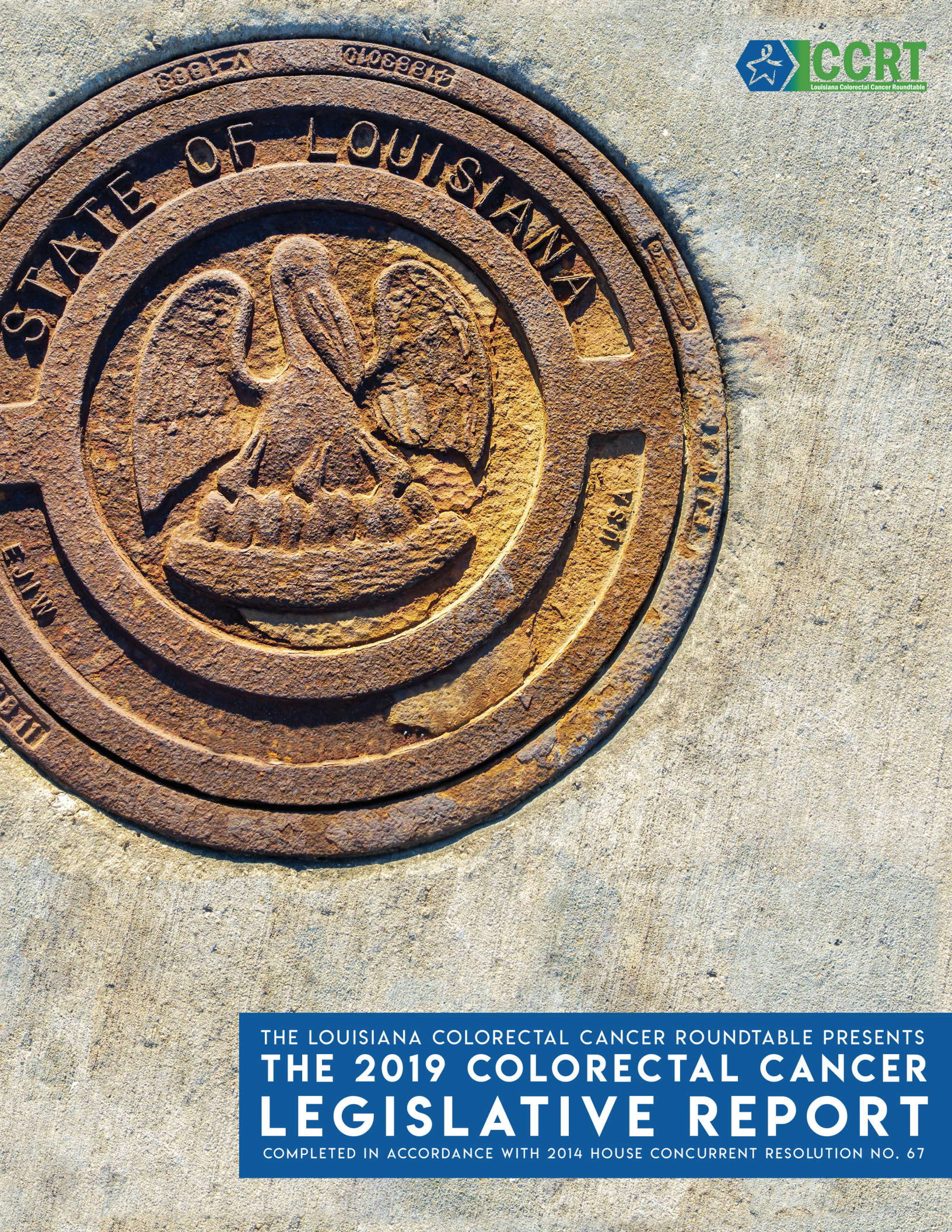

CCRT
Louisiana Colorectal Cancer Roundtable

THE LOUISIANA COLORECTAL CANCER ROUNDTABLE PRESENTS

THE 2019 COLORECTAL CANCER LEGISLATIVE REPORT

COMPLETED IN ACCORDANCE WITH 2014 HOUSE CONCURRENT RESOLUTION NO. 67

Dear Louisiana Legislators,

Colorectal cancer (CRC) is a chronic disease that continues to impact our state both physically and financially. In 2017, Louisiana reported 2,150 new cases of colorectal cancer with 830 disease-related deaths and $30 million worth of spending on CRC treatment. Seeing that a fifth of Louisiana's population is now eligible to begin screening (aged 50 to 75), but only two-thirds of this group act on the recommendation, over 400,000 Louisianans are left at risk of developing CRC. *That's enough people to fill the Mercedes-Benz Superdome over five times!*

Thankfully, this disease is one of two cancers that can be largely prevented through screening. Collaborative efforts led by groups such as the Louisiana Colorectal Cancer Roundtable (LCCRT) have helped our state achieve a screening rate of 64.3%. And while that rate is still shy of the national goal, we have tangible evidence that strategic planning and coordinated care can lead to improved patient outcomes.

In the last four years, LCCRT has formed over 40 partnerships across the public and private sectors to address this deadly disease. By bringing together the brightest minds in medicine, public health, business, and community, LCCRT has gained serious momentum in reaching the 80% CRC screening goal. Even more impressive, all of the work accomplished by LCCRT has been without a single dime! Just look at what has been accomplished in the last year, and imagine what could be done with a mere budget of $500,000:

- LCCRT hosted the 3rd Annual Southeastern Colorectal Cancer Consortium that highlighted new research while earning Louisiana thousands of dollars in tourism.
- The Roundtable collaborated with several partners to facilitate a provider education series focused on quality improvement and evidence-based practices.
- Blue Cross and Blue Shield of Louisiana and the Roundtable continued to promote the Quality Blue Primary Care (QBPC) initiative which encourages providers to make colorectal health a priority.
- Various partners launched a month-long, multi-organizational social media campaign aimed at increasing colorectal cancer screening rates throughout the state.

While these are only a handful of its successes, LCCRT has made a sizeable impact on Louisiana and proven itself a catalyst of change. With this in mind, we ask that you take a moment to review the enclosed legislative report as we make CRC prevention a priority in Louisiana.

Sincerely,

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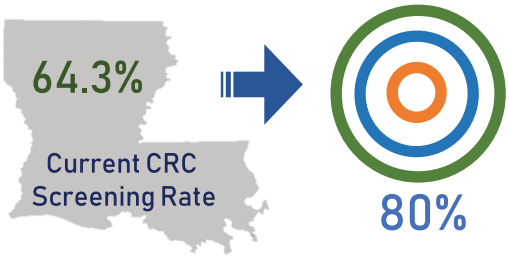
Colorectal Cancer in Louisiana: An Overview

Colorectal cancer (CRC) is one of two cancers that can be largely prevented by screening. Through various tests such as FITs and colonoscopies, patients can increase their chances of identifying and removing pre-cancerous polyps.



Roughly one-fifth of Louisiana's population is of age to begin screening for CRC. However, only 2 out of 3 adults actually undergo screening. Those who don't can cost the state millions in treatment, lost productivity, and death.

LCCRT has been working hard to increase CRC screening access, awareness, and rates through means such as ...

The 2018 SE Colorectal Cancer Consortium....

Quality improvement (QI) webinars for health providers and systems...

Sustained partnerships with payers like BCBSLA

BlueCross BlueShield

And Workforce expansion

Resources needed to increase CRC prevention efforts throughout Louisiana...

1) Funding for LCCRT and QI Initiatives

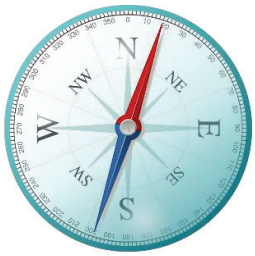
CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

2) Coordination between state and federal agencies regarding data sharing

3) Increased reimbursement rates for preventative screenings

LOUISIANA DEPARTMENT OF HEALTH

4) Resources to fund a centralized patient navigation system



With your support and funding of HCR No. 67 of the 2014 Legislative Session, we can continue to serve the state through CRC prevention and control as we make colorectal cancer history in Louisiana.

Introduction

Since its inception in 2014, the **Louisiana Colorectal Cancer Roundtable (LCCRT)** has served as the premier coalition for colorectal cancer prevention and awareness. This group is composed of physicians, insurers, academics, and researchers who have contributed a great deal of time and effort to meeting the **national CRC screening goal of 80% among 50- to 75-year-olds**. Through strategic planning, systemic interventions, and professional development, the LCCRT has produced several victories, resulting in millions of lives and dollars saved.

The Roundtable continues to engage payers, gather data, and increase access to screenings throughout the state. With help from its stakeholders and the state legislature, LCCRT aims to lead and assist in the prevention of unnecessary disease, disability, and premature death caused by colorectal cancer.

But before diving into the accomplishments of the Roundtable, it is important to understand the disease and its effects on Louisiana.

What is Colorectal Cancer?

Colorectal cancer (CRC) is the mutation and proliferation of cancer cells in the colon or rectum. Because the two cancers share many of the same traits, they are often grouped together. CRC usually begins as a non-cancerous growth called a **polyp** that develops on the inner lining of the large intestine and grows slowly over a period of 10 to 15 years [1,2]. Not all polyps are cancerous, but those that are can spread into blood and lymph vessels through a process called metastasis.

There are several risk factors associated with CRC. The main contributors are **age, inactivity, tobacco usage, and poor diet**—especially those high in red or processed meats [3]. In addition to those factors, gender, racial, and socioeconomic disparities are linked to CRC. When comparing males and females, men develop the disease more often than women—but only slightly. Among ethnicities, African Americans have the highest rates of developing and dying from CRC compared to their Caucasian, Hispanic, and Asian counterparts [3].

Research also shows a strong association between colorectal cancer and genetics. Familial adenomatous polyposis [FAP] and hereditary nonpolyposis colorectal cancer [HNPCC], more commonly known as Lynch Syndrome, are genetic disorders that are linked to an increased risk of developing CRC [4].

Colorectal cancer continues to be the **second leading cause of cancer-related death** in the United States. It is estimated that 135,430 new cases of CRC will be reported in the U.S. in 2018 with more than a third resulting in death [5]. In Louisiana, it is estimated that over 800 deaths will occur this year at the hand of colorectal cancer—a number far too great for a preventative disease [5].

On average, **1 in 22 (4.6%) men** and **1 in 24 (4.2%) women** are diagnosed with CRC in their lifetimes [3]. Individuals who develop CRC will undergo one or several types of treatment that can include radiation, chemotherapy, and surgery with the partial or complete removal of the large intestine (colon and rectum) [6].

Prevention

Regular screening is one of the most powerful weapons in preventing colorectal cancer. In fact, many experts attribute the nation's steadily declining rates to the increased utilization of screenings. These tests help providers find and remove polyps before they metastasize, or spread, and develop into more deadly cancers. Screenings also help identify cancers in early stages before they become difficult or impossible to treat.

Thankfully, in the 21st century, there are more screening options available than ever before. **Colonoscopies** utilize a flexible scope inserted through the rectum to examine the rectal and intestinal walls [7]. This test also allows clinicians to remove any pre-cancerous polyps before further development. The fecal immunochemical test, or **FIT**, is a non-invasive exam that can be done by anyone in the privacy of his or her home [7]. In recent years, at-home FIT-DNA tests have been added as a screening option. While these tests provide several benefits, it is important to recognize that positive results should always be followed up with a traditional colonoscopy. In the field of CRC prevention, we are fortunate to have a multitude of reliable screening options. While there are several to choose from, we believe the best option is the one that ultimately gets done.

Even with screening rates on the rise, there are still barriers hindering access to preventative screenings, diagnosis, and treatment of colorectal cancer. Failure to screen at appropriate intervals, failure to follow up on abnormal readings, and an overall lack of screening among the 50- to 75 age group have contributed to the high rates of CRC diagnosis and death in Louisiana. (For a complete list of screening options, please refer to Appendix C of this report.)

CRC in Louisiana

According to the most recent data from the Louisiana Tumor Registry (LTR), our state ranks **fourth in the nation for CRC incidence (new cases) and third in mortality (deaths)** [8]. As previously mentioned, in 2017 Louisiana reported 2,150 new cases of CRC with 830 deaths [4]. The tables below display the most recent statewide incidence and mortality rates, which are falling, but remain well above the national average—a clear sign of lingering health disparities.

Louisiana CRC-Related Incidence

	Caucasians			African-Americans		
	All	**Men**	**Women**	**All**	**Men**	**Women**
LA Incidence	**43.4**	51.2	37.1	**55.9**	66.7	48.4
US Incidence	**38.4**	44.1	33.5	**45.7**	53.9	39.9

Table 1: Age-adjusted incidence rates in 2011-2015 of CRC diagnosis per 100,000 people in LA and the US.

Louisiana CRC-Related Mortality

Table 2: Age-adjusted mortality rates for CRC in 2011-2015 per 100,000 people in Louisiana and the US.

	Caucasians			African-Americans		
	All	**Men**	**Women**	**All**	**Men**	**Women**
LA Mortality	**15.9**	19.2	13.4	**22.4**	28.5	18.2
US Mortality	**13.9**	16.4	11.8	**19.7**	24.9	16.2

Furthermore, every region in Louisiana has an incidence and mortality rate that exceeds the national average. Of the 64 parishes, 18 located in the **Acadian region** have the highest rates of CRC in the state. Not only that, but this area has been identified as having one of the **highest concentrations of hereditary colorectal cancer** in the entire country. (For an exhaustive list of parish-level CRC mortality data, please refer to Appendix A of this report.)

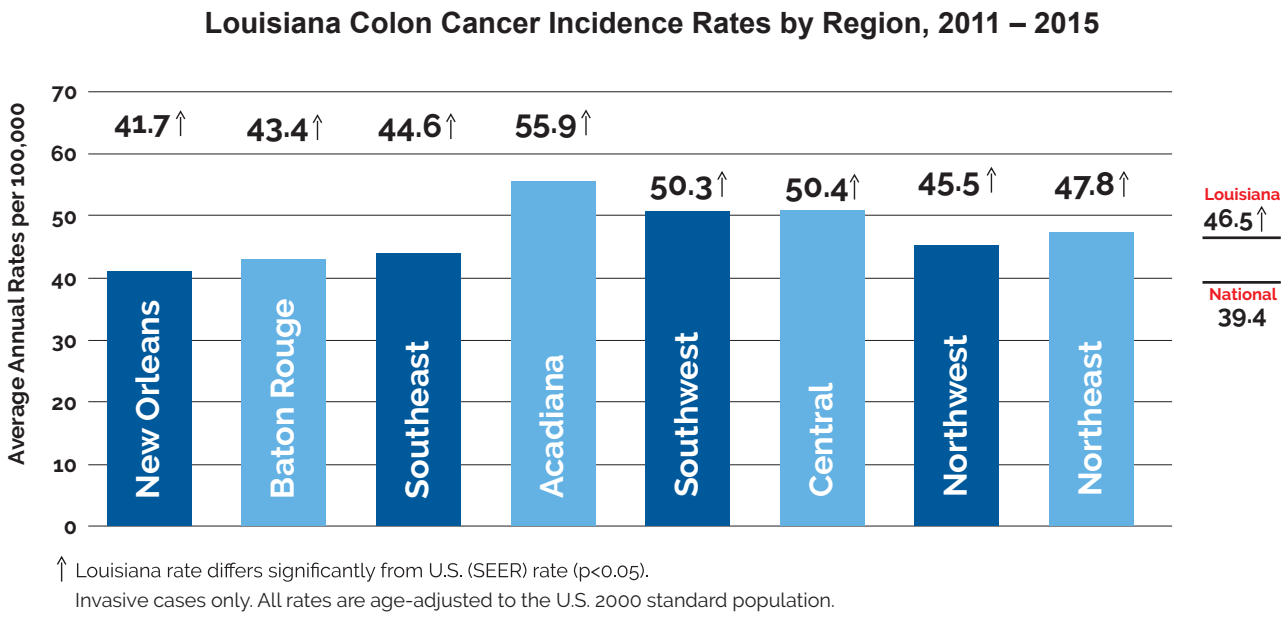


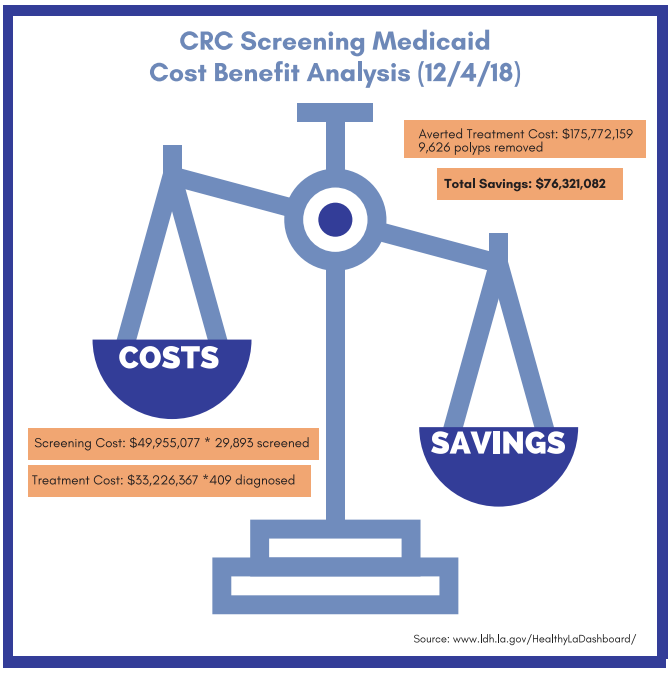
Figure 1: Incidence rates by geographic region with respect to state and national averages.

With such a large number of Louisianans affected by colorectal cancer, the impact of the disease can be felt on multiple levels.

The **average cost of treating** CRC in the initial year of diagnosis is estimated to be **$51, 570**[9]. Considering that the median household income in Louisiana is only $46,146, many residents are not in the financial position to properly address the disease[10]. In fact, even the state has felt the impact of CRC with **disease-related spending exceeding $30 million** in the last two years. That amount could fund an entire year of Louisiana's Go Grant program which helps fund students' college education.

In light of this, health providers, insurers and state legislators have taken a great interest in the cost-effectiveness of CRC screenings.

Each year, the LCCRT Data Task Group updates its Medicaid Cost-Benefit Analysis to portray how investing in CRC prevention is saving our state millions of dollars.



According to the Louisiana Department of Health's Healthy Louisiana Dashboard, our state has successfully **screened nearly 30,000 Medicaid recipients** for colorectal cancer and **removed over 9,000 polyps** since July 2016[11]. These services also prevented many new cancers and identified 409 CRC cases. Not only were lives saved, but over $175 million of potential treatment costs were averted. Without expansion, many of these individuals would have not been screened and their cancers would have been detected much later when they were harder, more painful, and more costly to treat.

THE LOUISIANA COLORECTAL CANCER ROUNDTABLE

As the state's premier coalition on CRC prevention, the **Louisiana Colorectal Cancer Roundtable (LCCRT)** provides a forum to gather and grow statewide and local initiatives. LCCRT's initiatives are aligned with the National Colorectal Cancer Roundtable (NCCRT)'s **goal of decreasing incidence, mortality and late-stage diagnosis of CRC**. In order to achieve this, LCCRT has adopted the national objective of increasing screening rates to **80%**.

Over the years, LCCRT has created a portfolio of over 40 partners composed of medical providers, professional associations, academics, public health practitioners, private health insurers, and state agencies. Within the Roundtable, there are several subcommittees and task groups charged with promoting the organization's mission and advancing its agenda throughout the state. These groups meet biweekly, quarterly, and annually to discuss the coalition's progress and strategic plan.

The Roundtable strives to provide its members with useful tools and resources to **promote prevention and access to early detection, treatment, and follow-up care**. Over the years, LCCRT has continued its commitment to increasing its presence throughout the state by means of project collaboration, professional development, and research.

To maintain transparency and encourage open channels of communication, the Roundtable would like to share some its most recent work with the state legislature. As always, questions, feedback, and suggestions are greatly welcomed.

The 3rd Annual Southeastern Colorectal Cancer Consortium

This past June, LCCRT hosted the 3rd Annual Southeastern Colorectal Cancer Consortium in New Orleans, bringing together 13 states and one U.S. territory. With over **200 attendees from the public, private, and non-profit sectors**, dozens of ideas and experiences were exchanged creating an atmosphere rich with knowledge and camaraderie. Participants were able to **share best practices and develop collaborative efforts** aimed at promoting CRC screenings in their states and communities.

The summit consisted of multiple abstracts, presentations, and exhibits that highlighted an array of **CRC-specific research, policies, and disparities**. Topics ranged from data interpretation and dissemination to increased access and patient navigation. Among the large number of exhibits, three Louisiana presentations yielded great attendance and feedback. These were delivered by Dr. Xiao-Cheng Wu, Director of the Louisiana Tumor Registry, Dr. Jordan Karlitz, Director of the Louisiana Hereditary GI Cancer Program at Tulane University's School of Medicine, and Dr. Donna Williams, Director of the Louisiana Cancer Prevention & Control Programs (LCP) at LSU's School of Public Health.

Hosting the event was a resounding success for the state of Louisiana, both scientifically and financially. In addition to securing speakers from national organizations like the Centers for Diseases Control & Prevention (CDC), the National Colorectal Cancer Roundtable (NCCRT), the American Cancer Society (ACS) and Kaiser Permanente, LCCRT was able to highlight and showcase our own exceptional leaders within the state, including Teche Action Clinic, Blue Cross and Blue Shield of Louisiana (BCBSLA), LSU Health Sciences Center at New Orleans, Ochsner Health System, Tulane University, the Louisiana Tumor Registry (LTR), and NOELA Community Health Center.

The Roundtable always appreciates the opportunity to **bolster the work of Louisiana** and its leaders in the fight against colorectal cancer. This conference provided a platform to share that work as well as advancements in research and methodology.

Engaging the Private Sector: Blue Cross and Blue Shield of Louisiana & LCCRT

As a coalition, LCCRT values its diverse memberships and constantly seeks different opportunities to support the work of its partners. In 2018, **LCCRT** continued its work with **Blue Cross and Blue Shield of Louisiana (BCBSLA)** to increase colorectal cancer screening rates throughout the state. Working with **Quality Blue Primary Care (QBPC)**, the insurer focused on patient-centered care through a friendly colorectal cancer screening competition among their primary care physicians.

QBPC's use of technology and resources allows physicians to provide enhanced care coordination to patients, helping to improve health outcomes. Physicians participating in the program focus on four clinical measures and are rewarded based on improvements in those areas. An additional benefit to physicians participating in this program is the access to data-tracking tools that show how their patients are doing across several metrics.

The CRC screening competition formally launched September 1, 2016 and was promoted among QBPC physicians internally. LCCRT has provided materials, tools, training opportunities, and quality improvement techniques to participants as it continues working with the clinical transformation team to identify strategies and opportunities to assist physicians.

This past November, LCCRT was invited to again participate in the BCBSLA QBPC Annual Collaborative, which brings together participating physicians from around the state. The collaborative offers participants the opportunity to network, learn about what is on the horizon for the program, and receive acknowledgement for reaching their targets. LCCRT recognized the 2**5 physicians able to hit an 80% screening rate** in the second year of the competition. QBPC was also able to increase their **average screening rate from 40% to 53%** in the first year, and another increase is projected for year two.
Following these accomplishments, LCCRT has highlighted the work of QBPC physicians through state newsletters, journals, social media postings, and traditional press releases. During March, which is Colorectal Cancer Awareness Month, the physicians will be recognized individually as champions of colorectal health.

Moving forward, LCCRT plans to work with BCBS of Louisiana to obtain data for an accurate representation of their screening rates and use this information to message to providers and patients. LCCRT is committed to its collaboration with BCBSLA to find a suitable and sustainable solution to these concerns.

LCCRT Professional Development

In 2018, multiple stakeholders, including the LA Primary Care Association and 504HealthNet, collaborated on a webinar series entitled **Quality Improvement 101 (QI 101)**. This 12-month webinar series educates providers and health professionals about the "Model of Improvement." This model focuses on how to **implement quality improvement processes**, how to **make the processes sustainable**, and what **screening and early detection processes** look like in different healthcare environments. To increase retention and participation in the series, participants are given assignments to complete and report back to the group. This allows for constructive conversation, situation analysis, and process mapping across health systems and communities.

With assistance from the LSU Health New Orleans' School of Medicine, the series is able to offer participants **continuing education units (CEUs)**. In an age where time and funding are often scarce, this series provides participants the necessary insight and tools needed to improve quality, enhance performance, and produce better, more patient-centered care.

Roundtable Research

The LCCRT has been very active with colorectal cancer data analysis and research over the past year. Multiple projects contributed to our ability to identify high-risk populations and assess healthcare disparities with regard to incidence, mortality, and screening access. Here are some of the most notable projects of the Roundtable in the past year:

1) In 2017, the LCCRT **surveyed gastrointestinal (GI) doctors throughout Louisiana to find out if they accept Medicaid for colonoscopy services**, and if not, what barriers may be preventing acceptance of this type of insurance. Analysis revealed that 58% of respondents did not accept Medicaid mainly because reimbursement rates were low. Providers also reported that patients with Medicaid weren't compliant with physician recommendations. Importantly, survey results also revealed that a higher number of providers than expected (27%) were unaware of Medicaid expansion. As an offshoot of this study, the LCCRT Data Task Group also mapped and compared the locations of GI providers who accept Medicaid and all GI doctors. A map of all 277 GI doctors in the state showed them well distributed throughout Louisiana. However, when only GI doctors accepting Medicaid were analyzed (120 GIs), there were large areas, particularly in western and central Louisiana, with no GIs.

The above studies were presented at the Annual CDC Conference and the American Association of Cancer Research Disparities Conference this past October. This research highlights the need to look at Medicaid reimbursement rates for colonoscopies and other changes that may improve the acceptance of Medicaid among providers. Colonoscopy services are not only important for screening, but also for diagnostic services if a patient experiences rectal bleeding or if they have a positive stool test that requires a follow up colonoscopy.

2) In 2018, the LCCRT **analyzed Behavioral Risk Factor Surveillance System (BRFSS) data to see which variables are associated with low colorectal cancer screening rates**. Important factors were insurance type, race, annual income and urban vs. rural residence. With regard to insurance, the lowest screening rates were in the Medicaid population (52.5%). This result is not surprising given the results of our Medicaid GI provider and mapping studies discussed above. Low Medicaid screening rates can disproportionately affect the African-American population as 52% of Louisiana's Medicaid are African American. Screening rates were also low among Hispanic populations (52.7%), those with low annual income (particularly those making less than $15,000 per year, 50.1%, or $15,000-$25,000 per year, 58.7%), and those living in rural areas (62.7%).

3) In 2018, LCCRT Gastroenterology Chair, Dr. Jordan Karlitz, also **published a national survey study** in Clinical and Translational Gastroenterology that **assessed barriers that physicians may experience when trying to test for a hereditary form of colorectal cancer** called Lynch syndrome. People with Lynch syndrome have up to an 80% lifetime risks of developing colorectal cancer. It is also associated with a number of other cancer types

including ovarian, uterine, and stomach cancer. This study is related to research that Dr. Karlitz published in 2015 in the American Journal of Gastroenterology that utilized LTR Data to assess Lynch syndrome screening rates in a statewide, early-onset CRC population. This was the first population-based study of its kind published in the U.S. and revealed that Lynch syndrome was only being screened for in 23% of patients. Because up to 17% of early-onset CRC patients may be Lynch syndrome carriers, 100% of early-onset CRC patients should be tested for Lynch.

To better understand these low rates, the study was conducted with a national group of GI physicians. The barriers that were most important to testing were lack of access to genetic counselors, testing cost concerns, unfamiliarity interpreting testing results, and unclear responsibility of which physician type (i.e. gastroenterologist, pathologist etc.) should be responsible for ordering tests. As demonstrated in previous studies, the Louisiana Acadian region has among the highest colorectal cancer incidence rates in the country, and there may be high rates of hereditary colorectal cancer in that population as well. Hence, understanding barriers to testing for this syndrome, which may be present in **1 out of every 300 people**, many of whom remain undiagnosed, is of critical importance to Louisiana's health.

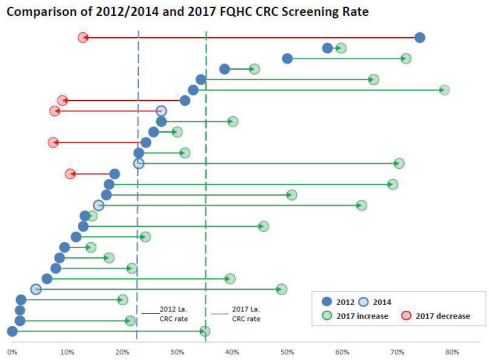
4) In 2018, **LCCRT and LTR conducted a mapping study that compared survival rates in advanced staged colorectal cancer** with proximity to the American College of Surgeon's Commission on Cancer accredited hospital-cancer program. The study demonstrated that the parishes with the worst 5-year survival rates (under 5%) were at relatively far distances from Commission on Cancer sites and tended to be rural. This contrasted with survival rates generally in the 10% or higher range (and even greater than 20% in some cases) in parishes that were in closer proximity to specialized centers.

LCCRT Data Task Group

At the very core of the Roundtable's work is the pursuit of complete and more comprehensive data. Since 2015, LCCRT's Data Task Group has worked with several public and private organizations to gather site-specific information on CRC screening rates, incidence, mortality, and late-stage diagnosis.

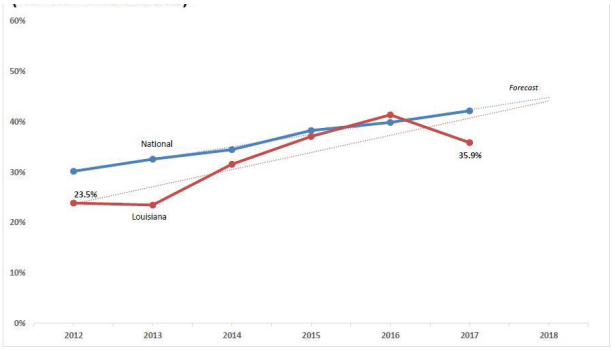
Here are just a few examples of the work developed and disseminated by the LCCRT Data Task Group in the past year:

LA FQHC CRC Screening Rate Comparisons



(2012 – 2017)

Uniform Data System CRC Screening Data (US v. LA)



(2012 – 2017)

Figure 2 (left): Comparison of CRC screening rates over time at each FQHC, showing increases and decreases from 2012 & 2014 to 2017.

Figure 3 (right): Uniform Data System (UDS) national data and Louisiana data yearly from 2012-2017.

In the previous figures, one can see the screening rates among Louisiana's FQHCs between 2012 and 2017. Of the 29 clinics that reported screening data, **more than 80% have increased** their overall screening rates since 2012. With CRC serving as a performance measure for these clinics, increased screening rates equate to subsequently lower late-stage diagnoses, mortality, and incidence rates. As compared to national FQHC data, Louisiana shows a steady upward trend for CRC screenings despite this year's mild setback, which is most likely due to improved data validation at the clinic level.

Referencing the map to the right, the locations of gastroenterologists throughout Louisiana can be seen from a geospatial view. While **less populated areas are expected to have fewer providers**, this map shows just how few GIs practice in rural Louisiana. As mentioned, a lack of personnel can greatly influence CRC screening rates and overall health outcomes. Like many other specialties, more resources for CRC prevention are located in more urban areas such as Baton Rouge and New Orleans—a pattern that the Roundtable is seeking to address through increasing access in more rural areas.

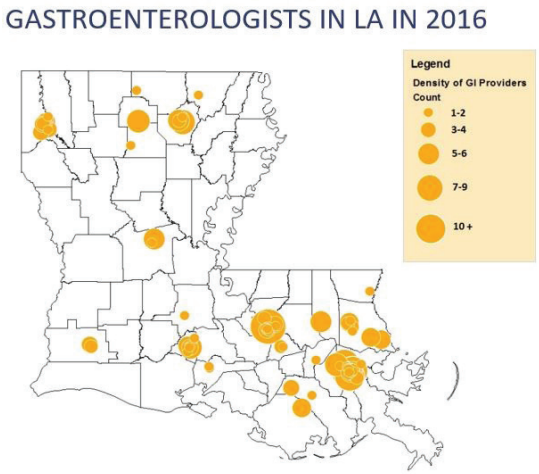


Figure 4: Louisiana GI physician density map.

Looking Forward: LCCRT and Policy

As legislators and members of the Roundtable, we know that well-crafted policies play an integral role in shaping healthcare in our state. In the past year, LCCRT has made significant progress on the policy forefront on both the community and national levels.

In August, the **LCCRT hired a program coordinator** through funding from LCP at LSU Health New Orleans to manage the structure, activities, and correspondence of the Roundtable. The coordinator has developed a bi-monthly newsletter, listserv, website, and membership roster to facilitate better, more frequent communication between the Roundtable's advisory committee and its partners. In addition to mapping the infrastructure and planning the annual summit, the coordinator has developed regional materials about CRC trends and LCCRT initiatives for community partners, advocates, and state legislators.

Aside from grassroots planning, **LCCRT and the American Cancer Society Cancer Action Network** (ACS CAN) have teamed up to **draft a legislative brief** to the United States Preventative Services Task Force (USPSTF) encouraging panelists to review their current CRC screening guidelines in light of the recent changes made by ACS. Building upon this, the Roundtable and ACS CAN have also been **educating stakeholders** about the federal **Medicare Loophole Legislation –H.R. 1017 and S. 479** –which is aimed at reducing financial burdens on Medicare A&B recipients.

At this time, a Medicare beneficiary can go into an endoscopy procedure to get a screening colonoscopy, which is typically requires no out-of-pocket in accordance with the Affordable Care Act. However, if a polyp is removed during the procedure, the procedure will be redefined as a diagnostic colonoscopy, and the patient will wake up owing a co-pay upwards to $500. For citizens on fixed incomes, such as seniors, that is a sizable amount of money.

Through these policy and advocacy efforts, LCCRT hopes to shape the way lawmakers look at the barriers that face patients seeking to maintain and address their colorectal health.

LCCRT Outlook

In light of the work that has been accomplished, LCCRT will not slow down in its pursuit of increasing CRC screening rates and awareness throughout the state of Louisiana. As the Roundtable prepares to convene for its fourth annual summit in March 2019, many thoughts of the future fill the minds of its leaders and stakeholders. Increased communications, partnership development, and health system integration are just a handful of initiatives that will be adopted by the Roundtable in the coming year.

The members of the Roundtable would like to share several recommendations with the state legislature concerning just how to reduce new cancer cases, mortality, late-stage diagnosis, and excess spending on CRC treatment.

LEGISLATIVE RECOMMENDATIONS

Funding the Roundtable

Like many initiatives before it, funding is a crucial component for the functionality and sustainability of the Louisiana Colorectal Cancer Roundtable. While many milestones of the strategic plan have been achieved through the work of volunteers and dedicated personnel, there is much more ground to cover for the state to reach an 80% CRC screening rate.

As LCCRT, we know funding from our state legislature would elevate the profile and expand the scope of work conducted by the Roundtable. With a mere **budget of $500,000 over three years**, we would be able to provide more educational opportunities to health professionals, develop CRC screening infrastructure, publish more research, and implement additional strategies for state-wide implementation.

Funding Patient Navigation

In addition to these projects, with funding from the state legislature, LCCRT can implement the highly anticipated and much needed **patient navigation program for colorectal cancer patients**. Through this initiative, the Roundtable could provide patients and providers with services that connect individuals to screening options, primary care providers, specialists, counseling services and an array of other resources. Not only would this increase the number of people who can be screened in a timely manner, it would help alleviate the patient backlog experienced by private and public health systems throughout the state. We would also see a more comprehensive approach to tracking CRC-specific data such as family history and survivorship within our rural and urban communities.

With LCCRT's extensive network, much of the infrastructure needed to execute this service is already in place. Our partners have extensive expertise in addressing colorectal cancer through patient navigation, so any funding from the state would only solidify the program's sustainability.

CONCLUSION

Colorectal cancer is a serious, but conquerable disease for millions of people. With incidence, mortality, and late-stage diagnosis rates far above the national average, Louisiana must take action now to avoid further loss of its citizens and livelihood. With champions in every corner of our state at the forefronts of medicine, research, advocacy and engagement, LCCRT finds itself in a prime position to help alleviate the emotional and economic burden inflicted by colorectal cancer. And, even as the Roundtable continues to produce victories, its full potential cannot be realized without the support of the Louisiana Legislature. Thank you.

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APPENDIX A: Colorectal Cancer Mortality Data

Table 3: Annual mortality rates and counts by parish in Louisiana, 2011-2015 per 100,000 people. (Age-adjusted rates).

Mortality from CRC, 2011-2015	Mortality Rate	Average Annual Death Count
Louisiana Registry	17.5	874
Acadia Parish	22.9	16
Allen Parish	26.9	7
Ascension Parish	15.1	15
Assumption Parish	17.2	5
Avoyelles Parish	24.2	12
Beauregard Parish	15.2	6
Bienville Parish	^	2
Bossier Parish	15.5	19
Caddo Parish	17.7	52
Calcasieu Parish	17.8	39
Caldwell Parish	^	*
Cameron Parish	^	*
Catahou Parish	^	2
Ciborne Parish	18.3	4
Concordia Parish	18.4	4
De Soto Parish	18	6
East Baton Rouge Parish	16.2	71
East Carroll Parish	^	2
East Feliciana Parish	21.5	5
Evangeline Parish	29	11
Franklin Parish	15.2	4
Grant Parish	26.7	6
Iberia Parish	19.9	15
Iberville Parish	23.5	9
Jackson Parish	17.8	4
Jefferson Parish	15.5	81
Jefferson Davis Parish	22.9	9
Lafayette Parish	16.6	37
Lafourche Parish	19	20
La Salle Parish	^	2
Lincoln Parish	16.6	7
Livingston Parish	15.7	20
Madison Parish	^	2
Morehouse Parish	16.4	6
Natchitoches Parish	24.2	11
Orleans Parish	16.1	61
Ouachita Parish	17.5	29
Plaquemines Parish	17.8	4
Pointe Coupee Parish	17.1	5
Rapides Parish	15.4	23
Red River Parish	^	3
Richnd Parish	19.1	4
Sabine Parish	23	8
St. Bernard Parish	16	6
St. Charles Parish	18.3	9
St. Helena Parish	^	3
St. James Parish	19.2	5
St. John the Baptist Parish	15.6	8
St. Landry Parish	23.1	22
St. Martin Parish	19.3	11
St. Mary Parish	21	13
St. Tammany Parish	14.2	38
Tangipahoa Parish	18	23
Tensas Parish	^	*
Terrebonne Parish	23.6	27
Union Parish	23.7	7
Vermilion Parish	18.4	12
Vernon Parish	13.9	6
Washington Parish	19.9	11
Webster Parish	14.7	8
West Baton Rouge Parish	14.3	4
West Carroll Parish	22.6	3
West Feliciana Parish	^	2
Winn Parish	24.5	4

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.

The Normal Digestive System

The colon and rectum are parts of the digestive system, which is also called the gastrointestinal (GI) system. (See Figure 5). 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.

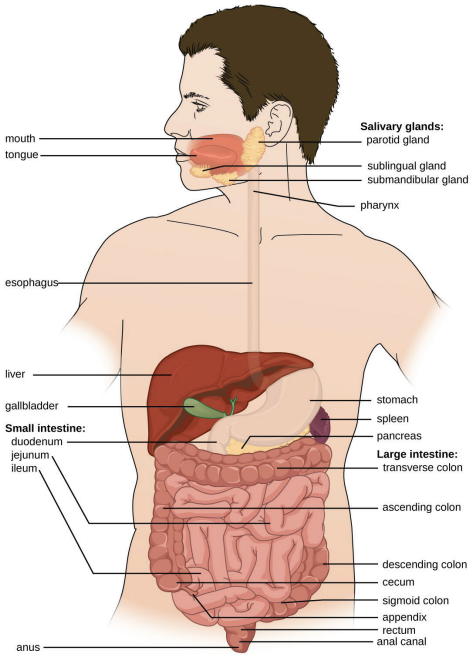

Figure 5: Anatomical digestive model

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 polyp 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 a benign, non-cancerous tumor. Some polyps can change into cancer but not all do. The chance of changing into a cancer depends on the kind of 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 precancerous 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 sign of 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 inner 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 itis 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.

APPENDIX C: CRC Screening Options

Considerations When Deciding with Your Doctor Which Test Is Right for You

	Benefits	Performance & Complexity*	Limitations	Test Time Interval
Visual Examinations				
Colonoscopy	• Examines entire colon • Can biopsy and remove polyps • Can diagnose other diseases • Required for abnormal results from all other tests	**Performance:** Highest **Complexity:** Highest	• Full bowel cleansing • Can be expensive • Sedation usually needed, necessitating a chaperone to return home • Patient may miss a day of work. • Highest risk of bowel tears or infections compared with other tests	10 years
Computed tomographic colonography (CTC)	• Examines entire colon • Fairly quick • Few complications • No sedation needed • Noninvasive	**Performance:** High (for large polyps) **Complexity:** Intermediate	• Full bowel cleansing • Cannot remove polyps or perform biopsies • Exposure to low-dose radiation • Colonoscopy necessary if positive • Not covered by all insurance plans	5 years
Double-contrast barium enema	• Can usually view entire colon • Few complications • No sedation needed	**Performance:** High (for large polyps) **Complexity:** High	• Full bowel cleansing • Some false-positive test results • Cannot remove polyps or perform biopsies • Exposure to low-dose radiation • Colonoscopy necessary if abnormalities are detected • Very limited availability	5 years
Flexible sigmoidoscopy	• Fairly quick • Few complications • Minimal bowel preparation • Does not require sedation or a specialist	**Performance:** High for rectum & lower one-third of the colon **Complexity:** Intermediate	• Partial bowel cleansing • Views only one-third of colon • Cannot remove large polyps • Small risk of infection or bowel tear • Slightly more effective when combined with annual fecal occult blood testing • Colonoscopy necessary if positive • Limited availability	5 years
Stool Tests (Low-sensitivity stool tests, such as single-sample FOBT done in the doctor's office or toilet bowl tests are not recommended.)				
Fecal immuno-chemical test (FIT)	• No bowel cleansing or sedation • Performed at home • Low cost • Noninvasive	**Performance:** Intermediate for cancer **Complexity:** Low	• Requires multiple stool samples • Will miss most polyps • May produce false-positive test results • Slightly more effective when combined with a flexible sigmoidoscopy every five years • Colonoscopy necessary if positive	Annual
High-sensitivity guaiac-based fecal occult blood test (gFOBT)	• No bowel cleansing • Performed at home • Low cost • Noninvasive	**Performance:** Intermediate for cancer **Complexity:** Low	• Requires multiple stool samples • Will miss most polyps • May produce false-positive test results • Pre-test dietary limitations • Slightly more effective when combined with a flexible sigmoidoscopy every five years • Colonoscopy necessary if positive	Annual
FIT-DNA test (Cologuard®)	• No bowel cleansing • Can be performed at home • Requires only a single stool sample • Noninvasive	**Performance:** Intermediate for cancer **Complexity:** Low	• Will miss most polyps • More false-positive results than other tests • Higher cost than gFOBT and FIT • Colonoscopy necessary if positive	3 years, per manufacturer's recommendation

*Complexity involves patient preparation, inconvenience, facilities and equipment needed, and patient discomfort.

APPENDIX D: LCCRT Membership