The 9th Annual San Diego Colorectal Cancer Screening Roundtable Presents

Back to the Future:
Getting CRC Screening Back on Track

Wednesday, February 22nd, 2023
Today's Agenda

- Welcome
- Colorectal Cancer Screening in San Diego: *How are we doing?*
- CRC Data: *Using CancerDAT to Inform Grants and Services*
- FQHC Case Studies
- Updates on Established and Emerging Screening Tests
- Panel on Expansion of Medi-Cal to All 50+ in California: *Opportunities for Screening and Education*
- CA CRC Coalition (C4) Advocacy Updates and Grants
Roundtable Reminders

Audio
Make sure your line is muted

Zoom Chat
Use the chat to introduce yourself & ask questions throughout the roundtable!

Roundtable Recording
Slides and recording will be shared with all attendees
Daniel Stonewall Anderson, MD, MACP
California Colorectal Cancer Coalition
Welcome & Colorectal Cancer Screening in San Diego: How are we doing?
San Diego CRC Roundtable

Welcome

Daniel S. Anderson MD MACP President
California Colorectal Cancer Coalition
February 22, 2023
Colorectal Cancer Screening in San Diego and California: How Are We Doing?

Daniel S. Anderson MD MACP
San Diego CRC Roundtable
February 22, 2023
**Trends in Age-Adjusted CRC Incidence Rates: California, 1988-2019**

Overall Decrease

44% M  
38% F

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**Overall Decrease**

**44% M**  
**38% F**
Overall Percent Change in CRC Incidence: California, 1988 - 2019

<table>
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<th>Males</th>
<th>Females</th>
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<td>-39%</td>
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<td>-46%</td>
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<td>-10%</td>
</tr>
<tr>
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<td>-30%</td>
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<tr>
<td>Native American</td>
<td>42%</td>
<td>57%</td>
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</table>
Overall Decrease

50 % M
48 % F
Colon and Rectum Long-Term Trends in Mortality Rates, 1988-2019
By Race/Ethnicity, Both Sexes, All Ages, California

Legend (Race/Ethnicity)
- American Indian / Alaska Native
- Asian / Pacific Islander
- Non-Hispanic Black
- Hispanic
- Non-Hispanic White

Rates are per 100,000 and are age-adjusted to the 2000 US Std Population (10 age groups - Census P25-1130).
The Annual Percent Change (APC) estimates were calculated from the underlying rates using the Joinpoint Trend Analysis Software (http://surveillance.cancer.gov/joinpoint), Version 4.8, March 2021, National Cancer Institute.
The APC's direction is "rising" when the entire 95% confidence interval (C.I.) is above 0, "falling" when the entire 95% C.I. is lower than 0, otherwise, the trend is considered "stable".
Hispanic is mutually exclusive from American Indian/Alaska Native, Asian/Pacific Islander, Non-Hispanic Black, and Non-Hispanic White.
See Definitions (https://explorer.cancer.gov/definitions.html) page for more details about the race/ethnicity coding used for California Cancer Registry data.
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<td>-47 %</td>
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<td>-55 %</td>
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<tr>
<td>Latino</td>
<td>-13 %</td>
<td>-22 %</td>
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<tr>
<td>Asian/Pacific Islander</td>
<td>-43 %</td>
<td>-37 %</td>
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<tr>
<td>Native American</td>
<td>114 %</td>
<td>196 %</td>
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San Diego Compared To California and the USA

Rate per 100,000 age-adjusted 2015-2019 from CCR

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<th>California</th>
<th>USA</th>
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<td>Incidence</td>
<td>30.2</td>
<td>30.2</td>
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<tr>
<td>Mortality</td>
<td>12</td>
<td>12.3</td>
<td>13.1</td>
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<tr>
<td></td>
<td>(11.3 in 2018)</td>
<td></td>
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<tr>
<td>Late Stage</td>
<td>49.9%</td>
<td>49.7%</td>
<td>57%</td>
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Cancer Statistics 2023 Estimated Deaths
California

1. Lung and Bronchus  9,380
2. Colon and Rectum  5,530
3. Pancreas          4,970
4. Breast           4,680
5. Prostate         4,090
How Well is San Diego Screening for Colorectal Cancer?

• Using the California Office of Patient Advocate [https://www.opa.ca.gov/reportcards/Pages/default.aspx](https://www.opa.ca.gov/reportcards/Pages/default.aspx)

• Using Uniform Data Systems Measures from the HRSA website [https://data.hrsa.gov/tools/data-reporting/program-data](https://data.hrsa.gov/tools/data-reporting/program-data)

• Not using Survey Data
California Screening Rates from OPA.GOV 2021
Health Plans Rates

1. Kaiser North and South 76%
2. Sharp Health Plan 74%
3. Health Net HMO 69%
4. Anthem Blue Cross HMO 67%
5. Blue Shield California HMO 66%
6. CIGNA HMO 64%
7. United Health Care 63%
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<tr>
<td>Kaiser</td>
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<tr>
<td>Sharp Rees-Stealy</td>
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<tr>
<td>Sharp Medical Group IPA</td>
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<tr>
<td>Scripps Medical Group</td>
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<tr>
<td>Primary Care Associates MG</td>
<td>61%</td>
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<tr>
<td>Scripps Costal Medical Center</td>
<td>59%</td>
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<tr>
<td>Rank</td>
<td>Medical Provider</td>
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<td>------</td>
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<td>1</td>
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<tr>
<td>2</td>
<td>UC San Diego Health</td>
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<tr>
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<td>Sharp Rees-Stealy</td>
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<td>Scripps Physician Medical Group</td>
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<td>9</td>
<td>Palomar Health Medical Group</td>
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<td>--------------------------------------------</td>
<td>----------------</td>
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<td>BORREGO HEALTH</td>
<td>San Diego</td>
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<td>CENTRO DE SALUD DE LA COMUNIDAD SAN YSIDRO</td>
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<td>VISTA COMMUNITY CLINIC VISTA</td>
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San Diego FQHCs

|                              |                |                |                | 24.15%        | 28.65%        | 35.32%        | 38.68%        | 41.01%        | 41.25%        | 42.56%        | 47.94%        | 40.98%        | 40.31%        |

Weighted by population screening rate without Borrego Health

25.40% 46.10%

Weighted by population screening rate with Borrego Health 2013

24% 42.20%

California 39.90%

National 42%
You’re Invited!

5K Challenge | Saturday, March 4, 2023
Mission Bay | 8am–1pm
San Diego, CA

To register: charity.pledgeit.org/
ScreenYourGutSaveYourButt

SUPPORT
Screen Your Gut - Save Your Butt
Run to defeat COLORECTAL CANCER

www.cacoloncancer.org
Tanya Penn, MPH
SDSU, Institute for Public Health
CRC Data: *Using CancerDAT to Inform Grants and Services*
USING CANCERDAT TO INFORM GRANTS AND SERVICES
Our Mission

Our mission is to improve the public's health by promoting best practices through quality evaluation, training, technology, practice-based research and effective partnerships that bridge academic and community knowledge.
How we got here

Data sources

Let’s take a tour!

Wrap it all up
How we got here
Memory Lane

- **2000-2015**: Identification of a need and a vision to address it
  - Listening, conversing, watching, dreaming

- **2015**: Funding!
- Build it. Then tear it down!
- Now do it again.
- Again.
- One more time.

- **2018**: We go LIVE with HealthDAT!
- **2018**: Funded proof of Concept for CancerDAT!
- Let’s just keep building and tearing it down, though.
Empowering San Diego Communities to Connect and Collaborate

San Diego DATA

Best Practices

San Diego Academic & Collaborative Resources

About Us
Empowering San Diego Communities to Connect and Collaborate

San Diego DATA

Best Practices

San Diego Academic & Collaborative Resources

About Us
What goes in?

DATA SOURCES
Health Outcomes

California Office of Statewide Health Planning and Development (OSHPD)
- ED Discharge
- Hospital Discharge
- In-patient Treatment (psychiatric and rehabilitation facilities)

County of San Diego
- Live Births
- Deaths
- Infant Mortality

California Cancer Registry
- Cancer Incidence
Demographics

- US Census Bureau
Social Determinants of Health

Data Sources
- California Health Places Index
- American Community Survey

Example of Types of Data
- Air Pollution
- Educational Attainment
- Food Insecurity
- Poverty
- Unemployment
Behaviors

Data Sources
- LiveWell San Diego
- Behavioral Risk Factor Surveillance System
- American Community Survey
- California Health Interview Survey
- CDC PLACES

Example of Types of Data
- Exercise
- Flu Vaccination
- Obesity
- Smoking
- Screening
  - Cholesterol
  - Colonoscopy
  - Mammography
  - Pap smear
Best Practices

- The Community Guide
- US Preventive Services Task Force
- Cochrane
- The Centers for Disease Control and Prevention
- National Library of Medicine
Let’s Take a Tour
Diseases and Conditions

CHOOSE FROM THE CATEGORIES BELOW:

- Brain Cancer
- Cervix Cancer
- Colorectal Cancer
- Female Breast Cancer
- Female Reproductive Cancer
- Liver Cancer
- Lung Cancer
- Melanoma of the Skin
- Non-Hodgkin's Lymphoma
- Non-melanoma Skin Cancer
- Ovarian Cancer
- Pancreatic Cancer
- Prostate Cancer
- Stomach Cancer
Diseases and Conditions

CHOOSE FROM THE CATEGORIES BELOW:

- Brain Cancer
- Cervix Cancer
- Colorectal Cancer
  - Death
  - Hospital Discharge
  - Invasive Colon & Rectal Cancer Incidence
- Female Breast Cancer
- Female Reproductive Cancer
- Liver Cancer
- Lung Cancer
- Melanoma of the Skin
- Non-Hodgkin's Lymphoma
- Non-melanoma Skin Cancer
- Ovarian Cancer
- Pancreatic Cancer
- Prostate Cancer
- Stomach Cancer
Colorectal Cancer/Death / Rate (per 100,000 population) / Unadjusted / 2018

Map showing San Diego County with different color codes indicating the rate of colorectal cancer deaths per 100,000 population. The rate ranges from 7-11, 11-15, 15-19, 19-23, 23+, and No Data.
Year(s)
2011-2018

Condition
Colorectal Cancer

Definition of Condition
Colorectal cancer is cancer that occurs in the colon or rectum. Sometimes it is called colon cancer, for short. Sometimes abnormal growths, called polyps, form in the colon or rectum. Over time, some polyps may turn into cancer. Screening tests can find polyps so they can be removed before turning into cancer. Screening also helps find colorectal cancer at an early stage, when treatment often leads to a cure. (CDC)

Outcome
Death

Outcome Definition
Death refers to the underlying cause of death. For a list of ICD-10 Mortality codes please see the Public Health Services Codebook which can be found on the HHSA website: https://www.sandiegocounty.gov/content/sdc/hhsa/programs/phs/community_health_statistics/regional-community-data.html

Rates Info
Rates per 100,000 population. Age-adjusted rates per 100,000 2000 US standard population.

Website Data Retrieved From

Source Name
County of San Diego Health and Human Services Agency Public Health Services

Original Source
Vital Records Business Intelligence System Data (Death and Birth Data)
<table>
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<tr>
<th>Data Source</th>
<th>Disease/Condition</th>
<th>Indicator</th>
<th>Region</th>
<th>Year</th>
<th>Total Cases</th>
<th>Unadjusted Rate</th>
<th>Age Adjusted Rate</th>
<th>Male Cases</th>
<th>Male Rate</th>
<th>Female Cases</th>
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<td>8</td>
<td>24.60</td>
<td>21.50</td>
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<td>Death</td>
<td>La Mesa</td>
<td>San Diego County</td>
<td>2018</td>
<td>11</td>
<td>18.01</td>
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<td>17.11</td>
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<td>16.09</td>
<td>14.70</td>
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<td>Santee</td>
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<td>10.71</td>
<td>6</td>
<td>21.17</td>
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**Aspirin Use to Prevent Cardiovascular Disease and Colorectal Cancer: Preventive Medication** (less)

The US Preventive Services Task Force (USPSTF) recommends initiating low-dose aspirin use for the primary prevention of cardiovascular disease (CVD) and colorectal cancer (CRC) in adults aged 50 to 59 years who have a 10% or greater 10-year CVD risk, are not at increased risk for bleeding, have a life expectancy of at least 10 years, and are willing to take low-dose aspirin daily for at least 10 years. The USPSTF found adequate evidence that aspirin use to reduce risk for cardiovascular events (nonfatal MI and stroke) in adults aged 50 to 69 years who are at increased CVD risk is of moderate benefit. The magnitude of benefit varies by age and 10-year CVD risk. The USPSTF found adequate evidence that aspirin use reduces the incidence of CRC in adults after 5 to 10 years of use.

Resources:
The US Preventive Services Task Force

**Cancer Screening: Client Reminders - Colorectal Cancer** (more)

**Cancer Screening: Reducing Structural Barriers for Clients - Colorectal Cancer** (more)
Wrap it all up!
How can I use this?

- Start a conversation about health outcomes in your own catchment area
- Identify disparities and see which actionable determinants pair with those disparities
- Use the maps and charts in presentations, reports, and grants
- Export the data to do your own analyses or create fancy charts and graphics
- Track change over time!
- Identify evidence-based practices to address health conditions
- Find local academics who share your interests and values
- Collaborate with other organizations or academic partners on funding opportunities

Drop us a line and tell us how you use it!
Marie Russell, MD, MPH
TrueCare
FQHC Case Study
Back to the Future: Getting CRC Screening Back on Track

Marie Russell, MD, MPH
CMO/COO
February 22, 2023
TrueCare – Health Inside, Welcome In!

- Providing quality healthcare services for 50+ years!
- First health center location in 1974
- 60K patients/year and growing!
- 300K+ visits annually
Service Area & Locations

• Grown to 13 health centers + 4 Mobile Units across two counties
• Comprehensive medical & dental services:
  • Primary care, dental, behavioral health, woman’s health, chiropractic & cardiology
• TrueCare WIC Locations
Leverage Technology
Continuous Quality Improvement

Identification
a. Care gaps in EMR
b. Identify previous results that could impact next screening (Care Everywhere, old records).

Communication
a. Care Team reviews gaps of care from Epic during huddles
b. WELL app auto-reminders
c. Standing Orders

Education (Staff/Clinicians)
a. Training for MA who provides health education for FIT and hands to patients
b. Ensure PCP is correct in patient’s chart: affects reports

Access
a. All providers, no matter specialty should be providing FIT test

Health Information
a. Patient education campaigns
b. Utilize Patient reminder function for MyChart
Positive FIT workflow:
• Provider reviews and forwards recommendation to care coordination team
• Care Coordinators calls patient to provide recommendation
  • 3 calls and mail certified letter
• If patient agrees to proceed with colonoscopy, care coordinator places colonoscopy referral.
  • Text message patient once referral is processed
• Care coordinator f/u every other week to see if they schedule appt for 6 weeks.
• Recall list – for patients who need repeat/surveillance colonoscopy
  • Live calls to patients and certified letter
• Self-pay patients
  • Lots of education and support
  • Use Colonoscopy Assist and Project Access
Impact

• 48 year old Hispanic old male had routine office visit in September 2021
  • FIT ordered…
  • …Came back positive

• Provider placed referral for colonoscopy and care coordinators went to work
  • Patient was self pay and care coordinators were able to work with patient to get colonoscopy through Colonoscopy Assist – October 2021
  • Patient found to have mass on colonoscopy and was diagnosed with colon cancer

• Timely referral to surgery and oncologist

As of last Fall, patient with no detectable disease!
Looking Ahead

Continuous Quality Improvement

Leverage Technology

Advocacy

Education

Partnerships
Michelle Hughes, PharmD, BCPS, BCAP
Neighborhood Healthcare
FQHC Case Study
Samir Gupta, MD, MSCS, AGAF

Moores Cancer Center at University of California, San Diego

Updates on Established and Emerging Screening Tests
Updates on Established and Emerging Colorectal Cancer Screening Tests

San Diego Colorectal Cancer Roundtable, February 22nd, 2023
Samir Gupta, MD, MSCS
Professor of Medicine, Division of Gastroenterology, UC San Diego
Staff Physician, Jennifer Moreno San Diego VA Medical Center
s1gupta@health.ucsd.edu @samirguptaGI
Disclosures

• Consulting: Guardant Health; InterVenn; Geneoscopy
• Consulting and stock options: CellMax Life
• Research support: Freenome; Epigenomics
• All of these companies are developing tests for colorectal cancer screening and surveillance
Case

• 48 year old man presents to establish primary care
  • PMHx: Hypertension, obesity
  • FMHx: No family history of colorectal cancer
  • Prior primary care physician had referred him at age 46 for colorectal cancer screening with colonoscopy which he did not complete

• Key questions:
  • What is the evidence base to support screening?
  • What test is best for this patient?

“...I try and do what my doctors tell me, but I’ve been busy with work and my young kids, and I heard I did not have to start until age 50.”
Outline

• Screening
  • Options
  • Impact on incidence and mortality
  • Comparative data
  • Emerging tests
Currently Available US Preventive Services Task Force Recommended Options

<table>
<thead>
<tr>
<th>Stool-based strategies</th>
<th>Direct-visualization techniques</th>
</tr>
</thead>
<tbody>
<tr>
<td>High-sensitivity FOBT</td>
<td>CT Colonography</td>
</tr>
<tr>
<td>Fecal Immunochemical Test (FIT)</td>
<td>Flexible Sigmoidoscopy</td>
</tr>
<tr>
<td>Stool DNA-FIT</td>
<td>Colonoscopy</td>
</tr>
</tbody>
</table>

Methylated serum septin 9 (Epi proColon) and PillCam COLON also FDA approved

Graphic courtesy of Dr. Folasade May, UCLA
Selecting a test today

• Base choice on:
  • Impact on CRC incidence/mortality
  • Sensitivity/specificity
  • Acceptability
  • Modelling
Study Casts Doubt On Effectiveness Of Colonoscopy As Cancer Screen

A 10-year clinical trial found that colonoscopies reduce colon cancer risk by only a fifth and did not significantly lower the chances of death. The results call into question the increased use of the procedure for screening purposes.

CNN: A Colonoscopy Study Has Some Wondering If They Should Have The Procedure. What You Should Know

A new European study on colonoscopies – the largest of its kind – has complicated results, and it’s left some people wondering whether they should have the procedure to screen for colon cancer. (Cohen, 10/10)

Stat: In Gold-Standard Trial, Colonoscopy Fails To Cut Rate Of Cancer Deaths

For decades, gastroenterologists put colonoscopies on a pedestal. If everyone would get the screening just once a decade, clinicians believed it could practically make colorectal cancer "extinct," said Michael Brethauer, a gastroenterologist and researcher in Norway. But new results from a clinical trial that he led threw confidence in colonoscopy’s dominance into doubt. (Chen, 10/9)

Bloomberg: Colonoscopy Screening Exams Fail To Prevent Cancer Deaths In Large Study

Colonoscopy screening exams that are recommended for older US adults failed to reduce the risk of death from colon cancer in a 10-year study that questions the benefits of the common procedure. (John Milton, 10/9)

NBC News: Video: Colonoscopies Made No Difference In Death Rates, European Study Finds

In one of the largest studies ever, researchers found colonoscopy screenings cut cancer risk by 18 percent and made no difference in death rates. (10/10)

“Now, a landmark study suggests the benefits of colonoscopies for cancer screening may be overestimated”

https://khn.org/morning-breakout/study-casts-doubt-on-effectiveness-of-colonoscopy-as-cancer-screen/

# NordICC (Nordic-European Initiative on Colorectal Cancer) trial

| Setting             | Norway, Sweden, and Poland 2009-2014  
|                     | • No usual care population CRC screening |
| Design              | • RCT among 84,585 individuals age 55-64 years comparing:  
|                     | • Colonoscopy invitation (n=28,220)  
|                     | • No invitation (n=56,365)  |
| Follow-up           | • Interim analysis through 10 years  |
| Primary outcomes    | • Incident and fatal CRC  
|                     | • Intent-to-screen analysis  
|                     | • Screening participation: 42% |
# Key Results: Colonoscopy Invitation vs. No Invitation

<table>
<thead>
<tr>
<th></th>
<th>CRC Incidence</th>
<th>CRC Mortality</th>
<th>Explaining the Disappointing Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intent-to-Screen</td>
<td>↓ 18%</td>
<td>↓ 10% (non-significant)</td>
<td>- Suboptimal participation</td>
</tr>
<tr>
<td>Per-protocol</td>
<td>↓ 31%</td>
<td>↓ 50%</td>
<td>- Exam quality limitations</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Insufficient follow up</td>
</tr>
</tbody>
</table>

## Explaining the Disappointing Results

### Intent-to-Screen

- Suboptimal participation
- Exam quality limitations
- Insufficient follow up

### Per-protocol

- Suboptimal participation
- Exam quality limitations
- Insufficient follow up

### Figures

**Figure S4**: 10-year cumulative colorectal cancer mortality in adjusted per-protocol analyses.
Conclusions from NordICC study

• Authors
  • Benefit of colonoscopy may be more limited than previously hypothesized

• Alternative
  • Effectiveness of colonoscopy highly dependent on participation, quality, and time to realize the benefit
Randomized trial evidence for incidence and mortality reduction

<table>
<thead>
<tr>
<th>Test Strategy</th>
<th>Relative impact of screening vs. no screening (as invited)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Incidence</td>
</tr>
<tr>
<td>Guaiac FOBT</td>
<td>↓ 20%</td>
</tr>
<tr>
<td>Sigmoidoscopy</td>
<td>↓ 22%</td>
</tr>
<tr>
<td>Colonoscopy</td>
<td>↓ 18%</td>
</tr>
</tbody>
</table>

- Sparse head-to-head comparison data
- Bottom line: incremental benefit of a program of colonoscopy screening over other strategies remains unclear
<table>
<thead>
<tr>
<th>Test</th>
<th>Sensitivity for CRC</th>
<th>Sensitivity for Advanced Polyps</th>
<th>Specificity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colonoscopy</td>
<td>95%</td>
<td>95%</td>
<td>~89%**</td>
</tr>
<tr>
<td>FIT OC Sensor and OC-Light,</td>
<td>~75%</td>
<td>~25%</td>
<td>~95%</td>
</tr>
<tr>
<td>Polymedco</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FIT-DNA</td>
<td>93%</td>
<td>47%</td>
<td>89%</td>
</tr>
<tr>
<td>Cologuard, Exact Sciences</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

gFOBT, guaiac fecal occult blood test; FIT, fecal immunochemical test; sDNA-FIT, muti-target stool DNA FIT test; RCT, randomized controlled trial; CRC, colorectal cancer
*within reach of the sigmoidoscope; **false positives are defined by polyps biopsied or removed which were not adenomas; ***reported sensitivity is for polyps > 1cm
Acceptability: Participation varies substantially by test offered.
Modelling: CRC Cases Prevented and Deaths Averted by Screening Strategy Starting at Age 45, USPSTF 2021

- FIT q1: Cases per 1,000 persons screened
  - Cases Prevented: 50
  - Deaths Averted: 26

- sDNA-FIT q3: Cases per 1,000 persons screened
  - Cases Prevented: 47
  - Deaths Averted: 25

- Colonoscopy q 10: Cases per 1,000 persons screened
  - Cases Prevented: 61
  - Deaths Averted: 28

Davidson JAMA 2021; Knudsen JAMA 2021; Figure design adapted from Peterse EFPJ Natl Cancer Inst. 2021
## 2021 USPSTF Recommendations

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Recommendation</th>
<th>Grade</th>
<th>Modalities</th>
</tr>
</thead>
<tbody>
<tr>
<td>50 to 75</td>
<td>Screen</td>
<td>A</td>
<td>- Guaiac FOBT annually</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Fecal immunochemical test (FIT) annually</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- FIT-DNA (Cologuard) q 1-3 yrs</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Colonoscopy q 10 yrs</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- CT colonography q 5 yrs</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Flexible sigmoidoscopy q 5yrs</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Flex sig q 10 years plus annual FIT</td>
</tr>
<tr>
<td>45 to 49</td>
<td>Screen</td>
<td>B</td>
<td>- Moderate certainty of moderate net benefit</td>
</tr>
<tr>
<td>76 to 85</td>
<td>Selectively offer screening</td>
<td>C</td>
<td>- Net benefit small, especially if previously up-to-date</td>
</tr>
</tbody>
</table>

- No major changes in modalities recommended
- No preference for one test over the other
- Age 45 now endorsed by ACS, AGA, ASGE, ACG

Davidson JAMA 2021; Peterse JNCI 2021; Laudabam Gastro 2018
Emerging tests: multiple trials of non-invasive tests set to report

<table>
<thead>
<tr>
<th>Trial (Sponsor)</th>
<th>Specimen Source</th>
<th>Number of Subjects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Validation of An Optimized Multi-Target Stool DNA (Mt-sDNA 2.0) Test, for Colorectal Cancer Screening &quot;BLUE-C&quot;. (Exact Sciences)</td>
<td>Stool</td>
<td>24,000</td>
</tr>
<tr>
<td>Clinical Validation of the ColonoSight Test: a Multi-target Stool RNA (Mt-sRNA) Assay for Colorectal Neoplasia Screening in Average-risk Individuals Aged &gt;45 Years Old. (Geneoscopy)</td>
<td>Stool</td>
<td>10,000</td>
</tr>
<tr>
<td>Prevention of Colorectal Cancer Through Multiomics Blood Testing. (PREEMPT, Freenome)</td>
<td>Blood</td>
<td>25,000</td>
</tr>
<tr>
<td>Evaluation of the ctDNA LUNAR Test in an Average Patient Screening Episode</td>
<td>Blood</td>
<td>20,000</td>
</tr>
</tbody>
</table>
Be prepared to consider two scenarios

- Stool-based test with performance better than current FIT-DNA
  - Imagine sensitivity 95% for CRC, 75% for advanced adenoma, specificity 90%
- Blood-based test with performance for CRC similar or better than FIT
  - ECLIPSE study preliminary results:
    - Sensitivity 83% for CRC, 13% for advanced adenoma; Specificity 90% (Guardant Health press release 12/22/22)
- Impacts:
  - Opportunity to get the 30% of population not up-to-date screened
  - More patients with abnormal tests requiring timely colonoscopy
  - Some patients and primary providers may increasingly choose non-invasive options for screening over colonoscopy
Back to our case

- 48 year old man presents to establish primary care
  - PMHx: Hypertension, obesity
  - FMHx: No family history of colorectal cancer
  - Prior primary care physician had referred him at age 46 for colorectal cancer screening with colonoscopy which he did not complete

- Approach:
  - Offer a choice of strategies based on preferences
    - Test sensitivity, specificity, effectiveness
    - Convenience and acceptability

“I try and do what my doctors tell me, but I’ve been busy with work and my young kids, and I thought I did not have to start until age 50.”

Image source: Harvard Gazette 2020
Thank you!

Acknowledgements
Grant Support: NCI UG3 CA233314 01A1 (Martinez, Gupta, Castaneda, MPI), Cancer Center Support Grant CA023100-32; NCI U54 CA132379 CA132384 (Martinez; Madanat); American Cancer Society RSG-17-232-01-CPPB (Nodora)
Contact:
s1gupta@health.ucsd.edu
@samirguptaGl
Modelling: CRC Cases Prevented and Deaths Averted by Screening Strategy Starting at Age 45, USPSTF 2021

Cases per 1,000 persons screened

- **gFOBT q1**: 42 cases
- **FIT q1**: 50 cases
- **sDNA-FIT q3**: 47 cases
- **CTC q5**: 55 cases
- **Sigmoidoscopy q5**: 51 cases
- **Colonoscopy q10**: 61 cases

Cases Prevented: 45 y | Deaths Averted: 45 y

Davidson JAMA 2021; Knudsen JAMA 2021; Figure design adapted from Peterse EFPJ Natl Cancer Inst. 2021
CRC Incidence Reduction vs. No Invite

↓ 18%

CRC Mortality Reduction vs. No Invite

↓ 10% (non significant)
**Figure S3: 10-year cumulative colorectal cancer incidence in adjusted per-protocol analyses**

![Graph of CRC Incidence Risk Ratio](image)

**Figure S4: 10-year cumulative colorectal cancer mortality in adjusted per-protocol analyses.**

![Graph of CRC Mortality Risk Ratio](image)

<table>
<thead>
<tr>
<th></th>
<th>CRC Incidence Risk Ratio (CI)</th>
<th>CRC Mortality Risk Ratio (CI)</th>
<th>Explaining the Differences</th>
</tr>
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<tbody>
<tr>
<td>Intent-to-Screen</td>
<td>↓ 18%</td>
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</tr>
<tr>
<td>Per-protocol</td>
<td>↓ 31%</td>
<td>↓ 50%</td>
<td></td>
</tr>
</tbody>
</table>
Panel on Expansion of Medi-Cal to All 50+ in California: Opportunities for Screening & Education

Helen Palomino, LCSW  
Cancer Resource Center of the Desert

Patrick Sweet III, MD  
Pioneers Memorial Healthcare District & UCSD Health

Mary Baker, MSN, RN, CNS, FNP-BC, PHNA-BC  
Southern California Care Community

Patrick Tellez, MD  
Community Health Group

Alan Conrad, MD  
Community Health Group
Daniel Stonewall Anderson, MD, MACP
California Colorectal Cancer Coalition
CA CRC Coalition (C4) Advocacy Updates and Grants
California Colorectal Cancer Coalition (C4)
Daniel S. Anderson MD MACP President
Board of Directors C4

California Advocacy Updates
C4 Grants Updates
Objectives

• Review changes to Medi-Cal that will impact CRC screening
• Describe the approach to anticipated problems in enrollment of undocumented Californians
• Review the process of adding colorectal cancer screening to the CMS Adult Quality Core Measures in 2022
• Discuss the next steps after health plans serving San Diego Medi-cal patients are published
• Review the C4 2023 Grants Program with CDHCS
Changes to Medi-Cal Enrollment Eligibility That Will Increase Colorectal Cancer Screening

- Assembly Bill (AB) 133 (Chapter 143, Statutes of 2021), amended Welfare and Institutions Code section 14007.8 to expand eligibility for full scope Medi-Cal to individuals who are 50 years of age or older, regardless of citizenship or immigration status, if otherwise eligible. Expected to extend coverage to more than 185,000 individuals who are 50 years of age or older.
- Implementation date May 1, 2022
Changes to Medi-Cal Enrollment Eligibility that Will Increase Colorectal Cancer Screening

- Final Budget 2022 approved the expansion of Medi-Cal eligibility to undocumented Californians age 26 to 49, effective no earlier than January 1, 2024
- This will provide insurance to an expected 700,000 Californians
- Medi-Cal covers 14 million Californians in 2022
- Undocumented sign-up rate is unknown and needs to be examined
Exploring Possible Problems in Enrolling Undocumented Californians in Medi-Cal

- The ACP Fall Meeting in San Diego resulted in a policy group being formed to evaluate the possible problem with enrollment of undocumented Californians in Medi-Cal.
- This group resulted in a group of students from the Kaiser Permanente School of Medicine and Wesley Health Centers developing a research project on undocumented Californians’ perception of Medi-Cal insurance in our community.
- The project will survey uninsured undocumented Californian’s over age 50 newly eligible for Medi-Cal.
- Presently recruiting FQHC to be partners in the project.
Exploring Possible Problems in Enrolling the Undocumented in Medi-Cal

Medi-Cal Expansion Project: FQHC Action Plan

Thank you for participating in the Medi-Cal expansion project! With your help, we will be able to gather important data on why many members of our community do not apply to Medi-Cal when they are eligible. Our aim is to dispel any myths surrounding public charge and get every member of our community to receive the healthcare they need. Please feel free to reach out to us with any questions or suggestions, thank you!
KPSOM Medi-Cal Enrollment Team

- KPSOM Medi-Cal Enrollment Team
- Olivia Goodman olivia.r.goodman@kp.org
- Victor Escobedo victor.s.escobedo@kp.org
- Deshae Gehr deshae.t.gehr@kp.org
- Emilia Zevallos-Roberts emilia.c.zevallos-roberts@kp.org
Exploring Possible Problems in Enrolling the Undocumented in Medi-Cal

- Medi-Cal Expansion Project Form
- Please complete this questionnaire and return it to clinic staff after completion. We appreciate your time and are happy to answer any questions. Thanks!
- Please complete this form if:
  - You are at least 50 years old
  - You identify as an undocumented immigrant
- Please note that your responses are for research purposes only and are anonymous
Survey Instrument for Patient

• What clinic are you reporting from?
• Date
• Are you, or is anyone in your household considered an undocumented immigrant?
• Have you enrolled in Medi-Cal?
• Are you aware of your eligibility for coverage under the Medi-Cal expansion?
• If you have not enrolled, why not?
• Any additional comments?
Adding Colorectal Cancer (CRC) Screening to the California Medi-Cal Managed Care Accountability Set

- FQHC’s Medical Director requested C4’s help in adding CRC screening to the Medi-Cal Quality Measures in 2016.
- California was ready to add CRC screening to the required Medi-Cal Quality Measures in Spring of 2019 when Medic-Cal Managed Care shifted their Quality Measures to the CMS Medicaid Adult and Child Core Set of Quality Measures.
- Colorectal cancer screening was and is not a CMS Medicaid Adult Core Set Quality Measure in 2019.
Importance of Adding CRC Screening to the CMS Medicaid Quality Measures

- Medi-Cal screening rates are unknown. It was 19% when last measured by the CDHCS in 2012.
- California's FQHCs whose insured population is mainly Medi-Cal has a 46% CRC screening rate which is far lower than California’s Medicare screening rate of 83% or overall screening rate of 71%.
- Medi-Cal’s insured population CRC late-stage diagnosis is the same as California’s uninsured population.

<table>
<thead>
<tr>
<th></th>
<th>Baseline (2017)</th>
<th>Target (2025)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medi-Cal</td>
<td>71%</td>
<td>64%</td>
</tr>
<tr>
<td>Uninsured</td>
<td>71%</td>
<td>64%</td>
</tr>
</tbody>
</table>
Percent Late Stage Diagnoses: California 2015-2017

- White, Non-Latino: 62.7%
- African American: 63.5%
- Latino: 63.9%
- Asian/Pacific Islander: 62.9%
- Native American: 62.6%
- Male: 62.8%
- Female: 63.1%
- 20-49: 67.6%
- 50-64: 60.1%
- 65 +: 63.0%
Steps Necessary to Add CRC Screening to the CMS Medicaid Adult Quality Measures Core Set

- CMS has contracted the nomination of new measures to Mathematica since 2019
  www.mathematica.org/features/MACCoreSetReview
  The process to add measures in 2022 was underway

- For addition of a new measure in 2022, the following steps were required:
  1. In the Fall of 2020, one of the Core Set Review Voting Group members must decide to introduce CRC screening as a new core set quality measure
Steps C4 and Partners have accomplished to date to add CRC screening to the 2022 CMS Medicaid Adult Core Set, Continued

• C4 has provided talking points to the proposers to be used during the voting meeting to obtain support of the 2/3 vote necessary for the addition of CRC screening.

• C4 is recruiting and informing members of the interested public who represent the cancer community to support the measure during public comment period of the May 4-6 meetings.
Colorectal Cancer Screening Submitted for Addition in January
Made the Cut to be a Measure for Addition in April
Discussed and Voted on in May

In May, after voting member discussion, public comments in support allowed by phone

Samir Gupta C4 UCSD
Daniel Anderson C4
Rachel Issaka University of Washington
Heidi Bossley Am College of Gastroenterology
Molly McDonnell Fight Colorectal Cancer
Richard Wender NCCRT and University of Pennsylvania
Bev Green Kaiser Permanente Washington
Heather Davis New York State Department of Health
Caroline Powers ACS/CAN
Gloria Coronado Kaiser Permanente Oregon

Colorectal Cancer Screening Was Recommended for Addition by a Unanimous Vote
Adding CRC Screening to the Adult Core Set of Quality Measures

• Final report released in August 2021
• Center for Medicaid and CHIP Services (CMCS) review of final report and additional stakeholder input September to December 2021
• 2022 Core Sets were released by December 31, 2021 containing the addition of CRC screening
Colorectal Cancer Screening Added to the CMS Adult Quality Core Measures Core Set in December 2021

- Added CRC Screening to the California Medi-Cal Quality Measures in 2022
- CRC Screening will be a California Disparity Quality Measure in Medi-Cal in 2023
- CRC Screening will be added to the NCQA HEDIS Quality Measures in 2022
- For more information go to the Gastroenterology OP-ED DOI: https://doi.org/10.1053/j.gastro.2021.12.253
DIVERSITY, EQUITY, AND INCLUSION IN GI

Advancing Health Equity for Medicaid Beneficiaries by Adding Colorectal Cancer Screening to the Centers for Medicare and Medicaid Services Adult Core Set

In May 2021, the Centers for Medicare and Medicaid Services (CMS) Quality Measures Voting Members unanimously recommended the addition of colorectal cancer (CRC) screening to the CMS Medicaid Adult Core Set of Quality Measures for adoption in 2022. However, CMS has the latitude to reject recommendations from the Voting Members. The proposed CMS Medicaid CRC screening quality measure should be supported because it is actionable, has alignment with other metrics, is appropriate, is feasible, and will promote equity for all people insured through CMS (Table 1).

The American Medical Association’s recently released social justice and health equity plan includes the addition of standards, benchmarks, incentives, and metrics to “Embed equity in practice, process, action, innovation, and organizational performance and outcomes.” Addition of CRC screening to the CMS Medicaid Adult Core Set may foster health equity for many Medicare beneficiaries who are more racially and ethnically diverse than Medicare beneficiaries. People from racial and ethnic minority groups comprise 54.0% of Medicaid beneficiaries but only 25.0% of Medicare beneficiaries (US average, 2019).

Quality measures are used by health-care organizations and insurance plans, states, and national agencies to assess and compare quality of care. The requirement to measure and improve a quality measure has had a profound impact on an organization’s decision to adopt evidence-based programs to improve that quality measure. The level of performance of this quality measure then influences payment, incentives, and accreditation.

CMS require managed Medicare Advantage programs to report a core set of quality measures including CRC screening and other measures, as part of the Star Rating Program. Plans receive reimbursement bonuses and other benefits based on their overall star performance, which provides strong motivation for health plans to focus on what is being measured. Indeed, it has been said, “what is measured gets done.” Further demonstrating the importance of quality measures is the fact that among 5-star health plans, Medicare CRC screening rates are consistently 20%, and 90% in some health plans. One caveat with assuming that the addition of a new Medicaid quality measure will result in CRC screening rates similar to Medicare beneficiaries is that the Medicaid beneficiaries may have different social and/or structural barriers to care than people receiving Medicare.

CMS Medicaid Adult Core Set of Quality Measures

As part of the Affordable Care Act, CMS is required to identify a core set of quality measures for Medicaid and states are required to have standardized reporting on all or a subset of these quality measures. Reporting will become mandatory for behavioral health quality measures in the CMS Medicaid Adult Core Set in 2024, but is not required for other adult measures such as for breast and cervical cancer screening. Long-term plans include linking all core set quality measures to Medicaid reimbursement. The current CMS Medicaid Adult Core Set of Quality Measures includes breast and cervical cancer screening but not CRC screening. There are currently no Medicaid-required cancer screening quality measures that apply to men.

The Burden of CRC in the United States

The American Cancer Society estimates that there will be 149,506 new cases of CRC diagnosed in 2021 with 52,980 people dying due to their disease. The 2021 data indicate that CRC is third in incidence for both women and men, with 4.3% of men (1 in 23) and 4.9% of women (1 in 21) being diagnosed with CRC sometime in their lifetimes. In addition, CRC deaths rank second overall for all cancer deaths when combining rates for men and women. Recent Surveillance, Epidemiology, and End Results (SEER) trends indicate that CRC incidence rates increased by 8.3% annually in those aged 50–64 years (2011–2018 data), in sharp contrast to decreases of 3.1% per year in adults aged 65 and older (2012–2018 data), which includes low-income individuals aged 50–64 years eligible for Medicaid insurance in most states. In May 2021, the United States Preventive Services Task Force expanded its CRC screening age recommendations to also include screening people 45–49 years of age at average risk. Pairing this information with CMS data that 34% of the Medicaid population is between the ages of 46 and 64, almost 9.2 million people covered by Medicaid need CRC screening.

Effectiveness and Health Disparities in CRC Screening Rates

CRC screening is effective, decreasing incidence by 25.5% and mortality by 52.4%, and potentially cost-saving because CRC treatment is expensive. In 2016, the percentage of Medicaid beneficiaries who were up-to-date with screening was 54% vs. 73% in Medicare-insured adults or 90% when combining screening rates for Medicare and commercial insurance. We believe this disparity is due in large part to the fact that Medicaid plans, unlike Medicare plans, are not required to report CRC screening rates. Medicaid enrollees are also 50% more likely to present with late-stage colon cancer and die due to it than those with commercial or Medicare insurance. California Cancer Registry data revealed that for all patients with CRC

Increasing Access to Colorectal Cancer Screening

April 12, 2022 • By Fight CRC

Advocacy Blog

We interviewed C4 President Daniel S. Anderson, MD, and Vice President, Margaret Hitchcock, PhD, to learn more.

Q. What are the CMS Medicaid Adult Core Set Quality Measures?

fightcolorectalcancer.org/blog/increasing-access-to-colorectal-cancer-screening/
Next Steps

• Medi-Cal insurance carriers’ colorectal cancer 2022 screening rates will be reported in 2023
• Identify the insurance carriers that are poor performers
• Set up training and interventions with Medi-Cal Managed Care to improve the poor performers’ colorectal cancer screening rate.
• Collaborating with Dr. Palav Babaria, Chief Quality Officer and Deputy Director of Quality And Population Health Management CA DHCS.
Medi-Cal Reporting of CRC Screening in 2022

- Expect the health plans’ CRC screening rates 2022 to be published by summer 2023
- Medi-Cal Health Plans in San Diego County:
  1. Aetna Better Health of California
  2. Blue Shield of CA (Promise)
  3. Community Health Group
  4. Health Net Community Solutions, Inc.
  5. Kaiser SoCal
  6. Molina Healthcare of California
  7. United Healthcare Community Plan
C4 Grants Program Overview

- Grants given in California since 2013: $640,435 to 71 organizations
- Grants given in San Diego County since 2013: $265,00 to 7 FQHCs and Champions For Health
- Recipients:
  1. Neighborhood Health Care
  2. Family Health Centers
  3. Champions For Health
  4. Vista Community Clinic
  5. St Vincent’s DePaul
  6. Operation Samahan
  7. San Ysidro
  8. Linda Vista Community Clinic
C4 Grants Project in 2023 with CDHCS

- Breast and Colorectal Cancer Screening Implementation Project (BCCSIP). $100,000 a year and $15,000 max award
- New C4 Grants Project in partnership with the Department of Health Care Services (DHCS)/Every Woman Counts (EWC) program and the California Comprehensive Cancer Control Program.
- The project focus is on adding evidence-based interventions to existing breast and colorectal cancer screening initiatives within Federally Qualified Health Centers (FQHC) with the aim of increasing screening rates for both cancers.
- Applications open on cacoloncancer.org and [https://drive.google.com/file/d/16yzBJ3NZFXjpas1IBlVM4yyQdpMoo7b/view?usp=share_link](https://drive.google.com/file/d/16yzBJ3NZFXjpas1IBlVM4yyQdpMoo7b/view?usp=share_link) Must be a FQHC Every Woman Counts Provider
Thank you
Get Involved

• Register for Moores Cancer Center COE’s new CRC collaborative. Link to register in the chat!

Evaluation

• Have any feedback? We would appreciate your feedback on today's event. Link for the eval. in the chat!

Stay Connected With COE

• Follow us on Twitter @UCSDCancer_COE for the latest updates!
Thank you!

Slides, resources and more coming soon