North Dakota Cancer Coalition

Planning for a cancer-free future.

NORTH DAKOTA COLORECTAL CANCER ROUNDTABLE

Joint Conference Call
Monday, Feb 4, 2018
12pm CST

Welcome! Please type your name in the chat box or unmute your line and introduce yourself for roll call

Welcome!

North Dakota Cancer Coalition

Planning for a cancer-free future.

NORTH DAKOTA COLORECTAL CANCER ROUNDTABLE

Dr. Donald Warne

Chair, ND CRC Roundtable

Agenda:

1. **ND Cancer Coalition Standing items**
   (Mallory Koshiol, Chair, NDCC)
2. **80% in Every Community**
   (Caleb Levell, National CRC Roundtable)
3. **Gearing up for CRC Awareness Month**
   (Tessi Ross, Shannon Bacon, Jesse Tran)
4. **2019 ND legislative update**
   (Kim Kuhlmann, ACS CAN)
5. **How to get involved in NDCC or NDCCRT**
   (Mallory Koshiol, Chair, NDCC)

Standing Items,
North Dakota Cancer Coalition

a. Approval of October minutes
b. Treasurer's Report
c. New members

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Save the Date!

North Dakota Cancer Coalition

Planning for a cancer-free future.

NDCC Annual Meeting

June 13, 2019

12:30 – 4pm

Minot, ND

Immediately following the Dakota Conference

All are welcome!

Lunch & Nursing CEU's available

An Update from the National Colorectal Cancer Roundtable

Caleb Levell
Program Manager, National Colorectal Cancer Roundtable
American Cancer Society

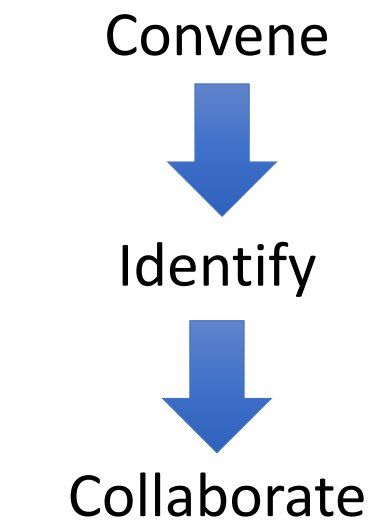
February 4, 2019

NATIONAL Colorectal Cancer ROUNDTABLE

National Colorectal Cancer Roundtable (NCCRT)

NCCRT is a national coalition of public, private, and voluntary organizations whose mission is to advance colorectal cancer control efforts by improving communication, coordination, and collaboration among health agencies, medical-professional organizations, and the public.

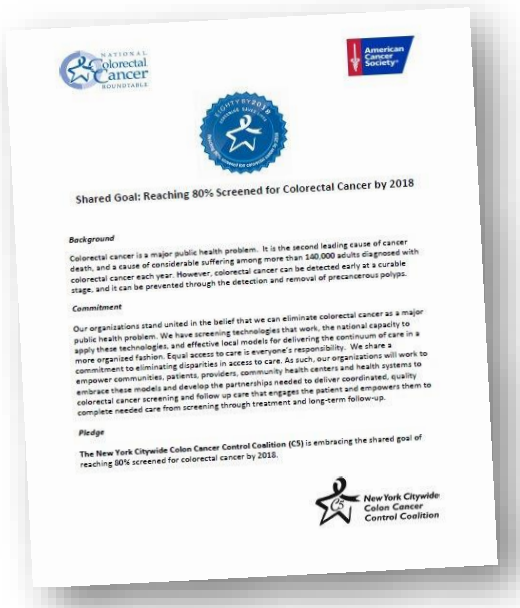
- Co-Founded by ACS and CDC in 1997
- Collaborative partnership of over 100 member organizations
- Includes many nationally known experts, thought leaders, and decision makers on colorectal cancer
- Work is conducted throughout the year through various Task Groups and Special Topic Meetings
- Annual Meeting addresses important topics and sets the following year's agenda



NATIONAL Colorectal Cancer ROUNDTABLE

80% by 2018

80% by 2018 was a movement in eliminating colorectal cancer as a major public health problem and focused on the shared goal of reaching 80% screened for colorectal cancer by 2018.



Shared Goal: Reaching 80% Screened for Colorectal Cancer by 2018

Background

Colorectal cancer is a major public health problem. It is the second leading cause of cancer death, and a cause of considerable suffering among more than 140,000 adults diagnosed with colorectal cancer each year. However, colorectal cancer can be detected early at a curable stage, and it can be prevented through the detection and removal of precancerous polyps.

Commitment

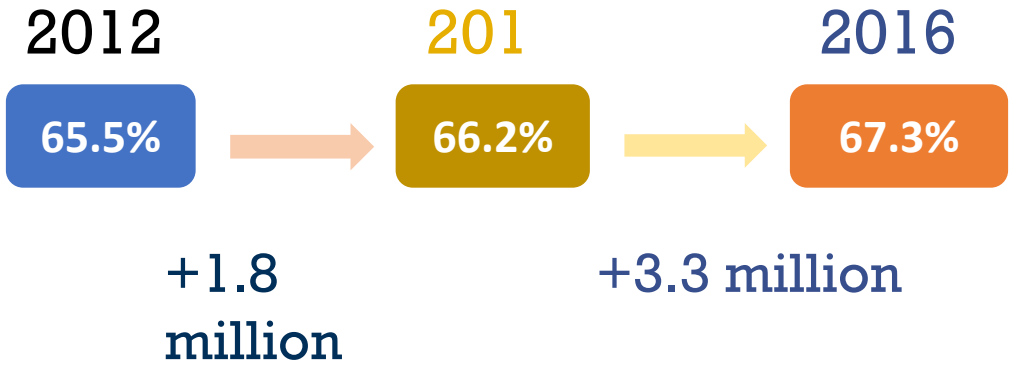
Our organizations stand united in the belief that we can eliminate colorectal cancer as a major public health problem. We have screening technologies that work, the national capacity to apply these technologies, and effective local models for delivering the continuum of care in a more organized fashion. Equal access to care is everyone's responsibility. We share a commitment to eliminating disparities in access to care. As such, our organizations will work to empower communities, patients, providers, community health centers and health systems to embrace these models and develop the partnerships needed to deliver coordinated, quality colorectal cancer screening and follow up care that engages the patient and empowers them to complete needed care from screening through treatment and long-term follow-up.

Pledge

The New York Citywide Colon Cancer Control Coalition (C5) is embracing the shared goal of reaching 80% screened for colorectal cancer by 2018.

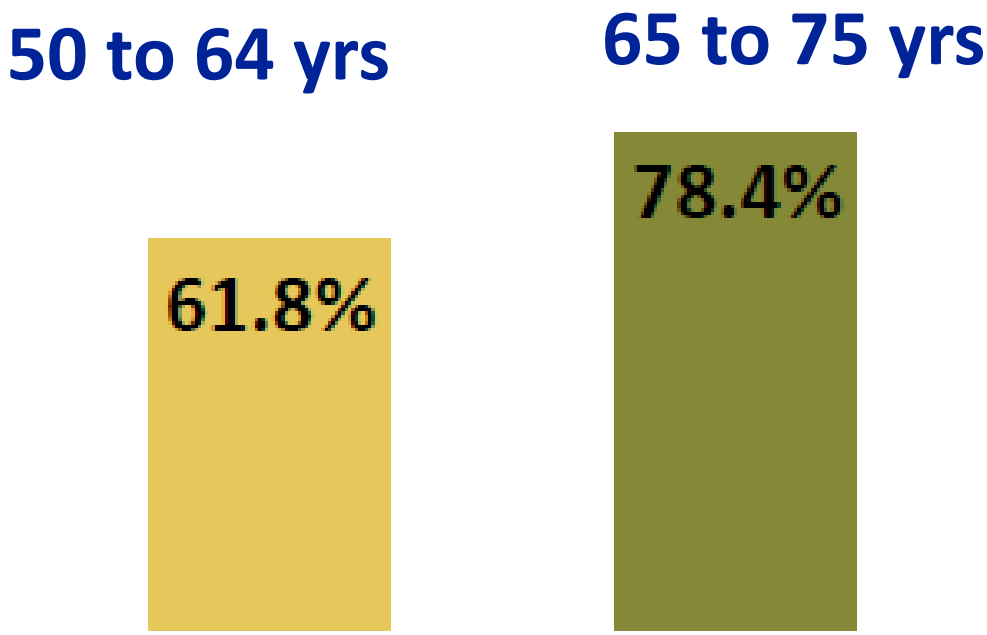
New York Citywide Colon Cancer Control Coalition

Percentage of U.S. Adults Age 50-75 years Up-to-Date with CRC Screening (BRFSS 2016)



Additional 5.1 million screened!

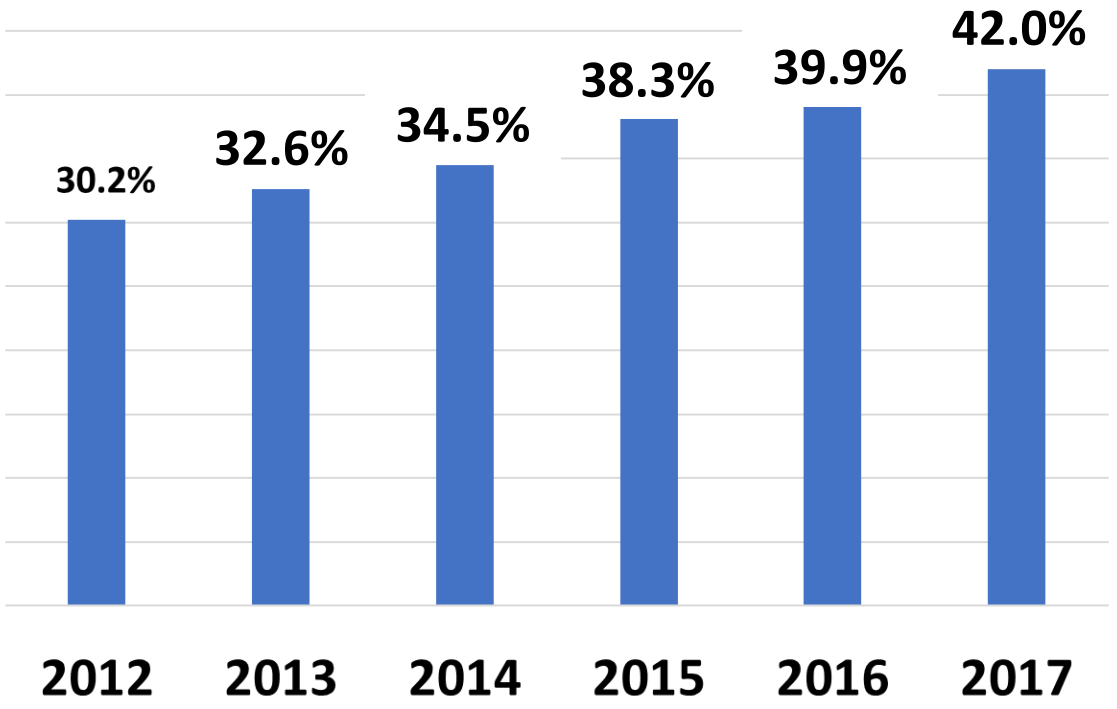
Amazing Screening Rates Among 65+ (BRFSS 2016)



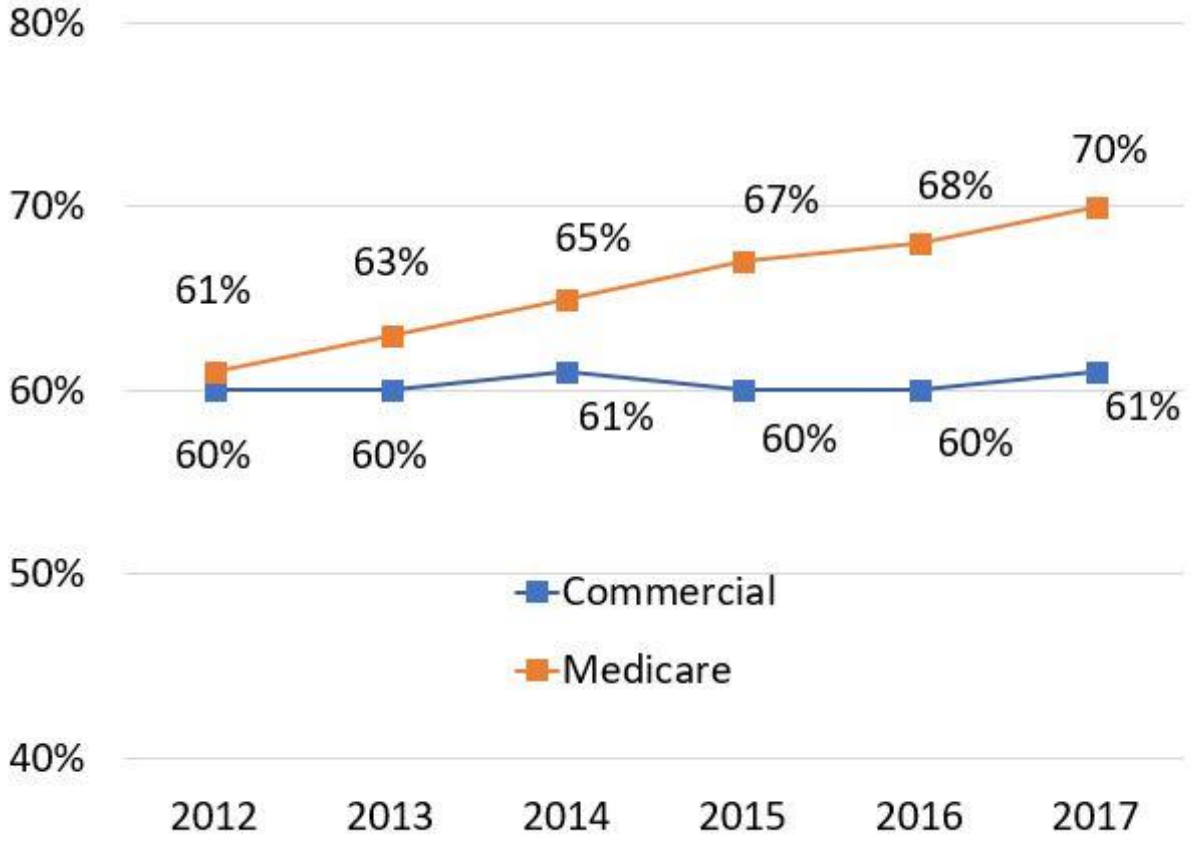
Source: BRFSS 2016

Colorectal Cancer Screening Rate

ALL FQHCs-UDS

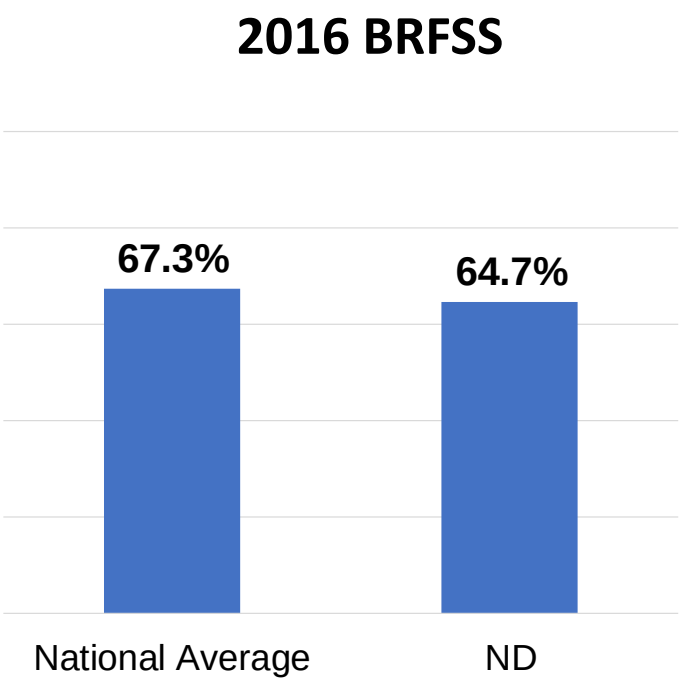


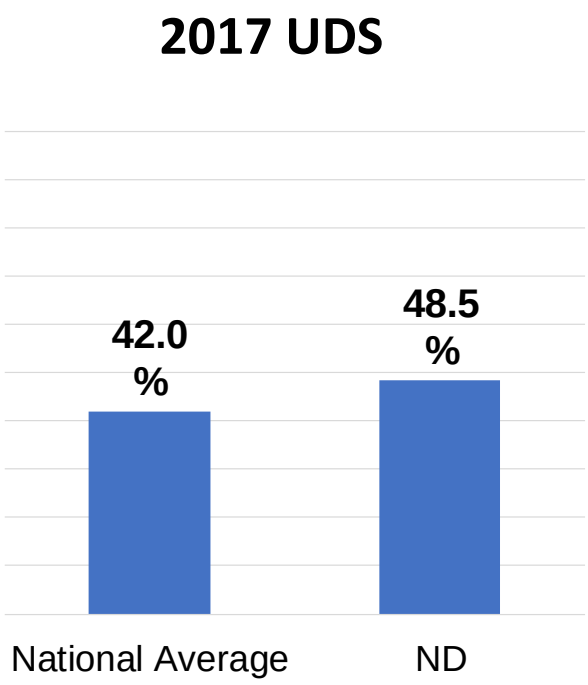
2012 – 2017 HEDIS



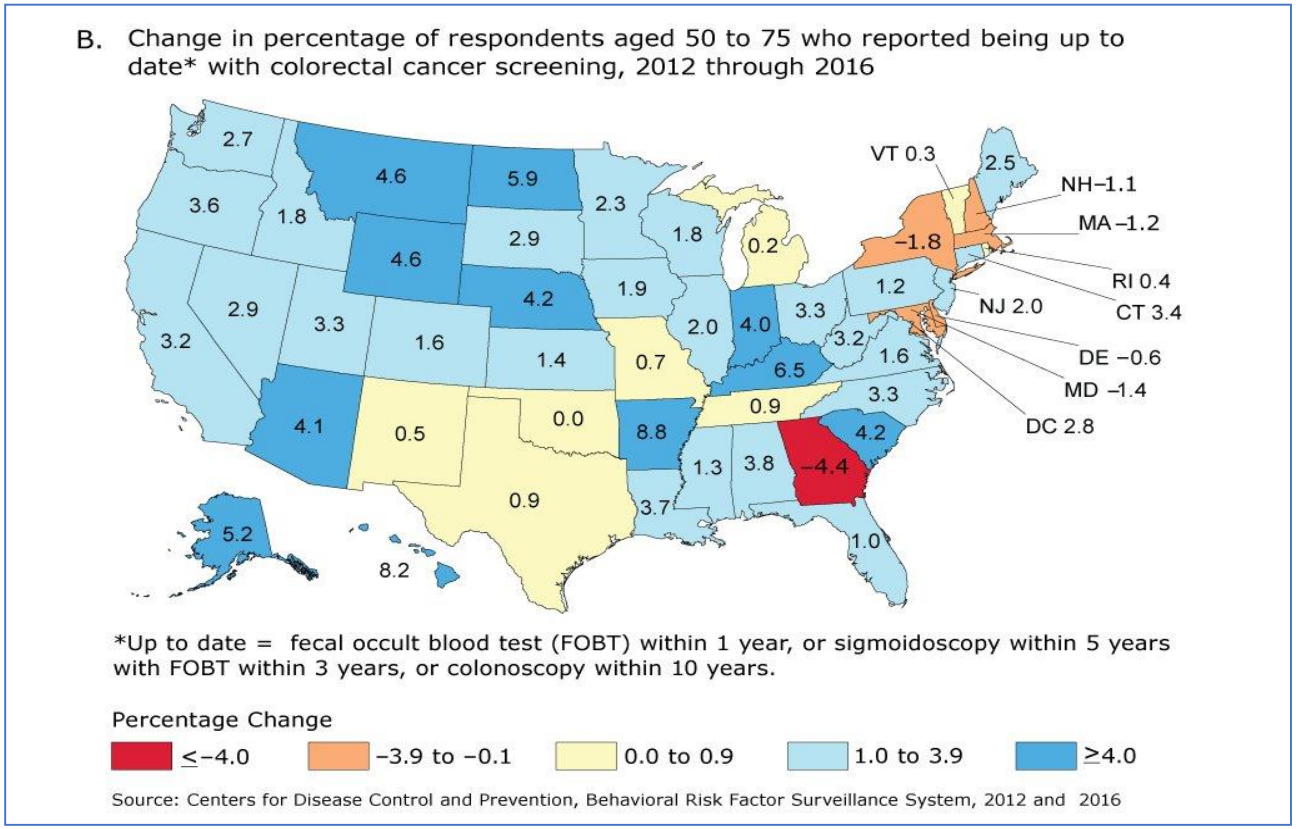
Percentage of U.S. Adults Age 50-75 years Up-to-Date with CRC Screening, Healthcare Effectiveness Data and Information Set

North Dakota CRC Screening Rates





Change in the Use of CRC Screening Tests by State, 2012-2016



Joseph DA, et al. Prev Chronic Dis 2018;15:170535. https://www.cdc.gov/pcd/issues/2018/17_0535.htm

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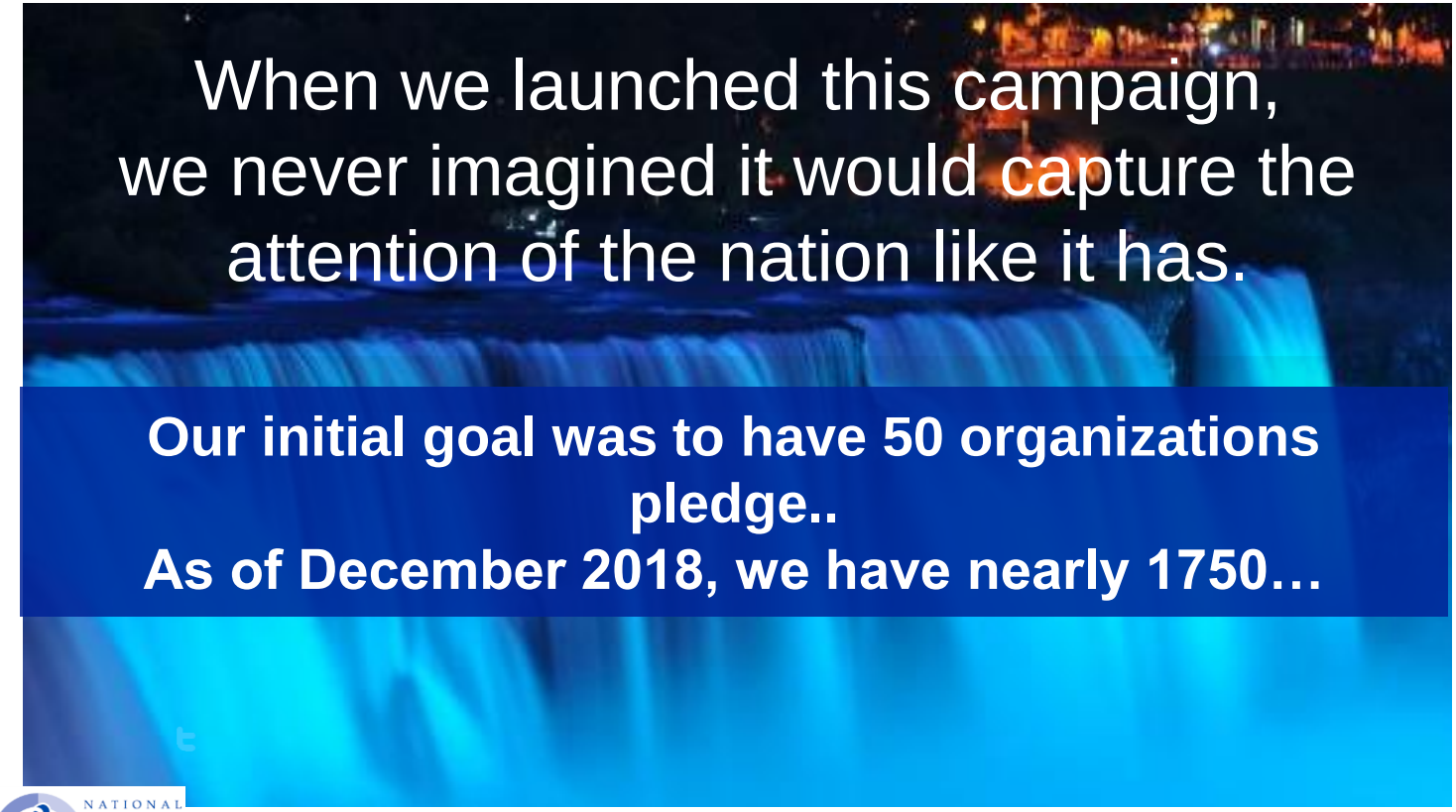
Current Strategic Plan Goals to Achieve – Update in 2019

Consumers
Move consumers to action

Systems
Use providers, payers, and employers to support screening

Policy
Increase access and remove barriers to screening

Process
Maintain momentum



NATIONAL Colorectal Cancer ROUNDTABLE

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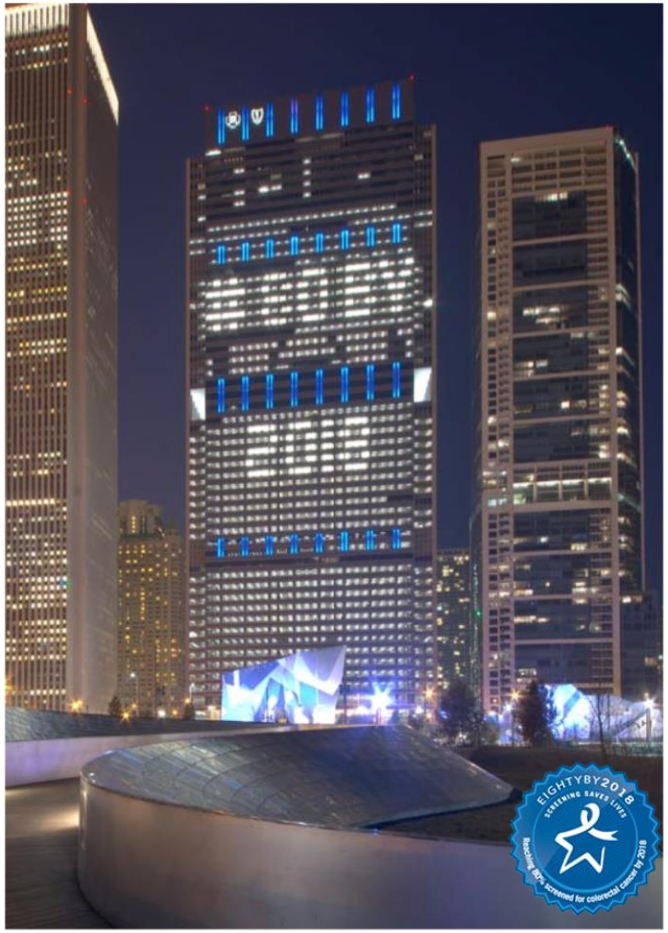
Over 20 - 80% Pledges from ND!

- Altru Health System
- Blue Cross Blue Shield of North Dakota
- Central Valley Health District
- CHI St Alexius
- City-County Health District
- Coal Country Community Health Centers
- Community HealthCare Association of the Dakotas (ND)
- Custer Health
- Elbowoods Memorial Health Care Center
- Essentia Health
- Family HealthCare
- Great Plains Tribal Chairmen's Health Board
- North Dakota Cancer Coalition
- North Dakota Department of Health
- North Dakota Medical Association
- Northland Community Health Centers
- Quality Health Associates of North Dakota
- Sakakawea Medical Center
- Sanford Health
- Sargent County District Health Unit
- Southwestern District Health Unit
- Trinity Health
- Valley Community Health Centers

Energy and enthusiasm
shown around the country!



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Beyond Thankful

80% by 2018: Our story of audacity, commitment & unity

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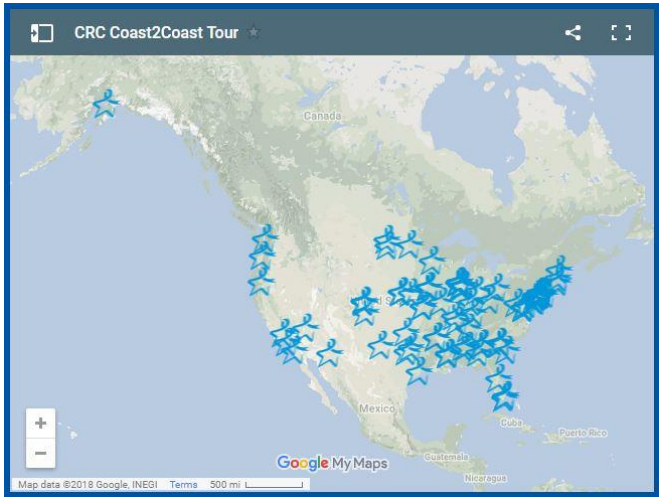
March 2018 – Local Engagement

- Wave of engagement from partners around the country hosting 80% by 2018 events
- 97 events throughout March
- Watch parties, state proclamation signings, lobby days, press briefings, radio interviews, state roundtable meetings, shining blue lights on buildings, bridges and skylines, health fairs and more



We’re setting our sights on…

#80InEveryCommunity

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“Beyond 80%” Listening Tour

- Outreach to members and 80% partner organizations
- Included surveys, focus groups, one on one interviews, online discussions, structured discussion at the last Steering Retreat, and other less formal discussions with partners in the field at conferences and meeting. (16 to 18 months)
  - 177 responses to our final Slogans and Descriptions survey
- That is to say… we spent a lot of time soliciting input, generating ideas, gathering feedback, and reflecting on the lessons from the last campaign.
- Many partners have expressed appreciation for this engagement and outreach .

Key Lessons Learned

80% by 2018 brought out the best in our organizations, and inspired collective, coordinated activity

A. Keep 80% as a theme
B. Intensify our focus on the commercially insured
C. Intensify our focus on key populations (such as African Americans, rural populations, Hispanic/Latinos, Asians, etc.)
D. Target 50 to 54 year olds, for whom the screening rate is 49%
E. Recruit new partners, such as media and employers
F. Consider a more emotionally compelling pitch to new partners, such as employers and media, that may not be swayed by a metrics-based campaign

Campaign Description

Partners in Saving Lives: 80% in Every Community

- 80% in Every Community is an NCCRT initiative that continues the progress and commitment from 80% by 2018, and reemphasizes our dedication to partnership, collective action, and the pooling of resources to reach 80% colorectal cancer screening rates nationally. Our shared efforts are working, community health clinics, health plans, employers, counties, and others are seeing 80% screening rates and higher.
- **But not everyone is benefiting equally**. There are still too many communities with lower colorectal cancer screening rates – rural communities, certain racial and ethnic communities, low income communities, and more. We will continue working to bring down barriers to screening, because everyone deserves to live a life free from colorectal cancer. Our mission isn't achieved until we see 80% screening rates in every community.

http://nccrt.org/80-in-every-community/

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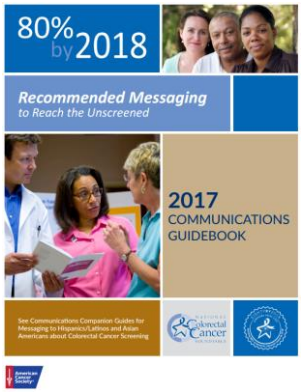
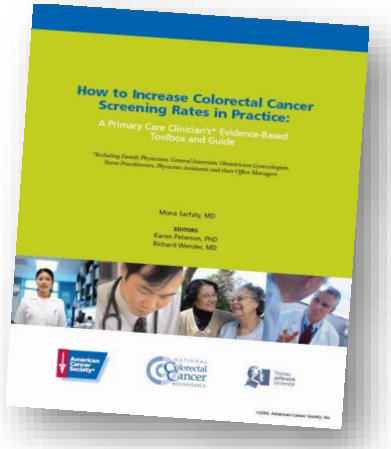
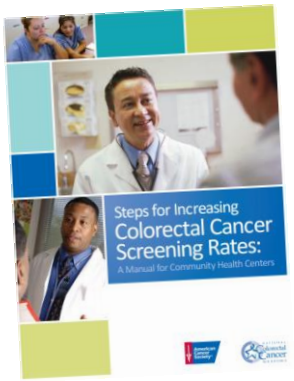
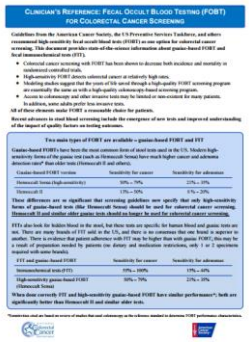
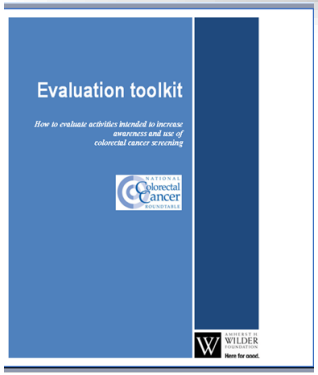
NCCRT Tools, Resources, and Publications







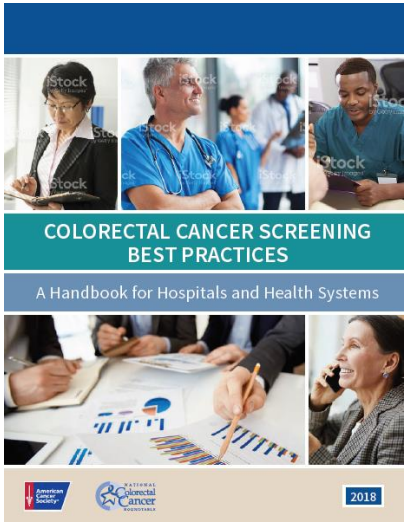


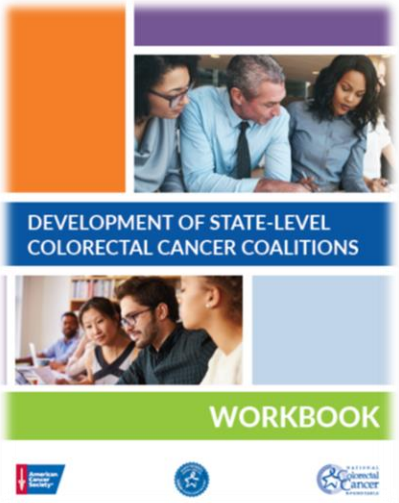


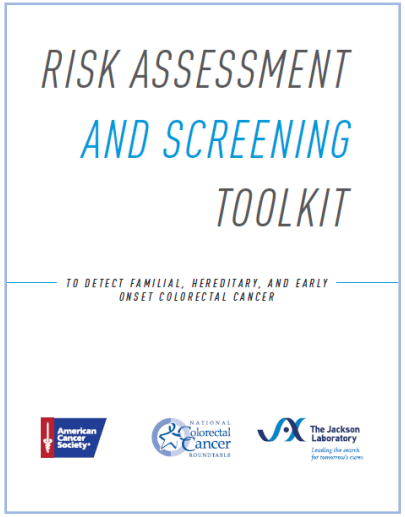
Available at:
nccrt.org/resource-center

New NCCRT resources released in 2018

- ✓ Hospital Systems Change package
- ✓ State Roundtable guide and workbook
- ✓ CRC Risk Assessment Tool
- ✓ Cancer Center Summit Report



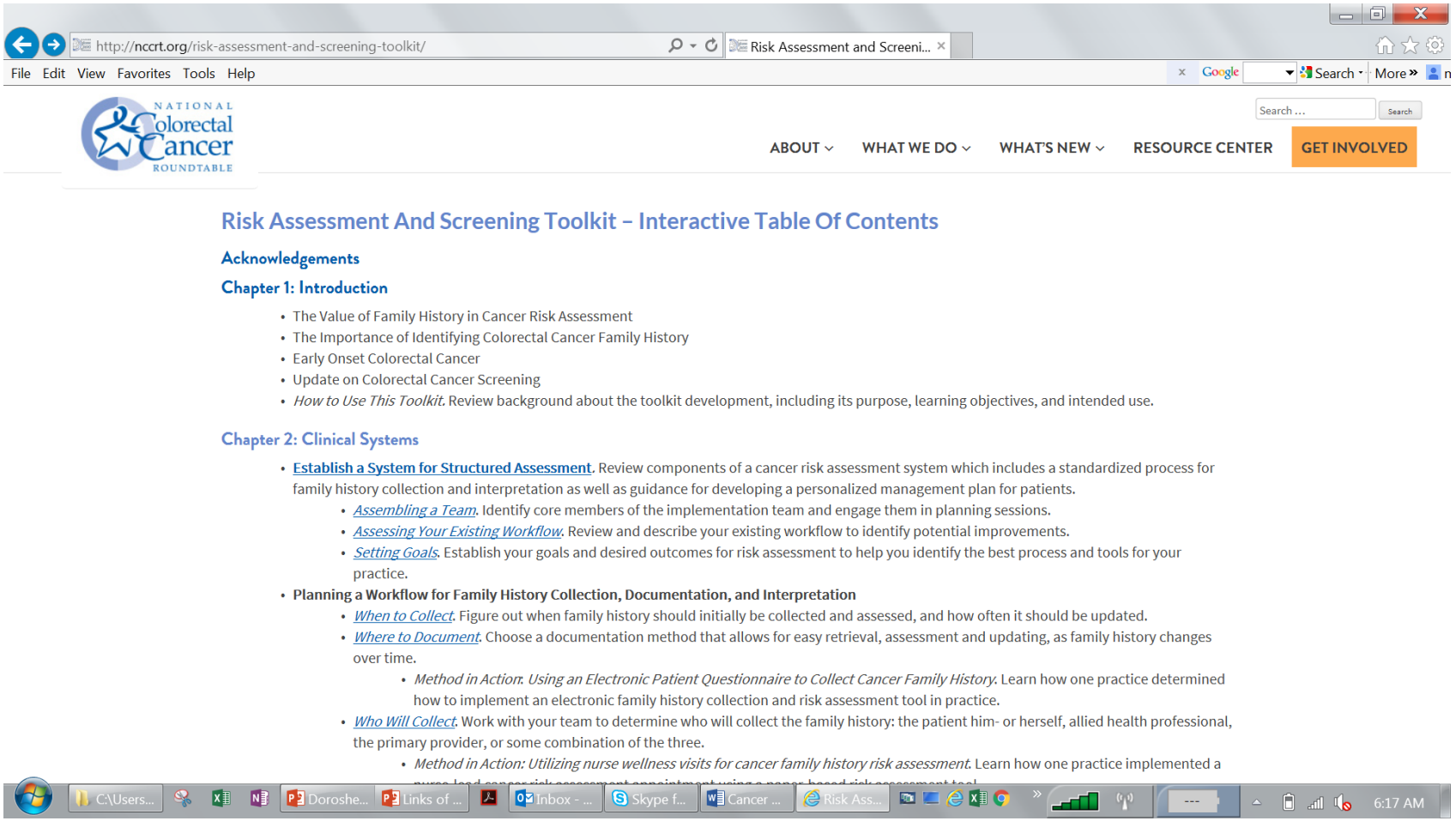




New NCCRT Resources under Development….

- ✓ Links of Care curriculum
- ✓ How to pay for screening navigation curriculum
- ✓ Deep dive into Medicaid best practices on CRC screening
- ✓ Beyond Thankful Report and Companion Video
- ✓ NextGen Best Practices and Workflow guide
- ✓ Update and modernize CHC Steps Manual
- ✓ Refresh market research with the unscreened

Experimenting with New Ways to Deliver Materials



ACS 2018 Recommendations for CRC Screening

- The ACS recommends that adults aged **45 years and older** with an average risk of colorectal cancer undergo regular screening with either a high-sensitivity stool-based test or a structural (visual) exam, depending on patient preference and test availability.
- *As a part of the screening process, all positive results on non-colonoscopy screening tests should be followed up with timely colonoscopy.*

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ACS 2018 Recommendations for CRC Screening

- The ACS recommends that average-risk adults in good health with a life expectancy of greater than 10 years continue colorectal cancer screening **through the age of 75 years**. *(qualified recommendation)*
- The ACS recommends that clinicians individualize colorectal cancer screening decisions for individuals aged **76 through 85 years**, based on patient preferences, life expectancy, health status, and prior screening history. *(qualified recommendation)*
- The ACS recommends that clinicians discourage individuals **over age 85 years** from continuing colorectal cancer screening. *(qualified recommendation)*

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ACS 2018 Recommendations for CRC Screening

- Options for CRC screening
  - Stool-based tests:
    - Fecal immunochemical test (FIT) every year
    - High sensitivity guaiac-based fecal occult blood test (HS-gFOBT) every year
    - Multi-target stool DNA test (mt-sDNA) every 3 years
  - Structural (visual) exams:
    - Colonoscopy (CSY) every 10 years
    - CT Colonography (CTC) every 5 years
    - Flexible sigmoidoscopy (FS) every 5 years
- As a part of the screening process, all positive results on non-colonoscopy screening tests should be followed up with timely colonoscopy.

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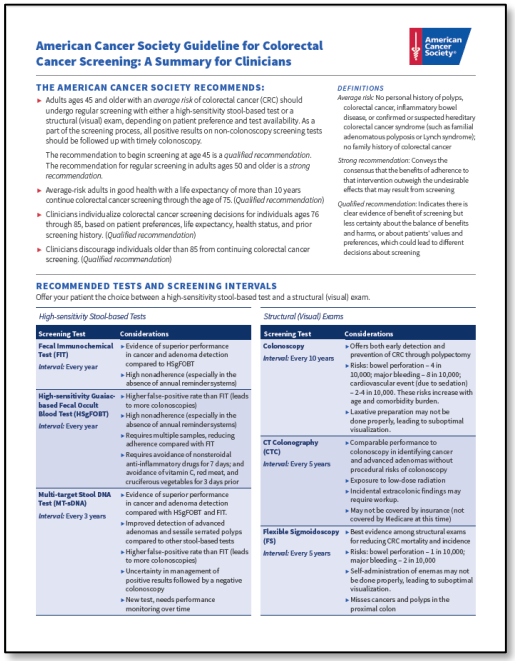
New Decision Aids for CRC Screening

Summary for Clinicians



American Cancer Society Guideline for Colorectal Cancer Screening: A Summary for Clinicians

THE AMERICAN CANCER SOCIETY RECOMMENDS:

- Adults ages 45 and older with an *average risk* of colorectal cancer (CRC) should undergo regular screening with either a high-sensitivity stool-based test or a structural (visual) exam, depending on patient preference and test availability. As a part of the screening process, all positive results on non-colonoscopy screening tests should be followed up with timely colonoscopy.

  The recommendation to begin screening at age 45 is a *qualified recommendation*. The recommendation for regular screening in adults ages 50 and older is a *strong recommendation*.
- Average-risk adults in good health with a life expectancy of more than 10 years continue colorectal cancer screening through the age of 75. (*Qualified recommendation*)
- Clinicians individualize colorectal cancer screening decisions for individuals ages 76 through 85, based on patient preferences, life expectancy, health status, and prior screening history. (*Qualified recommendation*)
- Clinicians discourage individuals older than 85 from continuing colorectal cancer screening. (*Qualified recommendation*)

DEFINITIONS

Average risk: No personal history of polyps, colorectal cancer, inflammatory bowel disease, or confirmed or suspected hereditary colorectal cancer syndrome (such as familial adenomatous polyposis or Lynch syndrome); no family history of colorectal cancer

Strong recommendation: Conveys the consensus that the benefits of adherence to that intervention outweigh the undesirable effects that may result from screening

Qualified recommendation: Indicates there is clear evidence of benefit of screening but less certainty about the balance of benefits and harms, or about patients' values and preferences, which could lead to different decisions about screening

RECOMMENDED TESTS AND SCREENING INTERVALS

Offer your patient the choice between a high-sensitivity stool-based test and a structural (visual) exam.

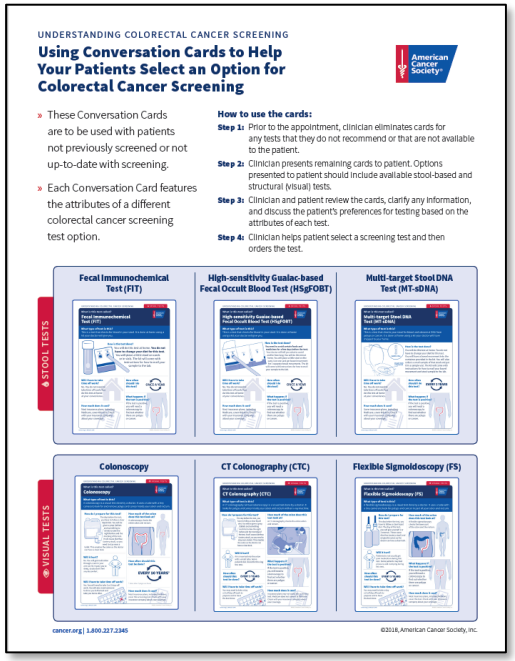
High-sensitivity Stool-based Tests

Screening Test	Considerations
Fecal Immunochemical Test (FIT) *Interval:* Every year	▸ Evidence of superior performance in cancer and adenoma detection compared to HSgFOBT ▸ High nonadherence (especially in the absence of annual reminder systems)
High-sensitivity Guaiac-based Fecal Occult Blood Test (HSgFOBT) *Interval:* Every year	▸ Higher false-positive rate than FIT (leads to more colonoscopies) ▸ High nonadherence (especially in the absence of annual reminder systems) ▸ Requires multiple samples, reducing adherence compared with FIT ▸ Requires avoidance of nonsteroidal anti-inflammatory drugs for 7 days; and avoidance of vitamin C, red meat, and cruciferous vegetables for 3 days prior
Multi-target Stool DNA Test (MT-sDNA) *Interval:* Every 3 years	▸ Evidence of superior performance in cancer and adenoma detection compared with HSgFOBT and FIT. ▸ Improved detection of advanced adenomas and sessile serrated polyps compared to other stool-based tests ▸ Higher false-positive rate than FIT (leads to more colonoscopies) ▸ Uncertainty in management of positive results followed by a negative colonoscopy ▸ New test, needs performance monitoring over time

Structural (Visual) Exams

Screening Test	Considerations
Colonoscopy *Interval:* Every 10 years	▸ Offers both early detection and prevention of CRC through polypectomy ▸ Risks: bowel perforation – 4 in 10,000; major bleeding – 8 in 10,000; cardiovascular event (due to sedation) – 2-4 in 10,000. These risks increase with age and comorbidity burden. ▸ Laxative preparation may not be done properly, leading to suboptimal visualization.
CT Colonography (CTC) *Interval:* Every 5 years	▸ Comparable performance to colonoscopy in identifying cancer and advanced adenomas without procedural risks of colonoscopy ▸ Exposure to low-dose radiation ▸ Incidental extracolonic findings may require workup. ▸ May not be covered by insurance (not covered by Medicare at this time)
Flexible Sigmoidoscopy (FS) *Interval:* Every 5 years	▸ Best evidence among structural exams for reducing CRC mortality and incidence ▸ Risks: bowel perforation – 1 in 10,000; major bleeding – 2 in 10,000 ▸ Self-administration of enemas may not be done properly, leading to suboptimal visualization. ▸ Misses cancers and polyps in the proximal colon

Conversation Cards



UNDERSTANDING COLORECTAL CANCER SCREENING

Using Conversation Cards to Help Your Patients Select an Option for Colorectal Cancer Screening

- These Conversation Cards are to be used with patients not previously screened or not up-to-date with screening.
- Each Conversation Card features the attributes of a different colorectal cancer screening test option.

How to use the cards:

Step 1: Prior to the appointment, clinician eliminates cards for any tests that they do not recommend or that are not available to the patient.

Step 2: Clinician presents remaining cards to patient. Options presented to patient should include available stool-based and structural (visual) tests.

Step 3: Clinician and patient review the cards, clarify any information, and discuss the patient's preferences for testing based on the attributes of each test.

Step 4: Clinician helps patient select a screening test and then orders the test.

STOOL TESTS

Fecal Immunochemical Test (FIT)

High-sensitivity Guaiac-based Fecal Occult Blood Test (HSgFOBT)

Multi-target Stool DNA Test (MT-sDNA)

VISUAL TESTS

Colonoscopy

CT Colonography (CTC)

Flexible Sigmoidoscopy (FS)

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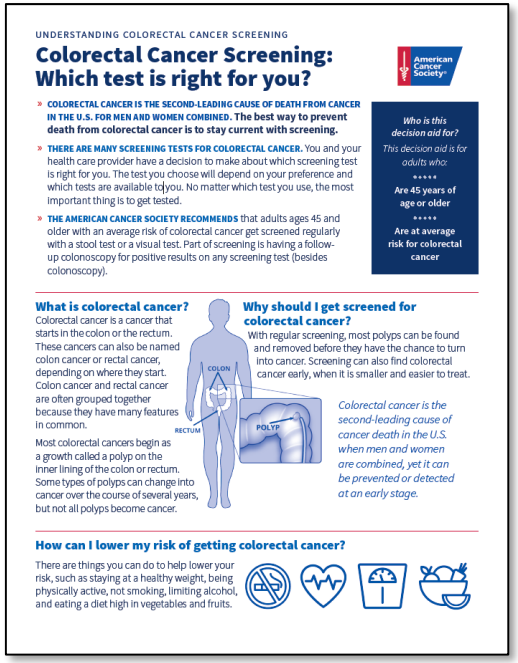
Patient Decision Aid



UNDERSTANDING COLORECTAL CANCER SCREENING

Colorectal Cancer Screening: Which test is right for you?

- **COLORECTAL CANCER IS THE SECOND-LEADING CAUSE OF DEATH FROM CANCER IN THE U.S. FOR MEN AND WOMEN COMBINED. The best way to prevent death from colorectal cancer is to stay current with screening.**
- **THERE ARE MANY SCREENING TESTS FOR COLORECTAL CANCER.** You and your health care provider have a decision to make about which screening test is right for you. The test you choose will depend on your preference and which tests are available to you. No matter which test you use, the most important thing is to get tested.
- **THE AMERICAN CANCER SOCIETY RECOMMENDS** that adults ages 45 and older with an average risk of colorectal cancer get screened regularly with a stool test or a visual test. Part of screening is having a follow-up colonoscopy for positive results on any screening test (besides colonoscopy).

Who is this decision aid for?

This decision aid is for adults who:

Are 45 years of age or older

Are at average risk for colorectal cancer

What is colorectal cancer?

Colorectal cancer is a cancer that starts in the colon or the rectum. These cancers can also be named colon cancer or rectal cancer, depending on where they start. Colon cancer and rectal cancer are often grouped together because they have many features in common.

Most colorectal cancers begin as a growth called a polyp on the inner lining of the colon or rectum. Some types of polyps can change into cancer over the course of several years, but not all polyps become cancer.

COLON

RECTUM

POLYP

Why should I get screened for colorectal cancer?

With regular screening, most polyps can be found and removed before they have the chance to turn into cancer. Screening can also find colorectal cancer early, when it is smaller and easier to treat.

Colorectal cancer is the second-leading cause of cancer death in the U.S. when men and women are combined, yet it can be prevented or detected at an early stage.

How can I lower my risk of getting colorectal cancer?

There are things you can do to help lower your risk, such as staying at a healthy weight, being physically active, not smoking, limiting alcohol, and eating a diet high in vegetables and fruits.

https://www.cancer.org/health-care-professionals/colon-md.html

CRC Screening Guidelines for Average Risk Adults: ACS (2018); USPSTF (2016)

Recommendations	ACS, 2018	USPSTF, 2016
Age to start screening S-strong Q-Qualified	Age 45y Starting at 45y (Q) Screening at aged 50y and older - (S)	Aged 50y (A)
Choice of test	High-sensitivity stool-based test or a structural exam.	Different methods can accurately detect early stage CRC and adenomatous polyps.
Acceptable Test options	• FIT annually, • HSgFOBT annually • mt-sDNA every 3y • Colonoscopy every 10y • CTC every 5y • FS every 5y All positive non-colonoscopy tests should be followed up with colonoscopy.	• HSgFOBT annually • FIT annually • mt-sDNA (aka FIT-DNA) every 1 or 3 y • Colonoscopy every 10y • CTC every 5y • FS every 5y • FS every 10y plus FIT every year
Age to stop screening	Continue to 75y as long as health is good and life expectancy 10+y (Q) 76-85y individual decision making (Q) >85y discouraged from screening (Q)	76-85 y individual decision making (C)

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2018 NCCRT Guideline Summit: *(September 20, 2018)*

- **What:** NCCRT convened a strategic meeting to consider how we promote CRC screening when recommendations differ.
- **Participants:**
  - 30+ attendees- experts/stakeholders
  - Broad array of backgrounds and perspectives
- **Format:** Informational presentations and group reflection, along with quite a bit of discussion, brainstorming, and workshop activities.

Objectives:

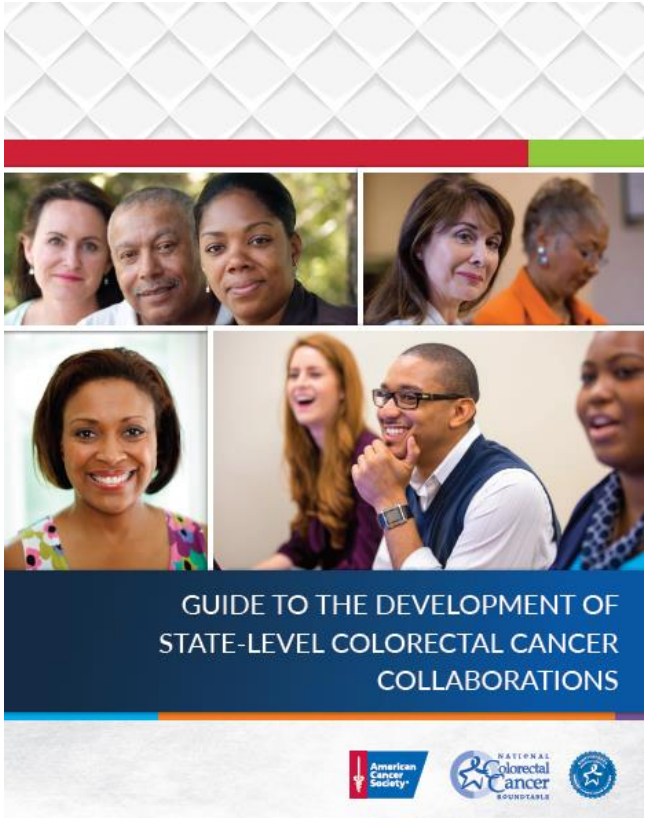
- Discuss where and how the differing starting ages will impact key strategy areas,
- Determine how the NCCRT can best continue to serve key and emerging constituencies as they implement CRC screening recommendations for their communities;
- Decide what changes are necessary to continue to support the shared goal to reach an 80% screening rate; and
- Explore any new opportunities that a recommendation to start screening at age 45 will present.

NCCRT Guideline Position Statement

The NCCRT supports member organizations in advancing their life saving missions around colorectal cancer screening, no matter which colorectal cancer screening recommendations they choose to follow. The NCCRT will continue to create an environment in which organizations with varying missions and policies can be heard, where differences of opinion are respected, where all organizations benefit from their membership in the NCCRT, and where the guiding philosophy emphasizes working toward the same end goal to save lives from this disease. Assuring health equity is our responsibility. The NCCRT will continue to provide resources that meet the needs of all members, serve as an information clearing house, address disparities issues, and identify opportunities to save lives from this disease, including those who are being diagnosed at younger ages.

Guide on Development of State-Level CRC Coalitions

Featuring the experiences of model programs in California, Delaware, Kentucky, Minnesota and South Carolina



10 Tasks New CRC Coalitions Should Address:

1. Prioritize colorectal cancer in your state
2. Establish a structure
3. Develop a vision
4. Recruit leadership and “staff”
5. Build a network of partners
6. Convene partners
7. Set goals and objectives
8. Maintain momentum
9. Get creative with funding and resources
10. Hold the group accountable

TASK 1 Prioritize Colorectal Cancer in Your State

HOW THEY CHOSE COLORECTAL CANCER

The **Minnesota Cancer Alliance** had 23 different objectives that they were working on simultaneously. However, they recognized that in order to make progress, they needed to focus on only a few.

After going through a disciplined evaluation process of all their objectives, colorectal cancer emerged as a top-three priority area and a subcommittee was established to focus on it.

The subcommittee brought together organizations across the state whose work aligned with this objective.

Addressing colorectal cancer (CRC) is a national priority. As the second leading cause of cancer death in the U.S. when men and women are combined and with more than 135,000 adults diagnosed each year, colorectal cancer is a source of considerable suffering. State-based partners are challenged with limited time and resources and must balance and prioritize the public health issues facing their unique populations.

Leaders from successful colorectal cancer collaborations have often started by clearly demonstrating to their partners and peers that the local toll taken by colorectal cancer justifies an immediate investment of local resources and a commitment to action to fulfill the great potential of screening.

Steps for prioritizing CRC in your state

1 Use state-specific data to make the case

- 80 by 2018 Impact by State (http://bit.ly/2o4VIdy)
- United States Cancer Statistics (http://bit.ly/2EMVYaQ)
- American Cancer Society Statistics Center (http://bit.ly/2Eyqbel)
- Multilevel Small-Area Estimation of Colorectal Cancer Screening in the United States (https://bit.ly/2GkLQn0)
- Behavioral Risk Factor Surveillance System (BRFSS) (http://bit.ly/2BWFesC)
- NCCRT Webinar: "Colorectal Cancer Screening Data Sets: What are they and what do they tell us?" (http://bit.ly/2HkqBCO)
- Other state-based resources: State Department of Health, Universities, cancer registries

2 Develop key messages for partner recruitment

- Colorectal cancer is one of the few cancers which can be prevented through screening.
- Even though colorectal cancer can be prevented or caught early, X # of people develop colorectal cancer in [STATE] and Y# of people will die from the disease.
- There are proven strategies local leaders can take to increase colorectal cancer screening and reduce the toll taken by this disease.

3 Align with national efforts

- Sign the pledge (http://bit.ly/2FavloE) – Commit to NCCRT's shared goal to get to 80% colorectal cancer screening rate.
- Engage with your state comprehensive cancer control program and coalition, your local CDC Colorectal Cancer Control program (if applicable), and utilize resources developed by the Comprehensive Cancer Control National Partnership (CCCNP) (http://www.cccnationalpartners.org/).
- Connect with your American Cancer Society state systems staff, who have unique skill sets to engage with state systems.
- Attend national conferences focused on cancer control, such as the Prevent Cancer Foundation's *Dialogue for Action™* meeting, the CDC Cancer Conference, or the Southeast Regional Colorectal Cancer Consortium.

4 Review key resources

- NCCRT Tools and Resources (http://bit.ly/2Ex7QOW)
- The Community Guide (CDC) (http://bit.ly/2gz5lvq)
- Research Tested Intervention Programs (NCI) (http://bit.ly/2ELMRqM)
- Colon MD (ACS) (http://bit.ly/2ocOZxn)
- Cancer Control Planet (NCI) (http://bit.ly/2F6LfFL)

MAKING THE CASE IN KENTUCKY

Whenever possible, pioneering state collaborations use local or state costs and data to make the case, rather than national figures.

For example, the Kentucky Cancer Consortium includes the following detailed impact data in their coalition plan, describing the costs to Kentucky's Medicaid program:

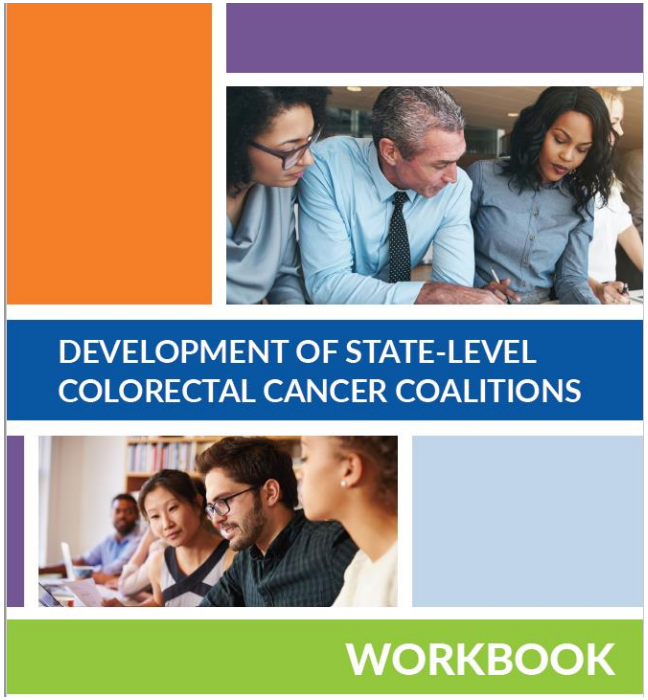
- Each year between 2004-2008, cancer treatments in Kentucky cost Medicaid $132 million, private insurance companies $836 million and Medicare $718 million.
- In 2010, cancer care in Kentucky cost approximately $2.2 billion. In 2020, it is estimated to increase by 69%, which would be approximately $3 .8 billion.
- The typical new cancer drug coming on the market in 2010 cost approximately $10,000/ month of treatment. Two of the new cancer drugs cost more than $35,000 per month of treatment.

"If we're really going to make an impact, let's focus."

- Kentucky Cancer Consortium

And Companion Workbook!

Featuring summary pages with brainstorming and action planning activities



TASK 1 Worksheets

Identify Existing Activities

Activity	Resource	Completed
Has your organization signed the NCCRT's pledge to reach an 80% screening rate?	http://nccrt.org/80-2018-pledge	☐
Have you identified the other organizations in your state that have signed the pledge?	http://nccrt.org/national-map-of-pledges	☐
Which other organizations need to sign the pledge?		☐
Are you coordinating with your state's CDC-funded comprehensive cancer control program or coalition?	https://www.cdc.gov/cancer/ncccp/index.htm	☐
Are you familiar with the Comprehensive Cancer Control National Partnership?	http://www.cccnationalpartners.org/increase-colorectal-cancer-screening-80-2018	☐
Does your state have funding from CDC for colorectal cancer control programming?		☐
Are you working with your ACS state systems staff?		☐
What national conferences focused on colorectal cancer control do you regularly attend?		☐

Identify Available Data

Activity	Resource	Completed
What are the CRC incidence and mortality rates for your state?	ACS Facts and Figures (http://bit.ly/2m98GqF) State Cancer Registry (http://bit.ly/2o4CFA1)	☐
What is the CRC screening rate for your state?	ACS Facts and Figures (http://bit.ly/2m98GqF) BRFSS (http://bit.ly/2BWFesC)	☐
How does your state rank/compare nationally?		☐
How many lives could be saved by an 80% screening rate in your state?	Impact on Lives Saved (http://bit.ly/2o4VIdy)	☐
What is the cost of colorectal cancer in your state?	ACS-CAN The Costs of Cancer (http://bit.ly/2puMSUE) An Unhealthy America: The Economic Burden of Chronic Disease (http://bit.ly/2FaUk0u)	☐

Create three key messages to help prioritize colorectal cancer in your state:

1	
2	
3	

Notes:

2018 CRC Research: Unscreened 50+ year olds

Background

The following presentation will summarize the findings from the first two phases of the 2018 CRC research and will focus on the 50+ Unscreened population. Findings from this research will be used to help craft the messaging to be tested in the final phase of this research.

Phase 1

Objective:

- *Measure awareness of screening methods*
- *Understand the rationale for being screened/not being screened*
- *Uncover potential motivators to encourage screening*

Methodology:
15-minute unbranded, online survey

Phase 2

Objective:
Dig deeper into the Unscreened population to better understand:

- *Overall health perceptions*
- *Reasons behind their choice to remain unscreened*
- *CRC & CRC screening perceptions*
- *Motivators to get screened*

Methodology:
(20) ***45-minute telephone IDIs***

Coming soon….

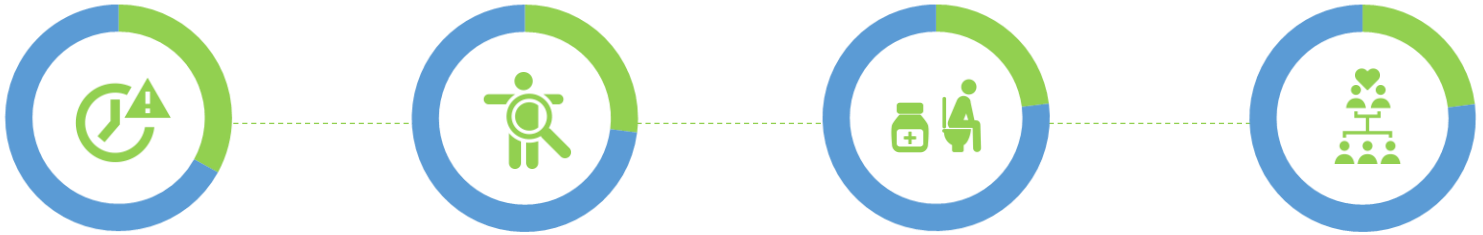
Phase 3

Objective:
Test potential messages to understand the impact they will have on motivating the Unscreened base

Methodology:
15-minute unbranded, online survey

Note: The research did capture insights from a smaller subset of 45-49 year olds, as well as Screened respondents. While both audiences may be briefly touched upon or referenced during this discussion, the main focus is the 50+ Unscreened age group.

Why aren't they getting screened?



PROCRASTINATION (33%)
Often triggered by concerns about prep or the unpleasantness of the procedure

LACK OF SYMPTOMS (27%)

UNPLEASANTNESS OF PREP (23%)

NO FAMILY HISTORY (23%)

COST CONCERNS

74% of the Uninsured are deterred by cost

Among the Insured, some have expressed cost concerns, mainly just not knowing what insurance would cover and what out-of-pocket costs they would incur

IMPORTANCE OF SCREENING

60% feel CRC screening is important

(Higher among young 50 & African Americans)

Top barriers:
- **42%** Procrastination
- **25%** Unpleasantness of prep
- **22%** No symptoms

Anxiety and fear *are leading emotions Unscreened participants have when they think of being screened, largely related to the prep and procedure, but some also fear the results.*

"I'm filled with a sense of dread for the preparation and the actual procedure."

CRC Screening Barriers – Population Differences

Race/Ethnicity

Barriers to screening are similar for Caucasians, Hispanics, and African Americans with procrastination leading

Caucasians:

More likely to cite:

- **Unpleasantness of prep**

Asians:

- Top barriers:
  - ✓ No symptoms
  - ✓ No family history
  - ✓ Doctor didn't recommend

More likely than others to cite:

- **Doctor didn't recommend**
- **Not thinking they were of age**

Young 50

More likely to cite:

- **Procrastination**

Females

More likely to cite:

- **Unpleasantness of prep**
- **No family history**

Rural Dwellers

More likely to cite:

- **Don't want to know if I have cancer**

Marketplace Insured

More likely to cite:

- **Can't afford out-of-pocket costs**

There are two main types of the Unscreened:

Those who acknowledge they should get screened and it's senseless they haven't

- *"I know it's stupid how I'm acting, but again, fears can be irrational. But, how I justify it is by saying, 'Well, I'm not saying I'm never going to do it. Maybe in some months I'll revisit it.' But then I put it out of my head and I don't think about it."*

Those who have a 'what's meant to be will be' mentality

- *"I think that if you get it, you get it. I don't think of it as something that's preventable where if you catch breast cancer early, you can prevent it, you can cure it. When I think of colon cancer, I don't think it's preventable or curable. I think once you get it, you get it and, again, your clock starts ticking."*

What Could Motivate Screening

What could trigger getting screened sooner rather than later:

- Stomach issues
- Someone they know having CRC
- Their doctor really pushing the issue

What could make screening easier/motivate action:

- Different/better test (21%)
- Lower cost/better insurance coverage (21%)
- Education on why it's important (15%)

How they think they'll feel prior:

- Many assume they will feel anxiety or dread about the prep and/or procedure
- Some note they would feel fine about the procedure, but would be anxious about the results

"I would be scared to death and embarrassed because you don't know what's going to happen. You feel exposed. It's not something you really want to do. You don't want to lay on a table while they stick a scope there."

Many note they would likely feel relieved after

What Could Motivate Screening – Population Differences

DIFFERENT/ BETTER TEST

Mentioned more by:

- Females
- Hispanics & Caucasians
- Insured

LOWER COST/BETTER INSURANCE COVERAGE

Mentioned more by:

- Uninsured

EDUCATION ON WHY IT IS IMPORTANT

Mentioned more by:

- Asians, African Americans, & Hispanics
- Insured

Population Summaries

Rural Dwellers - Unique Challenges & Opportunities

CHALLENGES

- Procrastination, no symptoms, & no family history top barriers

Compared to other Dwellers:

- More likely to cite not wanting to know if they have cancer as a barrier to screening
- Less likely to get annual physicals

OPPORTUNITIES

- Greater awareness of FIT-DNA test
- Lower prices/better insurance coverage leading motivator
- Message how screening can prevent colon cancer by removing polyps

"I really don't want to know if I have it or not. Sometimes, depending upon what it is, I have a certain mindset and my mindset about the whole thing is I don't have any symptoms. I don't have blood in the stool and I'm not having any problems with this and that. So why go looking?"

Young 50 *(50-54 year olds)* - Unique Challenges & Opportunities

CHALLENGES

- Procrastination leading barrier

Compared to 55+ year olds:

- More likely to cite procrastination, no time, and not thinking they are old enough as barriers
- More likely to be uninsured
- More likely to go to urgent care, a pharmacy, or the ER when sick

OPPORTUNITIES

- Place higher importance on screening
- More often desire health info from doctors and health portals
- Greater trust in receiving health info from family and government health organizations
- Message how screening can prevent colon cancer by removing polyps

> "I mean if I have the time I'll get it done. It just depends. I mean there are so many variables, and it depends on how my father's doing. One day he could be fine, and one day he's not."

Females - Unique Challenges & Opportunities

CHALLENGES

- Procrastination, no family history, test prep concerns, & no symptoms top barriers

Compared to Males:

- More likely to cite test prep or no family history as barriers
- More likely to have discussed the test prep with friends/family

OPPORTUNITIES

- Care a great deal about their health
- Go to NPs/PAs when sick
- More likely to cite different tests or better prep as motivators
- Greater awareness of stool and FIT-DNA tests
- Message screening tests that can be done at home

> "What I find is it's very, very stressful to prepare for the test. You need to be fasting and you need to try to get everything flushed out, which was very exhausting for my husband when he did it, and that makes me hesitate."

Market Place Insured - Unique Challenges & Opportunities

CHALLENGES

- Out-of-pocket costs leading barrier to screening

Compared to other insured:

- More likely to cite out-of-pocket costs as a barrier
- Less likely to get annual physicals
- Less likely to say they care a great deal about their health

OPPORTUNITIES

- Lower prices/better insurance coverage leading motivator
- Message how screening can find cancer early

"My insurance does not cover it."

African Americans - Unique Challenges & Opportunities

CHALLENGES

- Procrastination leading barrier

Compared to others:

- More likely to cite fear of results as a screening barrier for people in general

OPPORTUNITIES

- Increasing awareness/education on CRC screening most motivating
- Greater trust in receiving health info from government health organizations and insurance companies
- Message how screening can prevent colon cancer by removing polyps

Asians - Unique Challenges & Opportunities

CHALLENGES

- No symptoms, doctor didn't recommend, & no family history leading barriers

Compared to others:

- More likely to cite doctor didn't recommend or not thinking they are of age as barriers

OPPORTUNITIES

- Increasing awareness/education on CRC screening most motivating
- Message how screening can prevent colon cancer by removing polyps
- Materials at health care facility or news reports/stories viable info channels
- Greater trust in receiving health info from government health organizations and insurance companies

Thank You!

To follow NCCRT on social media:

Twitter: @NCCRTnews

Facebook:

www.facebook.com/coloncancerroundtable

Caleb.Levell@cancer.org

Gearing Up for Colorectal Cancer Awareness Month!

North Dakota Cancer Coalition

Planning for a cancer-free future.

NORTH DAKOTA COLORECTAL CANCER ROUNDTABLE

2019 Governor Proclamation

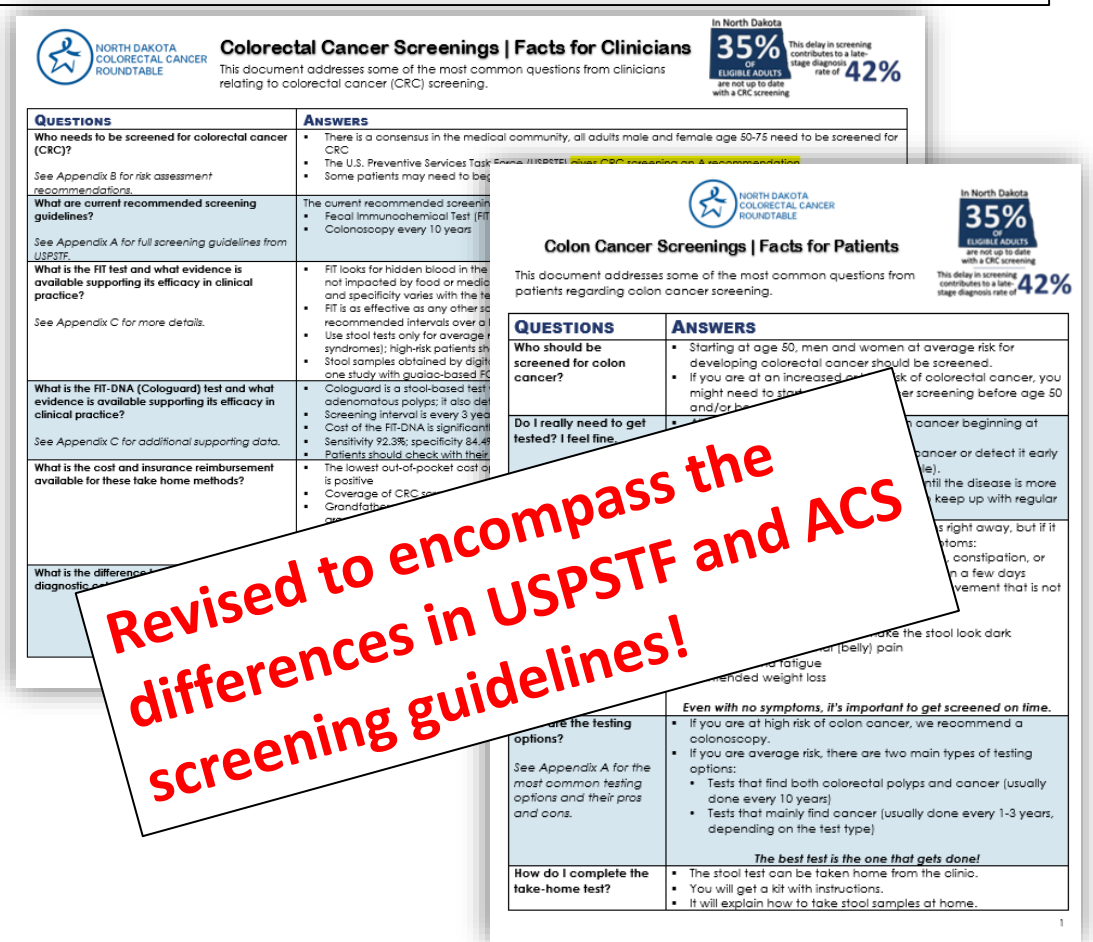
North Dakota will be a "Blue Star State"

Thank you to Amanda Houston for securing the proclamation!

State of North Dakota
Office of the Governor
Doug Burgum
Governor

Health Systems Tools:

FAQ Documents for Clinical Teams



NORTH DAKOTA COLORECTAL CANCER ROUNDTABLE

Colorectal Cancer Screenings | Facts for Clinicians

This document addresses some of the most common questions from clinicians relating to colorectal cancer (CRC) screening.

In North Dakota 35% OF ELIGIBLE ADULTS are not up to date with a CRC screening

This delay in screening contributes to a late-stage diagnosis rate of 42%

Questions	Answers
Who needs to be screened for colorectal cancer (CRC)? *See Appendix B for risk assessment recommendations.*	▪ There is a consensus in the medical community, all adults male and female age 50-75 need to be screened for CRC ▪ The U.S. Preventive Services Task Force (USPSTF) [illegible] CRC screening an A recommendation ▪ Some patients may need to beg
What are current recommended screening guidelines? *See Appendix A for full screening guidelines from USPSTF.*	The current recommended screenin ▪ Fecal Immunochemical Test (FIT ▪ Colonoscopy every 10 years
What is the FIT test and what evidence is available supporting its efficacy in clinical practice? *See Appendix C for more details.*	▪ FIT looks for hidden blood in the not impacted by food or medic and specificity varies with the te ▪ FIT is as effective as any other sc recommended intervals over a l ▪ Use stool tests only for average r syndromes); high-risk patients sh ▪ Stool samples obtained by digit one study with guaiac-based FO
What is the FIT-DNA (Cologuard) test and what evidence is available supporting its efficacy in clinical practice? *See Appendix C for additional supporting data.*	▪ Cologuard is a stool-based test adenomatous polyps; it also det ▪ Screening interval is every 3 yea ▪ Cost of the FIT-DNA is significant ▪ Sensitivity 92.3%; specificity 84.4% ▪ Patients should check with their
What is the cost and insurance reimbursement available for these take home methods?	▪ The lowest out-of-pocket cost o is positive ▪ Coverage of CRC sc ▪ Grandfather
What is the difference b[illegible] diagnostic	

Revised to encompass the differences in USPSTF and ACS screening guidelines!

NORTH DAKOTA COLORECTAL CANCER ROUNDTABLE

Colon Cancer Screenings | Facts for Patients

This document addresses some of the most common questions from patients regarding colon cancer screening.

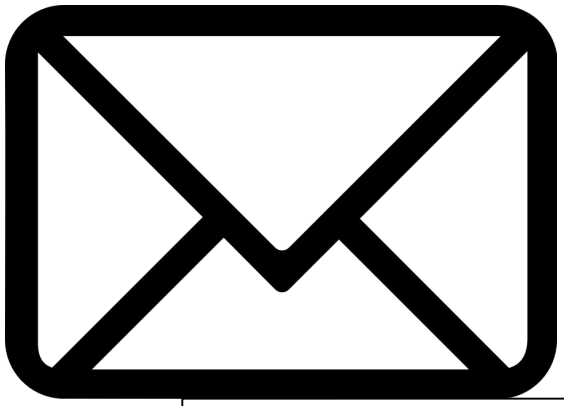
In North Dakota 35% OF ELIGIBLE ADULTS are not up to date with a CRC screening

This delay in screening contributes to a late-stage diagnosis rate of 42%

Questions	Answers
Who should be screened for colon cancer?	▪ Starting at age 50, men and women at average risk for developing colorectal cancer should be screened. ▪ If you are at an increased [illegible]sk of colorectal cancer, you might need to start [illegible]er screening before age 50 and/or h[illegible]
Do I really need to get tested? I feel fine.	[illegible] cancer beginning at [illegible]cancer or detect it early [illegible]e). [illegible]ntil the disease is more [illegible] keep up with regular
	[illegible]s right away, but if it [illegible]toms: [illegible], constipation, or [illegible]n a few days [illegible]vement that is not [illegible]ake the stool look dark [illegible] (belly) pain [illegible] fatigue [illegible]ended weight loss ***Even with no symptoms, it's important to get screened on time.***
[illegible]are the testing options? *See Appendix A for the most common testing options and their pros and cons.*	▪ If you are at high risk of colon cancer, we recommend a colonoscopy. ▪ If you are average risk, there are two main types of testing options: ▪ Tests that find both colorectal polyps and cancer (usually done every 10 years) ▪ Tests that mainly find cancer (usually done every 1-3 years, depending on the test type) ***The best test is the one that gets done!***
How do I complete the take-home test?	▪ The stool test can be taken home from the clinic. ▪ You will get a kit with instructions. ▪ It will explain how to take stool samples at home.

1

Sample email to Health System staff from leadership:



Coming Soon!

CRC Testimonials & Social Media Posts

“I am now a HUGE advocate for colorectal health and the importance of screening and early detection… I believe with all my heart, my beautiful mother would be alive today, had she had her first screening at the age of 50.”

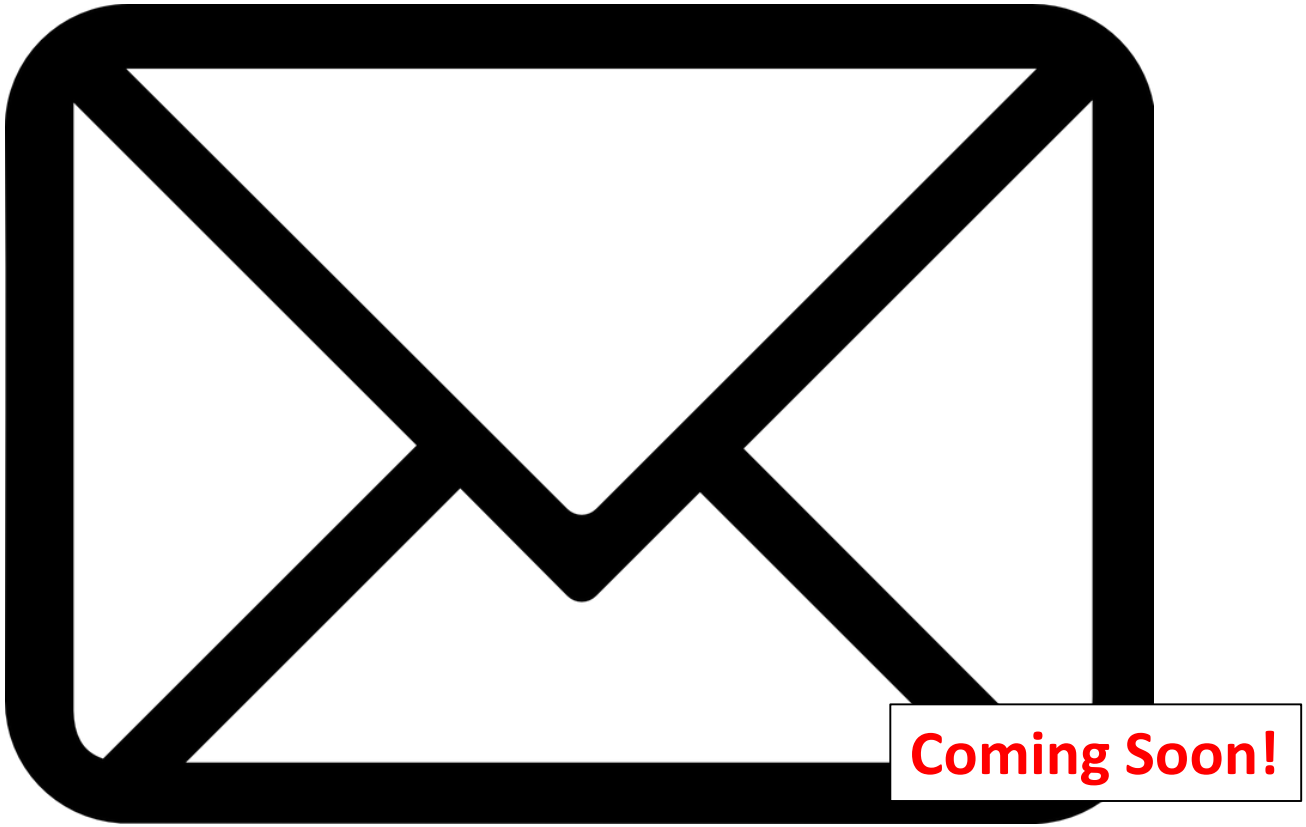
-Tania

Turn ND Blue Photo Contest

#TurnNDBlue

Submit your photo's March 1 – April 2

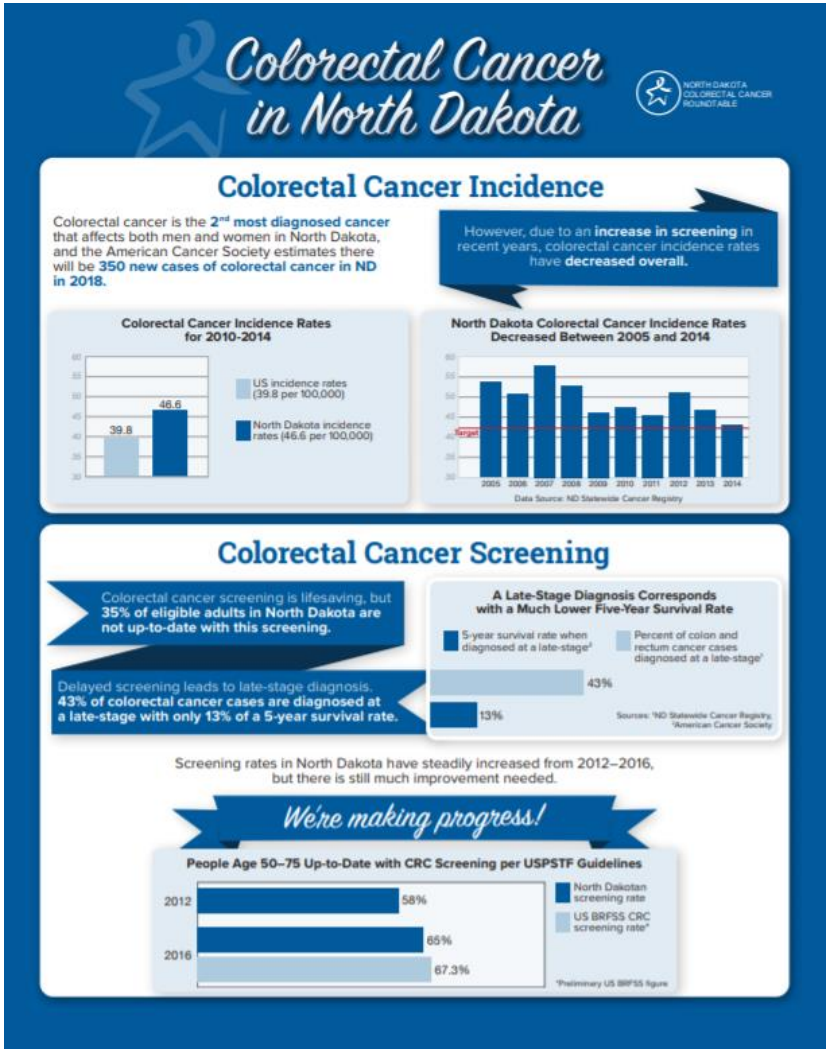
Sample email to staff for local businesses

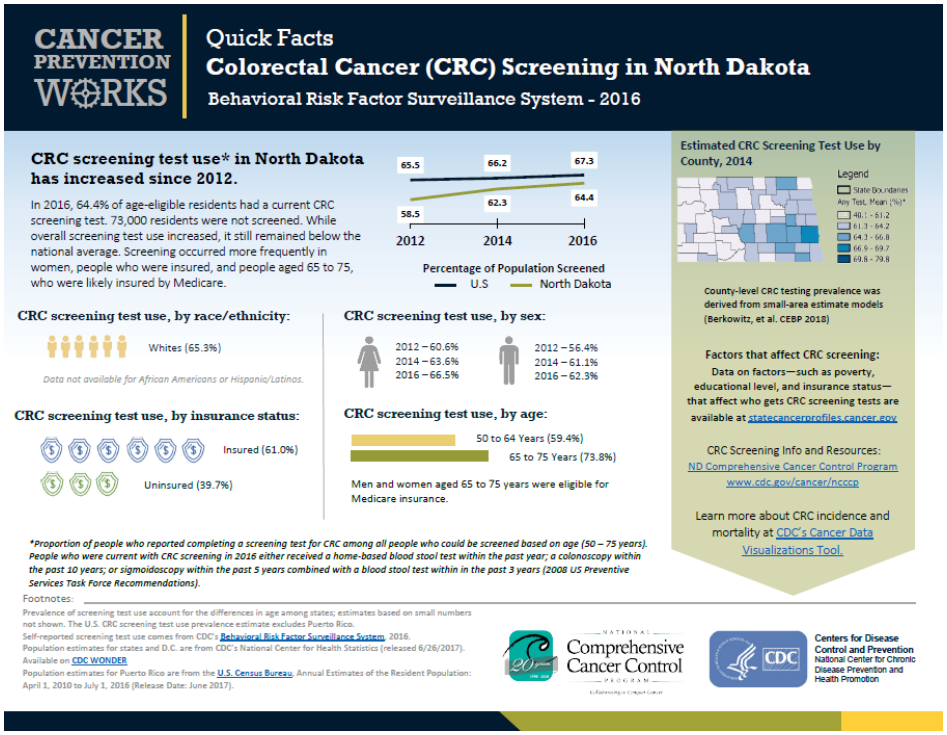


Thank you to all who submitted nominations for the 2019 North Dakota Colorectal Cancer Screening Achievement Awards!

Award Recipients will be announced in March.

Tools for sharing local data …



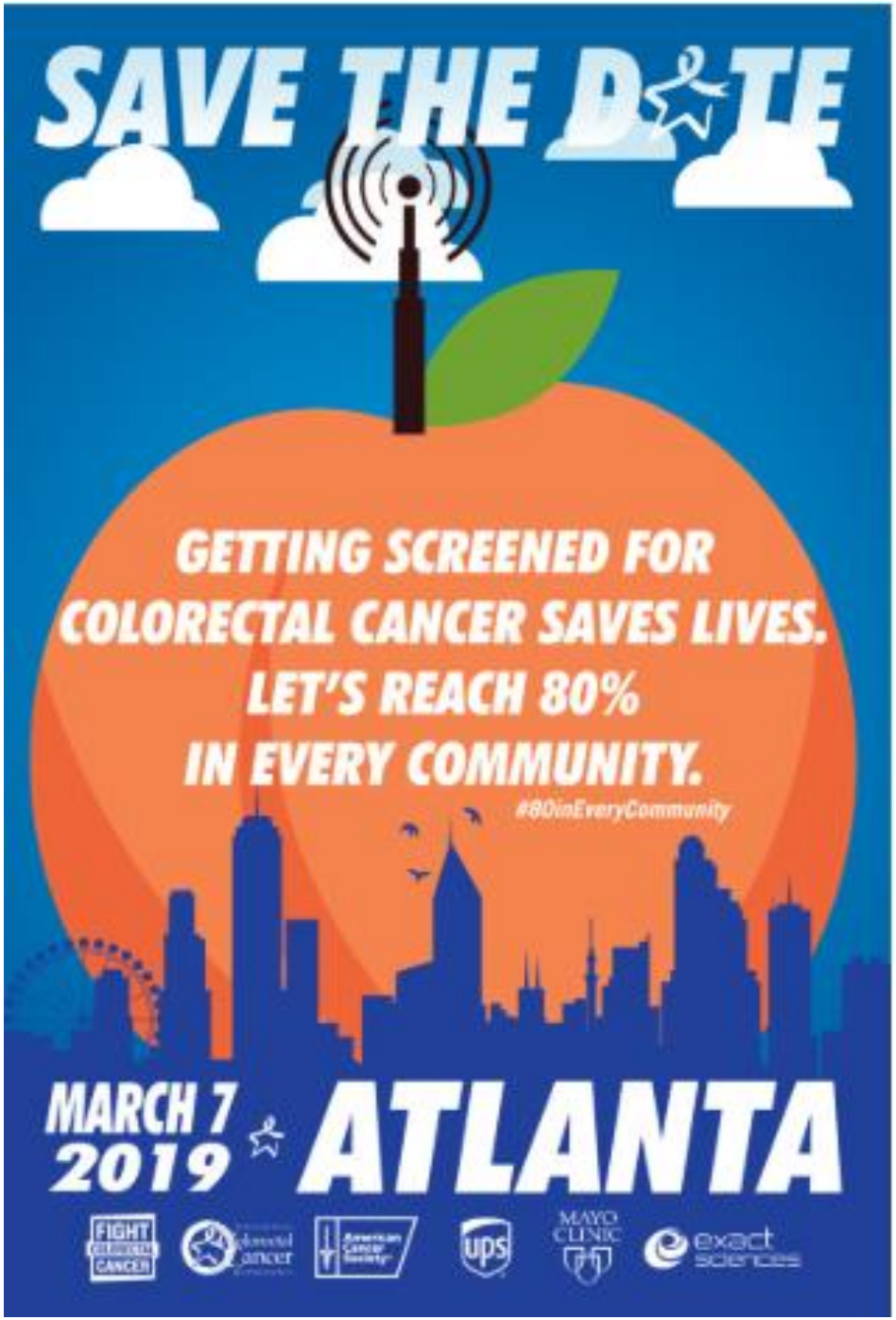


2019 North Dakota Legislative Update

Cancer Action Network℠
American Cancer Society®

How to Get Involved

North Dakota Cancer Coalition *Planning for a cancer-free future.*	NORTH DAKOTA COLORECTAL CANCER ROUNDTABLE
Workgroups: Screening & Early Detection, Treatment & Survivorship, HPV Taskforce **Learn more at:** **https://www.ndcancercoalition.org/** ➢ **Click "Join Us" on upper right** **Contact: ndcc@nd.gov**	**Workgroups: Provider Education & Public Awareness** **Learn more at:** **http://www.ndhealth.gov/compcancer/cancer-programs-and-projects/80-by-2018/** **Contact: shannon.bacon@cancer.org; jtran@nd.gov**



- **80% in Every Community Campaign Launch**
- **March 7, 2019**
- **1 – 2pm CST Livestream Broadcast**
- **Learn more & register: https://fightcolorectalcancer.org/80ineverycommunity/**
- **Follow #80inEveryCommunity on Twitter and Instagram**

YOU are helping to save lives in North Dakota!