



ScreenNJ – Progress and Prospects:
Summary of Proceedings from May 23, 2018
Colorectal and Lung Cancer Screening Symposium

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ScreenNJ is a collaborative project of organizations across the state committed to reducing cancer incidence and mortality through an effective cancer prevention and screening program. Lung cancer and colorectal cancer are among the most prevalent in New Jersey. In order to help improve the health of New Jersey’s residents, the initial focus of ScreenNJ is on lung cancer and colorectal cancer. These cancers have better outcomes if detected early through proven screening methods such as low dose computerized tomography (CT) scans for lung cancer and colonoscopy for colorectal cancer. Under the leadership of Rutgers Cancer Institute of New Jersey and working in partnership with the New Jersey Department of Health, primary care providers and a number of organizations throughout the State, the goal of ScreenNJ is to increase screening for lung and colorectal cancer, to reduce cancer mortality rates and to educate New Jersey residents about the importance of cancer screening, early detection, and prevention. ScreenNJ was launched in 2017 and is funded in part by the State.

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Executive Summary

Under the leadership of Rutgers Cancer Institute of New Jersey and working in partnership with the New Jersey Department of Health, ScreenNJ, launched in 2017. Funded in part by the State of New Jersey, ScreenNJ is a collaborative project of organizations across the state committed to reducing cancer incidence and mortality through an effective cancer education, prevention, and screening program.

New Jersey is ranked in the top ten nationally for cancer incidence. Lung cancer and colorectal cancer are among the most prevalent in New Jersey, thus the initial focus of ScreenNJ is on lung cancer and colorectal cancer. These cancers have better outcomes if detected early through proven screening methods such as low dose computerized tomography (CT) scans for lung cancer and colonoscopy for colorectal cancer.

On May 23, 2018, health care providers, community members, and researchers from across the state came together at the ‘Conference for Change’ event, hosted by the New Jersey Primary Care Association and sponsored by ScreenNJ, to reflect on the progress and prospects following year 1 of the ScreenNJ project. Conference speakers and participants contributed their expertise and discussed comprehensive strategies to increase screening rates as well as promising practices in the field. Key recommendations from the conference included:

- Launching public awareness and education campaigns across the state on the importance of screening through aggressive marketing and a multitude of venues
- Encouraging ScreenNJ to implement recommendations for clinical support tools for inclusion in electronic medical records
- Focusing on the critical role of patient navigators and education in boosting screening efforts.
- Monitoring and targeting screening efforts to vulnerable populations (i.e., uninsured, Medicaid) as well as younger adults, as incidence rates for colorectal cancer among adults under age 50 have increased.
- Linking smoking cessation efforts with simplified steps to improved lung cancer screening.
- Continuing the program and expanding it statewide as funding allows.

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Summary of Proceedings from May 23, 2018 Colorectal and Lung Cancer Screening Symposium

On May 23, 2018, in collaboration with the New Jersey Primary Care Association and the Rutgers Cancer Institute of New Jersey, ScreenNJ convened a symposium with stakeholders throughout the state – including clinicians, health care leaders, representatives from community organizations, public health practitioners, and researchers – to assess and review progress toward its goal of increasing awareness and education about the importance of screening for colorectal and lung cancer among New Jerseyans. Specific focus in its inaugural year on these cancers – two of the most common and most deadly – has generated significant insight into effective strategies for increasing screening rates as well as potential barriers to recommended screening implementation. Working with providers in counties throughout the state, there have been considerable successes in adopting practice changes that have led to early detection and treatment of these cancers. Continuing to foster and spread these promising practices while supporting research to help identify additional opportunities for improvement will help further advance progress toward colorectal and lung screening goals. This white paper provides an overview and highlights from discussions at the symposium, as well as recommendations for moving forward.

Colorectal and Lung Cancer: Two of New Jersey’s Most Common and Deadly Cancers

New Jersey is among the “top ten” states for overall cancer incidence,¹ and more than 16,000 New Jerseyans are lost to cancer each year (for all types of cancer combined).² ScreenNJ, a collaborative led by the Rutgers Cancer Institute of New Jersey in collaboration with the New Jersey Department of Health, is spearheading efforts to increase early detection and treatment of lung and colorectal cancers to help reduce this burden on our state.

According to the New Jersey State Cancer Registry, in 2015 (the most recent available), lung and colorectal cancers were the second and third most common cancers in New Jersey, just behind

Figure 1: New Jersey State Cancer Registry Data Brief: Ten Most Common Cancers in 2015

Table 1. Ten Most Common Types of Cancer Incidence among New Jersey Females, 2015*

Rank	Cancer Site	Rate [^]	Count
	All Sites	452.6	25,922
1	Breast	134.8	7,582
2	Lung and Bronchus	51.2	3,081
3	Colon and Rectum	34.4	2,026
4	Corpus and Uterus, NOS	31.3	1,893
5	Thyroid	27.7	1,355
6	Non-Hodgkin Lymphoma	18.5	1,069
7	Melanoma of the Skin	18.1	1,008
8	Pancreas	12.5	761
9	Ovary	12.2	698
10	Urinary Bladder	10.7	659

Table 2. Ten Most Common Types of Cancer Incidence among New Jersey Males, 2015*

Rank	Cancer Site	Rate [^]	Count
	All Sites	521.5	25,095
1	Prostate	127.2	6,527
2	Lung and Bronchus	61.0	2,846
3	Colon and Rectum	47.9	2,280
4	Urinary Bladder	40.8	1,881
5	Melanoma of the Skin	28.2	1,341
6	Non-Hodgkin Lymphoma	26.8	1,230
7	Kidney and Renal Pelvis	22.4	1,078
8	Leukemia	19.8	903
9	Oral Cavity and Pharynx	16.0	808
10	Pancreas	15.7	734

Source: New Jersey State Cancer Registry December 2017 file, New Jersey Department of Health. [^]Rates are per 100,000 and age-adjusted to the 2000 US population standard. *2015 data are preliminary. Non-melanoma skin cancers are not included.

breast cancer for females and prostate cancer for males (see Figure 1). Lung and colorectal cancers accounted for 20% of the more than 50,000 new cancer cases reported in 2015 (with 11.6% of cases being lung cancer and 8.4% being colorectal cancer).³ Moreover, among cancers affecting both men and women, they are the top cancer killers, with lung cancer being the leading cause and colorectal cancer the second leading cause of cancer deaths.⁴

Fortunately, early detection through screening can lead to dramatic improvements in survival rates (with 92% five-year survival rates for colorectal cancer and between 68-92% five-year survival rates for non-small cell lung cancer cases discovered in Stage I).⁵ Unfortunately, population level screening rates are suboptimal, with just 67% of adults in the nation (65% in New Jersey) being up-to-date on colorectal cancer screening and only 4% of those eligible for lung cancer screening receiving it.^{6,7}

Why Focus on Colorectal and Lung Cancer Screening?

Mary O'Dowd, MPH, Executive Director of Health Systems and Population Health Integration for Rutgers Biomedical and Health Sciences and Internal Advisory Board Member at the Rutgers Cancer Institute of New Jersey, opened the symposium by discussing rationale for ScreenNJ's initial focus on colorectal and lung cancer:

1. Both are among the most common and deadly cancers within the state;
2. Screening is effective for both, with improved outcomes though methods such as low-dose computerized tomography (CT) scans for lung cancer and colonoscopy and fecal immunochemical tests (FIT) for colorectal cancer;
3. There are evidence-based screening recommendations;
4. Screening is underutilized; and
5. Screening is covered by most health insurance plans.

About ScreenNJ

Under the leadership of the Rutgers Cancer Institute of New Jersey, ScreenNJ is a collaboration of healthcare, academic and community organizations working to reduce cancer mortality rates through effective cancer education, prevention and screening.

In collaboration with the New Jersey Department of Health and key partners throughout the state, ScreenNJ has supported efforts and launched campaigns over the last year to emphasize the importance of screening, early detection and prevention for colorectal and lung cancer.

The ultimate goal of ScreenNJ is to help improve cancer outcomes through early detection and treatment.

2018 ScreenNJ Partners:*

Rutgers Cancer Institute of New Jersey
American Cancer Society, NJ
Hackensack Meridian Health
Ocean Medical Center
MD Anderson at Cooper
New Jersey Department of Health
New Jersey Primary Care Association
Ocean Health Initiatives, Inc.
Project H.O.P.E.
Rutgers Health
Rutgers University
RWJBarnabas Health
Center for Asian Health
Saint Barnabas Medical Center
University Hospital
Zufall Health Center

*Additional partners are being added continually

Just the Basics: Screening Guidelines for Colorectal and Lung Cancer

There are a range of methods available for **colorectal cancer screening**, as recommended by the U.S. Preventive Services Task Force:

- Colonoscopy (recommended every ten years) which may also be used to follow up on abnormalities found in other tests, including:
- Fecal Immunochemical Tests (FIT) (every year),
- Flexible Sigmoidoscopy (every five years),
- Fecal Occult Blood Test (every year),
- Stool DNA Tests (every one or three years as suggested by the manufacturer),
- CT colonography or virtual colonoscopy (every five years), and
- Flexible Sigmoidoscopy (every ten years) plus FIT (every year).

The Multi Society Task Force’s 2017 guidelines “tiers” these colorectal screening tests, with Tier 1 (being most preferred or what they term the “cornerstone” tests) including Colonoscopy (every ten years) and FIT testing (annually), with a sequential approach of colonoscopy offered first and FIT offered to patients who decline colonoscopy. Experts generally recommend people at average risk for colorectal cancer get screened at regular

intervals starting at age 50* and continuing through age 75. Between age 75 and 86, screening determinations are made based on life expectancy, health status, comorbid conditions and prior results. Routine screening after age 86 is not generally recommended. In addition, patients at increased risk for colorectal cancer may be advised to start screening before age 50, as well as recommended for more frequent screening.^{8,9}

*Within a week of the ScreenNJ conference, the American Cancer Society issued updated screening recommendations for average-risk adults age 45 years and older to undergo regular screening with either a high-sensitivity stool-based tests (i.e., FIT, FOBT, stool DNA test) or visual (structural) exams (i.e., colonoscopy, CT colonography, flexible sigmoidoscopy), based on personal preferences and test availability.¹⁰

For **lung cancer screening**, the U.S. Preventive Services Task Force recommends an annual low-dose Computerized Tomography (CT) Scan for people between the ages of 55 and 80 who have a smoking history of 30 or more "pack-years," which is calculated by multiplying the number of years smoked by the number of packs smoked per day. For example, one pack a day for 30 years equals 30 pack years. Research shows that screening is beneficial for both current and former smokers. Former smokers who meet the above age and pack-year criteria and who quit smoking within the past 15 years are still at increased lung cancer risk and should be screened. People should be tested for as long as they meet the screening requirements, unless they develop a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery.¹¹

Meeting the Challenge: What the Data Say about Colorectal and Lung Cancer in New Jersey

The first panel at the symposium highlighted challenges related to combating lung and colorectal cancer by reviewing overall data and trends over time. While incidence for both cancers have decreased over time, racial/ethnic disparities persist and more New Jerseyans are being diagnosed with colorectal cancer at a younger age. In addition, screening for both cancers is underutilized, especially among the most vulnerable populations

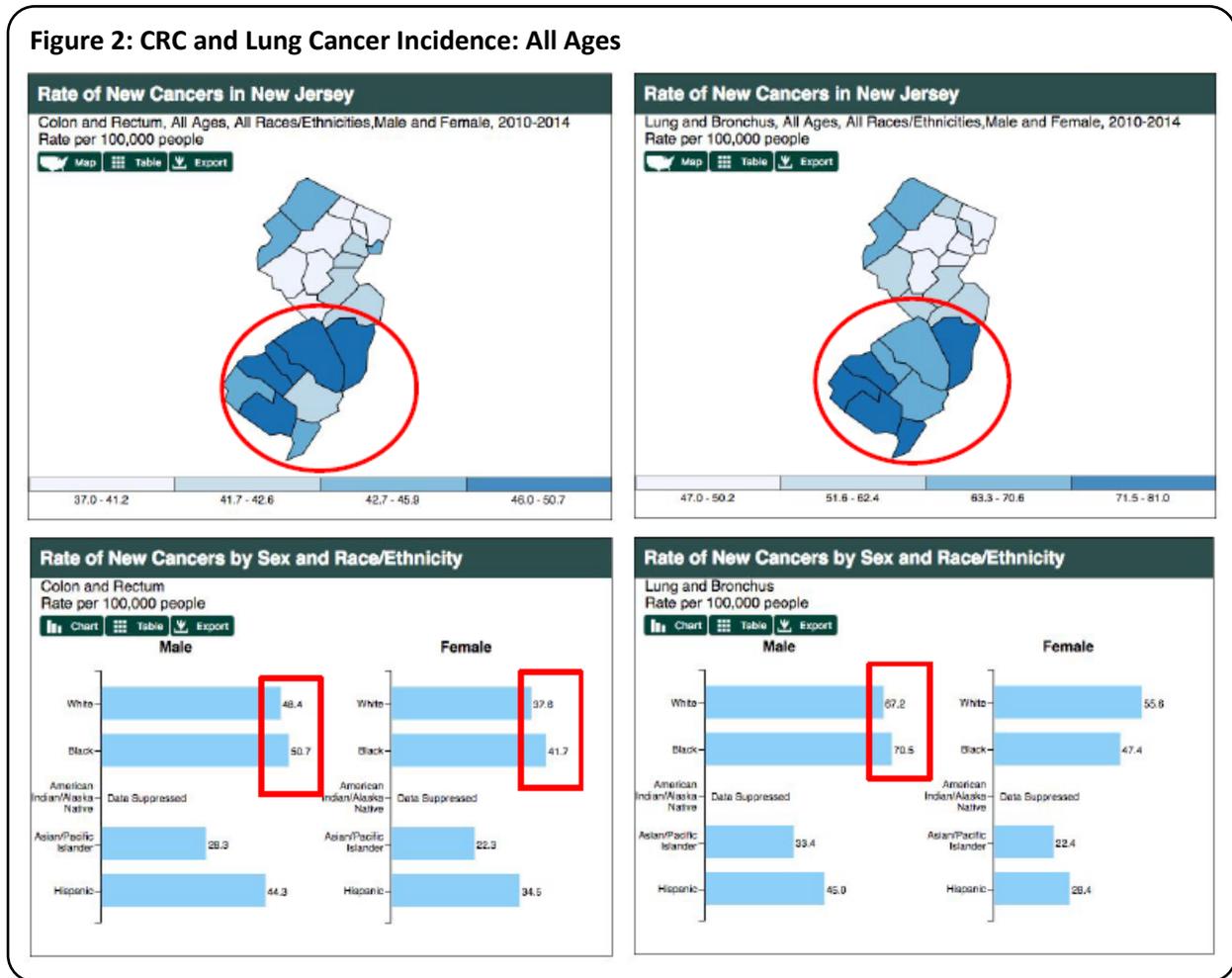
Statewide Burden of Colorectal and Lung Cancers: Deaths, Late-Stage Diagnosis and Screening

Antoinette (Nan) Stroup, PhD, Director of the New Jersey State Cancer Registry and Associate Professor at the Rutgers School of Public Health, reviewed the overall trends for both cancers. Both colorectal and lung cancer incidence has decreased in New Jersey, with colorectal cancer incidence declining for both men and women since 1998 and lung cancer incidence declining for men since 1991 and for women since 2007.

Despite these declines, colorectal and lung cancer still take a tremendous toll on New Jerseyans, accounting for more than 5,000 deaths annually. Further, disparities across subgroups are notable in the following categories:

- **Geography:** After adjusting for age, the rate of new colorectal and lung cancers are highest among residents in the southern part of New Jersey (see Figure 2).
- **Race/ethnicity:** Blacks have a higher incidence of colorectal cancer (see Figure 2) and Non-Hispanic Blacks have fewer cases of lung cancer diagnosed at earlier stages.
- **Insurance status:** Among those without health insurance and those covered through Medicaid, Stroup noted both cancers are detected at later stages when survival chances are at their lowest.

Figure 2: CRC and Lung Cancer Incidence: All Ages



Despite overall reduced rates of colorectal cancer over time, there is a concerning trend that more individuals are being diagnosed with colorectal cancer at a younger age. According to an analysis of New Jersey State Cancer Registry data, there has been a subtle yet significant steady increase in colorectal cancer incidence for non-elderly adult (20-49 years) men (+1.16% per year)

and women (+1.46% per year) over the past two decades.¹² Stroup noted that colorectal cancer is a “significant” problem among millennials and that further discussion was warranted around screening this group. Interestingly, shortly after the symposium, the American Cancer Society revised its recommendations to begin screening earlier – at age 45 rather than age 50 for adults considered to be at average risk.¹³

In summarizing follow-up discussion, **Susan Goodin**, PharmD, FCCP, BCOP, Executive Director of Statewide Affairs at the Rutgers Cancer Institute of New Jersey,* mentioned that adhering so closely to existing practice guidelines can lead providers to sometimes overlook cancer risks for younger patients who present with symptoms.

*Subsequent to the compilation of this report, Dr. Goodin resigned from Rutgers Cancer Institute of New Jersey.

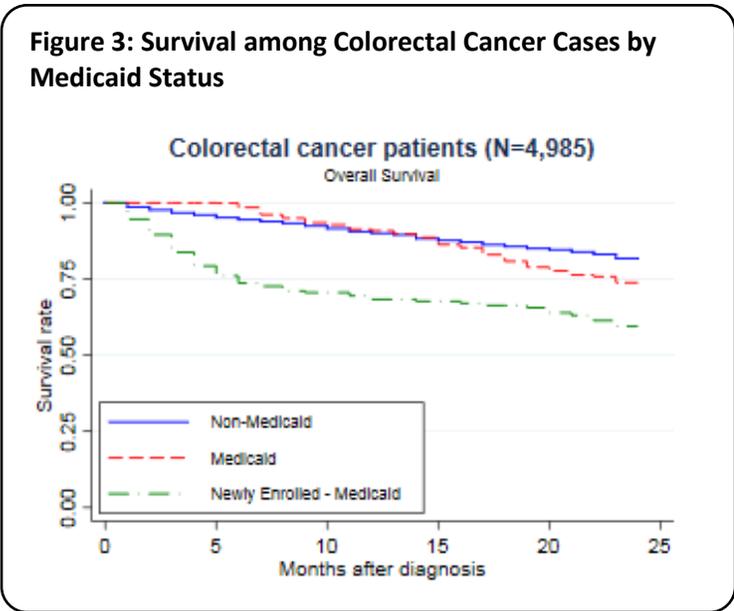
Patterns of Screening among Colorectal Cancer Patients in the New Jersey Medicaid Program

Jennifer Tsui, PhD, MPH, Assistant Professor at Rutgers Cancer Institute of New Jersey and the Rutgers School of Public Health, presented work done in collaboration with Rutgers Center for State Health Policy that examined screening patterns among Medicaid enrollees diagnosed with colorectal cancer.

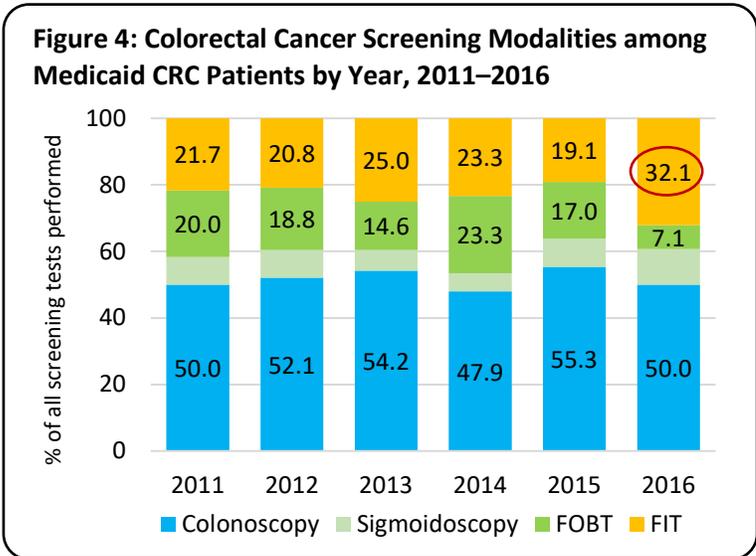
Based on Behavioral Risk Factor Surveillance System data for New Jersey, screening rates are lower among the uninsured, with only between 36-41% of NJ’s uninsured patients getting colorectal cancer screening over a five-year period (2012-2016), compared to rates between 66-67% among those with health insurance.

In addition, individuals covered through Medicaid are more likely to be diagnosed with colorectal cancer at a later stage, with 11.5% of Medicaid patients diagnosed at Stage IV compared to just 6.5% of non-Medicaid patients diagnosed at Stage IV. In addition, a larger proportion of Medicaid patients are being diagnosed with colorectal cancer at a younger age compared to their non-Medicaid counterparts. Over time, further study could focus on screening patterns among the entire Medicaid population – not just for colorectal cancer, but for lung cancer as well.

There are also differences among those newly-enrolled in Medicaid (enrolled recently or upon being diagnosed with cancer) compared to those continuously covered by Medicaid. Patients who have been more recently enrolled have lower colorectal cancer survival rates compared to patients who have been enrolled in Medicaid over a longer period of time and patients with other types of insurance (Figure 3). Recent enrollees are also less likely to get colorectal cancer screening.



Examining colorectal screening modalities over time among individuals enrolled in Medicaid showed that while the proportion screened through colonoscopy remained relatively constant at roughly 50%, there was an increasing trend in FIT testing, rising from 22% of screens in 2011 to 32% in 2016 (see Figure 4). Further discussion around the implications of this shift followed throughout the day (see page 13).

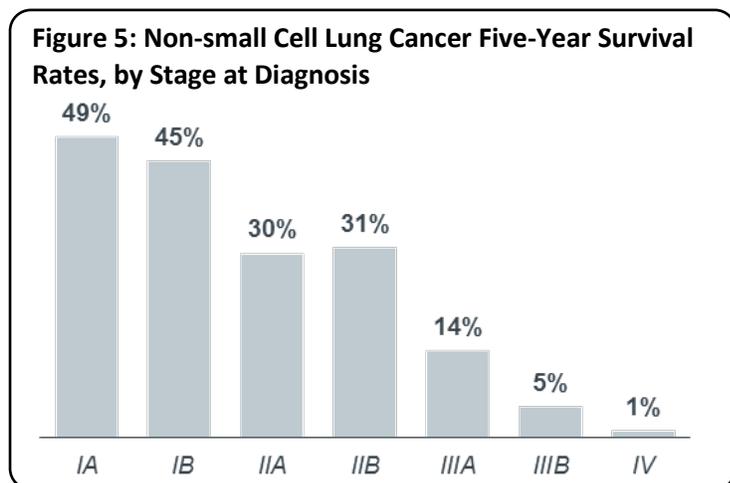


Linking Lung Cancer Screening and Tobacco Dependence Treatment

Michael Steinberg, MD, MPH, Professor and Chief in the Division of Internal Medicine and Vice Chair for Research at Rutgers Robert Wood Johnson Medical School and Director of the Rutgers Tobacco Dependence Program, focused on lung cancer screening.

Dr. Steinberg emphasized that with up to 90% of lung cancer cases being related to tobacco use – one of the strongest exposure/disease linkages – the need to pair screening with smoking

cessation is paramount. Even quitting at age 50 significantly reduces risks, Steinberg noted, reiterating that patients and providers need to know “It’s never too late.”



While lung cancer is often viewed “pessimistically,” early detection is key, with survival rates considerably higher when cancer is found earlier through screening (see Figure 5).

The 2011 National Lung Screening Trial of over 50,000 heavy smokers found that those screened through low-dose CT scans had a 20% lower risk of death.¹⁴ The U.S. Preventive

Services Task Force now recommends annual screening for lung cancer with low-dose computed tomography (LDCT) in adults aged 55 to 80 years who have a 30 pack-year smoking history and currently smoke or have quit within the past 15 years.

Because screening recommendations for lung cancer are newer (with the American College of Chest Physicians just updating their own recommendations in 2017) and require the identification of high-risk (smoking history/status), which is not the case for the screening recommendations for other cancer sites (breast, cervical, colorectal), Steinberg pointed to the need for more provider education, along with automatic ways to target patients who are candidates for screening through an easy prompt in the EMR. He highlighted development of a clinical decision support tool within Rutgers Health Group utilizing EMR technology to identify eligible patients and prompt clinicians to order the low-dose CT. Further, he indicated that the process should be as simple as: counsel to quit and click to order (the CT scan).

Word on the Street: How Community Health Centers Are Working to Increase Screening Rates

The second panel at the symposium focused on work within health systems. Providers helped to shed further light on the data trends by reviewing successes and challenges they face in their daily work to increase screening and prevention efforts within their systems.

Increasing Colorectal and Lung Cancer Screening at Zufall Health Center

Rina Ramirez, MD, Chief Medical Officer for Zufall Health Center, discussed how Zufall, serving over 37,000 patients across six counties in New Jersey, has worked to increase its screening rates for both colorectal and lung cancer.

Zufall serves some of the poorest residents in New Jersey. In addition to 23 centers, it brings care to many of its clients through medical and dental vans. Transportation is a big issue for many of those they serve. Ramirez noted how the Affordable Care Act (ACA) has cut the rate of their uninsured clients, which used to be about 90%, to less than 50% uninsured. They are currently focused on improving 16 measures, including those related to colorectal cancer, where their own screening rates have jumped from 40% to 63%. How did they achieve this improvement? Through “a lot of work!” Ramirez says. They adopted a “whole team” approach to change – educating clinicians and reviewing guidelines, and involving patients, for many of whom, Ramirez noted, “screens are the last thing they think about.” They work to make the patients feel at home through a one-stop-shopping approach, offering translation services and FIT tests at every and any visit. Dedicated patient navigators were key to their success; according to Ramirez, “when we got navigators, our rates went from 40% to 56%.”

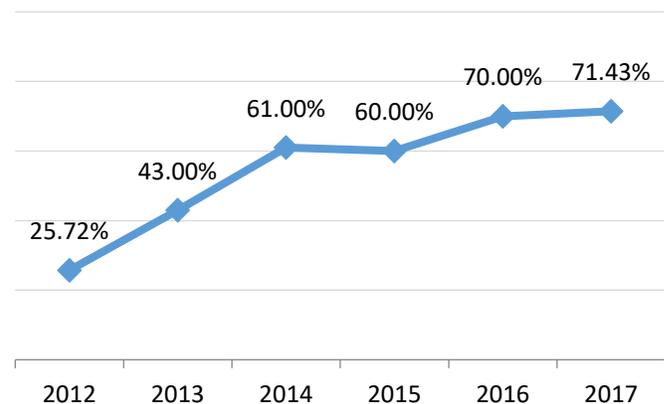
Zufall has also worked on lung cancer and tobacco cessation through counseling and motivational interviewing. At Zufall, Ramirez explained, “the most important factor driving their own improvement was the patient. Seeing the late stage cases was so disheartening that it makes us want to do better on the *first* visit.” The rate of screening with low dose CTs has also improved from 13% to 19%. As with colorectal cancer efforts, involving and educating staff about the importance of this screening increased results. Ramirez noted, “how critical it is to make patient identification easier through EMRs and other tools. We had 200 former smokers, but couldn’t tell who would fit into the criteria.”

Colorectal Screening in North Hudson Community Action Corporation

Flordeliz Panem, MD, Chief Medical Officer at North Hudson Community Action Corporation (the largest FQHC in New Jersey, with more than 70,000 patients), discussed the challenges faced in working to boost colorectal cancer screening. According to Panem, key challenges include a reluctance to do the test and lack of health insurance.

Like Ramirez, Panem emphasized the importance of training and educating all staff to get buy in on screening improvements. North Hudson makes FIT kits accessible in clinical areas to make it easy for patients to submit specimens at appointment times. Two administrative steps also helped to increase rates: first, ensuring that tests are separated into individual, standing orders; and second, making sure that results from both FIT tests and colonoscopies are available in separate retrievable fields so that information can be easily accessed. Medical assistants transitioned to become navigators to help coordinate follow-up appointments and reminders, with some specifically dedicated to colorectal screening.

Figure 6: North Hudson CRC Screening Rates



Interestingly, Panem spoke of the need to leverage friendly natural competition among staff, sharing regular comparative data to help foster and engage that competitive spirit. How has all this worked? Over a six-year period, screening rates nearly tripled – rising from 26% to 71% (see Figure 6). An ongoing challenge is that, with a sizeable share of patients lacking health insurance, the cost of testing represents a barrier to

screening. There are also issues with colonoscopy results not being received from specialists, requiring additional staff time for patient coordination to gain access to records necessary for patient follow-up.

Lessons from Campus Cessation and Screening Initiatives

Andy Berman, MD, Division Director Division of Pulmonary and Critical Care Medicine/Allergy, Rutgers New Jersey Medical School, shared his observations on coming to New Jersey after training and practicing in New York. He was surprised at the number of patients smoking outside of hospital front doors, even some while “waiting to be called by the ER.” He was also surprised by the number of abnormal chest CTs and the number of advanced cases of lung cancer he found, with most presenting at stage four.

These observations pushed him into action to try to create a smoke-free campus in Newark. He began to understand the various stakeholders, engage them, and work to respond to their needs. For example, the unions were concerned with smokers’ rights. He surveyed employees to better understand their feelings and concerns to help ensure the success of the initiative. There were also security concerns with state laws related to entrances. They had to develop a script to help staff members feel comfortable telling people not to smoke near the entrance. Berman also worked with others to establish several tobacco cessation initiatives.

He describes these programs as efforts for an “addicted group of people” who often feel persecuted. He got buy-in from a number of University Hospital sectors to join causes. With help, they established a lung cancer screening program, including a patient navigator. The program, now in operation for 18 months, has had over 450 referrals, both finding and treating cancer cases in earlier stages. He spoke of the importance of reaching out to communities that have the highest rates of New Jersey’s lung cancer incidence maps to engage high-risk individuals in

counseling and early screening efforts. Berman also spoke of the importance of engaging leaders by effectively presenting the economic case for early detection of cancer.

Several points followed in the panel’s discussion of strategies for reaching the unscreened:

- Practitioners indicated that having a point person for the various screening improvement initiatives works best. In Ocean Health, for example, they have seen a difference when a single person is dedicated to enforcing a particular screening policy. Even with a point person, providers spoke of the importance of cross-training staff (including nurse practitioners and physician assistants) and widespread staff education on screening recommendations.
- Some discussed the importance of including patient education at every visit. Others spoke of the need to get frontline workers armed with the research in easy-to-understand language to better present the case for screening to the patient community. Practitioners also talked about the importance of getting the conversation and questions started with tools like t-shirts and pins (some even featuring the poop emoji!).
- Practitioners commented on the importance of engaging communities through culture and language, using a range of tools. Some mentioned successes, such as efforts to reach Asian Americans online through modes like “WeChat” (a social media app that covers a full range of functions – from booking doctors’ appointments to hailing cabs and sending money).¹⁵ Others emphasized the need for more “boots on the ground” and increased use of community health workers who outreach to the community and return to the office with key information about opportunities for prevention and follow-up.
- Some stressed meeting patients at their need and then using that opportunity to shift to screening. For example, one Camden provider spoke of first addressing acute needs for opioid-related services, and then, later, using that patient-contact opportunity to shift to discussions about cancer screening.
- There were several suggestions to borrow and adapt colorectal cancer screening strategies to lung cancer screening, perhaps even developing a tool kit for widespread distribution.
- The group also discussed the importance of aligning payments with screening performance and ensuring processes are in place not just to screen, but provide adequate follow-up from screening results.

Keeping Up with the Joneses: What Can New Jersey Learn from Experience in Other States and Our Own Experience in Understanding Cancer Prevention and Treatment?

The final panel focused on other states’ success stories to boost screening and cancer prevention in the State of Delaware and City of New York. Additionally, a review of recent studies from New

Jersey-based researchers focused on the importance of considering a range of contextual factors in developing future screening initiatives.

Saving Lives in Delaware: A Focus on Cancer Screening

First, **Karyl Rattay**, MD MS, Director, Division of Public Health in Delaware's Department of Health and Social Services, shared Delaware's experience in working to improve the state's cancer incidence with a focus on racial/ethnic disparities.

Rattay credits much of the work to effective partnerships, with a cancer consortium, involving hospitals, FQHCs, nonprofits, government agencies and legislators, a key ingredient to the state's success. While Delaware has the advantage of small size, its cancer statistics were worse than New Jersey's, ranking second in the nation in mortality – 10% above the national average, with colorectal mortality 40% higher among African Americans than Caucasians.

In 1997, Delaware began its "Screening for Life" program. The state committed a significant portion of tobacco settlement funds to cancer prevention and control. A landmark program in Delaware also covers cancer treatment services for the uninsured and underinsured up to 24 months after diagnosis. Rattay underscored the importance of including access to treatment in state cancer control efforts.

One thing Delaware launched was a "bucket list" campaign. Working with their Division of Motor Vehicles, they sent 50th birthday cards to everyone in the state reminding them of the linkages between colorectal screening and being able to achieve all the items on their bucket lists.

Rattay credits patients who became community health workers acting as champions and community advocates for the effort. Nurse navigators also followed patients until they were linked with cancer care coordinators.

As a result, at least in part through these efforts, Delaware's incidence and mortality dropped, including colorectal cancer mortality reductions of 45% among African American males and 52% among African American females. "You *can* move the needle on colorectal numbers," Rattay assured. Delaware's mortality rates are significantly lower, and the state shifted from ranking 2nd to ranking 18th among states in cancer mortality.

In terms of lung cancer, Delaware launched a comprehensive campaign in 2014. Rattay echoed Steinberg's emphasis on linking screening efforts with tobacco cessation. Reminders in the form of wall posters and prescription pads were implemented, but the ultimate goal is using payments to incentivize change within practices.

One powerful tool Delaware pursued throughout these efforts was showing legislators customized figures of what cancer statistics actually looked like in their districts to help drive changes in policy and practice.

Colorectal Cancer Prevention in New York City

Jim DiLorenzo, MD, Managing Physician at New York Associates of Gastroenterology at Montefiore Medical Center, discussed New York City’s experience to boost colorectal screening rates city-wide. They started with a baseline of 41.7% and have been closer to 70% since 2011.

DiLorenzo spoke of the importance of gathering and utilizing cancer assets in the community in a meaningful way. He believes that “pushing colonoscopy for people at large” has an impact on death rates (see Figures 7 and 8), with some reduction in mortality possibly attributable to increased screening over the time period.

The New York initiative worked on a variety of targeted culturally appropriate messages, including those that addressed Chinese, Russian, and Latino/Hispanic populations. According to DiLorenzo, who examined racial differences year after year, with “timely colonoscopy, racial differences disappear over time.”

DiLorenzo spoke of the importance of relying on colonoscopy, what he described as “the best screening modality,” rather than the FIT test, which he noted is appearing to become the “screening of choice.” He emphasized that a FIT test needs to be done every year for ten years to approach the power of colonoscopy. Moreover, colonoscopy is the only test that enables removing pre-cancerous polyps – in other words, the only test effective in reducing cancer.

Figure 7: Prevalence of Timely Colonoscopy among NYC Adults Ages 50+ Years, 2003–2016

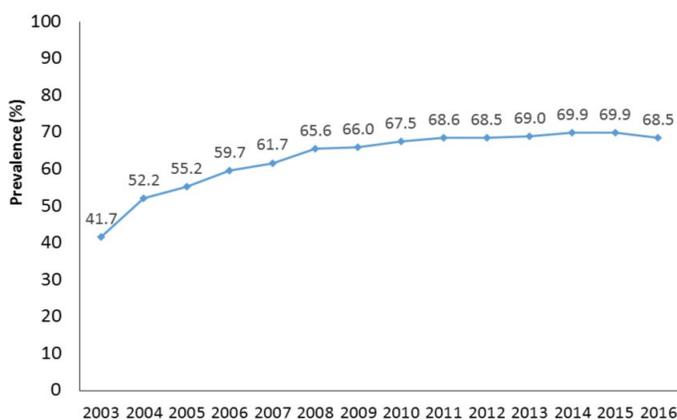
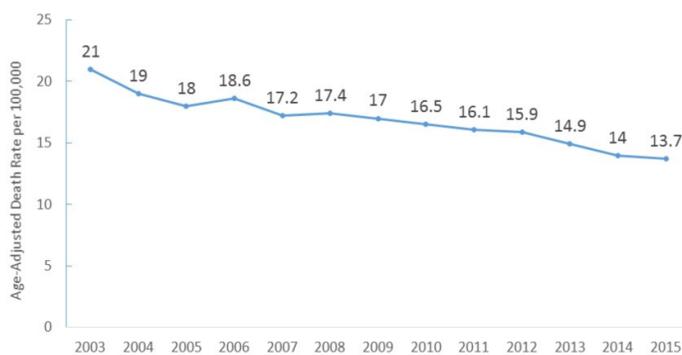


Figure 8: Age-Adjusted Death Rate per 100,000 Population from Colorectal Cancer in NYC, 2003–2015



Having said that, DiLorenzo cautioned, “The most important test is the one that gets done.” Recognizing that colonoscopy isn’t always available or achievable (often people do not have the opportunity to take time from work for an extended procedure), *“any test is better than no test.”*

The bottom line is that colonoscopy is appropriately the gold standard, but since not everyone is able to get a colonoscopy, they should get the test that they can get done, with appropriate follow-up as necessary. DiLorenzo capped the discussion simply with, “Let’s make the right recommendation, but let’s get the test that will get done.”

In examining their own data, the New York initiative noted the important role of a primary care physician, with screening prevalence only 38% among those without a primary care physician compared to 71% for those with a primary care physician. New York City’s rates mirror New Jersey’s, with some 40% of those without insurance (and likely no usual source of care) getting colorectal screening, compared to some 70% of those with insurance.

A New York “Community Cares” project helps link those without insurance from Community Health Centers with endoscopy centers who provide colonoscopies free of charge through charity care. According to DiLorenzo, “Getting from Point A to Point B requires stakeholder champions, partner, and, often, linkages with ambulatory surgery centers.”

Context Factors that Impact Cancer Screening: Implications for Screening Implementation from New Jersey Based Colorectal Cancer Studies

Shawna Hudson, PhD, Professor and Research Division Chief Department of Family Medicine, Rutgers Robert Wood Johnson Medical School, closed the panel by reviewing a set of studies by New Jersey-based researchers examining a range of contextual factors that impact screening. While many were specific to colorectal screening, some of the findings are transferrable to lung cancer screening as well.

- Medical neighborhood: First, Hudson emphasized considering the larger context or complete “medical neighborhood” factors that play into screening and follow-up, such as family and social supports, provider teams, practice settings, and the local and state context for patients.
- Role of clinical staff: A study led by Hudson and colleagues involving New Jersey practices found that enhanced health behavior education and patient reminders were positively linked to increased colorectal screening rates, indicating a potential positive role for general health behavior education and follow-up from non-physician medical staff in efforts to further boost screening rates.¹⁶
- Role of physicians: Separate research also conducted by Hudson and colleagues underscored the critical role physicians can play in emphasizing the importance of

screening to *all* (not just high-risk) patients, with high adherence among groups like Hispanics, who are more adherent in following up on medical recommendations and yet are often not given screening recommendations as frequently.¹⁷

- Physician-patient relationships: A study by Dr. Jennifer Tsui and colleagues at Rutgers Cancer Institute of New Jersey and the Rutgers School of Public Health emphasized the importance of *gender* concordance (meaning, patients and providers being of the same gender), rather than *racial* concordance in terms of increasing patient adherence to routine breast, colorectal, and cervical cancer screening.¹⁸
- Patient connections and awareness: Research by Shannon Christy and colleagues from the Division of Population Science at the H. Lee Moffitt Cancer Center and Research Institute related to health literacy among minority men showed the importance of peer relationships, perhaps indicating an opportunity to extend messages beyond patients to family members and peers.¹⁹ Another study by Sharon Manne of Rutgers Cancer Institute of New Jersey and colleagues, including Michael Steinberg, focused specifically on foreign-born South Asian patients. Among this population, screening awareness and uptake was low, perhaps pointing to an opportunity for targeted outreach including emphasis on the importance of cancer screening overall.²⁰

Susan Goodin, PharmD, FCCP, BCOP, Executive Director of Statewide Affairs at Rutgers Cancer Institute of New Jersey,* summarized some highlights from the day's discussions to close. She acknowledged, "The reality is – our incidence is high... We have a long way to go," but she affirmed that the research and discussion can help to improve awareness and screening rates:

- Learn more about screening patterns among vulnerable New Jerseyans: more information is needed about screening patterns among vulnerable New Jerseyans, including those who are uninsured and covered through Medicaid.
- Ensure younger patients are not overlooked: With respect to colorectal cancer, we have to recognize symptoms in younger patients who can sometimes get overlooked with existing guidelines.
- Link smoking cessation efforts with simplified steps to improved lung cancer screening: In terms of lung cancer, we need to make sure cessation is linked to screening, fund more training for providers and ensure simplified steps to a CT screen prescription.
- Ensure smarter systems support screening and follow-up: We heard strategies for success from health centers who are working on steps to ensure the "right fields" are housed within electronic medical record systems to ensure adequate screening follow-up. We also heard about the need to leverage competition among staff, providers, and systems.
- Recognize critical role of navigators and education: We also need to recognize the critical role navigators can play in boosting screening efforts. The importance of education was

*Subsequent to the compilation of this report, Dr. Goodin resigned from Rutgers Cancer Institute of New Jersey.

also stressed throughout the day – education for patients, providers, and across whole systems.

- Simplify screening messages and broaden their reach: In terms of patients, a range of means are needed to simplify messages about what screening is and why it is important, including marketing aggressively through birthday cards, social media and champions, including local champions and patients with successful outcomes. We also need to educate and recruit families to act as messengers and mouthpieces for these efforts, including working with children in schools.

While we are making advances, there is still more to do to realize our goal, but through partnering, filling the knowledge gaps and continuing to work and challenge our assumptions, we will achieve our goal together.

Recommendations for Moving Forward:

The meeting closed with the group forming recommendations for ScreenNJ to help increase cancer screening rates. Key recommendations included:

Colorectal Cancer:

- Ensure that colonoscopy is the first recommendation for screening, but “meet the patients where they are” and emphasize that the right test is the one that gets *done*.
- Examine policy and program implications for colorectal cancer patients screened and diagnosed through the New Jersey Cancer Education and Early Detection Program, but not medically eligible for Medicaid or other coverage.
- More closely examine Medicaid-insured and overall populations with early onset of colorectal cancer.
- Recognize management implications for two distinct Medicaid patient groups – patients newly enrolled or enrolled upon cancer diagnosis, versus longer-term Medicaid patients.
- Further study patterns of screening modalities over time and differences across insurance status.

Lung Cancer:

- Increase awareness of lung cancer screening benefits among both providers and tobacco users and migrate some successful colorectal screening uptake strategies to lung efforts.
- Implement system-efforts to more easily identify eligible individuals for lung cancer screening and offer these screenings to all populations.
- Link evidence-based tobacco treatment with lung screening efforts.

Overall Policy and Practice Recommendations:

- Expand focus of ScreenNJ to all counties
- Encouraging ScreenNJ to implement recommendations for clinical support tools for inclusion in EMRs
- Targeting state funding for quality incentives related to increased cancer screening
- Launching public awareness and education campaigns on the importance of screening through aggressive marketing and a multitude of venues
- Consider creating a report card indicator for screening for Medicaid population.
- Examine screening rates for entire Medicaid population (not just Medicaid CRC diagnosed patients) and conduct similar analyses with lung cancer screening.
- Conduct applied research to help further understand some of the promising contextual factors that stand out as important in boosting screening rates.
- Foster partnerships across clinical teams and through ScreenNJ, capitalizing on utilizing partner expertise in a structured way.
- Leverage competitive nature among staff and providers to increase rates.
- Ensure front line workers can talk to patients in a way that they can understand how screening can help them through translation of research messages like, “It’s never too late to quit.”
- Implement whole team change in clinical settings, bringing all on board on importance of boosting rates.
- Consider dedicated navigators to specialize in assisting patients with tests and follow-up.
- Expand reach and follow-up through messages to family members and peers.
- Boost role for community health workers and leverage experience of former patients.
- Work with the State of New Jersey to implement 50-year-old bucket list birthday cards for New Jerseyans.
- Develop data charts of localized cancer incidence and burden to share with key stakeholders, including mayors, county officials and legislators.
- Consider working with municipalities’ competitions or launch campaign with 50-and-older mayors going for screenings.

Conference Agenda

Conference for Strategic Change: Colorectal and Lung Cancer Screening Innovation



#IncreaseCancerScreening

Wednesday, May 23, 2018
8:00 AM – 4:00 PM

Boathouse at Mercer Lake
West Windsor, New Jersey

WELCOME

The NJPCA Team, in collaboration with [ScreenNJ](#), Rutgers CINJ and the New Jersey Department of Health (DOH) welcomes you to our Conference for Change: Colorectal (CRC) and Lung Cancer Screening Innovation. For more than 50 years, Federally Qualified Health Centers have provided quality and affordable healthcare services to millions of uninsured and medically underserved populations nationwide. With 24 health centers operating 134 sites in each of the 21 counties of New Jersey, Community Health Centers provide comprehensive, culturally sensitive and high quality primary medical, dental and behavioral health services for patients of all ages. Thank you for your hard work, compassion, and tireless commitment to the patients you serve every day.

- The Conference for Change will focus on strategies to increase cancer screening rates, reduce cancer mortality rates and educate New Jersey's most vulnerable residents about the importance of cancer screening, early detection, and prevention.

We will learn from experts in this subject matter and our peers as they share their success stories and promising practices.

We hope what you take away from this conference is informative and motivating!

Stephanie Gee, Quality and Integration Specialist

2018 NJPCA Conference for Change: Colorectal and Lung
Cancer Screening Innovation

May 23, 2018

Boathouse at Mercer Lake, West Windsor, New Jersey



Agenda

8:00 AM – 9:00 AM	Registration and Breakfast
9:00 AM – 9:15 AM	Welcome
9:15 AM – 10:00 AM	Meeting the Challenge: Statewide Panel Discusses CRC and Lung Cancer Rates Rutgers, NJ Department of Health, share perspectives and data on the status of NJ CRC and Lung cancer and screening rates
10:00 AM – 10:15 AM	BREAK
10:15 AM – 11:00 AM	Word on the Street: Public Health Panel How Community Health Centers are transforming CRC AND Lung screening rates in communities
11:00 AM – 11:30 AM	Group Strategy Discussions
11:30 AM – 12:00 PM	Group Strategy Reports
12:00 PM – 12:45 PM	LUNCH
12:45 PM – 1:00 PM	BREAK
1:00 PM – 2:00 PM	Keeping Up with the Joneses: Neighboring State Panel How NJ can use neighboring state knowledge to increase screening rates and overcome disparities.
2:00 PM – 2:30 PM	Group Strategy Discussions
2:30 PM – 3:00 PM	Group Strategy Reports
3:00 PM – 3:30 PM	Determining Next Steps and Strategies for Change/Closing Remarks
3:30 PM – 4:00 PM	Recommendations to Screen New Jersey

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