Colorectal Cancer in Louisiana

LOUISIANA COLORECTAL CANCER ROUNDTABLE: AMERICAN CANCER SOCIETY, LOUISIANA CANCER PREVENTION & CONTROL PROGRAMS & THE FEIST-WEILLER CANCER CENTER

COMPLETED IN ACCORDANCE WITH 2014 HOUSE CONCURRENT RESOLUTION NO. 67

Dear Legislators,

Colorectal cancer takes a huge toll on Louisiana in both lives and money, as the state has one of the highest rates of the disease in the country. The good news is 1) Colorectal cancer is one of only two cancers that can be prevented by screening; and 2) The Louisiana Colorectal Cancer Roundtable (LCCRT) has made great strides in working to increase those screening rates.

Here's the bad news: This effort is not going to continue to succeed unless the state commits funding to it. The LCCRT has built a strong foundation, but this all-volunteer group needs help to push its work to the next level and make a lasting impact on Louisiana's mortality rate and bottom line.

Just look at we have accomplished without funding since LCCRT began as an unfunded mandate by the Louisiana Legislature in 2014:

* LCCRT has attracted statewide public and private partners, bringing together medical and public health experts, researchers, insurance and pharmaceutical representatives, community members and more in a concerted, broad-based effort, with all making screening for colorectal cancer, and reaching an 80% screening rate by 2018, a top priority.

* LCCRT is using available data, as well as creating new sources of data, to get a better picture of rates and screenings and thus pinpointing problems and solutions in specific areas of the state.

* Blue Cross Blue Shield of Louisiana (an LCCRT member) created a colorectal cancer screening competition for its providers as a quality improvement measure and, incredibly, 22 doctors have already reached the 80% screening rate goal.

* University Medical Center (UMC) improved its screening access and made CRC a priority at the urging of LCCRT partner, 504Healthnet and has:

- Reduced patient backlogs
- Implemented Open Access Endoscopy for quicker response times
- Hired a new gastroenterologist
- Hired a patient navigator
- Clearly defined referral pathways

* LCCRT has created overall clinic policies to help raise screening rates.

* LCCRT is educating healthcare professionals and the public alike, with everything from webinars to a public service announcement by Bobby Hebert, former Saints quarterback to raise awareness, including the extra risk faced by Cajuns and African Americans.

The LCCRT has also looked elsewhere for inspiration. As a result of our connections with other states, LCCRT will be hosting the Southeastern Colorectal Cancer Consortium on June 27-29, 2018 in New Orleans. Best practices on getting people screened for colorectal cancer are shared and past conferences of this group already have already had a positive impact on Louisiana.

Most importantly, in addition to the tourist and tax dollars this conference will bring to the state, we will be demonstrating the good work LCCRT is doing - all of which has been uncompensated, with no organization reaping personal gain for its participation, other than higher screening rates and better access to care for Louisiana residents.

Still, as we said above, we can't do more without funding. During our initial meeting of the Louisiana Colorectal Cancer Roundtable, a member of the National Roundtable said “Louisiana is at a tipping point.” It's your responsibility now to decide which way it tips.

Sincerely,

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LCCRT
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INTRODUCTION

Following the passage of unfunded House Concurrent Resolution No. 67 of the 2014 Louisiana Legislative Session, a group of healthcare leaders and advocates convened in March 2015, with the intention to bring together key participants to reduce the high burden of colorectal cancer in the state. The Louisiana Colorectal Cancer Roundtable (LCCRT) was formed, and agreed that the best means to achieve this goal is through increasing colorectal cancer screening rates of the eligible population to the national goal of 80% by the end of 2018.

Since our initial meeting in 2015, LCCRT has developed a working foundation, created goals, developed strategies, and begun working on projects with volunteers to reduce the costly burden of avoidable and preventable colorectal cancer in Louisiana. The passion and the willingness of organizations and individuals from the LCCRT to work together to increase screening for every resident is evident by the projects the LCCRT has chosen to focus on, all without pay. With continued perseverance and new funding, the partnership between the LCCRT and the Louisiana legislature to reduce the burden of colorectal cancer can be a model for other states, saving lives and money.

What is Colorectal Cancer?

Colorectal cancer (CRC) is a term used for cancer that starts in the colon or the rectum.
Most CRC develops slowly over 10-15 years. Before a cancer develops, a growth of tissue or tumor usually begins as a non-cancerous polyp on the inner lining of the colon or rectum. Some polyps can change into cancer (malignant tumor), but not all do (benign tumor or polyp). If a polyp becomes cancerous, it can spread into blood or lymph vessels, which travels to nearby lymph nodes or to distant parts of the body, such as the liver. When cancer spreads to distant parts of the body, it is called metastasis.

Overall, the lifetime risk for developing CRC is about 1 in 20 (5%). However, CRC is the second leading cause of cancer deaths in the US, leaving much to overcome with screening and prevention.

Screening for Colorectal Cancer Saves Lives and Dollars

Regular screening is one of the most powerful weapons for preventing CRC. The incidence rate of the disease has been dropping for about the last 20 years, in large part due to screening. CRC screening tests can find polyps that can be removed before they develop into cancers, as well as find very early stage cancers. The relative 5-year survival rate for CRC when diagnosed at an early stage before it has spread is about 90%, but only about 4 out of 10 are found then. When cancer has spread outside the colon, or metastasizes, survival rates drop.

CRC screening save lives, while also saving money. Studies have shown that the cost-effectiveness of colorectal screening is consistent with many other kinds of preventive services and has lower costs than treating cancer. It is simply much less expensive to remove a polyp during screening than to try to treat advanced CRC. As new, more expensive treatments become standards of care, screening is likely to become even more cost-effective. To further illustrate this point, a cost-benefit analysis for Louisiana, Medicaid expansion, CRC and screening, is available in this report.

Attacking Risk Factors for Colorectal Cancer

A risk factor is anything that affects the chances of getting a disease such as cancer. Different cancers have different risk factors. For example, exposing skin to strong sunlight is a risk factor for skin cancer and smoking tobacco is for multiple cancers. However, having a risk factor, or even several risk factors, does not mean that someone will necessarily develop the disease. Furthermore, occasionally there can be protective factors that lessen your risk for a disease if you partake in the behavior or have the characteristic.

Researchers have found several risk and protective factors that may increase or decrease a person's chance of developing colorectal polyps or CRC. Examples of CRC risk factors include eating a diet high in red or processed meat, and a low level of physical activity. Protective factors include being under 50 years old, eating a diet high in fruits, vegetables and whole grains and being physically active. To see a more exhaustive list of risk and protective factors, see Appendix C.

Genetics and Inherited Syndromes

About 5% to 10% of people who develop CRC have increased risk due to inherited gene defects (mutations) that can lead to them getting the disease, often at a younger age. The mutations can also be linked to other cancers besides CRC. Identifying families with these inherited syndromes, such as Lynch Syndrome, is important because doctors can recommend specific steps such as screening and other preventive measures at an early age.

Louisiana has a high burden of Lynch syndrome, which is an issue that is being explored and addressed by the LCCRT through multiple avenues. It is important to note the LCCRT Gastroenterologist Chair, Dr. Jordan Karlitz has found that colorectal cancer incidence rates are among the highest in the United States, as the proportion of French speakers increases, like those living in Acadiana. This appears to be the first study identifying a high rate of cancer in a US Founder population, raising the possibility of a genetic predisposition. Future studies are needed to identify genetic and or other risk factors in this population.

THE LOUISIANA COLORECTAL CANCER ROUNDTABLE (LCCRT)

The LCCRT provides a forum to gather and create statewide and local initiatives. These Louisiana-specific initiatives align with the work of the National Colorectal Cancer Roundtable (NCCRT), with the ultimate goals of the LCCRT being to decrease incidence, reduce mortality, and reduce late-stage diagnosis of CRC. In order to reach our goal, the LCCRT has implemented the national objective of increasing screening rates to 80% by 2018. LCCRT steering committee members are leaders in the CRC field, represent various communities throughout the state, and provide expertise in the development of plans to reach 80% by 2018. These representatives include large private insurance companies, rural health associations, business associations, academic institutions, professional societies, medical doctors, public health experts and health advocates. See Appendix D for membership roster.

In order to reach an 80% screening rate, the LCCRT is focusing on five critical areas: data collection, provider education, policy, outreach, and increasing screening access. Multiple projects have been spearheaded to increase CRC screenings and reduce mortality - and have been completed in under three years with almost no funding - a confirmation of these organizations' intense commitment to reducing CRC. The following pages describe the stellar volunteer work and projects that LCCRT members and task groups have undertaken to give us a picture of CRC in Louisiana, the levers that raise rates, policy recommendations, and the monetary benefits of screening.

DATA IN LOUISIANA: A COMPREHENSIVE PICTURE

There is a direct correlation between screening rates and mortality rates; higher screening rates lead to lower mortality rates. However, at this time, there is no state or national registry for CRC screenings. Additionally, other than the Behavioral Risk Factor Surveillance Survey (a self-reported survey), there is no other way to measure progress. The LCCRT Data Task Group has made a concerted effort to paint a comprehensive picture of CRC screening, incidence, mortality, and late-stage disease. Increasing the amount of data that we have and presenting the data effectively allows for better resource allocation and management. The Louisiana Cancer Prevention and Control Programs (LCP), the Louisiana Tumor Registry (LTR) (both of which are housed at LSU Health New Orleans), the American Cancer Society (ACS) and others use this data to improve their intervention targeting.

The LCCRT has developed parish-level maps to show where the highest incidence, mortality, and late stage diagnosis exists in Louisiana. It is clear that low screening rates lead to poorer outcomes for patients.

Incidence and Mortality

CRC is the 3rd most common cancer in men and women and the 2nd leading cause of cancer death overall in the U.S. Louisiana suffers a particularly high colorectal cancer burden with some of the

highest incidence and mortality rates in the U.S. Between 2010 and 2014, Louisiana had the 3rd highest incidence rate in the nation for CRC, and was 3rd in the nation for mortality rates due to this disease. Table 1 shows incidence rates with respect to gender and race. It is important to note the demographic differences when looking at these ranks and rates. While all categories are above the national average and in the top quarter of incidence for the U.S., note that black men have much higher incidence rates when compared to other Louisianans, and even more so when compared to the nation.

	Whites			Blacks		
	Men and Women	Men	Women	Men and Women	Men	Women
Incidence rates, Louisiana	44.6	52.5	38.2	57.2	66.8	40.9
Incidence rates, U.S.	38.9	44.7	33.9	46.7	55.1	50.4
Louisiana rank	5	5	5	3	4	2
Average Annual Count, LA	1,584	859	725	755	383	373

Table 1: Age-adjusted incidence rates in 2010-2014 of colorectal cancer diagnosis, per 100,000 people, in Louisiana and the U.S., as well as the overall rank of Louisiana, compared to other U.S. States

We see a very similar story when we examine mortality rates for CRC. Mortality rates across all demographics in Louisiana rank in the Top 10 in that nation. Table 2 shows mortality rates overall were consistently high and, in most cases, different than incidence, which may indicate more circumstances at play in Louisiana for CRC. from screening all the way to mortality.

	Whites			Blacks		
	Men and Women	Men	Women	Men and Women	Men	Women
Mortality rates, Louisiana	16.1	19.5	13.5	23.3	29.5	19.1
Mortality rates, U.S.	14.4	17.2	12.1	20.0	25.3	16.5
Louisiana rank*	8	7	8	5	6	9
Average Annual Count, LA	575	307	268	292	155	137

Table 2: Age-adjusted mortality rates for colorectal cancer in 2010-2014, per 100,000 people, both in Louisiana and the U.S. as a whole, with a rank comparison of Louisiana to other states.

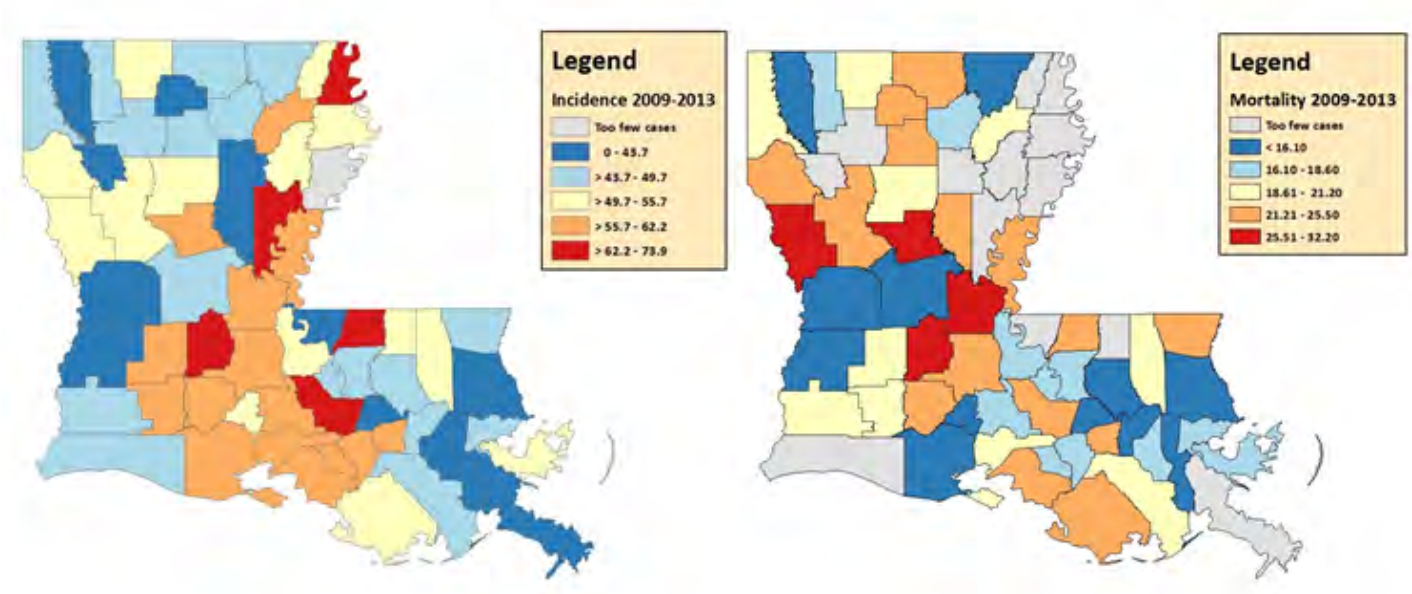


Figure 1: Average incidence (left) and mortality (right) rates by Louisiana parish from 2009 to 2013.

Late-Stage Disease

Although much of the data in this report is from the Louisiana Tumor Registry (LTR), LCCRT approached the LTR to work on a special project that would use cancer registry data at the census-tract level to identify target areas for establishing effective interventions. In collaboration with national GIS experts, LTR used geospatial software (ARC GIS) to analyze cancer data at the census-tract level to identify geographic areas with higher late-stage CRC incidence rates and areas with a higher proportion of late-stage CRC cases, compared with overall Louisiana rates and proportions. This will allow for the development of more tailored and targeted interventions for CRC screening and prevention across the state.

LCP, LTR and LCCRT are in the process of incorporating data on population characteristics and local resources of CRC screening into the geospatial analysis.

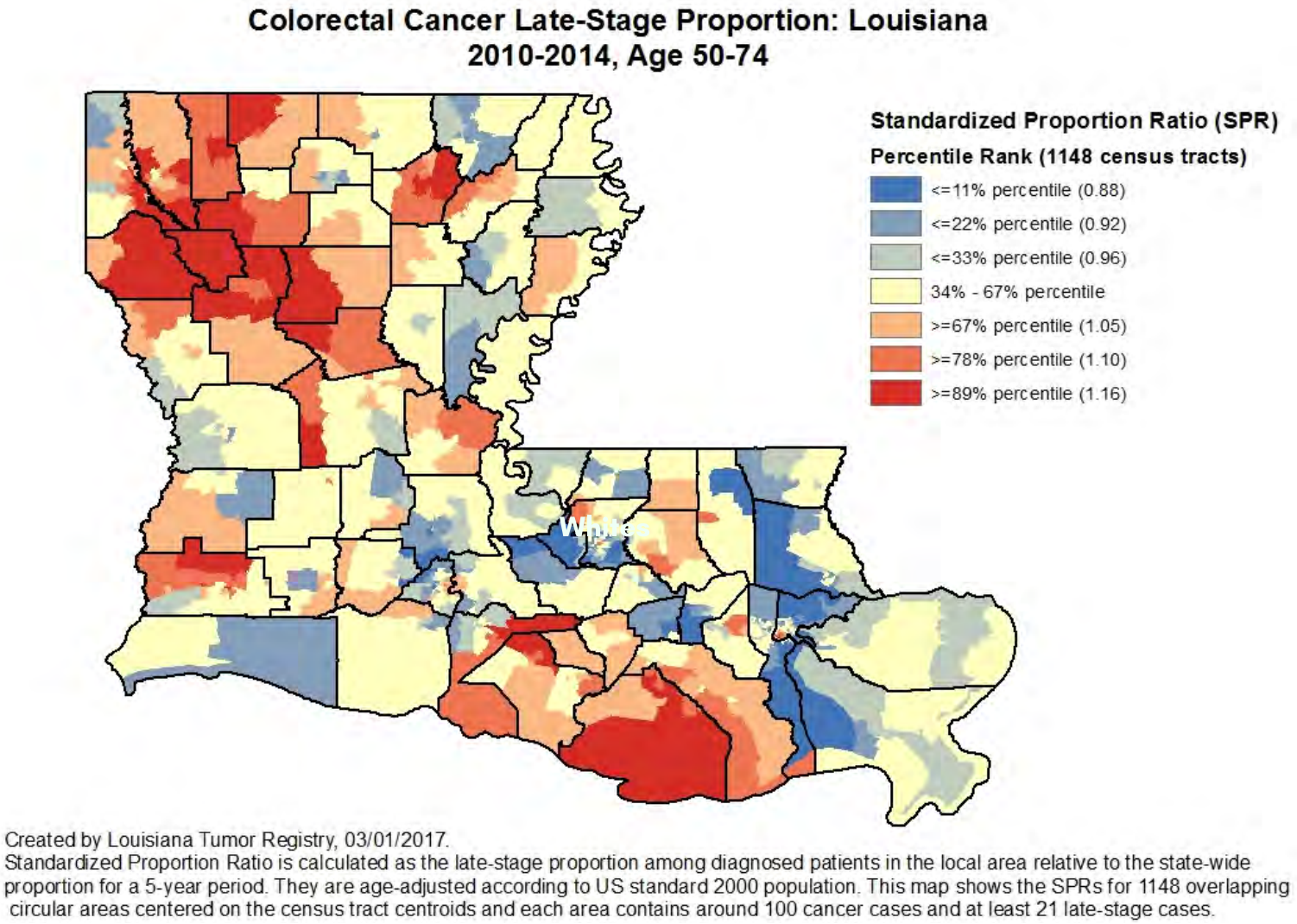


Figure 2: CRC late-stage proportion within Louisiana (2010-2014), i.e. the number of late-stage cases (regional and distant) over the total number of cases in the area (all stages, including in situ).

Screening

There is no single source of CRC screening data. Louisiana, as well as the rest of the nation, uses the biannual cancer survey section of the Behavioral Risk Factor Surveillance System (BRFSS) as our metric for reaching CRC screening rates of 80% by 2018. Currently, Louisiana's screening rate is 64.3%. The BRFSS is a phone survey and has its limitations. To compare screening rates over time and comprehensively understand screening in Louisiana, the LCCRT has identified secondary sources of screening data. They include Medicare (claims data), Uniform Data System (screenings reported to HRSA by federally qualified health centers), and claims data from a large private insurer (Electronic Health Record data). As more age-appropriate patients are screened for CRC, cancer is caught early or prevented altogether. Over time, fewer patients should be diagnosed with late-stage disease, which is difficult and costly to treat and carries a lower survival rate. It is well established that CRC screening saves lives and money.

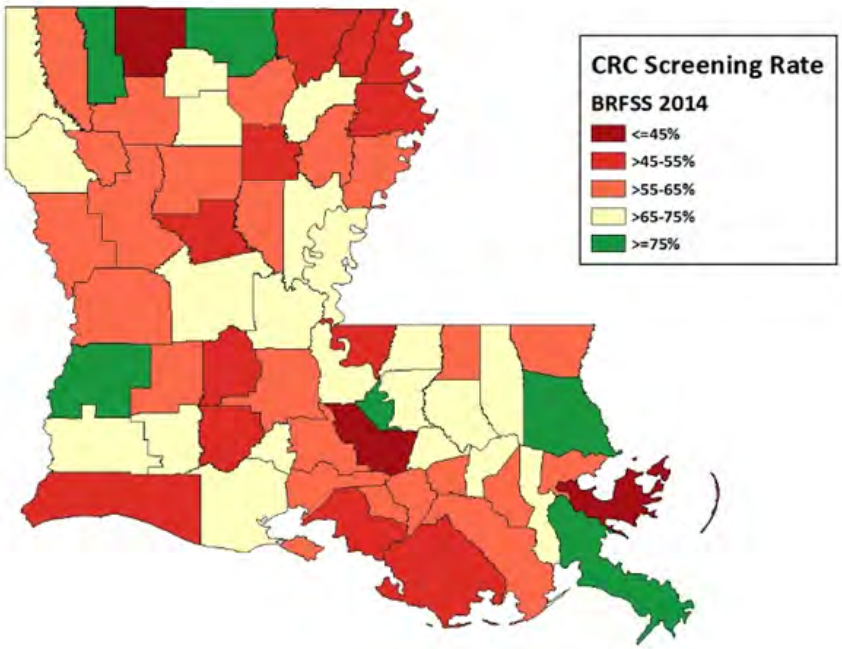
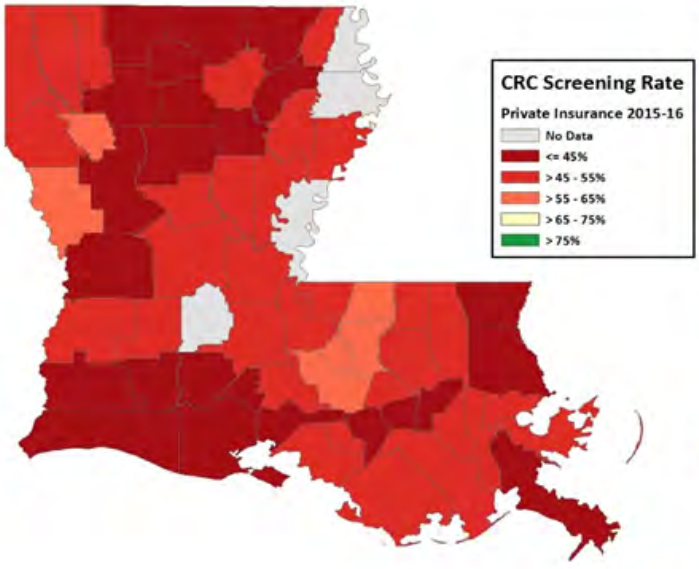
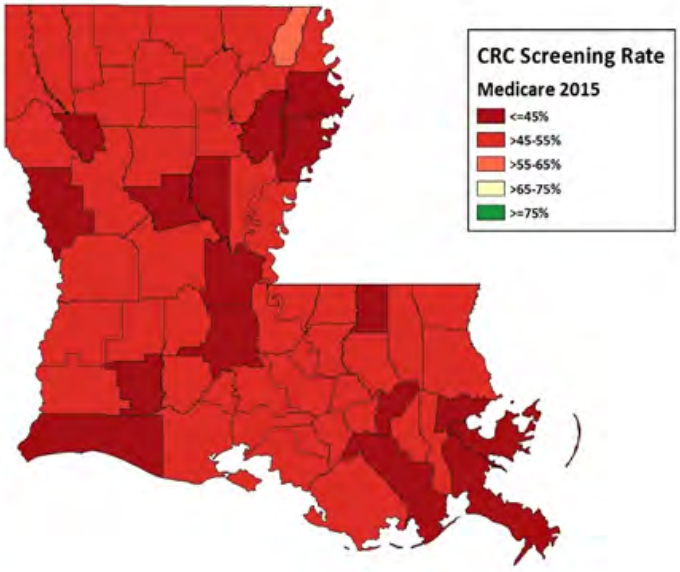


Figure 3 (Left): Louisiana parish level data showing self-reported phone survey rates of CRC screening from BFFSS in 2014.

Figure 4 (Below); Secondary sources of data on CRC screening rates at the parish level, with the left portraying a large private insurer's electronic health record data, and the right, Medicare claims data.





Federally Qualified Health Center (FQHC) Data

Another vital, secondary source of data is the Uniform Data system, HRSA's required system for FQHC clinical data. Louisiana's FQHCs and the Louisiana Primary Care Association have prioritized CRC screening and have been working hard over the past several years to improve their CRC screening rates (see Figure 5). In the most recent reporting period of 2016, Louisiana surpassed the national UDS rate (See Figure 6). Given the improvements over the past several years, Louisiana is projected to continue to increase the gap between the U.S. rate and Louisiana's. However, there is still wide variation in clinic screening rates, as evidenced by the 2015 ranking of FQHC rates. (See Figure 7.)

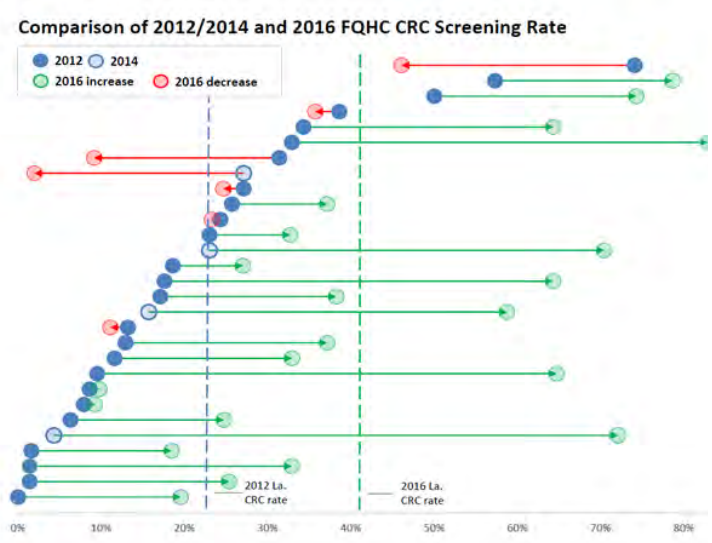


Figure 5: Comparison of CRC screening rates over time of each FQHC, showing increases/decreases from 2012 & 2014 to 2016.

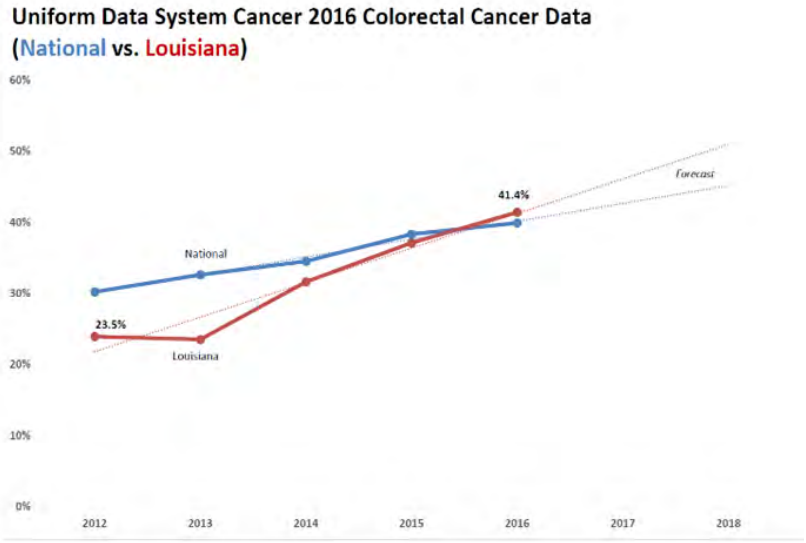


Figure 6: Uniform Data System (UDS) national data and Louisiana data yearly from 2012-2016.

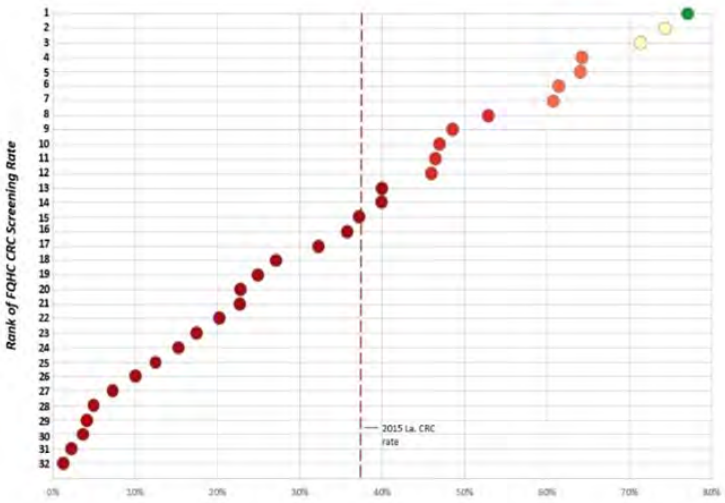


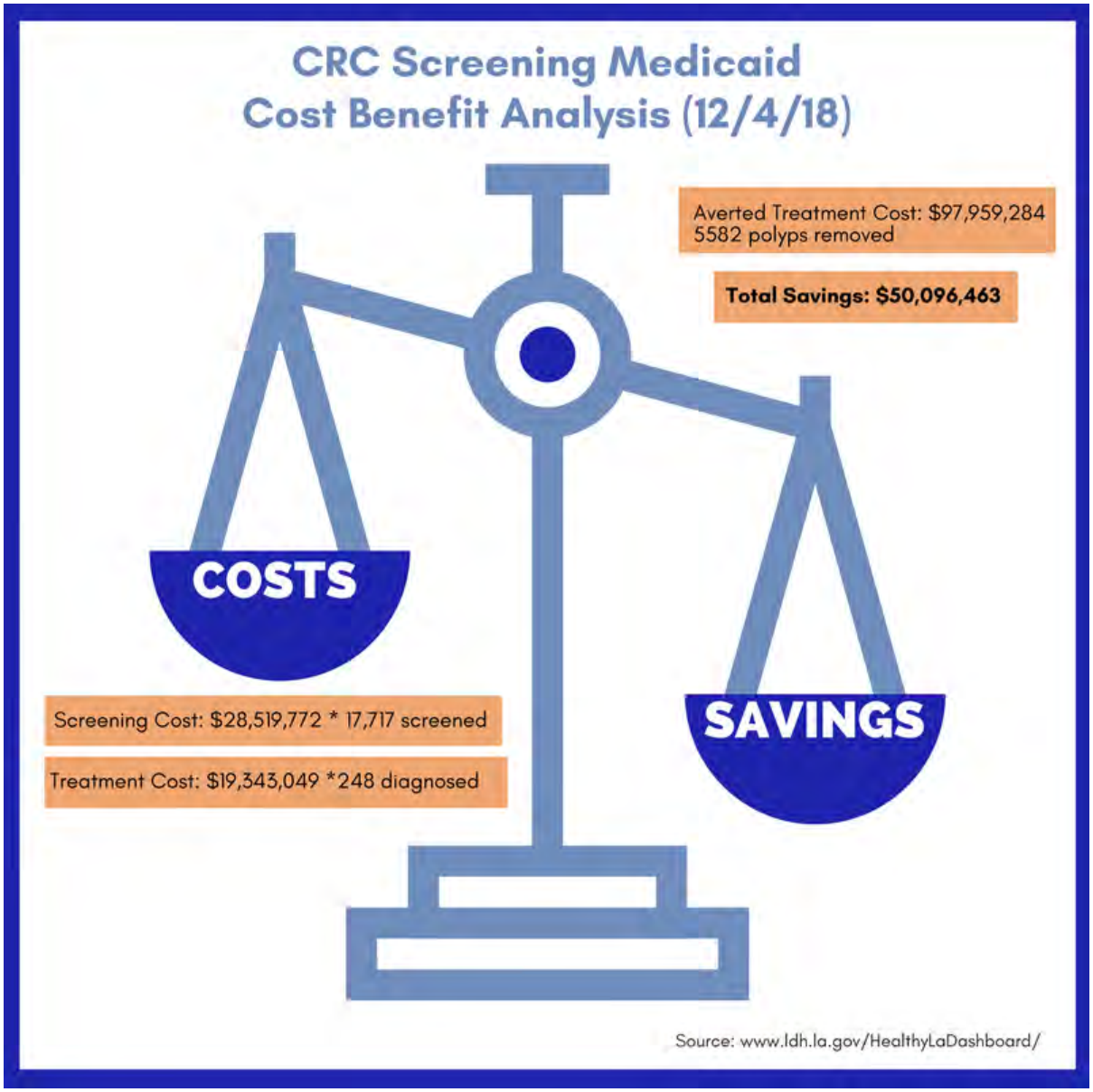
Figure 7: Each LA FQHC screening rate ranked from best (green) to worst (dark red) from 2015 UDS data.

GETTING PEOPLE SCREENED FOR CRC

Getting people screened for CRC has been an important issue both nationally and in Louisiana for years and faces numerous obstacles, making it a major focus for LCCRT. These problems include: 1) Historically, there have not been enough providers to screen patients with a colonoscopy; 2) Providers choose which insurance to accept and many do not accept Medicaid; and 3) There are backlogs of patients, both insured and uninsured, needing diagnostic services at the public-private hospitals. Another previously huge barrier was insurance status. Colonoscopy, while not extraordinarily expensive, can be cost-prohibitive for many people, especially in Louisiana.

Medicaid Expansion

Thanks to the Louisiana Legislature and its decision to expand Medicaid, more than 434,000 people are now eligible for the preventive CRC screening that privately insured and Medicare recipients receive. See following Medicaid CRC Screening Cost Benefit Analysis:



This cost benefit analysis demonstrates yet again what experts in public health know: preventive health care measures, such as cancer screenings like these, not only save lives, but dollars as well.

Screening costs were estimated by using Behavioral Risk Factor Surveillance System (BRFSS) insurance and screening data from the year 2014 to determine the proportion of Medicaid patients receiving colonoscopies vs. FIT/FOBT (83% and 17%, respectively). Costs of screening tests were estimated on the high end at $2600 for colonoscopy and $30 for a FIT/FOBT. Screening costs were multiplied by the proportion of screening test for Medicaid patients in BRFSS. An estimate of 10% for patients with positive FITs, who will then need a diagnostic colonoscopy, was also included.

Treatment cost estimates were predicted by using lifetime costs by stage at diagnosis from a 2000 study (Sonnenberg 2000). These costs were updated to 2015 dollars using the medical care component of the Consumer Price Index. The proportion of patients diagnosed at local, regional, and distant stages of cancer were derived from LTR data for Medicaid patients. From that data, we obtained the ratio of 34%, 35%, and 29% for local, regional, and distant stages at diagnosis, respectively.

Savings from screening were calculated by estimating an average number of polyps per person (three) based on data on adenomas, with the proportion of polyps likely to result in cancer estimated to be 5-10% (Risio 2010). Using this proportion range, the number of polyps likely to result in cancer were then multiplied by the same treatment costs calculation outlined above to determine the amount of savings.

Gastroenterology Survey

The LCCRT suspects that contributing factors to access issues and high incidence and mortality rates are the number of providers accepting Medicaid and where they are located. To explore capacity issues, the LCCRT conducted a recent survey of GI doctors in Louisiana to determine their familiarity with Medicaid expansion and requirements for reimbursement. Results indicated that 27% of providers were unaware that Medicaid expansion had taken place in Louisiana. Only 42% of GI providers accept Medicaid and 75.5% stated that the reason they do not accept Medicaid is due to low reimbursement rates. When asked what percentage of Medicare rates would be required for GI providers to routinely perform colonoscopy in Medicaid patients, the number one response was 96-100% of Medicare rates. Some of the comments from physicians surveyed, included:

> *...Medicaid patients are some of the sickest.*
>
> *You must realize that once you do the screening colonoscopy this patient is yours for the rest of your professional life for any pains between the nose and the anus and represents an enormous increase in the demands on your practice and those of your partners.*
>
> *•If you want physicians to take Medicaid, they need to be reimbursed appropriately.*
>
> *In addition to low fees, the State is often slow to pay or just doesn't pay at all.*
>
> *... No show rate for this group of patient approaches 50% in our practice.*

Although adequate Medicaid reimbursement rate is a key topic that should be addressed, the LCCRT is exploring other ways to increase screening rates, including more robust patient navigation services and working more closely with the Managed Care Organizations to identify other clinicians to provide colonoscopy. The LCCRT has recently requested the location of and number of Medicaid claims for CRC services and, once obtained, this information will be mapped and assessed to see where additional resources and services may be needed.

Open Access Endoscopy

It was common knowledge throughout the region's primary care clinics that University Medical Center (UMC) in New Orleans had a diagnostic colonoscopy patient backlog. The wait was as long as nine months for patients, regardless of insurance status. The rumored 'unwritten policy" among referring physicians was if one had a patient needing a timely diagnostic colonoscopy, "send them to the emergency room."

In early 2017, a new management team at the hospital prioritized screening colonoscopy in order to save lives and reduce treatment costs. At the urging of the LCCRT, partner 504Healthnet, provided input to help improve the hospital's diagnostic colonoscopy screening processes as well. First, 504Healthnet assessed the bottleneck. Although there were several issues associated with the backlog, a major one was that only two, half-days were devoted to the gastroenterology clinic. It became clear this short, weekly schedule was not enough to reduce the long wait times for a diagnostic colonoscopy, so a new process was developed. Primary care providers with sicker patients (showing symptoms) were given a choice of where and how to refer their patients - specifically three referral options: 1) Gastrointestinal clinic; 2) Ambulatory colorectal clinic; and 3) General surgery clinic. Expanding the number of specialty physicians seeing patients dramatically reduced the wait time, with patients needing diagnostic services now being seen within approximately 30 days.

At the same time, the referral process for screening colonoscopies was updated and simplified, with the hospital now promoting Open Access Endoscopy. "Open Access" means endoscopic procedures requested for healthy patients by referring physicians, are done without an initial gastroenterologist's consult. Open Access Endoscopy has been shown to decrease costs by eliminating potentially unnecessary office-based consultations. Now at UMC, there are two screening colonoscopy referral options: 1) Contact the gastroenterology clinic via the electronic health record; or 2) Call the nurse navigator directly. Once either takes place, the nurse navigator contacts the patient to schedule the colonoscopy, educate the patient, etc. All of the information needed for both the electronic referral and the nurse navigator was defined and shortened into simple clinician instruction. UMC also hired another GI and a primary care navigator.

Once the processes for both screening and diagnostic colonoscopies were improved, the LCCRT promoted the new processes to those who could benefit from them. The LCCRT chair, Dr. Karlitz, held an educational seminar where continuing education credits were offered for clinicians to promote referral policies. They were also promoted online via social media throughout the region, on-site, and to care coordinators and clinicians at regional clinics.

Initial results look promising, with the added navigation alleviating no-show rates and poor bowel prep, which helps decrease patient backlog and increases screening rates. To further this already successful outcome, we recommend funding either a centralized patient navigation system or clinic-level patient navigation.

PROVIDER EDUCATION

Since the LCCRT formed in March 2015, provider education has been extremely important. Initially, we wanted to make certain all providers were up to date with CRC guidelines and the 80% by 2018 screening initiative. Topics then expanded to quality improvement, genetic testing, Lynch syndrome, implementing FLU FIT and coding. The LCCRT offered education on all these topics via multiple mediums, including webinars, blogs, podcasts, morning talk shows, radio talk shows, social media, on-site professional development, professional conferences, articles through professional magazines and newsletters, and a website. When resources permit, we offer continuing education credits. In addition, Bobby Hebert also completed a short PSA on behalf of the LCCRT.

Webinars/Presentations/Conferences:

Chretien-Bass, Shimeka, Ryan Colleen, Winfrey, Keith. "Best Practices for Improving Preventive Screening Rates in a Community Health Setting." Louisiana Primary Care Clinical Conference, 11 October 2017, Lake Charles, LA Breakout Session.

Karlitz, Jordan. " Colon Cancer Screening." 22, September 2017, New Orleans, LA. Webinar.
Kaufman, Randi. "Colonoscopy Capacity in Louisiana: GIs' Acceptance of Medicaid." CDC Cancer Conference, August 16, 2017, Atlanta, GA, Presentation.

Maniscalco MPH, Lauren, Henry PHD, Kevin, Yi PhD, Yong. "Identifying Target Areas for Colorectal Cancer Screening in Louisiana through GeoSpatial Analysis" Louisiana Tumor Registry, NACCR Conference, 10 August 2017, Atlanta, GA, Presentation.

Winfrey, Keith. "Colorectal Cancer Screening: Achieving High Quality and High Screening Rates." Friday, April 21, 2017, New Orleans, LA, Webinar.

Winfrey, Keith. "Implementing a FLUFIT Campaign within a Primary Care Setting," January 2017. Webinar.
Smith, Robert Smith, "Improving CRC Screening and Outcomes in the FQHC Setting: System Changes and the Importance of the Medical Neighborhood." 34th Annual Louisiana Primary Care Clinical Conference, June 2016, Baton Rouge, LA, Presentation.

Brooks MD, Durado. "Overview of Stool Tests for Colorectal Cancer Screening." LAFP 69th General Assembly. 16 July 2016. Destin FLA, Presentation.

Karlitz, Jordan. "Colorectal Cancer in Louisiana." March 2015. New Orleans, LA, Webinar.

Articles:

Karlitz, Jordan MD, Oliphant MPP, Anne-Louise, Greenwald MD, David & Pochapin M.D., Mark B. The American College of Gastroenterology and the 80% by 2018 Colorectal Cancer Initiative: A Multifaceted Approach to Maximize Screening Rate. The American Journal of Gastroenterology. 08 August 2017.

Ricks, Laura. "Louisiana's Attack Against its High Colorectal Cancer Rates." Louisiana Family Doctor. Spring 2016.

Ricks, Laura. "Screening for Colorectal Cancer: Louisiana's Diagnosis Rate is the Second Highest in the US." Gambit Weekly. 2 March 2015.

Blogs:

Schwartz, Deb. "What to Expect During Your First Colonoscopy." Vitals, Vitals.lifehacker.com, 8 Sept. 2017, vitals.lifehacker.com/what-to-expect-during-your-first-colonoscopy-1802016520.

Podcasts:

Karlitz, Jordan J. "ACG and the 80% by 2018 Colorectal Cancer Initiative." ACG and the 80% by 2018 Colorectal Cancer Initiative | American College of Gastroenterology, gi.org/physician-resources/podcasts/the-american-journal-of-gastroenterology-author-podcasts/karlitz/.Podcasts

Securing speakers, writing articles, booking morning news shows, writing press releases, planning professional development education credits, updating content for social media, developing a website that acts as a nerve center for Louisiana clinicians, takes time and staff resources. Having funds to have dedicated staff time and paying for the development of a website are essential as we move forward.

Engaging The Private Sector: Quality Blue Competition

The LCCRT partnered with Blue Cross Blue Shield of Louisiana (BCBSLA) to increase CRC screening rates. Working with Quality Blue Primary Care (QBPC), Blue's value-based program focused on patient-centered care, we are promoting a friendly CRC screening competition among their primary care physicians through the end of 2018.

QBPC's use of technology and resources allows physicians to provide better care for patients, helping to improve health outcomes. Physicians participating in the program focus on four clinical measures, and are rewarded based on improvements in these areas. An additional benefit to those participating in this program is that physicians have access to a data-tracking tool that shows how their patients are doing across dozens of metrics.

LCCRT has worked closely with BCBSLA's Clinical Transformation Team to devise a way to increase their CRC rates. The competition formally launched September 1, 2016, and was promoted among QBCP physicians internally. LCCRT has provided materials, tools and quality improvement techniques to participants, and will continuing working with the clinical transformation team to assist physicians.

On November 2, 2017, LCCRT was invited to participate in the BCBSLA QBPC Collaborative, which brings together participating physicians from around the state. The collaborative offers participants the opportunity to network, learn about what's on the horizon for the program, and receive acknowledgement for reaching their targets. LCCRT Primary Care Chair, Dr. Keith Winfrey, was honored to recognize the 22 physicians that hit an 80% screening rate in the first year of the competition. LCCRT plans to promote QBPC and these physicians in state newsletters, journals, social media postings and traditional press releases. Additionally, we will use the month of March to highlight these physicians individually, championing their efforts and acknowledging their hard work.

While there is still much work to do, we also recognize that having an accurate representation of data could be a reason these screening rates appear low. LCCRT is committed to helping QBPC continue to improve the average screening rate among physicians, assist more in reaching that 80% screening mark, and work with physicians to utilize their data properly.

WHAT LEGISLATORS CAN DO: POLICY RECOMMENDATIONS

As the members of LCCRT look to the future, there are specific policies that LCCRT recommends to reduce mortality and the costs of colorectal cancer in Louisiana in the coming years.

Fund the LCCRT

Everything that has been accomplished so far by the LCCRT is due strictly to our dedicated volunteer network. With only in-kind guidance, multiple projects have been implemented, data has been analyzed to guide projects- all of which have been designed to reduce CRC mortality and incidence rates, saving the state money and lives. This return on investment, a clear health and monetary win, could be stabilized, institutionalized and mobilized more quickly if funding were provided through a general fund dedication or through the Louisiana Department of Health. And the amount being requested is a mere drop in the bucket: $200,000. This money would fund a dedicated full-time LCCRT person to coordinate partners and activities, and cover additional nominal costs associated with the continuation of projects.

Patient Navigation

After much study, it is clear to the LCCRT that developing a robust, statewide patient navigation program would save money and increase screening rates. Patient navigation is a conducive and cost-effective way to guide patients through the healthcare system. According to the CDC, it saves health systems money by

decreasing the no-show rate for a screening, and better guarantees a screening will be done correctly, with proper prep. As demonstrated in other states, CRC navigators can also recruit the patient and ensure that the patient receives follow-up care. All of these actions add up to reduced costs over time, due to higher numbers of patients completing screenings and the screenings being prepared for correctly. New Hampshire and South Carolina have proven that such patient navigation programs work, so it would be an effective way for the Louisiana legislature to save health care dollars, as well as lives.

Increasing Medicaid to Medicare Rates

One concern the LCCRT has uncovered is colonoscopy access for new Medicaid recipients. The LCCRT has mapped the location of gastroenterologists who accept Medicaid, with initial results showing that residents in rural Louisiana have limited access to those physicians. Large areas of our state have no providers at all, and over one in four GIs didn't even know Medicaid had been expanded. The survey of GIs we conducted also showed many providers do not accept Medicaid, even if they are in an area of need because of the low reimbursement rates. Increasing the reimbursement rate for Medicaid to Medicare would likely significantly affect how many people could get colonoscopies and save later treatment costs and lives.

CMS Data Linking

While not a direct link to the legislature, putting policies in place for data-sharing between the state Centers for Medicaid and Medicare (CMS) and the LTR to get more data for future prevention, screening, and research efforts is essential. As we try to gain more information and make better choices on where and who to target for CRC prevention in the state, having LTR have as much information as possible is key. While LTR and CMS have had data-sharing agreements in the past, they have lapsed due to internal issues. Championing the sharing of data is the responsibility of legislators, LCCRT and CRC advocates.

CMS Coverage for Genetic Testing

An easy win for the state, which has a high burden of genetic-related CRC, is to have CMS cover genetic testing for Lynch Syndrome and other genetic cancers. Genetic testing for any cancers, as previously mentioned, gives patients and their doctors more information to plan for treatment or screenings, usually leading to better quality and longer lives, at less cost for the patient and the state. Currently, this is something that LCCRT is working with CMS and LDH on, but again, having legislative champions on our side for this no-brainer policy is essential.

CONCLUSIONS

Colorectal cancer is a real, yet correctable, problem for our state. We have incidence and mortality rates far above the national average, and a high percentage of late-stage cancers at diagnosis throughout the state. This occurs despite having numerous effective and affordable screening options that are proven to reduce deaths from CRC. Expanding Medicaid to allow people who otherwise would not be able to afford these life-saving, cost-effective screenings is a win for both the state's coffers and for everyone in Louisiana. LCCRT is looking ahead to more state-level interventions to screen 80% of residents by 2018 and beyond, which could make an even bigger cost-benefit impact if the state funds a coordinator for the program. The LCCRT has proven its worth. Now it's time for you as a legislator to prove your dedication to reducing death and health care costs in Louisiana. As we noted at the beginning of this report, the state is at a tipping point when it comes to CRC. It's up to you to see it tips the correct way.

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APPENDIX A: COLORECTAL CANCER DATA

Table 3: Annual mortality rates and counts by parish in Louisiana, 2010-2014, per 100,000 people. (Age-adjusted rates)

Mortality from Colorectal Cancer, 2010-2014, by Parish		
	Mortality Rate	Average Annual Count
Louisiana	17.9	874
Acadia Parish	21.9	15
Allen Parish	28.1	8
Ascension Parish	15.3	14
Assumption Parish	17.6	5
Avoyelles Parish	27.1	14
Beauregard Parish	14.9	6
Bienville Parish	*	3 or fewer
Bossier Parish	15.5	19
Caddo Parish	19.2	57
Calcasieu Parish	18.7	40
Caldwell Parish	*	3 or fewer
Cameron Parish	*	3 or fewer
Catahoula Parish	*	3 or fewer
Claiborne Parish	17.6	4
Concordia Parish	22.9	5
De Soto Parish	20	6
East Baton Rouge Parish	16.5	71
East Carroll Parish	*	3 or fewer
East Feliciana Parish	19.8	5
Evangeline Parish	32.4	12
Franklin Parish	12.1	3
Grant Parish	26.8	6
Iberia Parish	21.6	16
Iberville Parish	25.4	9
Jackson Parish	21.5	4
Jefferson Davis Parish	19.8	7
Jefferson Parish	16.2	83
La Salle Parish	21	4
LaFourche Parish	19.7	20
Lafayette Parish	15.1	33
Lincoln Parish	18.7	8
Livingston Parish	15.5	19
Madison Parish	*	3 or fewer
Morehouse Parish	14	5
Natchitoches Parish	20.4	9
Orleans Parish	16.5	61
Ouachita Parish	17.1	28
Plaquemines Parish	*	3 or fewer
Pointe Coupee Parish	17.5	5
Rapides Parish	16.5	25
Red River Parish	*	3 or fewer
Richland Parish	23	5
Sabine Parish	23.8	8
St. Bernard Parish	19.1	6
St. Charles Parish	17.6	9
St. Helena Parish	*	3 or fewer
St. James Parish	20.7	5
St. John the Baptist Parish	15.8	7
St. Landry Parish	22.3	21
St. Martin Parish	19.5	11
St. Mary Parish	22.3	13
St. Tammany Parish	14	37
Tangipahoa Parish	19.8	25
Tensas Parish	*	3 or fewer
Terrebonne Parish	22.7	25
Union Parish	23	7
Vermilion Parish	15.1	10
Vernon Parish	14.7	6
Washington Parish	22.2	12
Webster Parish	17	9
West Baton Rouge Parish	*	3 or fewer
West Carroll Parish	*	3 or fewer
West Feliciana Parish	*	3 or fewer
Winn Parish	25.2	5

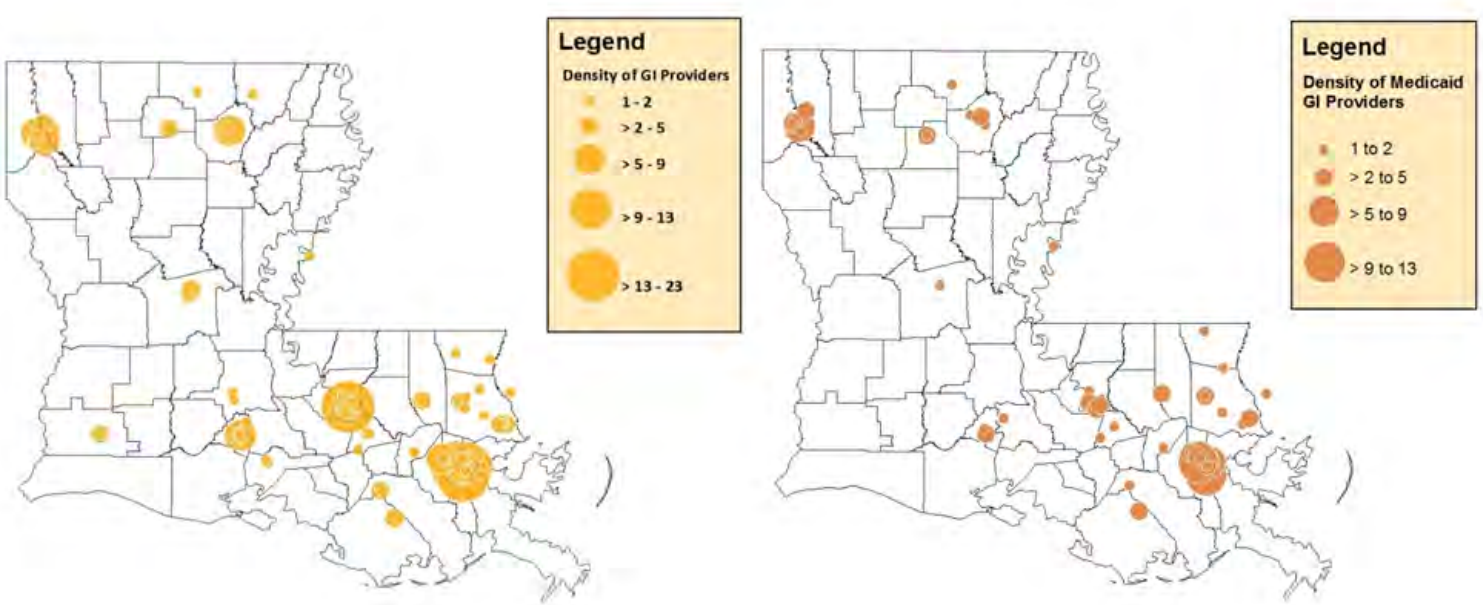

Figure 8: Comparison of Gastroenterologists (GIs) density spatially in the state of Louisiana, as well as the density of GIs that accept Medicaid.

APPENDIX B: WHAT IS COLORECTAL CANCER? A CLOSER LOOK

Colorectal cancer is a term used for cancer that starts in the colon or the rectum. These cancers can also be referred to separately as colon cancer or rectal cancer, depending on where they start. Colon cancer and rectal cancer have many features in common.

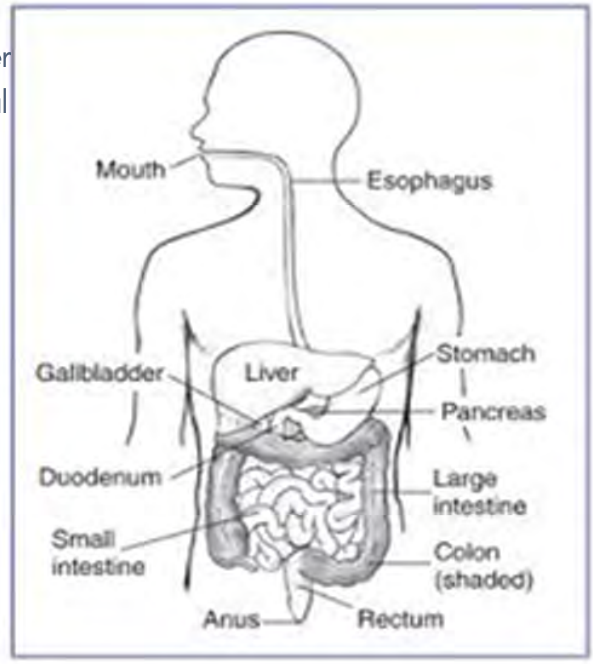

Figure 9: Basic anatomical model of the human digestive system.

The Normal Digestive System

The colon and rectum are parts of the digestive system, which is also called the gastrointestinal (GI) system (see Figure 8). The first part of the digestive system (the stomach and small intestine) processes food for energy while the last part (the colon and rectum) absorbs fluid to form solid waste (fecal matter or stool) that then passes from the body.

Abnormal Growths

Most colorectal cancers develop slowly over several years. Before a cancer develops, a growth of tissue or tumor usually begins as a non-cancerous polyps on the inner lining of the colon or rectum. A tumor is abnormal tissue and can be benign (not cancer) or malignant (cancer). A polyp is a benign, non-cancerous t Some polyps can change into cancer but not all do. The chance of changing into a cancer depends on the ki polyp. The 2 main types of polyps are:

1) Adenomatous polyps (adenomas) are polyps that can change into cancer. Because of this, adenomas are called a pre-cancerous condition.

2) Hyperplastic polyps and inflammatory polyps, in general, are not pre-cancerous. But some doctors think that some hyperplastic polyps can become pre-cancerous or might be a sign of having a greater risk of developing adenomas and cancer, particularly when these polyps grow in the ascending colon.

Another kind of pre-cancerous condition is called dysplasia. Dysplasia is an area in the lining of the colon or rectum where the cells look abnormal (but not like true cancer cells) when viewed under a microscope. These cells can change into cancer over time. Dysplasia is usually seen in people who have had diseases such as ulcerative colitis or Crohn's disease for many years. Both ulcerative colitis and Crohn's disease cause chronic inflammation of the colon.

Start and Spread of Colorectal Cancer

If cancer forms in a polyp, it can eventually begin to grow into the wall of the colon or rectum. When cancer cells are in the wall, they can then grow into blood vessels or lymph vessels. Lymph vessels are thin, tiny channels that carry away waste and fluid. They first drain into nearby lymph nodes, which are bean-shaped structures containing immune cells that help fight against infections. Once cancer cells spread into blood or lymph vessels, they can travel to nearby lymph nodes or to distant parts of the body, such as the liver. When cancer spreads to distant parts of the body it is called metastasis.

Types of Cancer in the Colon and Rectum

Several types of cancer can start in the colon or rectum.. Adenocarcinomas account for more than 95% of colorectal cancers. Less common types of cancer in the colon and rectum are carcinoid tumors, gastrointestinal stromal tumors (GISTs), lymphomas, and sarcomas.

CRC Testing

CRC can be diagnosised in multiple ways. See Figure 10 for some tests associated with diagnosing colorectal cancer. Of particular interest for the LCCRT is the model of a FIT/FOBT Test, followed by colonoscopy, although patients are encouraged to discuss their treatment plan with their doctor.

*Figure 10: Tests types associated with CRC diagnosis and cancer monitoring. Test solely for monitoring, or used after diagnosis, are marked with an asterik **

Type of Test			
Blood Test	**Visual Test**	**Genetic Test**	**Other**
• Complete Blood Count (CBC) • Liver Enzymes* • Tumor Markers*	• Colonoscopy • Magnetic Resonance Imaging (MRI) • Ultrasound • Positron emission tomography (PET) • Computed tomography (CT)	• Microsatellite Instability (MSI)* • BRAF mutations* • KRAS mutations*	• Physical exam • Medical History

FIT/FOBT tests are cost-efficient tests that can be a precursor for a colonoscopy, if positive. FIT/FOBT tests measure the occult (o hidden, invisible to the naked eye) blood in the patient's stool. This is a test that can be done in the doctor's office, or at home and brought in for the lab to test. It is cheap and time-efficient for the doctor and more comfortable for the patient. If there is occult blood in the stool, that would mark the test positive and the doctor would schedule a colonoscopy to find the source of the occult blood. See Figure 11 for a flow chart of the process.

Several types of cancer can start in the colon or rectum.. Adenocarcinomas account for more than 95% of colorectal cancers. Less common types of cancer in the colon and rectum are carcinoid tumors, gastrointestinal stromal tumors (GISTs), lymphomas, and sarcomas. Colonoscopies are a test that can be performed for screening or diagnostic purposes.

Treatment

The main types of treatment that can be used for colon and rectal cancer are:

- Surgery for colon and rectal cancer
- Radiation therapy
- Chemotherapy
- Targeted therapy

For advanced colon and rectal cancer, ablation or embolization may also be used. Depending on the stage of the cancer, two or more of these types of treatment may be combined at the same time or used after one another. It is important to discuss all treatment options with a doctor to help make the best decision. In choosing a treatment plan, one of the most important factors is the stage of the cancer. Othe factors to consider include overall health, the likely side effects of the treatment, and the probability of curing the disease, extending life, or relieving symptoms. Also when considering treatment options, it is often a good idea to seek a second opinion, if possible. This may provide the patient with more information and help him or her feel more confident about the treatment plan.

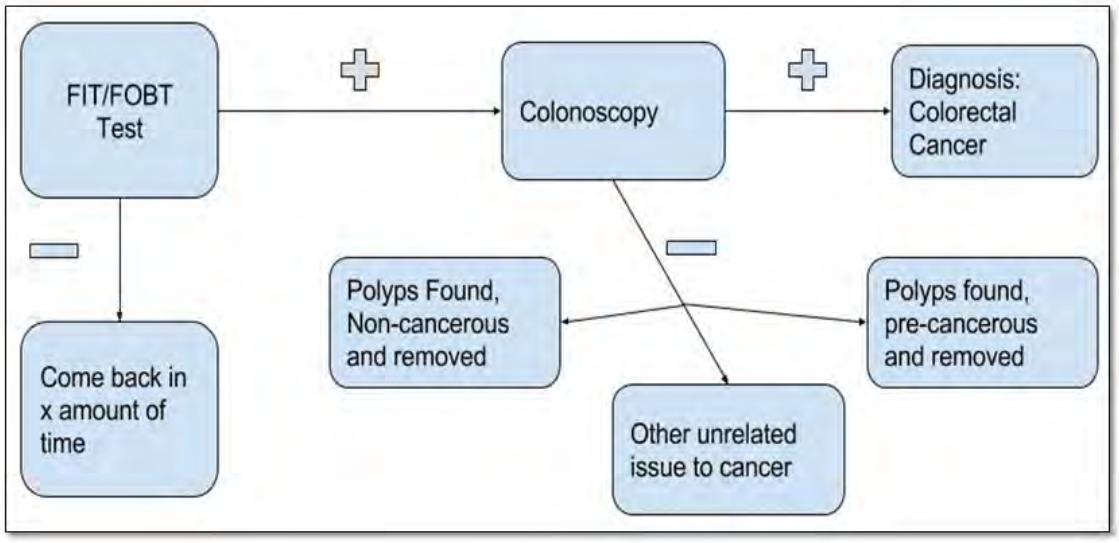

Figure 11: Flow diagram of testing for CRC using the FIT/FOBT and diagnostic colonoscopy model.

APPENDIX C: Colrectal Cancer Risk Factors

A risk factor is anything that affects the chances of getting a disease such as cancer. Different cancers have different risk factors. For example, exposing skin to strong sunlight is a risk factor for skin cancer. Smoking is a risk factor for lung cancer as well as many others cancers.

But risk factors don't tell us everything. Having a risk factor, or even several risk factors, does not mean that someone will develop the disease. Some people who get the disease may not have any known risk factors. Even if a person with colorectal cancer has a risk factor, it's often very hard to know how much that risk factor might have contributed to the cancer. Furthermore, occasionally there can be protective factors that lessen your risk for a disease if you partake in the behavior or have the characteristic.

Researchers have found several risk and protective factors that may increase or decrease, respectively, a person's chance of developing colorectal polyps or colorectal cancer.

*Table 5: Risk and protective factors for CRC. *Family history normally indicates a first-degree relative (parent, sibling, grandparent) has been diagnosed with CRC or adenomatous (pre-cancerous) polyps. Of particular risk are those diagnosed before age 50. This should be communicated within the family and with a doctor.*

Risk Factor	Protective Factor
Diet: • High in red meat • High in processed meat • Cooking meat a very high temperature	Diet: • High in vegetables, fruits • High in whole grains (but not fiber supplements)
Physical Inactivity	Physical Activity
Obesity	Maintaining a healthy weight
Smoking	Not smoking
Heavy alcohol use	Limiting alcohol use to no more than 1 or 2 drinks a day, respectively for women or men
Racial/ethnic Background: • African Americans • Jews of Eastern European descent (Ashkenazi)	Not applicable
Aging over 50 years old	Aging under 50 years old
Having Type 2 Diabetes	Not applicable
Personal history of colorectal cancer or polyps	Not applicable
Personal history of inflammatory bowel disease (IBD)	Not applicable
Family history of colorectal cancer or polyps*	Not applicable

Genetics and Inherited Syndromes

About 5% to 10% of people who develop colorectal cancer have inherited gene defects (mutations) that can cause family cancer syndromes and lead to them getting the disease. These syndromes often lead to cancer that occurs at a younger age than is usual. They are also linked to other cancers besides CRC. Some of these syndromes are also linked to polyps. Identifying families with these inherited syndromes is important because then doctors can recommend specific steps for them, such as screening and other preventive measures, at an early age.

The two most common inherited syndromes linked with CRC are familial adenomatous polyposis (FAP), accounting for 1% of diagnoses, and hereditary non-polyposis colorectal cancer (HNPCC), which causes 2-4% of colorectal cancers. Other rarer syndromes can also increase CRC risk. These include Turcot Syndrome, Peutz-Jehgers Syndrome, and MUTYH-associated polyposis. For more in depth information on these genetically inherited syndromes, please refer to the American Cancer Society's website.

APPENDIX D: LCCRT MEMBERSHIP ROSTER

Name	Credentials	Title	Place of Work	Organizations Represented
Birkhoff, Terry		Senior Manager, Primary Care Systems	American Cancer Society	ACS
Sylvester, Kaitlin	MPA	State Health Systems Manager	American Cancer Society	ACS
Williams, Amy	MBA	Health Systems Manager, Hospitals	American Cancer Society	ACS
Kuykendal, Lydia	MPH	Louisiana Government Relations Director	American Cancer Society Cancer Action Network	ACS CAN
Batie, Dr. Donnie	MD	Primary Care Physician, Board Member	Baton Rouge General Hospital	BR General, LAFP
Cole, Dr. Kenny	MD, MPH	Director of Transformation	Baton Rouge General Hospital	
Muscalus, Dr. Robert	MD	Director of Care Transformation	Blue Cross Blue Shield of Louisiana	BCBSLA
Hobley, Dr. James	MD	President for the Louisiana Gastroenterology Society	Gastrointestinal Specialists	LGS
Albert, Lee Ann	RN	Membership and Education Director	Louisiana Academy of Family Physicians (LAFP)	LAFP
Huard, Colleen Ryan	MPH	LPC Program Manager	Louisiana Cancer Prevention & Control Program	LCP, LCHP, LSU HSC New Orleans, School of Public Health
Thelen, Aubree	MPH	Policy Coordinator	Louisiana Cancer Prevention (LCP)	LSU HSC-New Orleans, LCP
Giancola, Mack	MPH	Program Manager	Louisiana Cancer Prevention (LCP), Manager of Service Area, Louisiana Healthy Communities Coalition, Statewide Co-Chair	LCP, LHCC
Oubre, Dr. David	MD	State Affiliate	Louisiana Oncology Society	Louisiana Oncology Society
Robertson, Shannon	RN, BSN	Interim Clinical Quality Director	Louisiana Primary Care Association (LPCA)	LPCA
Chang, Doreen		Public Health Associate, HIT Coordinator	Louisiana Primary Care Association (LPCA)	LPCA, CDC
Davis, Gerrelda	MBA	Executive Director	Louisiana Primary Care Association (LPCA)	LPCA
Fontenot, Stacy		Executive Director	Louisiana Rural Health Association	LRHA
Andrews, Patty	MPH	Instructor, Registry Liaison (retired)	Louisiana Tumor Registry	La Tumor Registry, LSU HSC New Orleans, School of Public Health
Wu, Dr. Xiao-Cheng	MD, MPH	Director of La Tumor Registry	Louisiana Tumor Registry	La Tumor Registry, LSU HSC New Orleans, School of Public Health
Williams, Dr. Donna	DrPH	Director, Louisiana Cancer Prevention and Control Programs	LSU HCS New Orleans, School of Public Health	LSU HSC, School of Public Health, LPC
Wilbright, Dr. Wayne	MD, MS	CEO	LSU HCSD	LSU HCSD
Verret, Keith		Information Technology Project Coordinator	LSU Health Care Services Division	LSU HCSD
Kamerman-Burns, Leigh Anne	MS, LDN, RD	LSU HCSD Clinical Lead Cancer Screening and Wellness	LSU HSC	LSU HCSD
Fontham, Dr. Elizabeth	MPH, DrPH	Founding Dean LSU School of Public Health	LSU HSC New Orleans	LSU HSC-New Orleans, School of Public Health, ACS
Rivers, Michael	MA	Data & Evaluation Specialist	LSU HSC New Orleans	LSU HSC-New Orleans, LCHP
Kauffman, Dr. Randi	DrPH	Assistant Professor - Research and Director of Public Practice	LSU HSC New Orleans, School of Public Health	LSU HSC, School of Public Health
Ssenkoloto, Nannozi	MPA, MPH	Director, Louisiana Breast and Cervical Health Program	LSU HSC New Orleans, School of Public Health	LSU HSC-New Orleans, LBCHP
Chu, Dr. Quyen	MD	Professor of Surgery	LSU HSC-Shreveport	LSU HSC-Shreveport, American College of Surgeons, CoC State Chair
Davis, Dr. Terry	PhD	Professor, Departments of Medicine and Pediatrics	LSU HSC-Shreveport	LSU HSC-Shreveport
McLarty, Dr. Jerry	PhD	Director of Cancer Prevention and Control	LSU HSC-Shreveport	LSU HSC-Shreveport, LSU Feist-Weiller Cancer Center
Mills, Dr. Glen	MD	Director Feist-Weiller Cancer Center	LSU HSC-Shreveport	LSU HSC-Shreveport, LSU Feist-Weiller Cancer Center
Abel, Greg		New Orleans Accounts	Myriad Genetic Laboratories	Myriad Genetic Laboratories
Winfrey, Dr. Keith	MD	Clinical Branch Chairman	NOELA Community Health Center	NOELA, LPCA
Finan, Dr. Kelly	MD, MSPH, FACS, FASCRS	Colorectal Surgeon	Our Lady of the Lake Physicians' Group, Colon Rectal Associates	OLOL
Fabre, Jennifer	MSN, APRN, ANP/FNP-C, CDE	Clinical Coordinator, Joint Commission/Quality Assurance Coordinator and Assistant Chief Health Officer	Teche Action Clinic	Teche Action Clinic
Wiltz, Dr. Gary	MD	CEO	Teche Action Clinic	Teche Action Clinic
Karlitz, Dr. Jordan	MD	Assistant Clinical Professor of Medicine	Tulane University School of Medicine	Tulane, VA, AGA
Netters, Tiffany	MPA, PMP	Director of Health Policy and Government Affairs	Louisiana Primary Care Association (LPCA)	LPCA
Loupe, Selina		Director of Clinical Partnerships	Blue Cross Blue Shield of Louisiana	BCBSLA
McMillan, Mary	RN, BSN	Manager Care Transformation, Clinical Partnerships	Blue Cross Blue Shield of Louisiana	BCBSLA

Report Prepared by Founding Members:

LOUISIANA CANCER PREVENTION & CONTROL PROGRAMS @ LSU Health NEW ORLEANS

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For more information or questions, please contact: Aubree Thelen, Louisiana Cancer Prevention Policy Coordinator at athelelsuhsc.edu.