Increasing Colorectal Cancer Screening in Mississippi

State Engagement Meeting
Jackson, MS
May 30, 2019
Funding for this conference was made possible by the Centers for Disease Control and Prevention. The views expressed in written conference materials or publications and by speakers and moderators do not necessarily reflect the official policies of the Department of Health and Human Services, nor does the mention of trade names, commercial practices, or organizations imply endorsement by the U.S. Government.
Welcome and Introductory Remarks

Jason Brown, MPH
Office Director
Office of Preventive Health
Mississippi State Health Department

Tiffany M. Pertillar, MSW, MPH
Public Health Consultant
National Association of Chronic Disease Directors
Association Overview

• Leverages 30 years of experience
• Founded in 1988 in partnership with CDC to strengthen state-based leadership and expertise in chronic disease prevention and control
• Member-based, Member-driven, Member-led
• Nationally recognized thought leaders
• Members impact every area of Chronic Disease: programs, advocacy, education, communication, funding
Core Planning Team

• Mississippi State Department of Health
• University of Mississippi Medical Center
• American Cancer Society
• National Association of Chronic Disease Directors (NACDD)
• Centers for Disease Control and Prevention (CDC), Division of Cancer Prevention and Control
Increasing Colorectal Cancer Screening: Understanding the National Landscape

Lisa Richardson, MD MPH
Director
Division of Cancer Prevention and Control
Centers for Disease Control and Prevention
Increasing Colorectal Cancer Screening
*Understanding the National Landscape*

Lisa C. Richardson, MD, MPH
*Division Director, CDC, NCCDPHP, DCPC*

CDC StEM Meeting--Mississippi
May 30, 2019
Capturing the Attention of our Audience

The average attention span of a human plummeted to 8 seconds--down from 12 seconds in 2000--which means at 9 seconds, goldfish now have a longer attention span than the typical consumer.
So why are we here?
Rate of New Cancers in the United States

Colon and Rectum, All Ages, All Races/Ethnicities, Male and Female Rate per 100,000 people, 2015

https://gis.cdc.gov/Cancer/USCS/DataViz.html
Rate of Cancer Deaths in the United States

Colon and Rectum, All Ages, All Races/Ethnicities, Male and Female Rate per 100,000 people, 2015

https://gis.cdc.gov/Cancer/USCS/DataViz.html
Among adults aged 50 to 75, **one quarter** have never been screened

- **Screened, up-to-date**: 67.3%
- **Screened, not up-to-date**: 7.1%
- **Never screened**: 25.6%

Among the never screened: **85% are insured**

Source: CDC Behavioral Risk Factor Surveillance System (BRFSS)
Percentage of adults aged 50-75 up to date with CRC screening - BRFSS 2016

*Up-to-date = Fecal occult blood test (FOBT) within 1 year, or sigmoidoscopy within 5 years with FOBT within 3 years, or colonoscopy within 10 years.

Data Source: CDC Behavioral Risk Factor Surveillance System (BRFSS).
Change in percentage of adults aged 50-75 up to date with CRC Screening – BRFSS 2016

Percent Change
- ≤ 4.0
- -3.9 to -1.0
- -0.9 to 0.9
- 1.0 to 3.9
- ≥ 4.0

*Up-to-date = Fecal occult blood test (FOBT) within 1 year, or sigmoidoscopy within 5 years with FOBT within 3 years, or colonoscopy within 10 years.

Data Source: CDC Behavioral Risk Factor Surveillance System (BRFSS).
CRC Screening and Guidelines
## Guideline Comparison: Age

<table>
<thead>
<tr>
<th>ACS</th>
<th>USPSTF</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Strong Recommendation</strong></td>
<td><strong>Grade A</strong></td>
</tr>
<tr>
<td>Screen age 50 and older</td>
<td>Start age 50</td>
</tr>
<tr>
<td><strong>Qualified Recommendation</strong></td>
<td><strong>Grade C</strong></td>
</tr>
<tr>
<td>Start age 45</td>
<td>Individualized decision age 76 – 85</td>
</tr>
<tr>
<td>Stop age 75</td>
<td>Do not recommend screening age ≥86 (no grade)</td>
</tr>
<tr>
<td>Individualize screening 76-85</td>
<td></td>
</tr>
<tr>
<td>Discourage screening over age 85</td>
<td></td>
</tr>
</tbody>
</table>
# Guideline Comparison: Tests

<table>
<thead>
<tr>
<th>ACS</th>
<th>USPSTF</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Stool based tests</strong></td>
<td></td>
</tr>
<tr>
<td>FIT annually</td>
<td>Hs-gFOBT annually</td>
</tr>
<tr>
<td>Hs-gFOBT annually</td>
<td>FIT annually</td>
</tr>
<tr>
<td>Mts-DNA every 3 years</td>
<td>FIT-DNA every 1 or 3 years</td>
</tr>
<tr>
<td><strong>Structural Examinations</strong></td>
<td></td>
</tr>
<tr>
<td>Colonoscopy every 10 years</td>
<td>Colonoscopy every 10 years</td>
</tr>
<tr>
<td>CTC every 5 years</td>
<td>CTC every 5 years</td>
</tr>
<tr>
<td>Flexible sigmoidoscopy every 5 years</td>
<td>Flexible sigmoidoscopy every 5 years</td>
</tr>
<tr>
<td></td>
<td>Flexible sigmoidoscopy every 10 years with FIT annually</td>
</tr>
</tbody>
</table>
Colorectal cancer screening in the U.S.

The percent of U.S. adults aged 50 to 75 years up-to-date with colorectal cancer screening increased 1.1 percentage points from 2014 to 2016.

66.2% 2014

67.3% 2016

Source: CDC Behavioral Risk Factor Surveillance System (BRFSS)

Represents an additional 3.3 million adults aged 50 to 75 screened for CRC
### Median increase in completed screening in Community Guide reviews, by CRCCP EBI

<table>
<thead>
<tr>
<th>EBI</th>
<th>Screening type</th>
<th># Studies</th>
<th>Median Percentage Point Change (IQI/Range)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient reminders</td>
<td>Colorectal cancer</td>
<td>4</td>
<td>11.5 (IQI 8.9, 20.3)</td>
</tr>
<tr>
<td>Provider reminders</td>
<td>Colorectal cancer</td>
<td>6</td>
<td>15.3 (IQI 1.0, 24.2)</td>
</tr>
<tr>
<td>Reducing Structural Barriers</td>
<td>Colorectal cancer</td>
<td>6</td>
<td>16.1 (IQI 12.1, 22.9)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4</td>
<td>36.9 (range 16.3, 41.1)</td>
</tr>
<tr>
<td>Provider Assessment and Feedback</td>
<td>Breast, Cervical, &amp; Colorectal Cancer</td>
<td>7</td>
<td>13.0 (IQI 5.5, 21.8)</td>
</tr>
</tbody>
</table>

Increase in colorectal cancer screening using multicomponent interventions* in Community Guide reviews

<table>
<thead>
<tr>
<th>CRC screening type</th>
<th>Median percentage point change (IQI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any test** (39 study arms)</td>
<td>15.4 (IQI 6.0, 21.6)</td>
</tr>
<tr>
<td>Colonoscopy (9 study arms)</td>
<td>10.2 (IQI 5.0, 12.5)</td>
</tr>
<tr>
<td>FOBT (21 study arms)</td>
<td>7.7 (IQI 2.3, 21.1)</td>
</tr>
<tr>
<td>Flexible sigmoidoscopy (5 study arms)</td>
<td>-0.5 (IQI -0.9, 1.8)</td>
</tr>
</tbody>
</table>

FOBT = Fecal occult blood testing, IQI = interquartile interval

*Multicomponent interventions (MCIs) combine two or more intervention approaches from the following: client reminders, client incentives, small media, mass media, group education, one-on-one education, reducing structural barriers, reducing client out-of-pocket costs, provider assessment and feedback, provider incentives, provider reminders; or two or more intervention approaches to reduce different structural barriers. MCIs may be coordinated through healthcare systems, delivered in community settings, or both.

**Clients screened by having any of the following tests: colonoscopy, FOBT, or flexible sigmoidoscopy

The Community Guide
https://www.thecommunityguide.org/topic/cancer
Mississippi Data
Colorectal Cancer in Mississippi

[Map showing the rate of new cancers in Mississippi, colored by rate per 100,000 people, with areas shaded to indicate different rate ranges.]
Cancer Burden: Mississippi

Top 10 Cancers by Rates of New Cancer Cases

<table>
<thead>
<tr>
<th>Cancer Type</th>
<th>Rate per 100,000 people</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prostate</td>
<td>126.7</td>
</tr>
<tr>
<td>Female Breast</td>
<td>117.3</td>
</tr>
<tr>
<td>Lung and Bronchus</td>
<td>72.3</td>
</tr>
<tr>
<td>Colon and Rectum</td>
<td>48.1</td>
</tr>
<tr>
<td>Corpus and Uterus, NOS</td>
<td>23.1</td>
</tr>
<tr>
<td>Kidney and Renal Pelvis</td>
<td>20.3</td>
</tr>
<tr>
<td>Urinary Bladder</td>
<td>16.3</td>
</tr>
<tr>
<td>Non-Hodgkin Lymphoma</td>
<td>16.0</td>
</tr>
<tr>
<td>Melanomas of the Skin</td>
<td>15.5</td>
</tr>
<tr>
<td>Pancreas</td>
<td>14.6</td>
</tr>
</tbody>
</table>

Top 10 Cancers by Rates of Cancer Deaths

<table>
<thead>
<tr>
<th>Cancer Type</th>
<th>Rate per 100,000 people</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lung and Bronchus</td>
<td>54.7</td>
</tr>
<tr>
<td>Prostate</td>
<td>24.6</td>
</tr>
<tr>
<td>Female Breast</td>
<td>21.6</td>
</tr>
<tr>
<td>Colon and Rectum</td>
<td>17.8</td>
</tr>
<tr>
<td>Pancreas</td>
<td>13.8</td>
</tr>
<tr>
<td>Liver and Intrahepatic Bile Duct</td>
<td>8.0</td>
</tr>
<tr>
<td>Leukemias</td>
<td>6.8</td>
</tr>
<tr>
<td>Ovary</td>
<td>5.6</td>
</tr>
<tr>
<td>Brain and Other Nervous System</td>
<td>5.5</td>
</tr>
<tr>
<td>Non-Hodgkin Lymphoma</td>
<td>5.2</td>
</tr>
</tbody>
</table>

Colorectal Cancer Burden: Mississippi

Rate of New Cancers by Sex, All Races/Ethnicities
Colon and Rectum, United States, 2015

Rate of New Cancers by Race/Ethnicity, Both Sexes
Colon and Rectum, United States, 2015

Rate of New Cancers by Sex and Race/Ethnicity
Colon and Rectum, United States, 2015

## CRC screening test use* in Mississippi has increased since 2012.

In 2016, 59.9% of age-eligible residents had a current CRC screening test. 345,000 residents were not currently screened. African Americans lagged behind whites when it came to having a current screening test. Screening occurred more frequently in men and people aged 65 to 75, who were likely insured by Medicare.

### CRC screening test use, by race/ethnicity:

|            | Whites (61.9%) | African Americans (56.3%) |

| CRC screening test use, by insurance status: |

|            | Insured (59.4%) | Uninsured (22.9%) |

### CRC screening test use, by sex:

|            |

- 2012 – 60.6%
- 2014 – 60.7%
- 2016 – 59.4%

### CRC screening test use, by age:

- 50 to 64 Years (54.0%)
- 65 to 75 Years (72.1%)

Men and women aged 65 to 75 years were eligible for Medicare insurance.

*Proportion of people who reported completing a screening test for CRC among all people who could be screened based on age (50 – 75 years). People who were current with CRC screening in 2016 either received a home-based blood stool test within the past year; a colonoscopy within the past 10 years; or sigmoidoscopy within the past 5 years combined with a blood stool test within in the past 3 years (2008 US Preventive Services Task Force Recommendations).*
What are we doing?
Why CDC for Cancer Prevention and Control?

DCPC’s Cancer Prevention Point of View

Data

Translation and Evaluation

Partnerships

Uniquely Positioned to Drive Outcomes
All People Free of Cancer

Aspirations

Elimination of preventable cancers

All people get the right care at the right time for the best outcome

Cancer survivors live longer, healthier lives

Strategic Priorities

Reduce the incidence of preventable cancers by reducing modifiable risk factors and promoting healthy behaviors

Scale our best practices to increase impact of screening continuum

Improve health outcomes for cancer survivors

Our Guiding Principles

Address Health Disparities  Define Expected Outcomes Upfront  Collaborate  Communicate: Tailor to a Specific Audience

Our Key Strengths

Data  Translation & Evaluation  Partnership
Colorectal Cancer Control Program (CRCCP)

The CRCCP is a CDC funded cooperative agreement to increase colorectal cancer (CRC) screening rates among low-income, high-need populations by collaborating with health systems partners to implement evidence-based interventions* (EBIs) and supporting activities (SAs) in health care clinics with the goal to increase CRC screening rates.

# How CDC’s CRCCP has evolved over time

<table>
<thead>
<tr>
<th>Time</th>
<th>CRCCP Demonstration</th>
<th>CRCCP First Phase</th>
<th>CRCCP Second Phase</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005-2009</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CRCCP Demonstration</td>
<td>5 grantees (state, county, city, and university)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Focus:</strong></td>
<td>Delivery of colorectal cancer (CRC) screening and diagnostic services</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Results:</strong></td>
<td>Viable strategy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2009-2015</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CRCCP First Phase</td>
<td>29 grantees (states, tribes, and territories)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| **Focus:**  | 1. Delivery of CRC screening and diagnostic services  
              2. CRC screening promotion for underserved populations |                |                    |
| **Results:**| Limited reach        |                |                    |
| 2015-2020    |                      |                   |                    |
| CRCCP Second Phase | 30 grantees (states, universities, and tribe) |                |                    |
| **Focus:**  | 1. Health systems change  
              2. Delivery of CRC screening and diagnostic services (6 grantees only) |                |                    |
The CRCCP funded 30 grantees in 2015

- 23 States
- 6 Universities
- 1 Tribe
CDC aims to increase CRC screening in clinics through health system change

- Grantees
- Partnerships
- Assessment and implementation support
- EBI and SA implementation
- EHR improvements
- Data reporting
- Increased screening rates
Tenets of the CRCCP model

- Integrate public health and primary care
- Focus on defined, high-need populations
- Establish partnerships to support implementation
- Implement sustainable health system changes
- Use evidence-based strategies to maximize limited public health dollars
- Encourage innovation in adaptation of EBIs
- Use data for program improvement and performance management
EBIs and SAs to increase CRC Screening through the CRCCP

Evidence-based Interventions*

- Patient reminders
- Provider reminders
- Provider assessment and feedback
- Reducing Structural barriers

Supporting Activities

- Small media
- Patient navigation
- Community health workers
- Provider education

*The Community Guide
https://www.thecommunityguide.org/topic/cancer
The reach of the CRCCP grantees is significant

240 Health systems
761 Clinics
6,039 Providers
1,240,336 Patients aged 50-75

Source: Clinic data submission, April 2019, (Includes clinics recruited in PY1, 2, 3 and through April. 2019 of PY4)
A closer look at CRCCP clinics

761 CRCCP Clinics

70% are Federally-Qualified Health Centers (FQHCs)

27% serve high percentages of uninsured patients (>20%)

50% use FOBT/FIT tests as the primary CRC screening test type

Source: Clinic data submission, April 2019, (Includes clinics recruited in PY1, 2, 3 and through April. 2019 of PY4)
Among clinics enrolled in the first year of CRCCP, CRC screening rates rose an average of **10.3 percentage points** since baseline.

**CRCCP Mean Weighted Screening Rate**

<table>
<thead>
<tr>
<th>Year</th>
<th>Screening Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline</td>
<td>42.9%</td>
</tr>
<tr>
<td>Year 1</td>
<td>47.8%</td>
</tr>
<tr>
<td>Year 2</td>
<td>51.7%</td>
</tr>
<tr>
<td>Year 3</td>
<td>53.2%</td>
</tr>
</tbody>
</table>

Source: Clinic data submission August 2019= PY1 Clinics only.
The increase in clinic CRC screening rates through PY3 is greater with each additional EBI that is newly implemented.

Source: CRCCP Clinic Data April, 2019 data submission. PY1 Clinics only; Years 1-3.
Using evaluation results to...

**Improve**
grantee programs

**Inform**
future programmatic planning and policy making

**Strengthen**
accountability of CDC to Congress and the public
How did we get here?
20 Years of Collaborating to Conquer Cancer

NCCCP supports—

• All 50 states and the District of Columbia
• 7 U.S. territories
• 8 tribes and tribal organizations

Since 1998—

• More than 98,000 people have been involved in cancer coalitions.
• 69 cancer plans have been created and updated.
Who Are Our Partners?

95% include representatives from academic & medical institutions
85% include representatives from business & industry
94% include members of professional associations
72% include government partners
100% include representatives from public health programs
76% include policy makers
95% include representatives from community-based organizations
Comprehensive Cancer Control National Partnership
80 by 2018 Forums

• Forums to Increase CRC Screening in Community Health Centers through Enhanced Partnerships with Cancer Coalitions and FQHCs

  • Collaboration of CCC National Partners
  • Delivered between September 2015 and 2017
  • 33 state teams
  • Follow-up technical assistance provided (9 – 12 months)
CCCNP CRC Action-Planning Forum Participants

- Selected through application process
- Considered need, existing partner collaborations, and readiness.

Forum 1 Participants, September 2015
Forum 2 Participants, June 2017 (Includes Puerto Rico)
Forum 3 Participants, August 2017
Sample Plans
Framing the StEM Project

- NACDD, CDC, and Leavitt Partners have come together to increase colorectal cancer screening rates in six states. We will do this by implementing the State Engagement Model (StEM):

  1. **State Intelligence Development**
     - Using the web-based mapping and intelligence platform, Torch Insight

  2. **Engaging Stakeholders**
     - To strengthen relationships, provide education, and identify opportunities to collaborate

  3. **StEM Meetings**
     - Action Plan formation, followed by 18 months of technical assistance
StEM States

- Alaska
- Georgia*
- Louisiana
- Mississippi*
- Oklahoma*
- West Virginia
- Iowa
- Tennessee*

* States that have not expanded Medicaid
StEM Meeting Participants

- Payers and Employers
- Providers
- Coalitions and Associations
- Community Organizations
- State Health Departments

Key Elements:
- Constant Communication
- Aligned Collaboration
- Streamlined Assessment
- Supportive Infrastructure
- Shared Objectives
- Aligned Collaboration
Colorectal Cancer Screening

Evidence is the Medium for Exchange

CDC
NCCRT
ACS
State
FQHC
NCI

Division for Cancer Prevention and Control
Trusted. Scientific.
Action is the foundational key to all success.

Imperfect Action is Better than Perfect Inaction

Success consists of going from failure to failure without loss of enthusiasm.
QUESTIONS?
COMMENTS?
Thank you!

Go to the official federal source of cancer prevention information:
www.cdc.gov/cancer
Understanding the Mississippi Landscape

Deirdre Rogers, PhD, CTR
Mississippi Cancer Registry Director
University of Mississippi Medical Center

Dr. Roy Duhe
Professor
University of Mississippi Medical Center
Burden of Colorectal Cancer in Mississippi

Deirdre Rogers, PhD, CTR
Director, UMMC and Mississippi Cancer Registry
Graduate Faculty, Department of Population Health Science
I acknowledge the Centers for Disease Control and Prevention and the University of Mississippi Medical Center for their support of the MCR staff. The contents of this presentation are solely the responsibility of the author and do not necessarily represent the official views of the CDC or UMMC.
Mississippi ranks 2nd in incidence and 3rd in mortality for colorectal cancer among US states.

Source: United States Cancer Statistics, 2017
Age-Adjusted Invasive Colorectal Cancer Incidence, Mississippi, By Race and Sex

Rates age-adjusted to the 2000 U.S. Standard Million Population
Age-Adjusted Colorectal Cancer Mortality, Mississippi, By Race and Sex

Rates age-adjusted to the 2000 U.S. Standard Million Population
Colorectal Cancer Screening Rates
Behavioral Risk Factor Surveillance System, 2016

Mississippi had the 4th lowest screening rate at 60.5%. The US rate is 67.7%.

For Whites, Mississippi has the 5th lowest screening rate at 63.0%. The US rate is 69.0%.

For Blacks, Mississippi has the 2nd lowest rate among states with a large enough population to assess at 56.0%. The US rate is 66.2%.
Colon & Rectum Cancer by Stage, Mississippi Ages 50+

Rates age-adjusted to the 2000 U.S. Standard Million Population
Relative Survival, Colon & Rectum Cancer By Race and Stage, 2011-2015 (Followed through 2016)
Understanding the Mississippi Colorectal Cancer Landscape: The 70x2020 Initiative

Improving Colorectal Cancer Screening in Mississippi
Jackson, MS
May 30, 2019

Roy J. Duhé, Ph.D.
Professor of Pharmacology; Professor of Radiation Oncology
University of Mississippi Medical Center
@70x2020Guy rduhe@umc.edu (601) 984-1625


We are here
Disclaimers

• Time does not allow me to acknowledge the dozens of active individuals who are responsible for the accomplishments of the 70x2020 Partnership, much less the hundreds of individual 70x2020 Partners.

• I am a member of the Advisory Board of the Mississippi Cancer Registry and the Medical/Research Advisor to the Mississippi Partnership for Comprehensive Cancer Control Executive Board; these are uncompensated voluntary appointments.

• Otherwise, I have no conflicts of interest to disclose.

• The statements and views expressed in this presentation are my own and may not reflect the opinions of the University of Mississippi Medical Center or any other organization with which I am associated.
A brief history of 70x2020

70x2020
Colorectal Cancer Screening Initiative
Our Goal

The goal of the 70x2020 Colorectal Cancer Screening Initiative is to ensure that at least 70% of Mississippians are up–to–date with recommended colorectal cancer (CRC) screening by the year 2020.
The priorities of 70x2020 are data-driven. This study provided an initial statewide assessment.

The impact of preventive screening resource distribution on geographic and population-based disparities in colorectal cancer in Mississippi

Fazlay S. Faruque\textsuperscript{1}, Xu Zhang\textsuperscript{2}, Elizabeth N. Nichols\textsuperscript{3,9}, Dena E. Bradley\textsuperscript{3,10}, Royce Reeves-Darby\textsuperscript{4}, Vonda Reeves-Darby\textsuperscript{5} and Roy J. Duhe\textsuperscript{6,7,8*}

http://www.biomedcentral.com/content/pdf/s13104-015-1352-0.pdf
Public Health District-level analysis identified priority areas for colorectal cancer screening intervention (this analysis was possible with pre-consolidation PHDs)

Faruque et al. BMC Res Notes (2015) 8:423
Zip-code-level mapping of CRC screening resource distribution revealed the impact of free-market healthcare economics.
Community-level wealth & per-capita income affects resource distribution

Table 4 Incomes within and beyond 30-min drives to colonoscopy facilities

<table>
<thead>
<tr>
<th>Variable</th>
<th>Within 30-min drives</th>
<th>Beyond 30-min drives</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median household income</td>
<td>33,607</td>
<td>33,953</td>
<td>0.597</td>
</tr>
<tr>
<td>Mean household income</td>
<td>46,291</td>
<td>45,279</td>
<td>0.194</td>
</tr>
<tr>
<td>Per capital income</td>
<td>17,797</td>
<td>17,141</td>
<td>0.049</td>
</tr>
</tbody>
</table>

79% of the state (38% of the population) is beyond a 30-minute drive to gastroenterologist

Table 5 Incomes within and beyond 30-min drives to gastroenterologists’ primary practice sites

<table>
<thead>
<tr>
<th>Variable</th>
<th>Within 30-min drives</th>
<th>Beyond 30-min drives</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median household income</td>
<td>35,058</td>
<td>33,889</td>
<td>0.279</td>
</tr>
<tr>
<td>Mean household income</td>
<td>47,370</td>
<td>45,572</td>
<td>0.083</td>
</tr>
<tr>
<td>Per capital income</td>
<td>18,334</td>
<td>17,294</td>
<td>0.016</td>
</tr>
</tbody>
</table>

Faruque et al. BMC Res Notes (2015) 8:423
A Round Table planning meeting was held on April 22, 2014

- Bettina Beech (UMMC Office of Population Health)
- Jennifer H. Boler (Mississippi Department of Health)
- Beth Dickenson (American Cancer Society)
- Roy J. Duhé (UMMC Cancer Institute)
- David J. Dzielak (Mississippi Division of Medicaid)
- Jennifer Myrick (American Cancer Society)
- Vonda Reeves-Darby (Mississippi Gastroenterology Society)
- Lolita M. Ross (CommonHealth ACTION)
- Phillips Strickland (Mississippi Insurance Department)
- Marsha Thompson (WLBT)
- Tasha Tilghman-Bryant (C-Change)
- Srinivasan Vijayakumar (UMMC Cancer Institute)
- Evelyn Walker (Mississippi Department of Health)
- Misty Watson (Mississippi Insurance Department)
- Freddie White-Johnson (Mississippi Network for Cancer Control & Prevention)

Planning Meeting Objectives

1) Develop strong commitment of key stakeholders to the 70x2020 goal
2) Participant identification of critical-path activities, benchmarks and obstacles which will either facilitate or impede 70x2020 goal attainment
3) Participant identification of additional statewide partners needed for 70x2020 goal attainment

Planning Meeting Outcomes

1) > 54 issues identified via PEST/SWOT analysis.
2) 15 specific action items w/ assigned lead facilitators.
The 70x2020 Partnership Represents All Stakeholders.

Communities
- Increase health literacy
- Create consumer demand

Health Care System
- Close existing gaps in availability and accessibility
- Initiate and follow-up on recommended service delivery

State Leadership
- Establish mandate for institutional responsibility, authority and accountability
- Provide system support
70x2020 Strategic Plan Conference
*(Plan your work, then work your plan)*

Jackson, Mississippi
October 5, 2015
Eugene Washington PCORI Engagement Award (contract EA-1148-UMC)
$250,000 total support; June 1, 2015 – May 31, 2017
Eight quarterly Community Engagement Meetings in Bolivar, Leflore & Washington Counties
March 2016 CRC Awareness Campaign

Mississippi Gastroenterology Society

Tupelo

Jackson
March 2017 CRC Awareness Campaign

- First-in-nation Colon Cancer Screening & Prevention Car Tag
- #getscreened4dak PSA campaign
- Several local events (including free Give Back screens by GI Associates)
- ACS-CAN Legislative Awareness
- National legislative CRC policy education
2018 March CRC awareness campaign
CRC screening rates *ARE improving*, CRC incidence *IS decreasing*, CRC mortality *IS decreasing*, and population-based disparities *ARE decreasing* in Mississippi.

<table>
<thead>
<tr>
<th></th>
<th>Age-adjusted Incidence per 100,000 (MCR)</th>
<th>Age-adjusted Mortality per 100,000 (MCR)</th>
<th>CRC screening compliance rate (BRFSS)*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Black</td>
<td>64.9</td>
<td>57.73 <em>↓</em></td>
<td>26.2</td>
</tr>
<tr>
<td>White</td>
<td>50.5</td>
<td>43.72 <em>↓</em></td>
<td>17.5</td>
</tr>
<tr>
<td>B-W gap</td>
<td>14.4</td>
<td>14.0 <em>↓</em></td>
<td>8.8</td>
</tr>
<tr>
<td>Total</td>
<td>54.49</td>
<td>48.11 <em>↓</em></td>
<td>19.79</td>
</tr>
</tbody>
</table>
Whether 70x2020 succeeds or fails, what will become of the momentum we created after the year 2020?

Growth: 15 to 675 Partners

Growth: $1,500 to $25,606
The Mississippi Colorectal Cancer Roundtable: Go beyond CRC screening?

MCCRT *could* aim to COMPLETELY eliminate premature death from CRC.
HOUSE CONCURRENT RESOLUTION NO. 58

A CONCURRENT RESOLUTION URGING THE UNIVERSITY OF MISSISSIPPI MEDICAL CENTER CANCER INSTITUTE TO COORDINATE THE MISSISSIPPI COLORECTAL CANCER ROUNDTABLE AND TO REPORT ITS FINDINGS TO THE LEGISLATURE.

WHEREAS, the stated intention of the 70x2020 Colorectal Cancer Screening Initiative is to end in the year 2020:

NOW, THEREFORE, BE IT RESOLVED BY THE HOUSE OF REPRESENTATIVES OF THE STATE OF MISSISSIPPI, THE SENATE CONCURRING THEREIN, That we do hereby urge the University of Mississippi Medical Center Cancer Institute to coordinate an initiative to be known as the Mississippi Colorectal Cancer Roundtable and to submit a written report on its findings concerning colorectal cancer prevention efforts in this state to the Legislature before January 1, 2021, and each year thereafter.

BE IT FURTHER RESOLVED, That the Mississippi Legislature does hereby affirm the commitment of this state to the goals of the National Colorectal Cancer Roundtable's "eighty percent in every community" initiative.

BE IT FURTHER RESOLVED, That a copy of this resolution be provided to the Chancellor of the University of Mississippi, the Vice Chancellor for Health Affairs of the University of Mississippi Medical Center and the Director of the University of Mississippi Medical Center Cancer Institute.
Lessons Learned & Goals for the Future

70x2020 Colorectal Cancer Screening Initiative

**POSITIVE LESSONS**

- Statewide voluntary partnership model allows greater creativity than traditional hierarchical models.

- Local community champions will take ownership of well-defined projects.

- Pre-existing organizational relationships are strengthened by collaborative projects.

**NEGATIVE LESSONS**

- The absence of dedicated staff, state or institutional mandate and justified budget impedes implementation of strategic plan & realization of specific health outcomes.
  - Health disparities are not eliminated in Mississippi via volunteerism.

Mississippi Colorectal Cancer Roundtable

- Build upon a (weak) legislative mandate.
  - Annual legislative report

- Rely less on voluntary champions, rely more on cornerstone organizations.
  - Create incentive to participate
  - Create expectation of organizational sponsorship

- Improve data collection & analysis.
  - Statewide assessment & evaluation
  - Re-examine reporting requirements

- Implement annual CRC projects.
  - Action-oriented
  - Systems-oriented
  - Quality improvement measures
  - Translational research (?)
Thank you for your attention. Any questions?
Networking Break
10:15 – 10:30 am
Partnership for Change: Opportunities for Increasing Colorectal Cancer Screening

Bo Nemelka, MPH
Vice President
Leavitt Partners
Partnerships for Change
In Mississippi
Section IV

Stakeholder Engagement
INNOVATIVE OFFERINGS
INCREASED CONSUMERISM
EXPANDED COLLABORATION
SUSTAINABLE ENGAGEMENTS
EVOLVING UTILIZATION
EXPANDED ACCOUNTABILITY

Evolving Relationships
Stakeholders and Partners: Combined Impact

We are observing a combined impact when payers and providers cross paths and the lines of distinction between them are blurred.

Providers
- Providers taking on risk and aggregating lives through alternative payment model (APM) participation
- Provider systems establishing plans or partnering very closely

Employers
- Employers self-insuring and contracting directly with providers
- Adopting cost control and transparency tools of their own
- Generating networks of high-value providers and Centers of Excellence

Payers
- Payers are purchasing provider groups to more effectively manage care
- Partnering or merging with collaborators that have brick and mortar locations

SOURCE: Leavitt Partners Intelligence
State Engagement Model

**Common Agenda:** Increase the rate of colorectal cancer screening in the participating states

**Shared Measurement:** Creates a baseline event to measure success against

**Mutually Reinforcing Activities:** Action plans focus on elements that can be directly affected by best-practice activities

**Continuous Communication:** Consistent, open communication that maintains trust and collaboration among stakeholders

**Support:** Teams of key stakeholders support and sustain each other in their efforts
## Stakeholder Motivations (Providers)

<table>
<thead>
<tr>
<th>HEALTH SYSTEM</th>
<th>PHYSICIAN GROUP</th>
<th>ACO</th>
</tr>
</thead>
</table>
| **Motivations** | - Quality care to patient  
- Screening can drive utilization and patient-physician engagement  
- Positive financial incentive (++) | - Quality care to patient  
- Screening can drive utilization and patient-physician engagement  
- Positive financial incentive (++) | - Quality care to patient  
- No 1-year ROI for screenings  
- FIT tests may drive “appropriate” utilization of screenings/tests  
- Financial incentive contingent upon risk structure (-/+)
| **Strategies** | - Patient reminders  
- Provider education  
- Formal systems (EHR)  
- Compliance feedback  
- Remove structural barriers | - Patient reminders  
- Provider education  
- Formal systems (EHR)  
- Compliance feedback  
- Remove structural barriers | - Patient reminders  
- Provider education  
- Formal systems (EHR)  
- Compliance feedback  
- Remove structural barriers |
## Stakeholder Motivations (Payers)

<table>
<thead>
<tr>
<th></th>
<th>COMMERCIAL PLANS</th>
<th>MEDICARE ADVANTAGE</th>
<th>MEDICAID</th>
<th>LARGE EMPLOYERS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Motivations</strong></td>
<td>- Quality product to enrollees</td>
<td>- Covers older population</td>
<td>- Quality care to vulnerable populations</td>
<td>- Quality benefits to employees</td>
</tr>
<tr>
<td></td>
<td>- “Doing the right thing”</td>
<td>- Implications for HEDIS star rating</td>
<td>- “Doing the right thing”</td>
<td>- “Doing the right thing”</td>
</tr>
<tr>
<td></td>
<td>- Negative financial incentive (--</td>
<td>- Negative financial incentive (-)</td>
<td>- Negative financial incentive (-)</td>
<td>- Negative financial incentive (--</td>
</tr>
<tr>
<td><strong>Strategies</strong></td>
<td>- Focus on less costly screenings</td>
<td>- Focus on less costly screenings</td>
<td>- Target population of appropriate age</td>
<td>- Focus on less costly screenings</td>
</tr>
<tr>
<td></td>
<td>- Employer wellness program partnerships</td>
<td>- Promote screening test choice through plan design</td>
<td>- Offer screenings for “CRC awareness month”</td>
<td>- Employer wellness program partnerships</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(i.e., value-based insurance design)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Section VII

Moving Forward
Gaining Momentum

**Headwinds**

- Immediate investment, delayed benefits
- Shortage of primary care physicians to provide screening and GI specialists to provide follow-on care
- Competing priorities for physicians, policymakers, and patients (diabetes, hypertension higher priority)
- Structural barriers, such as transportation issues in rural areas
- Lack of awareness

**Tailwinds**

- Increased focus on prevention of disease and whole-being care
- Increased flexibility through alternative payment models to pay for investment in non-clinical needs
- Increased partnerships between traditional and non-traditional stakeholders
- Data-sharing APIs (Application Programming Interface) making it possible to connect patients across the care continuum
- Focused interest from various stakeholders to take action
Cost Benefit Analysis in Medicaid

According to the Louisiana Department of Health’s Healthy Louisiana Dashboard, Louisiana has successfully screened nearly 30,000 Medicaid recipients for colorectal cancer and removed over 9,000 polyps since July 2016. These services also prevented many new cancers and identified 409 CRC cases.

Not only were lives saved, but over $175 million of potential treatment costs were averted. Without screening, many of these individuals and their cancers would have been detected much later when they were harder, more painful, and more costly to treat.
Strategies to Increase Screenings

**Activities**

- Build and maintain partnerships with stakeholders (payers, health systems, hospitals, associations, etc.)
- Implement priority EBIs*
  - Patient reminders
  - Provider reminders
  - Provider assessment and feedback
  - Reduce structural barriers
- Implement SAs* in health systems
  - Small media
  - Patient navigation
- Facilitate community-clinical linkages
  - Targeted outreach
  - Linkage to medical homes
- Deliver professional development trainings
- Provide IT support, including electronic health record systems

**Outcomes**

- Multi-stakeholder partnerships established
- Multiple strategies implemented within health systems/clinics
- Provider knowledge of CRC screening quality standards improved
- Health system/clinic data measured and used
- Increased health system/clinic CRC screening rates at lowest effective cost
- Decrease preventable deaths due to colorectal cancer

*EBI=Evidenced-based intervention
**SA=Supporting Activity

Focus Strategies for Mississippi

Interventions to Increase Community Access:
• Reducing structural barriers
• Reducing client out-of-pocket costs

Interventions to Increase Provider Delivery of Screening Services:
• Provider assessment and feedback
• Provider incentives
• Provider reminders

For more information, see The Community Guide.
## Implementing Strategies: Examples

### Washington

<table>
<thead>
<tr>
<th>Awardee</th>
<th>Washington State Department of Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Site(s)</td>
<td>HealthPoint (FQHC with 10 clinic sites)</td>
</tr>
<tr>
<td>Strategies</td>
<td>Mailed FIT program (including follow-up reminders)</td>
</tr>
<tr>
<td>Results</td>
<td>Mailed fecal immunochemical test (FIT) program had a test return rate of 31% with an average intervention cost of less than $40 per individual successfully screened.</td>
</tr>
</tbody>
</table>

### New York

<table>
<thead>
<tr>
<th>Awardee</th>
<th>New York State Department of Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Site(s)</td>
<td>Medicaid managed care</td>
</tr>
<tr>
<td>Strategies</td>
<td>Mailed screening reminder w/ and w/o a financial incentive</td>
</tr>
<tr>
<td>Results</td>
<td>No difference was observed with regard to screening uptake during the short follow-up of 4 to 5 months, remaining at less than 7.5%.</td>
</tr>
</tbody>
</table>

### Colorado

<table>
<thead>
<tr>
<th>Awardee</th>
<th>Colorado Department of Public Health &amp; Environment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Site(s)</td>
<td>2 FQHCs with multiple sites</td>
</tr>
<tr>
<td>Strategies</td>
<td>Multicomponent intervention*</td>
</tr>
<tr>
<td>Results</td>
<td>Increases in CRC screening uptake of 10% and 18%, respectively. The average implementation cost per person successfully screened at these 2 FQHCs was $29 and $24, respectively (not including clinical costs).</td>
</tr>
</tbody>
</table>

### Illinois

<table>
<thead>
<tr>
<th>Awardee</th>
<th>University of Chicago Medical Center</th>
</tr>
</thead>
<tbody>
<tr>
<td>Site(s)</td>
<td>Academic medical center</td>
</tr>
<tr>
<td>Strategies</td>
<td>Patient navigation</td>
</tr>
<tr>
<td>Results</td>
<td>Increased colonoscopy completion by 11% (compared with a usual-practice cohort) and reduced missed appointments and late cancellations from 15% to 8%. Estimated ongoing implementation cost of $88 to $215 per patient who successfully received patient navigation. The initial year of costs was higher, due to administrative costs.</td>
</tr>
</tbody>
</table>

* e.g., provider assessment and feedback, mailed FIT kits, and standardization of workflow processes

Mississippi Action for Combined Impact

We have a unique opportunity today to create the momentum for better health in Mississippi.

All the stakeholders in this room are motivated to create a healthier population and decrease preventable deaths.

What can we do today to make a healthier tomorrow? And who are our partners to create that future?
Spotlight on Success in Mississippi

Moderator: Chigozie Udemgba, DrPH CHES, MSDPH

Health Program Perspective
Amy Ellis- American Cancer Society

Health Care Systems Perspective
Todd Warren, MBA- GI Associates and Endoscopy Center
Improving Colorectal Cancer Screening in Mississippi

May 30, 2019
ColonMD: Clinicians' Information Source
www.cancer.org/colonmd

Health care professionals play the most important role in getting people screened for colorectal cancer. ACS offers free materials to help you encourage colorectal cancer screening among your patients to reach the goal of an 80% screening rate.

National Colorectal Cancer Roundtable
https://nccrt.org/

We are the National Colorectal Cancer Roundtable, an inclusive, accessible organization dedicated to engaging public, private, medical and civic organizations in the effort to promote colorectal cancer prevention and early detection.

Patient Decision Aids

Tools for Your Clinical Practice
ACS estimates 1,680 new cases of colorectal cancer in 2019.
ACS estimates 650 colorectal cancer deaths in 2019
Mississippi CRC Data

**Mississippi CRC Data**

**WHO GETS COLORECTAL CANCER?**

Anyone can get colorectal cancer, but some people are at an increased risk.

![WHO GETS COLORECTAL CANCER?](image)

**SCREEN TO SAVE**

A Colorectal Cancer Outreach and Screening Initiative of the National Cancer Institute's Center to Reduce Cancer Health Disparities

**Racial/Ethnic and SES Disparities exist**

The 3rd leading cause of death for men & women combined.

The 5th lowest screening rate for whites (63%) vs. U.S. (69%) and the 2nd lowest screening rates for Blacks (56%) vs U.S. (66.2%).

The 4th lowest screening rate in 2016 (60.5%) compared to U.S. (67.7%).

Sources: Mississippi Cancer Registrar and [https://www.cancer.org/cancer/colon-rectal-cancer/about/key-statistics.html](https://www.cancer.org/cancer/colon-rectal-cancer/about/key-statistics.html)
ACS Goal #1

Form and strengthen strategic partnerships on a local, state, and regional level to increase CRC screening rates.
ACS Staff partners with:

- Hospitals
- Federally Qualified Health Centers
- MS Department of Health
- MS Partnership for Comprehensive Cancer Control
- Health Plan Partners (BCBC*, UHC*)
- MCO’s (Magnolia, UHC, Molina)
- ACO (Aledade*)
- 70x2020 Initiative
- GI Associates
Resources for Mississippi’s FQHCs

COMMUNITY HEALTH CENTER PATIENTS - UDS
Percentage of Federally Qualified Health Center Patients ages 50-75 years Up-to-Date with CRC Screening, Uniform Data System²

<table>
<thead>
<tr>
<th>Year</th>
<th>UDS CRC Screening Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>30.2%</td>
</tr>
<tr>
<td>2013</td>
<td>32.6%</td>
</tr>
<tr>
<td>2014</td>
<td>34.5%</td>
</tr>
<tr>
<td>2015</td>
<td>38.3%</td>
</tr>
<tr>
<td>2016</td>
<td>39.9%</td>
</tr>
<tr>
<td>2017</td>
<td>42.0%</td>
</tr>
</tbody>
</table>

The UDS CRC screening rate reached 42% in 2017, which amounts to an additional 223,100 patients screened in the last year alone and an additional 467,500 patients screened in the last two years.
ACS Goal #2

Implement evidence-based interventions and quality improvement coaching
What are Evidence-Based Interventions?

https://www.cdc.gov/pcd/issues/2018/18_0029.htm

Provider Recommendations
#1 reason people get screened!!!!!

Systems & Policy Changes
Reduction of structural barriers, standing orders, medical neighborhoods, patient navigation

Patient & Provider Reminders
Includes provider prompts and use of EHR and population health management software

Provider Assessment & Feedback
Provider report cards
FQHC Partners
Implementing EBIs as part of a larger quality improvement project

Hospital Partners
Promoting colorectal cancer screening to patients and employees

MSDH & Comprehensive Cancer Coalition

ACS Goal #3
Cultivate Clinical Champions to open doors and elevate CRC screening as a system-wide priority with leadership
Increase support of the 80% in Every Community Public Health Campaign by Providing consultation, Support & Resources to engage in the campaign.
A N Y Q U E S T I O N S?
Improving Colorectal Cancer Screening in Mississippi

An Independent Private Practice Perspective

R. Todd Warren
Chief Executive Officer

todd@gi.md

www.gi.md
Why Are We Here?
Change your mindset
Why Are We Here?

- Identify strategies that will help **prevent** and/or **detect** colorectal cancer:
  - Educate with facts
  - Promote ideas
  - Incentivize & Challenge
Why Are We Here?

- Develop a plan of action to improve colorectal cancer screening rates in Mississippi
  - Target audience
  - Best screening options
  - Improve coverage
  - Eliminate red tape
  - Emphasis on Quality
  - Emphasis on Cost

Bottom Line...We Care About Mississippi!
Who Is GI Associates & Endoscopy Center?
Mississippi Landscape

- 30 Physicians
- 10 Nurse Practitioners
- 12 CRNAs
- 400 Employees
GIA Locations

- Flowood
- Vicksburg
- Madison
Travel Locations & Hospitals

- Carthage
- Forest
- Hazlehurst
- Kosciusko
- Magee
- Morton
- Newton
- Oxford
- Tupelo
- Yazoo City
- Jackson / Madison / Vicksburg
GIs In Mississippi

- Largest concentration of GI Physicians (outside of Jackson Metro) in Hattiesburg, Tupelo & Meridian.
- 61.8% from the Jackson Metro Area
- 6.7% from the Vicksburg Metro Area
- 7.1% from travel location areas
- Small impact beyond
GI Associates & Endoscopy Center

GIls In Mississippi

- Pediatric GI Footprint
# Where Are We Today With Colorectal Cancer Screening?

<table>
<thead>
<tr>
<th>Screening Method</th>
<th>Frequency</th>
<th>Evidence of Efficacy</th>
<th>Other Considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Steel-Based Tests</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>gFOBT</td>
<td>Every year</td>
<td>RCTs with mortality end points: High-sensitivity versions (eg, Hemoccult SENSA) have superior test performance characteristics than older tests (eg, Hemoccult II)</td>
<td>Does not require bowel preparation, anesthesia, or transportation to and from the screening examination (test is performed at home)</td>
</tr>
<tr>
<td>FIT</td>
<td>Every year</td>
<td>Test characteristic studies: Improved accuracy compared with gFOBT Can be done with a single specimen</td>
<td>Does not require bowel preparation, anesthesia, or transportation to and from the screening examination (test is performed at home)</td>
</tr>
<tr>
<td>FIT-DNA</td>
<td>Every 1 or 3 y&lt;sup&gt;d&lt;/sup&gt;</td>
<td>Test characteristic studies: Specificity is lower than for FIT, resulting in more false-positive results, more diagnostic colonoscopies, and more associated adverse events per screening test Improved sensitivity compared with FIT per single screening test</td>
<td>There is insufficient evidence about appropriate longitudinal follow-up of abnormal findings after a negative diagnostic colonoscopy; may potentially lead to overly intensive surveillance due to provider and patient concerns over the genetic component of the test</td>
</tr>
<tr>
<td><strong>Direct Visualization Tests</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Colonoscopy&lt;sup&gt;c&lt;/sup&gt;</td>
<td>Every 10 y</td>
<td>Prospective cohort study with mortality end point</td>
<td>Requires less frequent screening Screening and diagnostic follow-up of positive findings can be performed during the same examination</td>
</tr>
<tr>
<td>CT colonography&lt;sup&gt;e&lt;/sup&gt;</td>
<td>Every 5 y</td>
<td>Test characteristic studies</td>
<td>There is insufficient evidence about the potential harms of associated extracolonic findings, which are common</td>
</tr>
<tr>
<td>Flexible sigmoidoscopy</td>
<td>Every 5 y</td>
<td>RCTs with mortality end points: Modeling suggests it provides less benefit than when combined with FIT or compared with other strategies</td>
<td>Test availability has declined in the United States</td>
</tr>
<tr>
<td>Flexible sigmoidoscopy with FIT&lt;sup&gt;c&lt;/sup&gt;</td>
<td>Flexible sigmoidoscopy every 10 y plus FIT every year</td>
<td>RCT with mortality end point (subgroup analysis)</td>
<td>Test availability has declined in the United States Potentially attractive option for patients who want endoscopic screening but want to limit exposure to colonoscopy</td>
</tr>
</tbody>
</table>
## Where Are We Today With Colorectal Cancer Screening?

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
</table>
| 1 | • Colonoscopy*  
   |   • Fecal immunochemical test (FIT)  
| 2 | • CT Colonography  
   |   • Cologuard®  
   |   • Flexible sigmoidoscopy  
| 3 | • Capsule endoscopy  

In 2017, the U.S. Multi-Society Task Force on Colorectal Cancer (MSTF) ranked colonoscopy in the highest of three tiers for CRC screening options.

*MSTF recommends physicians offer **colonoscopy first**, annual FIT to patients who decline colonoscopy, then second-tier tests for patients who decline FIT.
Where Are We Today With Colorectal Cancer Screening?

- **GIA Focus:**
  - Gold Standard
  - “Preventing” vs. “Catching” Colon Cancer
  - Other options—
    - FIT before meeting criteria (cost) and for interval screening.

Reference Screening Guidelines & Education From Day 1
What Successes Has GIA Realized?

Successes:

• Marketing Strategies
• Awareness & Education about Access & Screening Options ([www.gi.md](http://www.gi.md))
• Exceeding National Quality Benchmarks (ADR)
• Get Screened License Plate campaign
• Guts & Butts 5K (70x2020 donation)
• GIA Giveback
Constantly pushing awareness
Constantly pushing awareness
Providing for the underinsured
Providing for the underinsured
Constantly pushing awareness

Colon Cancer Awareness

GUTS & BUTTS
Constantly pushing awareness
Constantly pushing awareness
What Challenges Is GIA Facing?

Challenges:

• Policy Barriers—Costs, Coverage, & Access
• Awareness & Education
• Quality shortcuts—surgeons / non-trained physicians performing colonoscopies
• Mismarketed ‘in-home DNA stool test screening’ options (not front line / not a replacement)
  • Too many false positives
  • Missed cancers (8%)
  • Benefit elimination issues
Who Have Been Our Major Partners in This Effort?

- 70x2020 Colorectal Cancer Screening Initiative
  - Guts & Butts 5K
  - Get Screened License Plates

- American Cancer Society (past partnership)
  - Joint promotion colorectal cancer screening awareness (80x2018)

- Digestive Health Physician Association (DHPA)
  - Private practice lobbying group
Why Are We Interested In Increasing Colorectal Cancer Screening, Particularly Collaborating At A State Level?

- 4 decades of caring
- Experts in delivering the highest quality
- Lowest cost
- Incredibly efficient
- Saving lives
- Doing it the right way
Why Are We Interested In Increasing Colorectal Cancer Screening, Particularly Collaborating At A State Level?

- This is about not taking shortcuts
- This is for the good of our State, our friends, our neighbors
- This is personal
- I’m tired of seeing Mississippi near the bottom
So Our Mission Should Be Simple...

Let’s focus on the following:

- Easy
- Affordable
- Best / appropriate test
- Educate patients of the benefits
- Quality care
- Accessible
- Cost efficient point of care
- Collaborate. We have to get everyone on the same page...

Let’s get serious about this now and make a difference for Mississippi’s future!
Overview of Action Planning Session

Catherine McCann, PhD, MSPH
Public Health Consultant
National Association of Chronic Disease Directors
Action Planning Groups

### Increasing Provider Delivery of Screening Services

**Room: Oxford**

- Reducing time or distance for service delivery
- Modifying hours to meet client needs
- Offering services in alternative or non-clinical settings
- Eliminating or simplifying administrative procedures

### Increasing Access to Screening Services

**Room: Nachez II**

- Provider assessment and feedback interventions
- Provider reminder and recall interventions
- Professional development training

---

Increasing CRC screening in clinics through health system change

---

*The Community Guide

https://www.thecommunityguide.org/topic/cancer
Networking Lunch
12:00 to 1:00 pm
Closing Remarks, Call to Action, and Evaluations

Tiffany M. Pertillar, MSW, MPH
Public Health Consultant
National Association of Chronic Disease Directors

Chigozie Udemgba, DrPH, CHES
Mississippi Comprehensive Cancer Control Director
Mississippi State Health Department
Please Complete Your Evaluation Form

• The MS State Department of Health will use your input for continued partnership development and to complete the Increasing CRC Screening Action Plan.
• NACDD will use your input to improve the state meeting engagement process.
Thank you and have a great evening!