greatly decrease the likelihood that they will adhere to colonoscopy screening recommendations. PN could then be tailored for individuals who face greater social burden, through the use of additional nonmedical interventions to focus on social determinants of health (Williams, Costa, Odunlami, & Mohammed, 2008) by offering child care services or vouchers on the day of the procedure, or working with employers and policy makers to ensure patients won't be penalized for taking time off for the procedure.

Surprisingly few male-specific issues surrounding screening and PN were noted in the current study, which contrasts findings from one study (Bass et al., 2011), which found that compared with women men expressed more fear of being screened because they might be diagnosed with CRC. More research is needed to investigate whether there are gender-specific barriers to colonoscopy screening and PN.

This study was not without limitations. First, our sample size was small, with only 16 participants interviewed. It is important to note, however, that many qualitative studies have used similar sized samples to develop a well-saturated theory and some qualitative researchers argue that a sample size of 12 is adequate, in most cases, for saturation (Guest, Bunce, & Johnson, 2006). Second, our sample was very homogeneous, in that most of the participants interviewed were female, unmarried, and less educated compared with participants who were not interviewed. Third, only 20% of transcripts were double coded, which reduces the trustworthiness of identified themes. Fourth, the retrospective nature of the current study is also problematic because it increased the likelihood of recall bias, social desirability and decreased sample size. Additionally, the questions included in the interview guide may have been limited in that *mostly* intrapersonal-level reasons for noncompletion were captured. Finally, although the response rate of noncompleters was acceptable, additional important information about the social contextual reasons for noncompletion was not captured from the interview questions used in the current study. Thus, our understanding of interpersonal- and community-level factors related to participants' nonadherence was limited. The in-depth interviews were exploratory and used for the purposes of hypothesis generating, therefore few generalizations should be drawn from the findings of this study.

Implications for Practice

The findings of this study have several important implications for improving PN interventions to increase CRC screening among African Americans. We offer the following recommendations for how PN interventions may be improved. First, we suggest the development and use of a screening questionnaire in PN interventions for CRC screening that could identify patients who may be more likely to not complete a colonoscopy because of varied intrapersonal-, interpersonal-, and community-level factors. Second, most participants of the current study described intrapersonal-level barriers, such as fear/anxiety and lack of knowledge, which affected their ability to complete the colonoscopy procedure. Therefore, future research interventions focused on these factors such as, increasing self-efficacy and changing participants' emotional responses to the colonoscopy procedure might be more effective than current methods. At an interpersonal level, training participants how to ask questions, describe symptoms, and/or effectively express fears or concerns with their physician may be advisable. The Rochester Patient Navigation Research Program has developed a patient navigation–activation intervention for recently diagnosed breast and CRC patients, which empowers patients to become more engaged in their care by coaching them in communication skills (Hendren et al., 2010). It may be worthwhile to adapt this model for screening PN interventions. Third, future research should also focus on changing participants' expectation that the procedure will be painful or that if diagnosed, cancer will lead to death by continuing to emphasize the value of preventive screening and early detection by incorporating more discussion about personal goal setting for preventive health behavior within navigation. Finally, providers should not only continue to recommend colonoscopy screening but also focus on patient-centered cancer communication (Epstein & Street, 2007), by explaining to their patients, using simple and understandable terms, the full scope of the colonoscopy procedure.

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Table 1**Constructs Addressed in Interviews and Sample Questions**

Constructs Addressed in Interviews	Sample Questions
Life history questions	<p>“Have you had any major life events in the past year? (e.g., as divorce, death of a loved one, loss of job, illness, etc.)”</p> <p>“Do you have enough money for basic needs each week?”</p>
Preventive health orientation	<p>“What kinds of things do you do to take care of your health?”</p> <p>“Do you think people should spend time and money on or for their health? Why or why not?”</p>
Access to care	<p>“Do you feel that you can get health care when you need it?”</p> <p>“Is there anything that makes it difficult to get health care?”</p>
General health	<p>“How is your physical health?”</p> <p>“How often do you go to see your primary care doctor?”</p>
Attitudes toward cancer, colorectal cancer, and screening	<p>“What first comes to your mind when you hear the word cancer?”</p> <p>“Do you know people that have had cancer?”</p>
Information about cancer and screening	<p>“Where or from whom do you get most of your information about cancer and cancer screening?”</p> <p>“Do you think that your doctors give you enough explanation about the tests that are done to look for cancer?”</p>
Patient navigation study	<p>“What made you decide to participate in the PN [patient navigation] study?”</p> <p>“What would you have changed about the study, in particular?”</p>
Colonoscopy related	<p>“What do you think of when you hear the word colonoscopy?”</p> <p>“Why do you think you haven’t had a colonoscopy yet?”</p>

Table 2

Sociodemographic Characteristics of Nonadherent Patient Navigation for Colorectal Cancer Screening Study

Characteristics	Interviewed		Not Interviewed		Total		<i>p</i> Value ^a
	<i>N</i>	Percentage	<i>N</i>	Percentage	<i>N</i>	Percentage	
Type of navigation ^b							1.00
Peer	8	72.7	3	27.3	11	50.0	
Nonpeer	8	72.7	3	27.3	11	50.0	
Gender							.13
Male	4	25.0	5	55.6	9	36.0	
Female	12	75.0	4	44.4	16	64.0	
Mean age in years (<i>SD</i>)	16	60.0 (5.95)	9	63.0 (6.82)	25	61.0 (6.27)	.15
Marital status							.41
Married	1	6.2	3	33.3	4	16.0	
Unmarried	15	93.8	6	66.7	21	84.0	
Employment status							.41
Employed	4	25.0	1	11.2	5	20.0	
Unemployed	6	37.5	4	44.4	10	40.0	
Retired	6	37.5	4	44.4	10	40.0	
Education							.32
High school	13	81.3	4	44.4	17	68.0	
Some college	3	18.7	5	55.6	8	32.0	
Income ^c							.36
<\$10,000	12	85.7	5	83.3	17	74.0	
\$10,001	2	14.3	1	16.7	3	26.0	

^aChi-square analysis performed; significant if $p < .05$.^bThree participants who were not interviewed refused any navigation and thus were not randomized to either condition.^cTotal does not equal 100 because of missing data.

Table 3**Reasons for Noncompletion of Scheduled Colonoscopy**

Theme (N)	Examples (N)
Intrapersonal-level reasons	
Lack of colorectal cancer and cancer knowledge (12)	Do not understand what colorectal cancer is (12)
	Lack of accurate information about cancer (4)
Fear/anxiety (8)	Fear of unknown expectations (6)
	Fear of pain from procedure (1)
	Fear of cancer diagnosis (1)
Cancer leads to death (10)	Associated cancer with death or dying
Interpersonal-level reasons	
Inadequate physician communication (8)	Primary care physician did not explain colonoscopy thoroughly (8)
	Primary care physician did not offer alternatives to colonoscopy (2)
Patient navigation issues (7)	Unable to call, did not receive a call (3)
	Too many calls (increased anxiety; 1)
	Laxative did not work (3)
Community-level reasons	
Social burden and life circumstances (4)	Prioritize other personal and family obligations over personal health