cancer plan minnesota

**Workgroup: Detection** **Date: 6-30-2016**

## Issue Statement:

Breast, cervical, and colorectal cancer are leading causes of cancer morbidity and mortality. Effective prevention and early detection may be achieved through screening, and screenings for these three cancers are prioritized by a large number of Minnesota Cancer Alliance members.

There are significant screening disparities between the Caucasian population and other racial, ethnic and linguistic groups. There are also screening disparities between commercially insured individuals and people who are enrolled in Minnesota Healthcare programs (e.g. Medicaid/medical assistance).

## Describe the issue using public health data, peer reviewed research, or other evidence:

**Breast:** Medicaid rates: 62%, other purchasers: 76%, → 14% gap
Recommended: every 2 years after the age of 50

**Cervical:** note- there has been a measurement change.
Screening rate is at 72% for those 21-64 years old.

**Colon:** 71% screening rate overall and growing by 1% every year,
>53% screening rate for other race, ethnicity and language disparate populations and Medicaid

## What factors contribute to this issue? What racial, economic, geographic and other barriers contribute to this issue?

**Breast:**
As elsewhere in the US, non-Hispanic white women in Minnesota are at the greatest risk of being diagnosed with breast cancer, but African American women are at the greatest risk of dying of this disease. African American and Hispanic women are also more likely to be diagnosed with late stage disease. Access to mammography may be an issue in some rural areas in Minnesota.

**Cervical:**
American Indian women are the most likely to develop cervical cancer in Minnesota. During 2008-2012, they were four times more likely to be diagnosed with this cancer than non-Hispanic white women, and Asian/Pacific Islander and Hispanic women were about two times more likely to be diagnosed with cervical cancer than non-Hispanic white women.

Pap smears are often perceived as a reproductive health issue so rates drop in women after menopause as well. Access to coloposcopy is limited.

**Colon:**

American Indians have the highest colon and rectal incidence in Minnesota. They are 85 percent more likely to be diagnosed with this disease than non-Hispanic whites and more than twice as likely to die from it. Colon and rectal cancer among American Indians in Minnesota is almost twice as high in Minnesota as in the US as a whole.

There are significant disparities between non-Hispanic whites and other race, ethnic and linguistic groups in Minnesota including African American, Hispanic and many new immigrant populations such as Somali and Hmong. There is a persistent 20% gap between the commercially insured population and enrollees in Minnesota Health Care programs.

In rural areas, access to endoscopy may be a significant barrier, particularly since the sedation that accompanies a colonoscopy may require that someone has a driver to get them to and from an appointment.

Awareness: most people know about colonoscopies but they are rarely given other options. Some cultures are very private and being given the option to use a test (Fit Kit) they do themselves at home is preferred. Some interpreters do not feel they should give out information beyond translation. There is evidence that messages about other options can increase screening rates.

## What are the gaps in policy, systems and/or environmental services that give rise to this issue?

1. **Individuals are more likely to be screened if cancer screening messages are tailored and targeted to people in need. In communities of color, cancer screening navigation has demonstrated significant progress in increasing screening rates but there is not consistent funding or education for professional and lay community health workers.**
2. **In some cases, health care cost sharing for diagnostic services may be a significant barrier for the uninsured and underinsured and a deterent to appropriate follow-up for positive stool tests. In other cases, it may prevent people from seeking screening of any kind.**
3. **Some populations may be at higher risk of developing cancer and might benefit from screening, or at least messaging about the importance of screening at an earlier age.**

**POLICY, SYSTEMS, and/or ENVIRONMENTAL (PSE) CHANGE: What are the policy, systems and/or environmental change opportunities to address this issue? What strategies would you recommend to achieve PSE change?**

- Strategy 4: Pursue opportunities to expand current data practices (i.e. Minnesota Community Measurement) to reflect colorectal cancer measure to include African Americans and American Indians starting screening age 45.
- Strategy 5: Expand screening and diagnostic options for the uninsured and the underinsured.

**HEALTH EQUITY: Which strategies promote health equity? Describe how they promote health equity.**

- **Strategy 1**: Identify and disseminate tools and resources based on CDC Community Guide (i.e. NCCRT toolkits).

The National Colorectal Cancer Roundtable has identified messages targeted to the African American and Hispanic Communities and resources to support communications which address the barriers they experience.

- **Strategy 2:** Develop and disseminate case studies and share examples of effectively implemented evidence-based practices and strategies used by Minnesota stakeholders to increase cancer screening.

Case studies could be developed for practices that have demonstrated the reduction in cancer screening disparities, based on evidence-based changes to their patients and members.

- **Strategy 3:** Encourage Minnesota stakeholders to partner with community organizations to develop targeted and tailored cancer screening messaging to reduce disparities.

Community-based organizations like churches and social service agencies often have strong credibility in communities of color. Their ability to share what they have learned and put us into communication with community members may help us develop better messages and an understanding of what is needed to help motivate behavior change.

- **Strategy 4:** Pursue opportunities to expand current data practices (i.e. Minnesota Community Measurement) to reflect colorectal cancer measure to include African Americans and American Indians starting screening age 45.

The Institute for Clinical Systems Improvement recommends earlier screening for these populations but it is unclear how many providers have implemented this recommendation or what impact it may have on screening and screening disparities.

- **Strategy 5**: Expand screening and diagnostic options for the uninsured and the underinsured.

Some providers are reluctant to offer screening for the uninsured without knowing how they will provide diagnostic services if they are needed.

**Developing the Minnesota Cancer Plan**
**Step 2: Recommend Objectives and Strategies**

**Workgroup:** **Detection** **Date: 6/30/2016**

**Objective:** Increase comprehensive screening across breast, cervical and colorectal cancer in alignment with existing evidence-based frameworks.

## Desired Outcome:

**At the end of five years, what would you like to accomplish? If you do not expect to achieve the objective by the end of five years, what would success look like?**

**Increased screening rates among all populations.**

## Alignment:

**Partners currently working on this objective and type of activity:**

| Organization | Activity (such as PSE change, education, programmatic) |
|---|---|
| MDH Sage Scopes | Sage Scopes has expanded from paying for the uninsured to provide more technical support for providers |
| American Cancer Society | Provider and community education |
| American Indian Cancer Foundation | Provider and community education |
| Stairstep Foundation | Cancer Awareness Sunday |
| Minnesota Health Insurance Plans | Provider Education, Member Education, Provider and Member Incentives |
| Minnesota Integrated Health Systems | Quality Improvement Measurement and Projects |

**Stakeholders for this issue not currently working on it and potential role:**

| Organization | Potential role (PSE change, education, programmatic) |
|---|---|
| Small rural clinics and hospitals, particularly safety nets | More emphasis on promotion of multiple tests |
| Minnesota Employers | Prioritize cancer screening as a wellness message |
| Minnesota State Legislators | Support for Screening Navigation |
| Somali and Hmong community organizations | Support tailoring messages |
| | |

## Strategies

**Strategy #1:** Identify and disseminate evidence based tools and resources (i.e. CDC Community Guide, National Colorectal Cancer Roundtable toolkits).

**Rationale:**
The CDC Community Guide has documented evidence-based best practices for client and provider interventions which can be found online at http://www.thecommunityguide.org/cancer/index.html and this work has been used to creating supporting tools. The National Colorectal Cancer Roundtable has created a host of resources based on these best practices at http://nccrt.org/tools/.

**Evidence:**
Leeman, J., Moore, A., Teal, R., Barrett, N., Leighton, A., Steckler, A. (2013). Promoting Community Practitioners' Use of Evidence-Based Approaches to Increase Breast Cancer Screening. *Public Health Nursing*, 30, 4; 323-331.

Sabatino, S., Lawrence, B., Elder, R., Mercer, Wilson, K., DeVinney, B., Melillo, S., Carvalho, M., Taplin, S., Bastani, R., Rimer, B., Vernon, S., Melvin, C., Taylor, V., Fernandez, M., Glanz, K. Effectiveness of Interventions to Increase Screening for Breast, Cervical, and Colorectal Cancers. (2012) *American Journal of Preventative Medicine*, 43, 1; 97-118.

**Strategy #2:** Develop and disseminate case studies and share examples of effectively implemented evidence-based practices and strategies used by Minnesota stakeholders to increase cancer screening.

**Rationale:**

Minnesota providers are interested in case examples that demonstrate that best practices and tools have been successful. Presentations and/or anecdotes from peers make it clear that these are not simply theories, but actual practices. It also makes it possible for these local peers to work together as part of learning network. Recent experience with MCA Colon Cancer webinars demonstrate greater participation and satisfaction with webinars which feature peer presentations. Examples of similar webinars can be found online at http://nccrt.org/webinars/

**Evidence:**
Jacobs, J. A., Jones, E., Gabella, B. A., Spring, B., & Brownson, R. C. (2012). Tools for Implementing an Evidence-Based Approach in Public Health Practice. *Preventing Chronic Disease*, *9*, E116. http://doi.org/10.5888/pcd9.110324

**Strategy #3:** Encourage Minnesota stakeholders to partner with community organizations to develop targeted and tailored cancer screening messaging to reduce disparities.

**Rationale:** The Minnesota Department of Health and the American Cancer Society have effectively partnered with African American and Hispanic Churches for two decades. These partners have demonstrated credibility in their community as trusted messengers. The National Colorectal Cancer Roundtable has developed tailored messages for African Americans and Hispanics at http://nccrt.org/tools/80-percent-by-2018/80-by-2018-communications-guidebook/ and http://nccrt.org/tools/80-percent-by-2018/hispanics-latinos-companion-guide/. There is potential to review and potentially improve upon these national messages with local partners.

In addition, Minnesota has other racial, ethnic and linguistic communities which experience disparities even when the health messages are translated. There are additional non-traditional community partners who might be effective in helping us develop and deliver effective cancer screening messages.

**Evidence:**

Maxwell, A. E., Danao, L. L., Cayetano, R. T., Crespi, C. M., & Bastani, R. (2014). Adoption of an evidence-based colorectal cancer screening promotion program by community organizations serving Filipino Americans. *BMC Public Health*, *14*, 246. http://doi.org/10.1186/1471-2458-14-246

Rapkin, B., Massie, M. J., Jansky, E., Lounsbury, D. W., Murphy, P. D., Powell, S. (2006). Developing a Partnership Model for cancer Screening with Community-Based Organizations: The ACCESS Breast Cancer Education and Outreach Project. *American Journal of Community Psychology*, 38, 3-4,; 287-297.

Resnicow, K., Zhou, Y., Hawley, S., Jimbo, M., Ruffin, M.m Davis, R., Shires, D., Laffata J. E. Communication preferences moderates the effect of a tailored intervention to increase colorectal cancer screening among African Americans. (2014). *Patient Education and Counseling, 97, 3; 370-375.*

Sewali, B., Pratt, R., Abdiwahab, E., Fahia, S., Call, K.T., Okuyemi, K.S. (2014). Understanding Cancer Screening Service Utilization by Somali Men in Minnesota. *Journal of Immigrant and Minority Health*, 17, 3; 773-780.

Filipi, M.K., Perdue, D.G., Hester, C., Cully, L., Greiner, A., Daley, C.M. (2016). Colorectal Cancer Screening Practices Among Three American Indian Communities in Minnesota. *Journal of Cultural Diversity*, 23, 1.

**Strategy #4:** Pursue opportunities to expand current data practices (i.e. Minnesota Community Measurement) to reflect colorectal cancer measure to include African Americans and American Indians starting screening age 45.

**Rationale:**
Evidence shows African Americans experience earlier onset of colorectal cancer (CRC). Both the American College of Gastroenterology and the American Society for Gastrointestinal Endoscopy recommend that CRC screening being at age 45 for average-risk African Americans.

ICSI has incorporated this recommendation into their colorectal cancer screening guideline (https://www.icsi.org/guideline_sub-pages/preventive_services_adults/level_i__colorectal_cancer_screening/) but it is unclear how many providers have implemented this guideline and what impact it has had or could have on reducing colon cancer disparities.

American Indian/ Alaskan Natives are 1.9 times more likely to be diagnosed with colorectal cancer than Non- Hispanic Whites (Minnesota Facts and Figures 2015).

**Evidence:**
Carethers, J. (2014). Screening for Colorectal Cancer in African Americans: Determinants and Rationale for an Earlier Age to Commence Screening. *Digestive Diseases and Sciences*, 60, 3; 711-721.

Congeni, J. P., Esber, C. M., El-Dika, S. (2014). Tu1028 Assessment of Colorectal Cancer Screening in Average-Risk African Americans Ages 45-49 in ambulatory Settings At an Academic Medical Center. *Gastroenterology*, 146, 5; S-731.

Sankineni, A., Friedenberg, F. (2010). M1528: Colorectal Cancer Screening in African Americans 45-49 Years Old. *Gastrointestinal Endoscopy*, 71, 5; AB245-AB246.

**Strategy #5:** Expand screening and diagnostic options for the uninsured and the underinsured.

**Rationale:**
There are limited resources to cover the cost of cancer screening for the uninsured. Although stool tests are relatively inexpensive, the cost of diagnostic colonoscopies can be a significant deterrent to screening, both to patients and to the providers who may feel that it is unethical to put a patient in that position. Eliminating the gap in diagnostic services can streamline workflows within clinics allowing providers to recommend screening regardless of insurance status.

**Evidence:**
Harcourt, N., Ghebre, R., Whembolua, G., Zhang, Y., Osman, S.W., Okuyemi, K.S. (2013). Factors Associated with Breast and Cervical Cancer Screening Behavior Among African Immigrant Women in Minnesota. *Journal of Immigrant and Minority Health*, 16, 3; 450-456.

Filipi, M.K., Perdue, D.G., Hester, C., Cully, L., Greiner, A., Daley, C.M. (2016). Colorectal Cancer Screening Practices Among Three American Indian Communities in Minnesota. *Journal of Cultural Diversity*, 23, 1.