Northwest Colorectal Cancer Task Force Meeting

June 3, 2025

Agenda

- Welcome & Introductions
- Overview of CRC Data for Oregon & Washington
- Presentation 1: CRC Screening & Outreach – Yakima Valley Farm Worker Clinic
- Share Updates & Upcoming Events
- Break
- Presentation 2: Overview of ‘PharmFIT’ Intervention
- Presentation 3: CRC Outreach and Follow up in Rural Oregon
- Project Brainstorming Discussion
- Wrap up

Welcome & Introduction

Please introduce yourself by typing in the chat your

Name, Organization and Title

Overview of CRC Data

OREGON STATE CRC DATA UPDATE

Presenter: Derrik Zebroski

Mobile Outreach Program Coordinator

OHSU Knight Cancer Institute

OREGON DATA

Prepared by Wesley Stoller and Derrik Zebroski
Knight Cancer Institute Community Outreach and Engagement

Oregon State CRC Screening Rate

	Female	Male	Overall
2022	67.1	36.8	65.5
2023	70.9	68.9	69.9

Estimates reflect the percentage of adults age 45-75 reporting that they have had a Fecal Occult Blood Test (FOBT) in the past year; a colonoscopy within the past 10 years; or, a sigmoidoscopy within the past five years as well as an FOBT within the past three years. Starting in 2020, virtual colonoscopies and stool DNA tests were added.

Overall Incidence Rates (per 100,000) for 2022

Type	Rate	Count
Total	30.8	1,644
Female	29.1	814
Male	32.6	830

Late Stage Incidence Rates (per 100,000) for 2022

Type	Rate	Count
Total	6.7	357
Female	5.8	159
Male	7.8	198

Overall Incidence Rate (per 100,000) by Race and Ethnicity 2018-2022

Race/Ethnicity	Incidence Rate per 100,000
White, non-Hispanic	31.8
Black	30.4
American Indian or Alaska Native	30.9
Asian, Native Hawaiian or Pacific Islander	26.8
Hispanic	23

Late Stage Incidence Rate (per 100,000) by Race and Ethnicity 2018-2022

Race/Ethnicity	Incidence Rate per 100,000
White, non-Hispanic	6.7
Black	7.3
American Indian or Alaska Native	5.9
Asian, Native Hawaiian or Pacific Islander	6.4
Hispanic	5.1

Overall Incidence Rate (per 100,000) by county of residence 2018-2022

County of Residence	Incidence Rate per 100,000
Oregon	30.8
Baker	42.7
Benton	26.5
Clackamas	29.9
Clatsop	34.8
Columbia	43.1
Coos	45.8
Crook	26.6
Curry	28.7
Deschutes	28.8
Douglas	28.2
Gilliam	~
Grant	~
Harney	~
Hood River	~
Jackson	35.1
Jefferson	60.9
Josephine	38.2
Klamath	48.2

Overall Incidence Rate (per 100,000) by county of residence 2018-2022

County of Residence	Incidence Rate per 100,000
Lake	32.5
Lane	23.7
Lincoln	28.9
Linn	30.8
Malheur	31.6
Marion	36.8
Morrow	40.5
Multnomah	31.7
Polk	30.7
Sherman	~
Tillamook	33.2
Umatilla	42.9
Union	40.3
Wallowa	28.5
Wasco	25.7
Washington	30.6
Wheeler	~
Yamhill	32.4

Overall Mortality Rates (per 100,000) for 2022

Type	Rate	Count
Total	12.2	666
Female	14.7	368
Male	10	298

Overall Mortality Rate (per 100,000) by Race and Ethnicity 2018-2022

Race/Ethnicity	Incidence Rate per 100,000
White, non-Hispanic	12.2
Black	14.6
American Indian or Alaska Native	10
Asian, Native Hawaiian or Pacific Islander	8
Hispanic	7.8

Overall Mortality Rate (per 100,000) by county of residence 2018-2022

County of Residence	Incidence Rate per 100,000
Oregon	12.0
Baker	12.63
Benton	12.0
Clackamas	12.0
Clatsop	20.4
Columbia	12.4
Coos	13.5
Crook	16.0
Curry	13.2
Deschutes	9.0
Douglas	13.6
Gilliam	~
Grant	20.3
Harney	~
Hood River	13.4
Jackson	11.2
Jefferson	9.3
Josephine	13.7
Klamath	15.2

Overall Mortality Rate (per 100,000) by county of residence 2018-2022

County of Residence	Incidence Rate per 100,000
Lake	15.57
Lane	12.83
Lincoln	14.01
Linn	11.59
Malheur	18.42
Marion	12.35
Morrow	16.61
Multnomah	12.05
Polk	12.01
Sherman	~
Tillamook	15.46
Umatilla	17.44
Union	14.49
Wallowa	~
Wasco	13.01
Washington	9.86
Wheeler	~
Yamhill	13.26

Oregon Data Sources

- Oregon State Cancer Registry
  - Incidence:
    - Overall incidence rate; Singular year: 2022
    - Rates by race/ethnicity and county of residence; Combined years: 2018-2022
- Oregon Health Authority
  - Mortality
    - Overall incidence rate; Singular year: 2022
    - Rates by race/ethnicity and county of residence; Combined years: 2018-2022
- Screening Data: Behavioral Risk Factor Surveillance System (BRFSS) 2023

Overview of CRC Data

WASHINGTON STATE CRC DATA UPDATE

Presenter: Sahla Suman

Implementation Coordinator| Comprehensive Cancer Control Program

Washington State Department of Health

WASHINGTON STATE COLORECTAL CANCER DATA UPDATE

Sahla Suman T.E, MPH
Comprehensive Cancer Control Program Implementation Coordinator
Office of Healthy and Safe Communities, WA DOH

Contact

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WA Data Sources

- Incidence Data: Dept. of Health Washington State Cancer Registry, released in January 2025.
  - Singular year: 2022
  - Combined years: 2018-2022
- Mortality Data: Dept. of Health Washington, Center for Health Statistics, released in September 2023
  - Singular year: 2022
  - Combined years: 2018-2022
- Population Data: Washington State Office of Financial Management, released in January 2025
- Screening Data: Behavioral Risk Factor Surveillance System (BRFSS) 2012- 2022

Washington State CRC Screening Rate 2022

Type	Proportion	95% CI
Total	**0.58**	0.57- 0.59
Female	**0.59**	0.57- 0.60
Male	**0.57**	0.55- 0.59

Proportion of adults aged 45-75 years who report up-to-date with at least one of the recommended colorectal cancer screening:

Sigmoidoscopy in the past 5 years; Colonoscopy in the past ten years; Had a stool DNA test in the past 3 years; A virtual colonoscopy in the past 5 years; A sigmoidoscopy within the past ten years and a blood stool test in the past year.

Overall Incidence Rates (per 100,000) for 2022

Type	**Rate**	95% Confidence Interval	**Count**
Total	**33.1**	31.9- 34.3	**3,046**
Female	**29.9**	28.3- 31.6	**1,427**
Male	**36.6**	34.7- 38.4	**1,618**

Late-Stage Incidence Rates (per 100,000) for 2022

Type	**Rate**	95% Confidence Interval	**Count**
Total	**19.9**	19- 20.9	**1,835**
Female	**17.6**	16.4-18.9	**845**
Male	**22.4**	21- 23.9	**990**

Overall Incidence Rate (per 100,000) by Race and Ethnicity 2018-2022

Race/Ethnicity	Incidence Rate per 100,000	95% Confidence Interval
White, non-Hispanic	**34.8**	34.2- 35.5
Black American	**38.7**	35.1- 42.5
American Indian or Alaska Native	**44.4**	38.3- 51.5
Asian	**29.1**	27.3- 31
Native Hawaiian or Pacific Islander	**35**	27.6- 45.5
Hispanic	**29.4**	27.2- 31.8

Late-Stage Incidence Rate (per 100,000) by Race and Ethnicity 2018-2022

Race/Ethnicity	Incidence Rate per 100,000	95% Confidence Interval
White, non-Hispanic	**21.6**	21.1- 22.1
Black American	**24.5**	21.7- 27.7
American Indian or Alaska Native	**26.3**	21.6- 32
Asian	**17.4**	16.1- 18.9
Native Hawaiian or Pacific Islander	**18**	12.8- 26.3
Hispanic	**18.5**	16.8- 20.3

Overall Incidence Rate (per 100,000) by county of residence 2018-2022

County of Residence	Incidence Rate per 100,000	95% Confidence Interval
Washington State Average	**33.7**	33.2- 34.3
Adams County	**32.8**	22.2- 47.3
Asotin County	**25.2**	17.5- 36.2
Benton County	**33.2**	29.9-36.9
Chelan County	**36.8**	31.6-42.8
Clallam County	**36**	31-41.9
Clark County	**28.6**	26.7-30.7
Columbia County	**43.1**	22.1- 86.2
Cowlitz County	**32.7**	28.5- 37.3
Douglas County	**32.2**	25.4- 40.5
Ferry County	**19.6**	8.7- 43.6
Franklin County	**36.5**	30.5- 43.3
Garfield County	**^**	^
Grant County	**29.1**	24.5-34.3
Grays Harbor County	**42.3**	36.8- 48.7
Island County	**38.9**	33.7-44.9
Jefferson County	**32.1**	25.1- 42.2

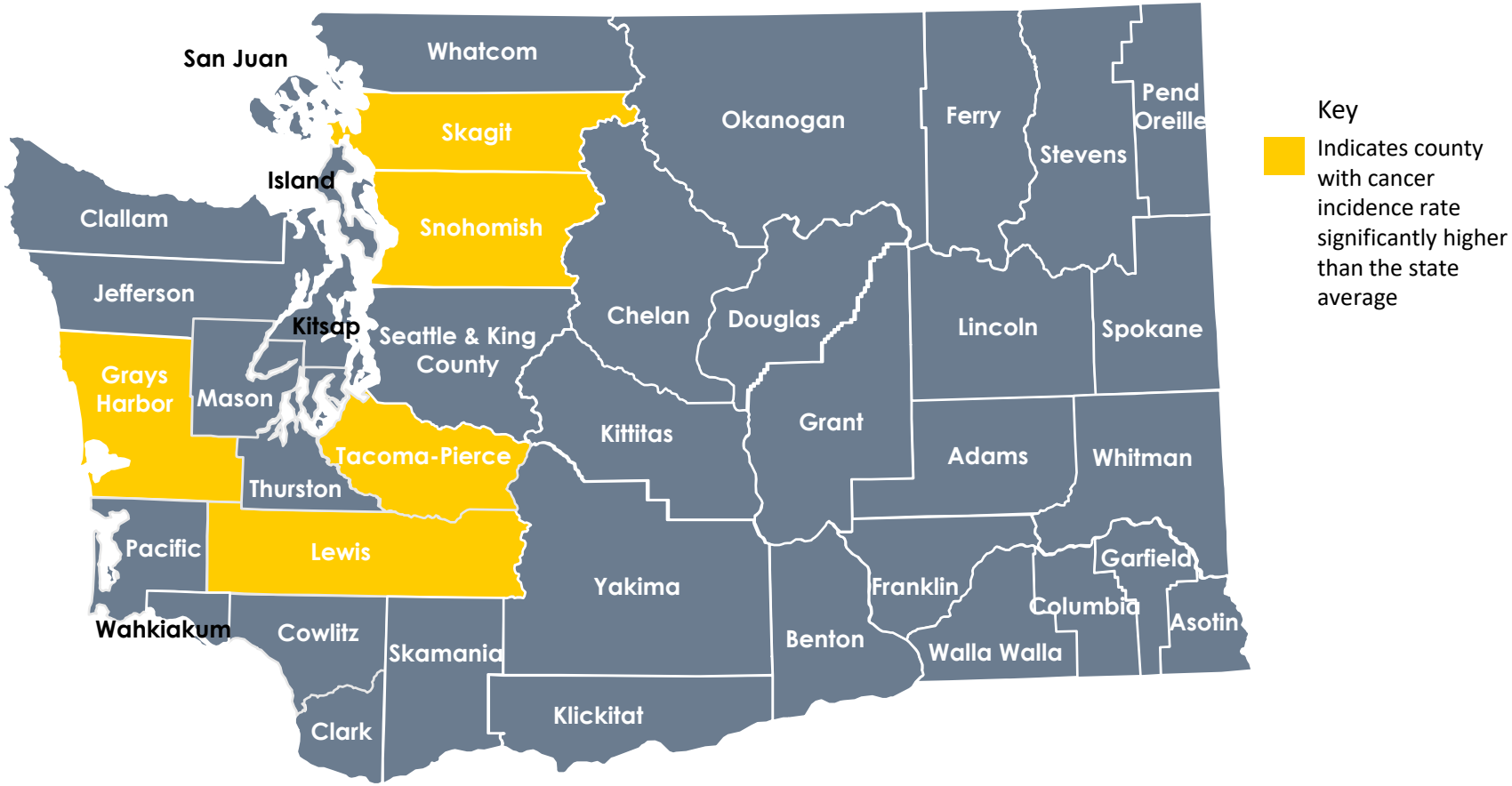
Overall Incidence Rate (per 100,000) by county of residence 2018-2022

County of Residence	Incidence Rate per 100,000	95% Confidence Interval
Washington State Average	**33.7**	33.2- 34.3
King County	**32.8**	31.8-33.9
Kitsap County	**34.2**	31.4- 37.3
Kittitas County	**26.5**	20.2- 34.5
Klickitat County	**28.8**	20.9- 40
Lewis County	**39.2**	34- 45.2
Lincoln County	**31.2**	20.3- 49.3
Mason County	**35.9**	30.5-42.2
Okanogan County	**40.4**	33.4- 49
Pacific County	**27.9**	20.8- 38.5
Pend Oreille County	**30.5**	20.5- 46.6
Pierce County	**36.7**	35- 38.4
San Juan County	**37**	27- 52.5
Skagit County	**38.1**	34- 47
Skamania County	**46.6**	31.8- 68.8

Overall Incidence Rate (per 100,000) by county of residence 2018-2022

County of Residence	Incidence Rate per 100,000	95% Confidence Interval
Washington State Average	**33.7**	33.2- 34.3
Snohomish County	**35.8**	34- 37.6
Spokane County	**31.4**	29.4- 33.5
Stevens County	**37**	30.3- 45.3
Thurston County	**36.5**	33.6-39.5
Wahkiakum County	**33**	15.4- 75
Walla Walla County	**27.5**	22.4- 33.5
Whatcom County	**31.9**	28.8- 35.3
Whitman County	**12.6**	7.8- 19.5
Yakima County	**30.5**	27.6- 33.6

Significant differences of incidence compared to state average



Overall Mortality Rates (per 100,000) for 2022

Type	Rate	95 % Confidence Interval	Count
Total	**12.2**	11.5- 12.9	1,148
Female	**10.8**	9.9- 11.8	548
Male	**13.7**	12.6- 14.9	600

Overall Mortality Rate (per 100,000) by Race and Ethnicity 2018-2022

Race/Ethnicity	Incidence Rate per 100,000	95% Confidence Interval
White, non-Hispanic	**12.2**	11.8- 12.6
Black American	**15.0**	12.7- 17.6
American Indian or Alaska Native	**20.1**	15.7- 25.5
Asian	**8.7**	7.7- 9.7
Native Hawaiian or Pacific Islander	**14**	9.6- 21.7
Hispanic	**8.9**	7.6- 10.3

Overall Mortality Rate (per 100,000) by county of residence 2018-2022

County of Residence	Incidence Rate per 100,000	95% Confidence Interval
Washington State Average	**11.8**	11.4- 12.1
Adams County	**14.9**	7.8- 26
Asotin County	**12.7**	8- 20.4
Benton County	**12.8**	10.7-15.1
Chelan County	**10.6**	8- 14
Clallam County	**12.3**	9.7- 16
Clark County	**11.8**	10.6- 13.2
Columbia County	**^**	^
Cowlitz County	**12.6**	10.1- 15.5
Douglas County	**10.8**	7.3- 15.9
Ferry County	**^**	^
Franklin County	**9.8**	6.8- 13.7
Garfield County	**^**	^
Grant County	**11.7**	8.9- 15.1
Grays Harbor County	**15.2**	12.1- 19.1
Island County	**13**	10.3- 16.4
Jefferson County	**9.7**	6.4- 16.6

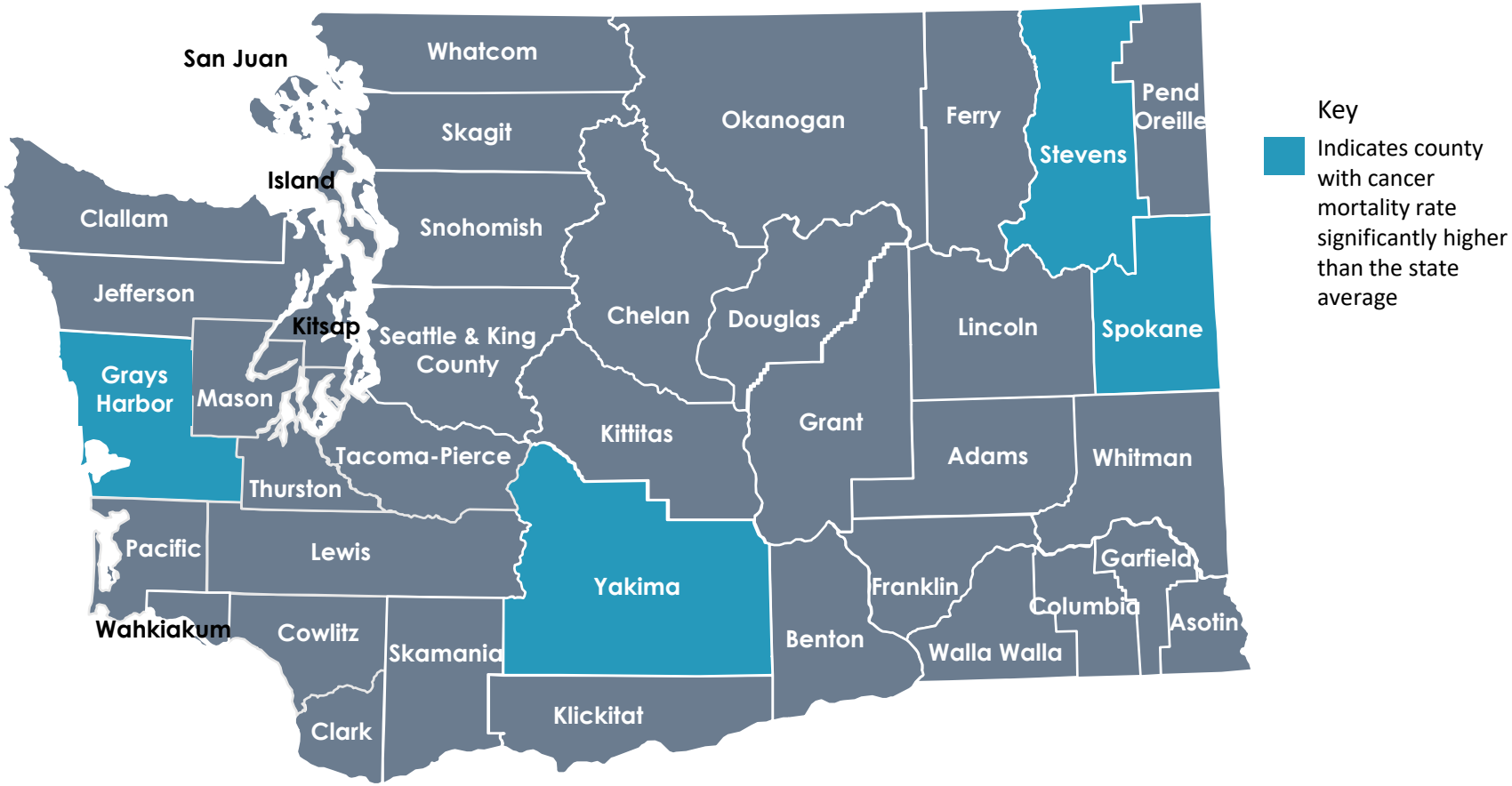
Overall Mortality Rate (per 100,000) by county of residence 2018-2022

County of Residence	Incidence Rate per 100,000	95% Confidence Interval
Washington State Average	**11.8**	11.4- 12.1
King County	**10.3**	9.7- 10.9
Kitsap County	**11.6**	10- 13.5
Kittitas County	**11.1**	7.3- 16.5
Klickitat County	**11**	6.4- 19.2
Lewis County	**14.4**	11.5- 18.1
Lincoln County	**9.7**	4.6- 23.2
Mason County	**12.7**	9.7- 16.7
Okanogan County	**12.9**	8.9- 18.6
Pacific County	**9.7**	6.1- 17.2
Pend Oreille County	**17.1**	10- 30.8
Pierce County	**11.5**	10.6- 12.5
San Juan County	**15.2**	9.3- 27.2
Skagit County	**12.7**	10.5- 15.3
Skamania County	**14.3**	6.8- 30

Overall Mortality Rate (per 100,000) by county of residence 2018-2022

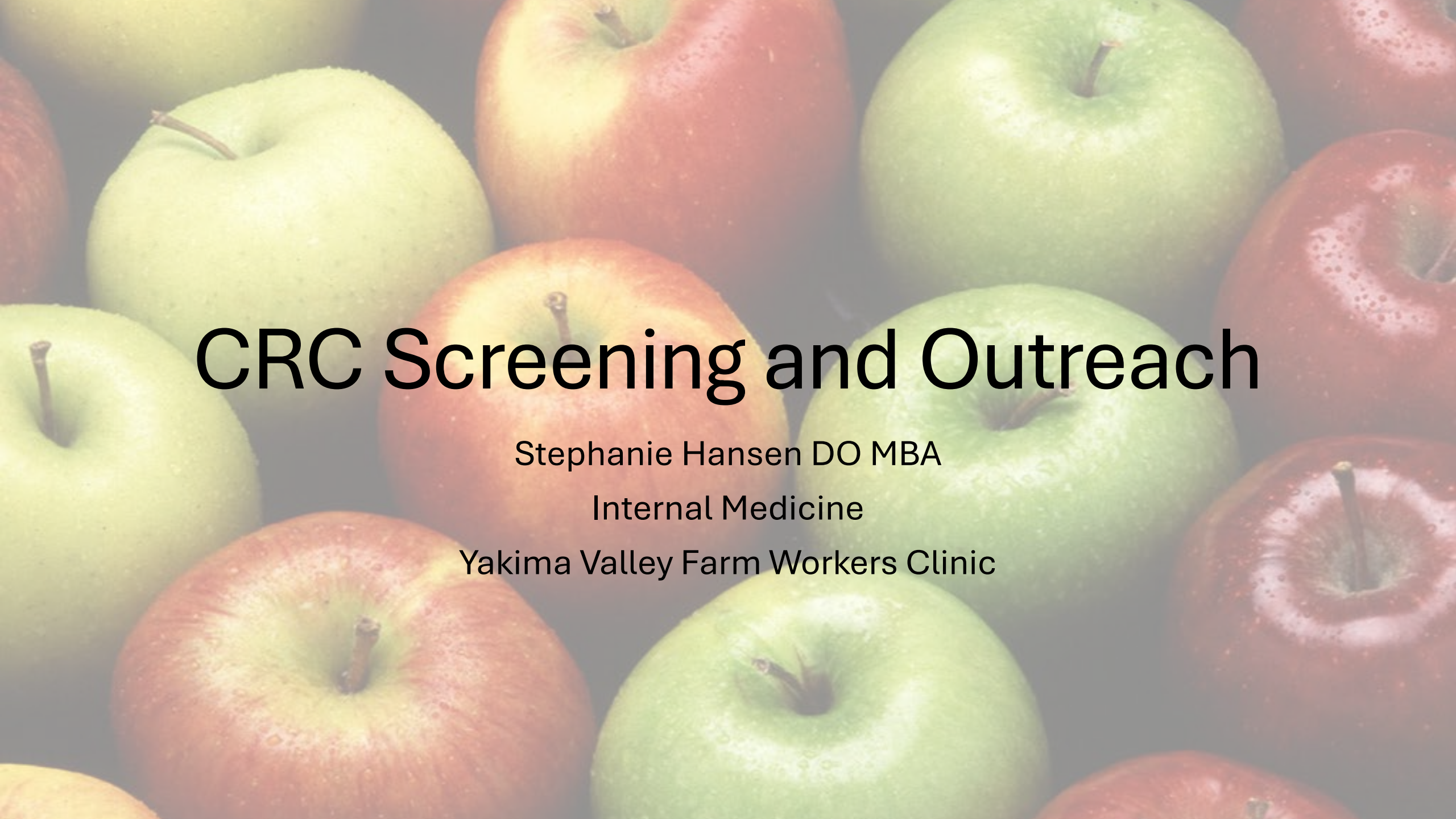
County of Residence	Incidence Rate per 100,000	95% Confidence Interval
Washington State Average	**11.8**	11.4- 12.1
Snohomish County	**12.6**	11.5- 13.7
Spokane County	**13.2**	12- 14.6
Stevens County	**17.2**	12.9- 23
Thurston County	**11.4**	9.9- 13.1
Wahkiakum County	**^**	^
Walla Walla County	**12.7**	9.4- 17
Whatcom County	**11.3**	9.5- 13.3
Whitman County	**8.3**	4.8- 13.9
Yakima County	**13.7**	11.8- 15.8

Significant differences of mortality compared to state average



Questions?

To request this document in another format, call 1-800-525-0127. Deaf or hard of hearing customers, please call 711 (Washington Relay) or email civil.rights@doh.wa.gov.



CRC Screening and Outreach

Stephanie Hansen DO MBA

Internal Medicine

Yakima Valley Farm Workers Clinic

Disclosures

- None

Central Washington Overview

Agricultural Hub

Central Washington is a key agricultural hub, producing apples, cherries, and hops. These crops contribute significantly to the region's economy.

Population and Geography

The population in Central Washington is approximately 750,000. The region features a diverse climate and geography, with both urban and rural communities.

Diverse Ethnic Composition

Central Washington has a diverse population with significant representation from various ethnic groups, particularly the Hispanic community.

Younger Median Age

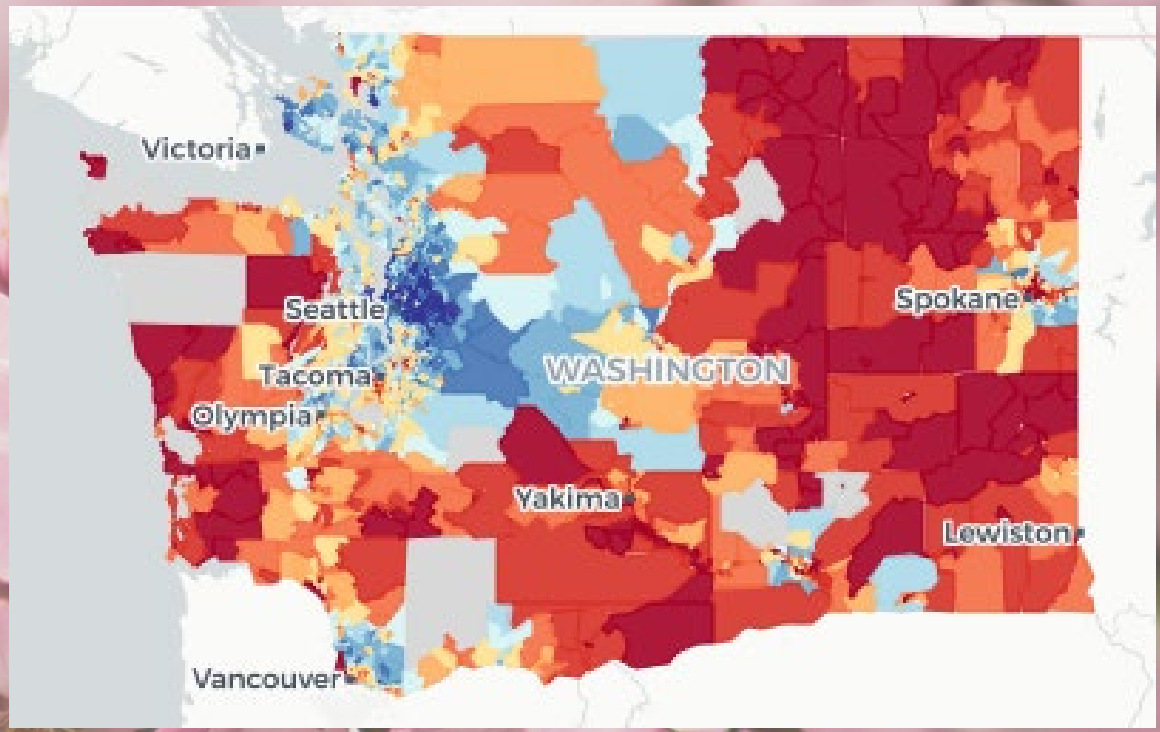
The region has a younger median age compared to the national average.

Yakima Valley Farm Workers Clinic

- Federally Qualified Health Center
- 37 Clinics in Washington and Oregon
- Sees Patients Regardless of Ability to Pay
- Patient Center Medical Home
- In Yakima Valley Majority of Patients Hispanic With English Not Primary Language

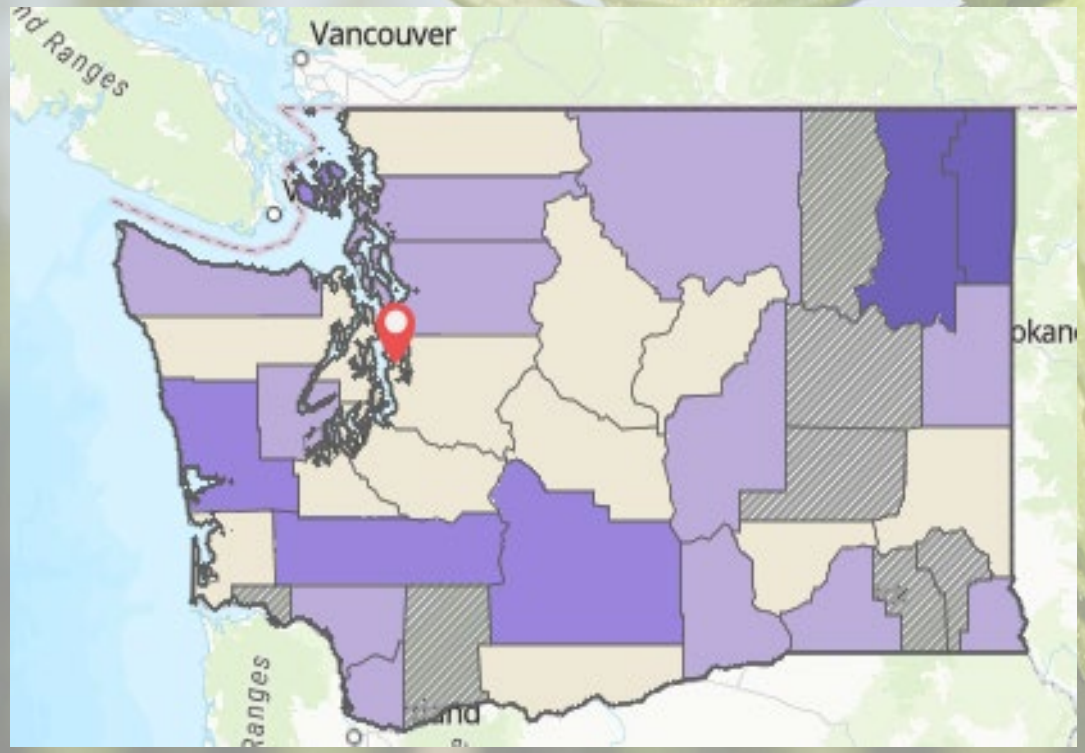
Area Deprivation Index

- The ADI is a combined measurement based on 17 indicators related to income, education, employment, and housing conditions at the Census Block Group level.
- It helps identify areas with high levels of deprivation, which are associated with poorer health outcomes.
- Yakima County: Higher poverty level, income disparities with mean income $68,000, housing instability and food insecurity



Kind AJH, Buckingham W. Making Neighborhood Disadvantage Metrics Accessible: The Neighborhood Atlas. *New England Journal of Medicine*, 2018. 378: 2456-2458. DOI: 10.1056/NEJMp1802313. PMCID: PMC6051533. AND University of Wisconsin School of Medicine Public Health. 2015 Area Deprivation Index v2.0. Downloaded from https://www.neighborhoodatlas.medicine.wisc.edu/ May 23, 2019.

Colorectal Cancer Stats



https://nccrt.org/colorectal-cancer-data-dashboard/

Yakima County

- Mortality Rate 14.2%
- Incidence 32.8%
- Screening 51.4%

Yakima County Farm Workers Clinic

- Screening (2024) 59.9%
- Screening (YTD) 42.8%

Self

- Screening (YTD) 58%

What Are the Barriers?

- Feel “Fine”
- Literacy
- Machismo
- Language
- Cost
- Transportation
- Dependence on Others
- “Ick’’ Factor
- Other World Factors
- Fear
- History of Abuse

What Are We Trying to Do?

- Team Based Approach
- EHR Alerts
- Quality Metric
- Trauma Based Care
- Motivational Interviewing
- Brainstorm
- Education

Perspective

Questions?

Do you have any Upcoming CRC Events that you would like to share with the Task Force Members?

Feel free to type it in the chat

Presentation 2

Overview of Pharm FIT Intervention

Speaker: Dr. Parth Shah

Assistant Professor | HICOR

Fred Hutch Cancer Research Center

Fred Hutch Cancer Center

Expanding colorectal cancer screening through community pharmacies: The PharmFIT study

Parth Shah, PharmD, PhD
Associate Professor
Cancer Prevention Program, Public Health Sciences
Hutchinson Institute for Cancer Outcomes Research
June 3, 2025

The PharmFIT™ Study

Study Purpose. To develop and pilot test models for delivering FIT kits for CRC screening in community pharmacies

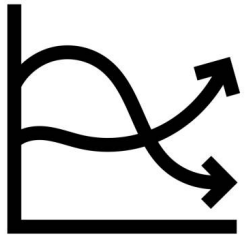
UNC CENTER FOR HEALTH PROMOTION AND DISEASE PREVENTION

Alison Brenner, PhD, MPH

Fred Hutch Cancer Center

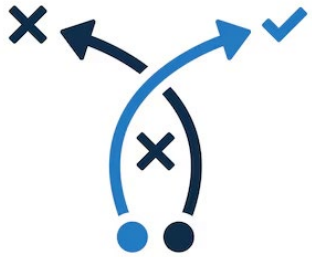
Parth Shah, PharmD, PhD

CRC screening challenges & opportunities



- Screening participation is **15-30 percentage points lower** in rural and low-income populations
- Additional disparities persist for racial & ethnic subgroups
- Screening interventions typically conducted in **traditional medical settings**

- Fecal immunochemical tests (FIT) are **highly effective** but underused
- Some interventions to increase CRC screening, including centralized mail-FIT programs, can **be costly and resource intensive**



- Need more **equitable approaches** to reach adults due for screening
- Screening strategies designed to be **sustainable**

Davis MM et al. 2022. *J Rural Health.;* Issaka RB et al. 2019. *Prev Med.*

Pharmacies as a place for CRC screening

Access, reach, convenience, & trust

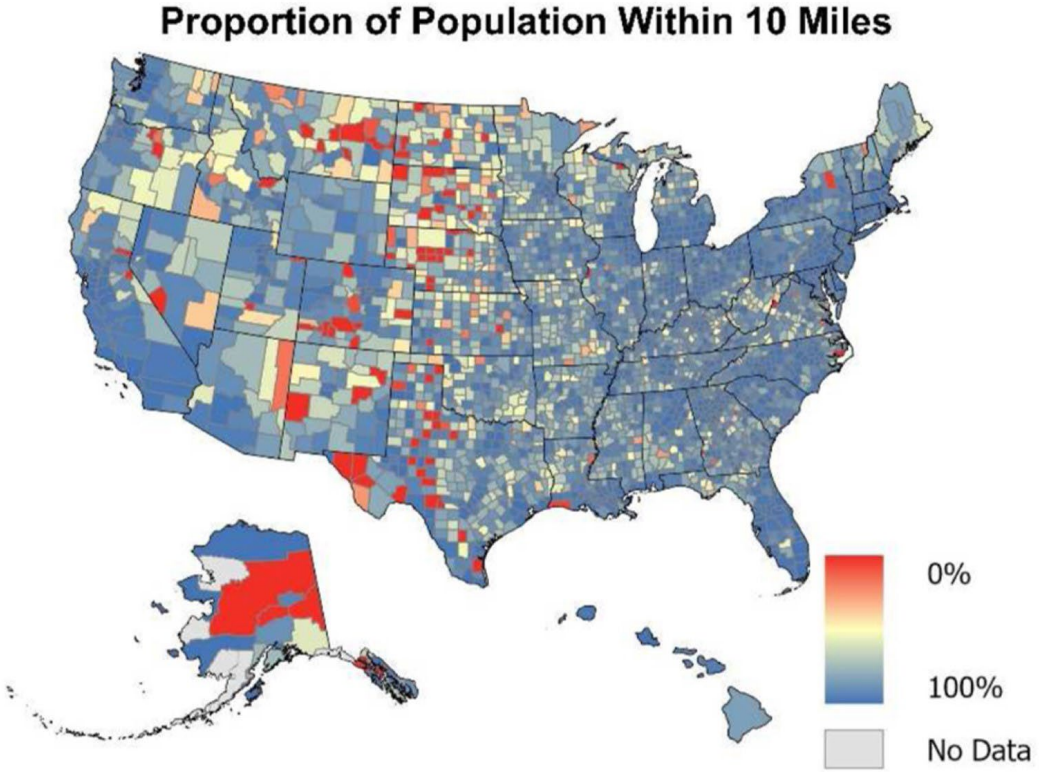
Geographic access

Most U.S. residents live within 5 miles of a community pharmacy

- 48% lived within 1 mile of a pharmacy
- 73% within 2 miles
- **89% within 5 miles**
- **97% within 10 miles**

	Pharmacy Minutes (avg)	Doctor's office Minutes (avg)
Rural (*n*=233)*	14.8	18.5
Urban (*n*=1,240)*	11.1	17.5

*$p<.001$



Brewer, Calo, Shah et al., 2017. AVIP studies.
Berenbrok et al., 2023. *JAPhA*.

Reach to medically underserved communities

Pharmacy can access certain harder to reach communities better than primary care

Independent pharmacies more likely to be accessed by:

- Rural residents
- Non-Hispanic Black residents in urban and rural areas
- 65+
- Low-income households

Hernandez et al., 2023. *Health Affairs Scholar.*

Trust & convenience

Adults visit pharmacies ~2x as often as their primary care providers

- True for many pt populations
- True for geography
  - Rural: ~3x
  - Metro: ~1.6x

Gallup. 2025.
Vallient at al. 2022. *JMCP*.
Berenbrok et al. 2020. *JAMA Netw Open*.

Formative PharmFIT studies

What we learned

Qualitative studies

Patients (*n*=32)

were **comfortable** with pharmacists providing FIT

Physicians (*n*=30)

were **accepting** of pharmacists delivering FITs to their patients

Pharmacists (*n*=23)

were **willing** to provide FIT and thought it was **compatible** with pharmacy workflow

Brenner et al. 2023. BMC HSR.; Ferrari et al. 2023. Trans Behav Med.; Waters et al. 2023. Prev Oncol Epidemiol.

Qualitative studies

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MD & Rx agreed that **appropriate training** should be provided to pharmacists and that **workflows and patient hand-offs** should be clearly detailed from the outset

Brenner et al. 2023. BMC HSR.; Ferrari et al. 2023. Trans Behav Med.; Waters et al. 2023. Prev Oncol Epidemiol.

Qualitative studies

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Pharmacists (*n*=23)

were **willing** to provide FIT and thought it was **compatible** with pharmacy workflow

MD & Rx agreed that **appropriate training** should be provided to pharmacists and that **workflows and patient hand-offs** should be clearly detailed from the outset

Everyone agreed that pharmacists and physicians **should coordinate care**, communicating test results and ensuring that patients are referred to colonoscopy following positive FITs

Brenner et al. 2023. BMC HSR.; Ferrari et al. 2023. Trans Behav Med.; Waters et al. 2023. Prev Oncol Epidemiol.

Quantitative studies

Patients (*n*=1,045)

- Were **highly willing** (>95%) to participate in PharmFIT™, provided **insurance coverage** and that **results are reported to physician**
- Wanted to receive a FIT and counseling **at the pharmacy**, referred by their **physician**, and **mail** the completed FIT back to lab

Pharmacists (*n*=578)

- Were **highly willing** (>95%) to implement PharmFIT™, provided **appropriate training** and **clear workflow/coordination** with physicians regarding test results and patient hand-off

Brenner et al. 2023. Cancer Causes Control.; Shah et al. 2023. CEBP.

Pilot tests of 3 models

Settings

- North Carolina
- Washington

Distribution goal

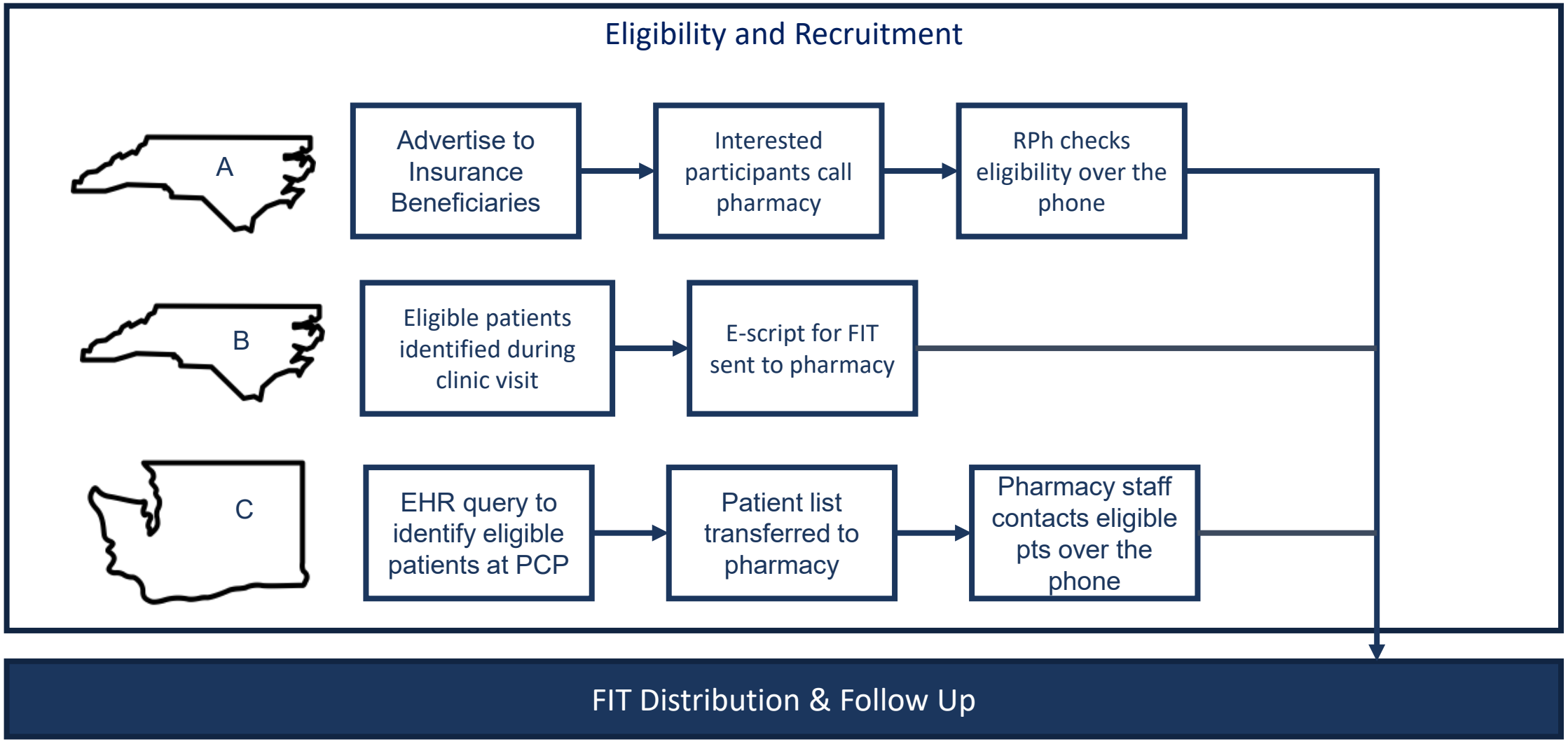
- ~50 FITs in NC
- ~50 FITs in WA

Sites

- 2 NC pharmacies
- 1 WA pharmacy

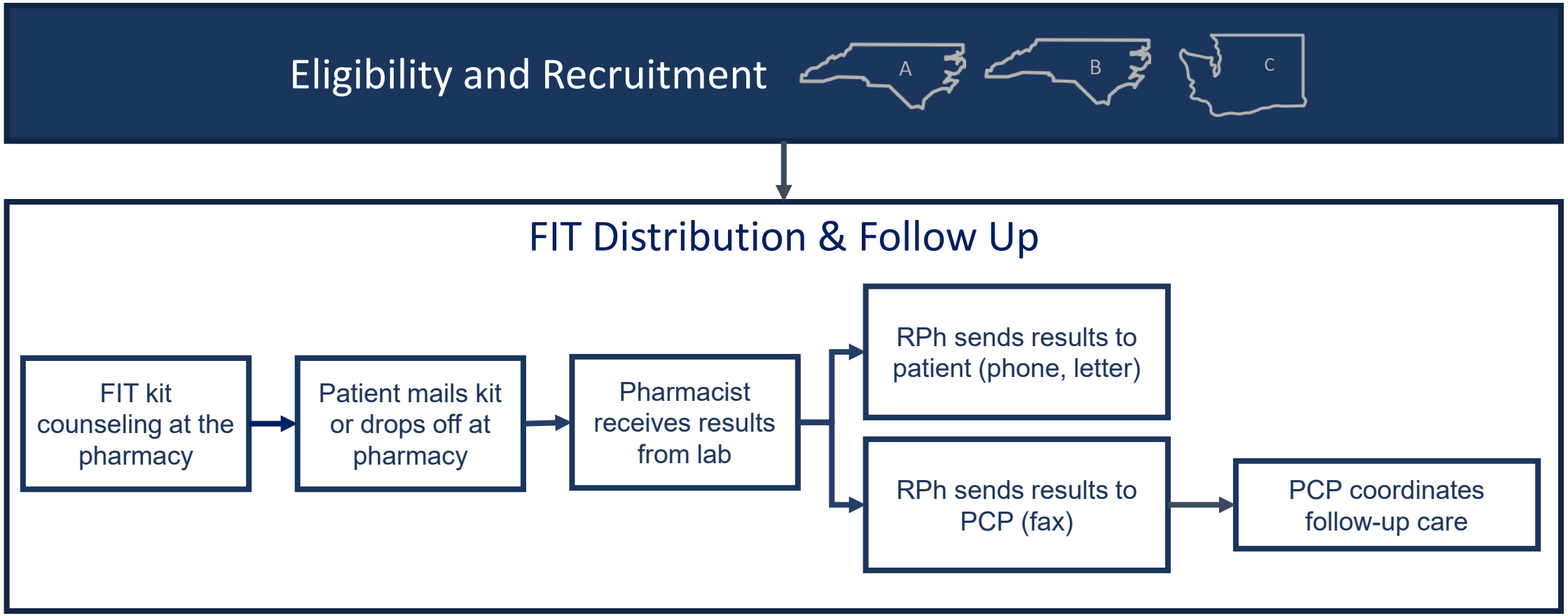
Wangen et al. *In prep.*

Pilot tests of 3 models



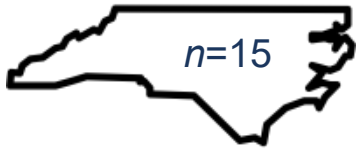
Wangen et al. *In prep.*

Pilot tests of 3 models



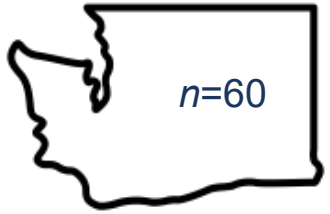
Wangen et al. *In prep.*

Preliminary outcomes assessment



Advertise to Insurance Beneficiaries → Interested participants call pharmacy → RPh checks eligibility over the phone → 93% (14) FIT Pick-up, 100% (14) FIT Return

Eligible patients identified during clinic visit → E-script for FIT sent to pharmacy → 72% (24) FIT Pick-up, 88% (21) FIT Return



EHR query to identify eligible patients at PCP → Patient list transferred to pharmacy → Pharmacy staff contacts eligible pts over the phone → 33% (20) FIT Pick-up, 40% (8) FIT Return

Wangen et al. *In prep.*

Lessons learned & insights

We conducted a rigorous adaptation of FIT outreach from traditional primary care settings to community pharmacies using EPIS

PharmFIT™ is feasible and adaptable for different pharmacy/primary care contexts

PharmFIT™ had a high response rate in all pilots, especially the North Carolina models

The Washington pilot response was comparable to other FIT outreach interventions

Current study

Purpose. To evaluate the effectiveness and implementation of delivering FIT kits for CRC screening in community pharmacies

Funder. National Cancer Institute (1R01CA279010: MPI: Brenner, Shah)

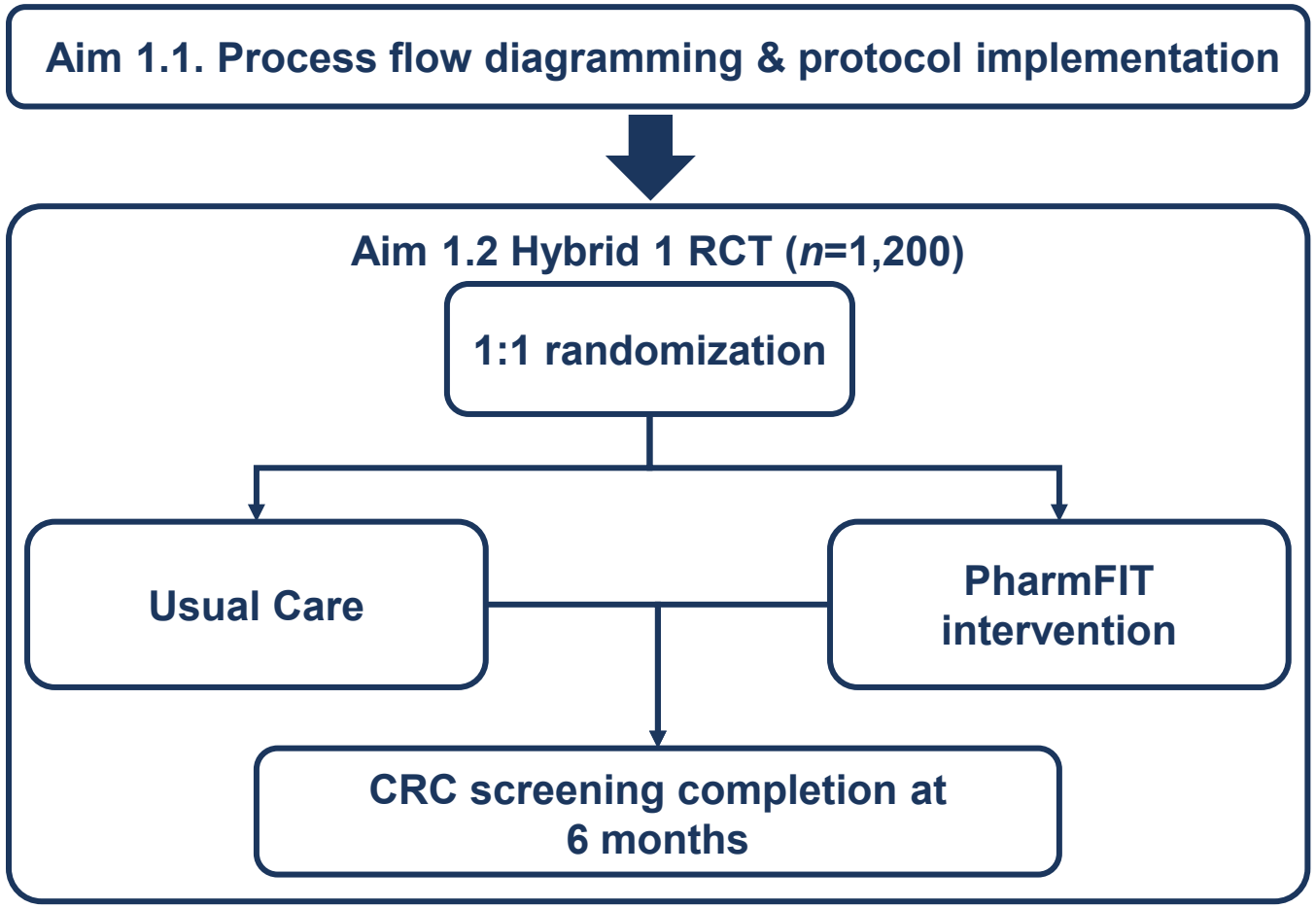
UNC CENTER FOR HEALTH PROMOTION AND DISEASE PREVENTION

Fred Hutch Cancer Center

PharmFIT R01

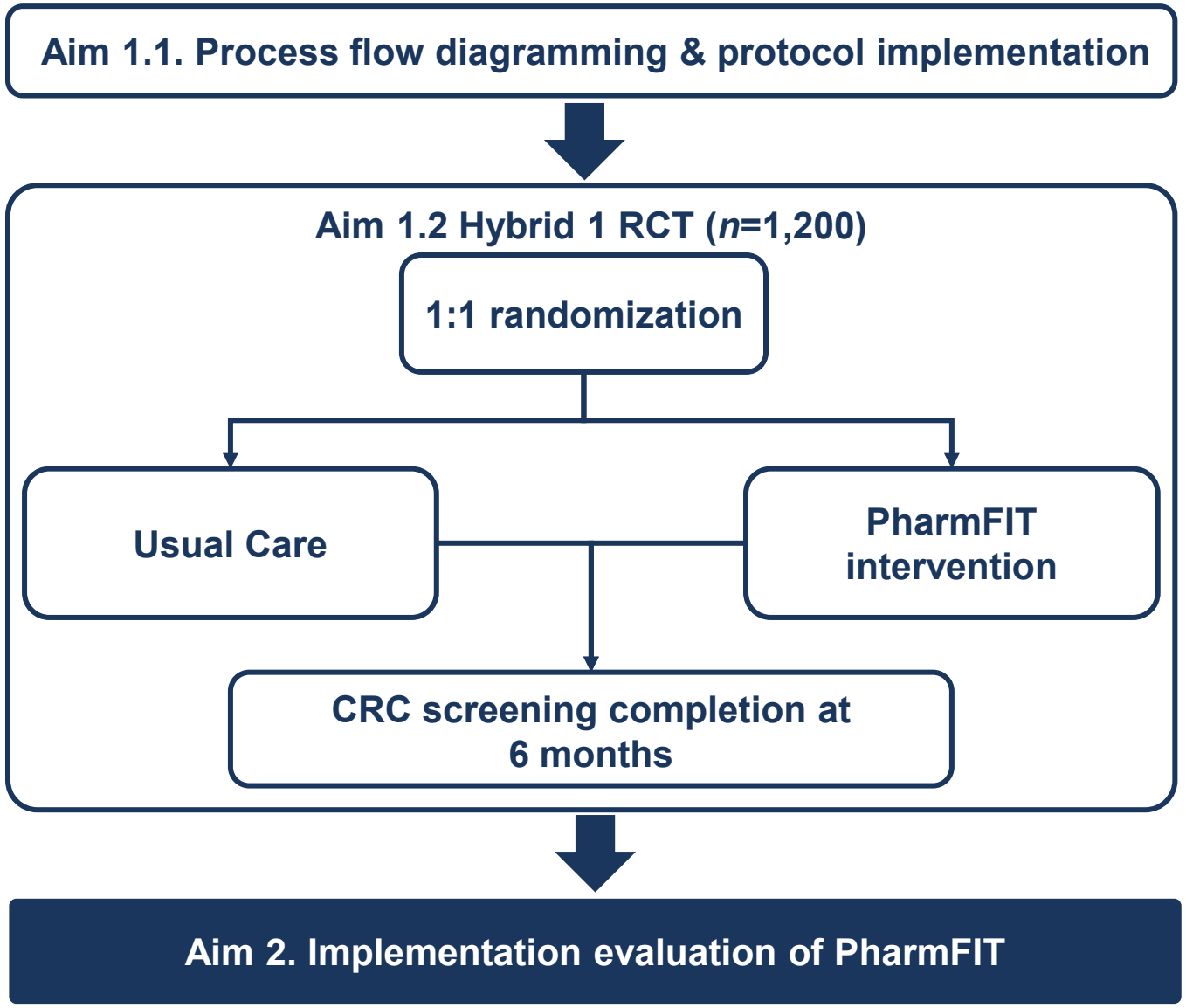
PharmFIT R01

Aim 1.



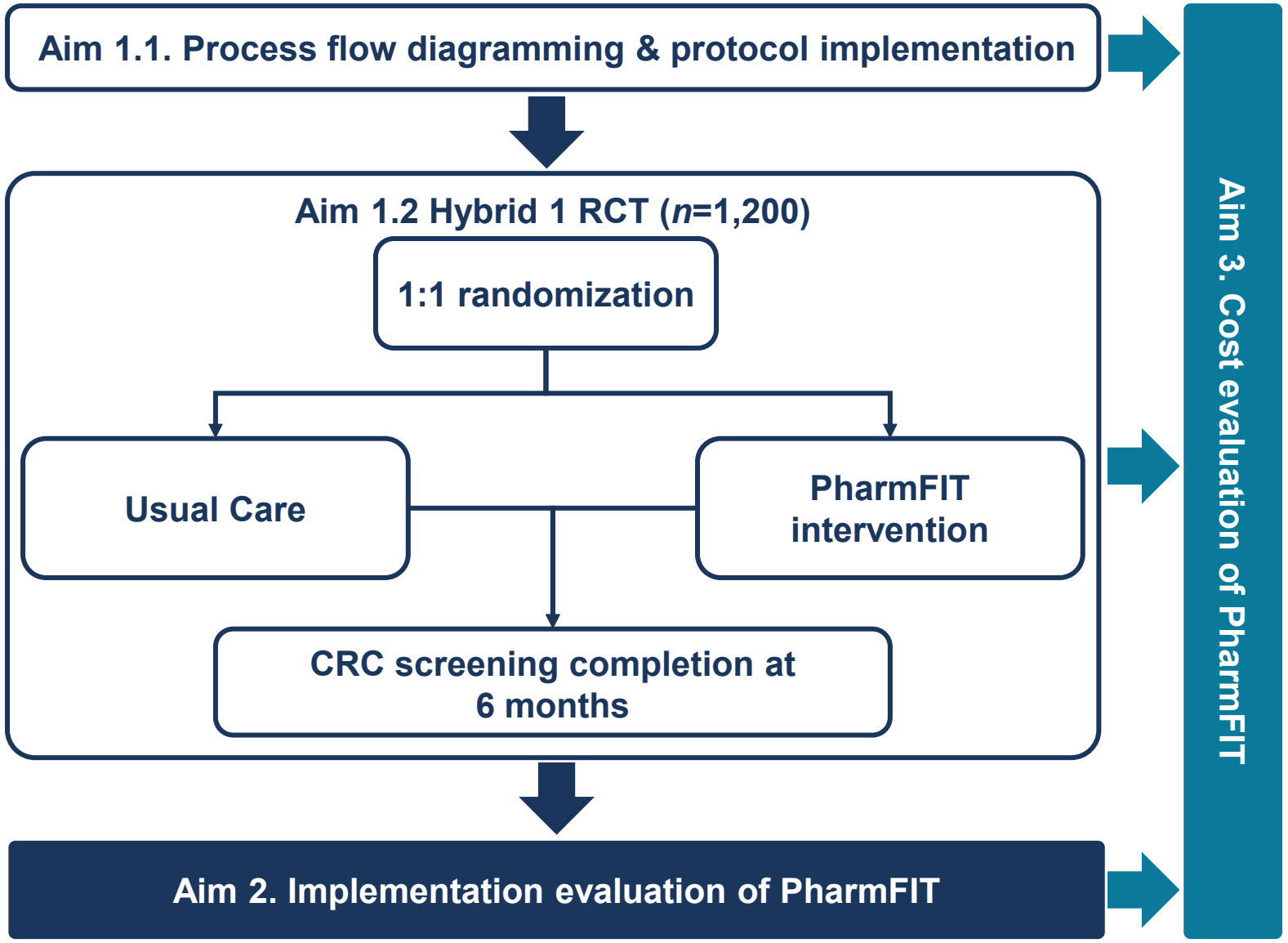
PharmFIT R01

Aim 2



PharmFIT R01

Aim 3



Current trial status

Human subjects approvals. IRB approved; Clinical trial registration

Recruitment. We are actively recruiting clinic/pharmacy clusters in WA state to participate in the study. Clinics qualify if they:

- Provide primary care services to screening eligible adults
- Seeking to improve CRC screening rates for their patient panels

We aim to recruit up to 2 clinics and 4 pharmacies (1:2) to conduct a trial with ~600 screening eligible patients

Fred Hutch
Cancer Center

Thank you

Email: pshah@fredhutch.org

Presentation 3

CRC Screening Outreach and Follow up in Rural Oregon

Speaker: Jennifer Coury, MA

Oregon Rural Practice-based Research Network

Oregon Health & Science University

Colorectal Cancer Screening Outreach and Follow-up in Rural Oregon

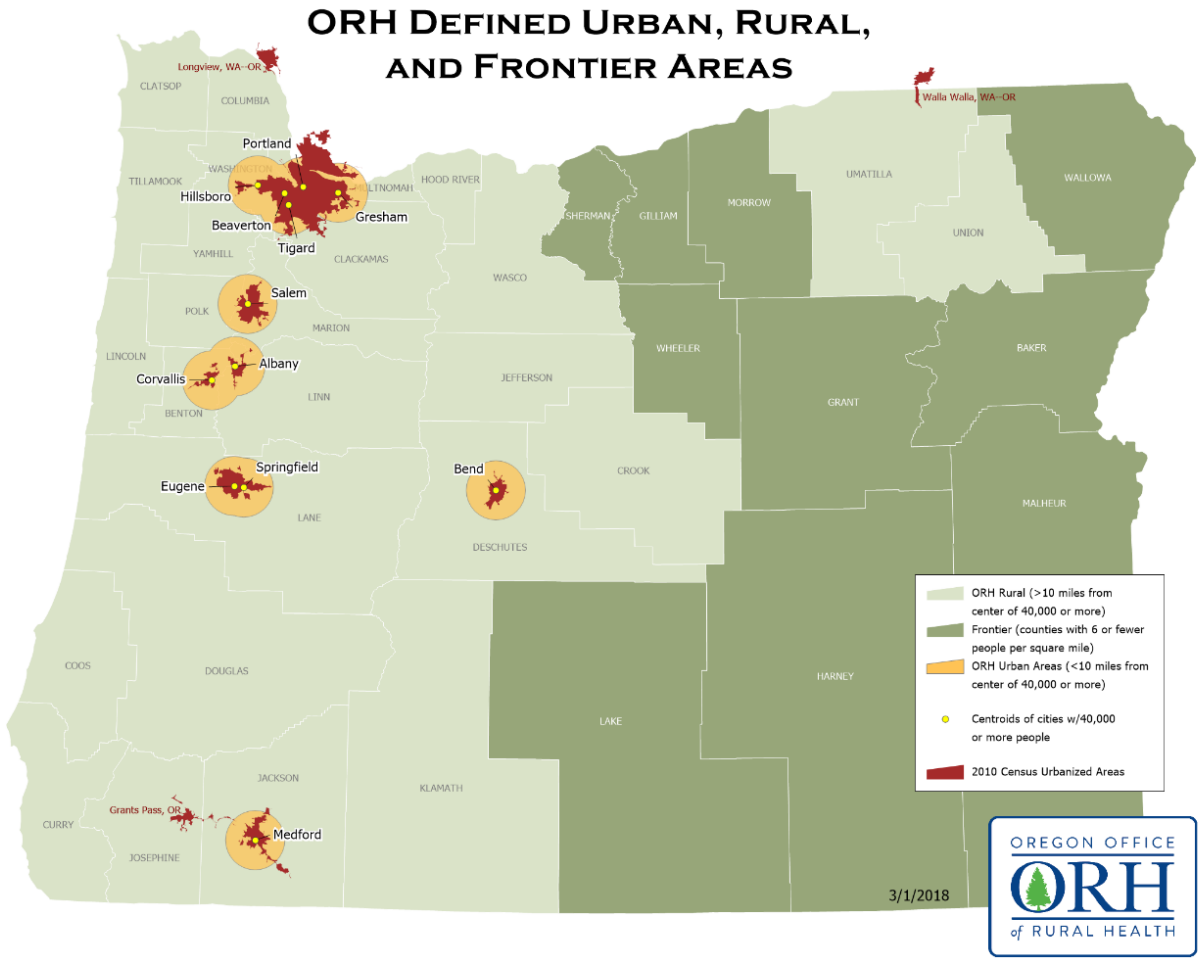
ACCSIS - Oregon

NW Colorectal Cancer Task Force
June 3, 2025

Presented by: Jennifer Coury, MA
Oregon Rural Practice-based Research Network, Oregon Health & Science University

Disparities in Rural Oregon

- 4.1 Million people in 36 counties
  - Majority are rural, 10 frontier
  - 640K people (15%) live in rural Oregon (USDA-ERS definition)
- Various Disparities
  - Income: $50K (rural) vs. $61K
  - Poverty: 15% vs. 12%
  - Education: 11% vs. 8% non-HS
  - Unemployment: 5% vs. 4%
- Higher excess deaths from cancer (62.7/100K)



https://www.ruralhealthinfo.org/states/Oregon; https://www.ohsu.edu/media/881; https://www.kff.org/medicaid/issue-brief/the-role-of-medicaid-in-rural-america/

SMARTER CRC Pragmatic Trial and Scale-up

SMARTER CRC
Improving colorectal health in rural communities

ACCSIS
Accelerating Colorectal Cancer Screening and Follow-Up Through Implementation Science

- Part of a national collaboration: the Accelerating Colorectal Cancer Screening and Follow-up through Implementation Science (ACCSIS)
- A Beau Biden Cancer Moonshot℠ Initiative, UH3CA244298
- Building the evidence base on multilevel interventions to increase rates of CRC screening, follow-up, and referral to care
- MPIs: Dr. Melinda Davis, ORPRN, and Dr. Gloria Coronado, University of Arizona (fmr. Kaiser Permanente Northwest)

Screening More patients for CRC through Adapting and Refining Targeted Evidence-based Interventions in Rural settings

SMARTER CRC Study Design

PHASE 1: PILOT

Adapted mailed FIT and patient navigation for rural and frontier settings

4 pilot clinical practices (~1 health plan)

2020

PHASE 2: INTERVENTION

Ran collaborative program for mailed FIT and patient navigation for abnormal FIT follow-up

28 rural or frontier clinical practices (~3 health plans)

2021	Deliver SMARTER CRC program (half the clinics)	Deliver usual care (half the clinics)
2022	Deliver SMARTER CRC program (all the clinics)	

PHASE 3: SPREAD

Scale-up the program to reach additional health plans, clinical practices, and community organizations

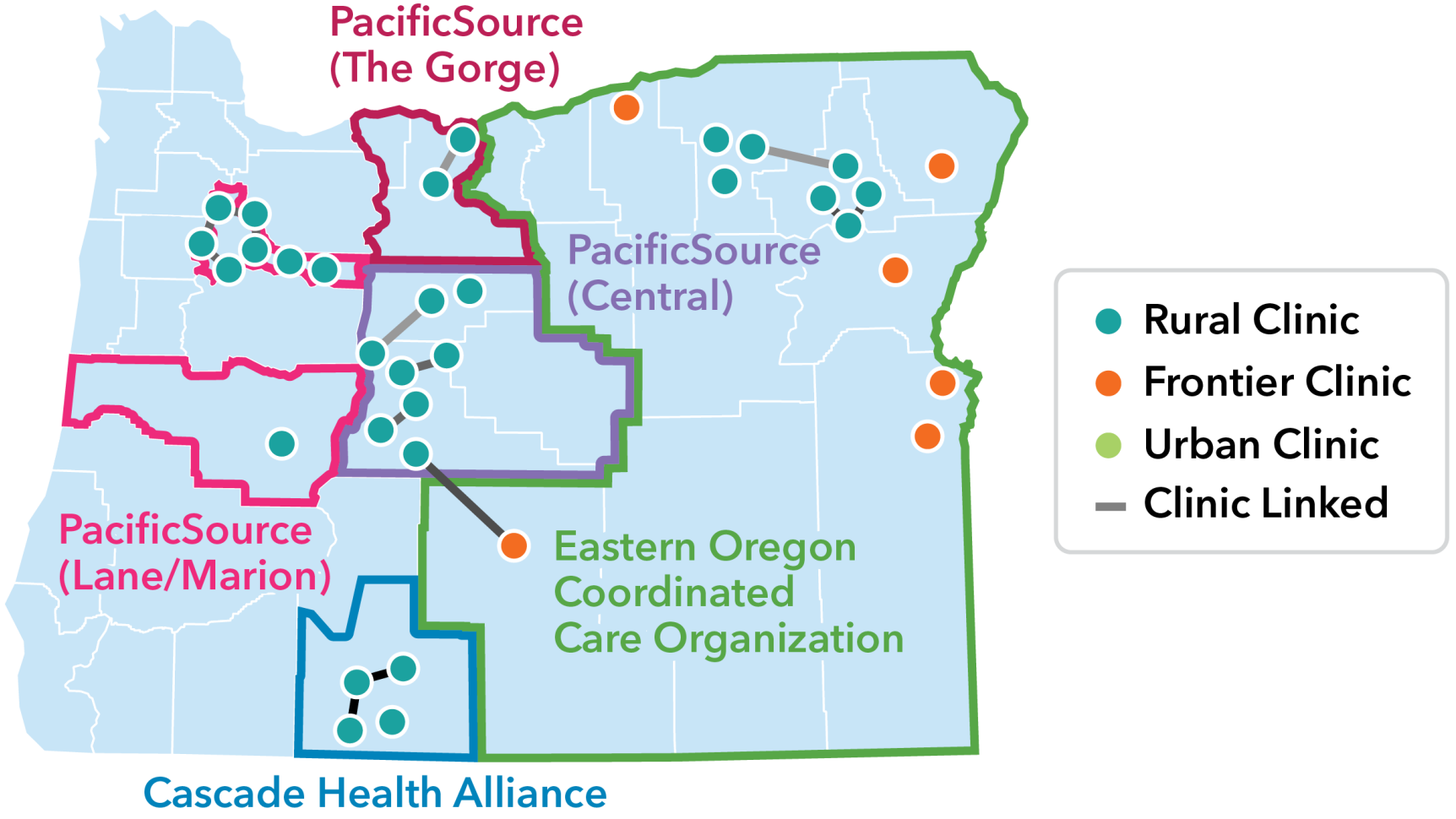
20 Organizations (~130 clinical practices)

- Deliver Learning Community ECHO Sessions on CRC Screening Outreach
- Provide Technical Assistance
- Additional Training and Implementation Materials

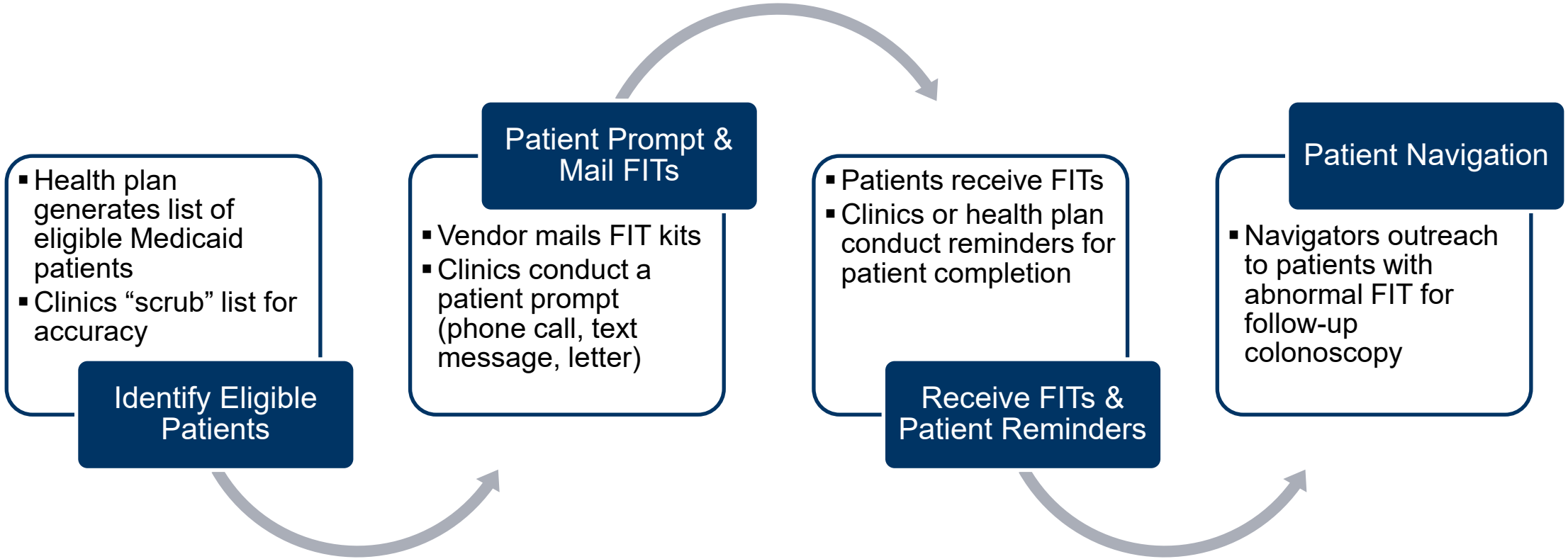
2023

Collaborative Model: Health Plans & Rural Clinics

Coordinated Care Organizations (CCOs)
Responsible for the physical, mental, and dental health of a Medicaid population, regional organizations



Collaborative Mailed FIT & Patient Navigation



SMARTER CRC
Improving colorectal health in rural communities

Characteristics of Participating Clinics

Clinic characteristic (n = 28)	Intervention Clinic Units (n=14)[a]		Usual Care Clinic Units (n=14)	
	N[b]	%	N[b]	%
Federal designation				
Rural Health Clinic	7	50.0	5	35.7
Federally-Qualified Health Center	1	7.1	4	28.6
Tribal Health Center	1	7.1	0	0
No Federal Designation	5	35.8	5	35.7
Clinic affiliation / network structure				
Hospital-affiliated	8	57.2	5	35.7
Health care network-affiliated	2	14.3	2	14.3
Clinic with multiple locations	1	7.1	5	35.7
Individual clinic (single location)	3	21.4	2	14.3
Eligible patients per clinic				
Less than 100	8	57.2	4	28.6
100 to 200	3	21.4	7	50.0
200 or more	3	21.4	3	21.4

[a] One clinic closed, patients were absorbed by other clinics
[b] Percentages do not add up to 100 because values are median clinic percentages.

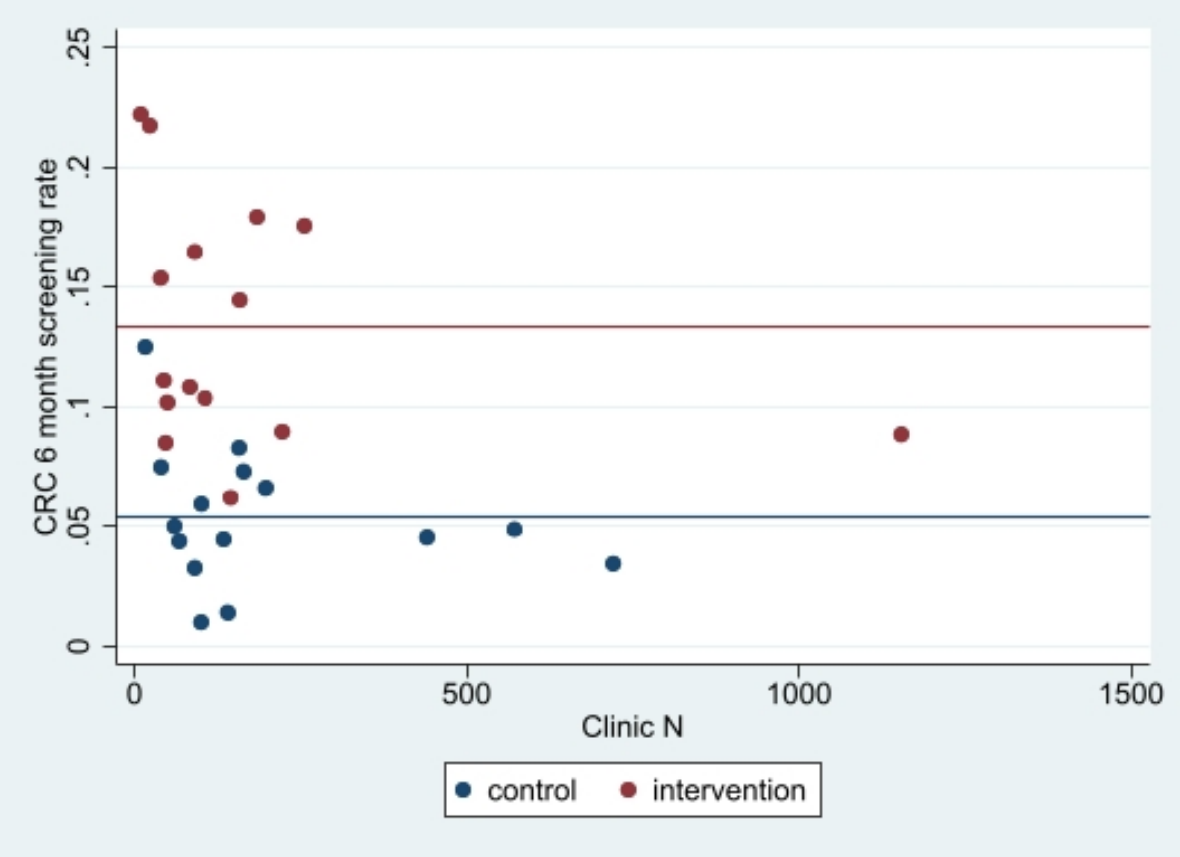
Colorectal cancer screening completion

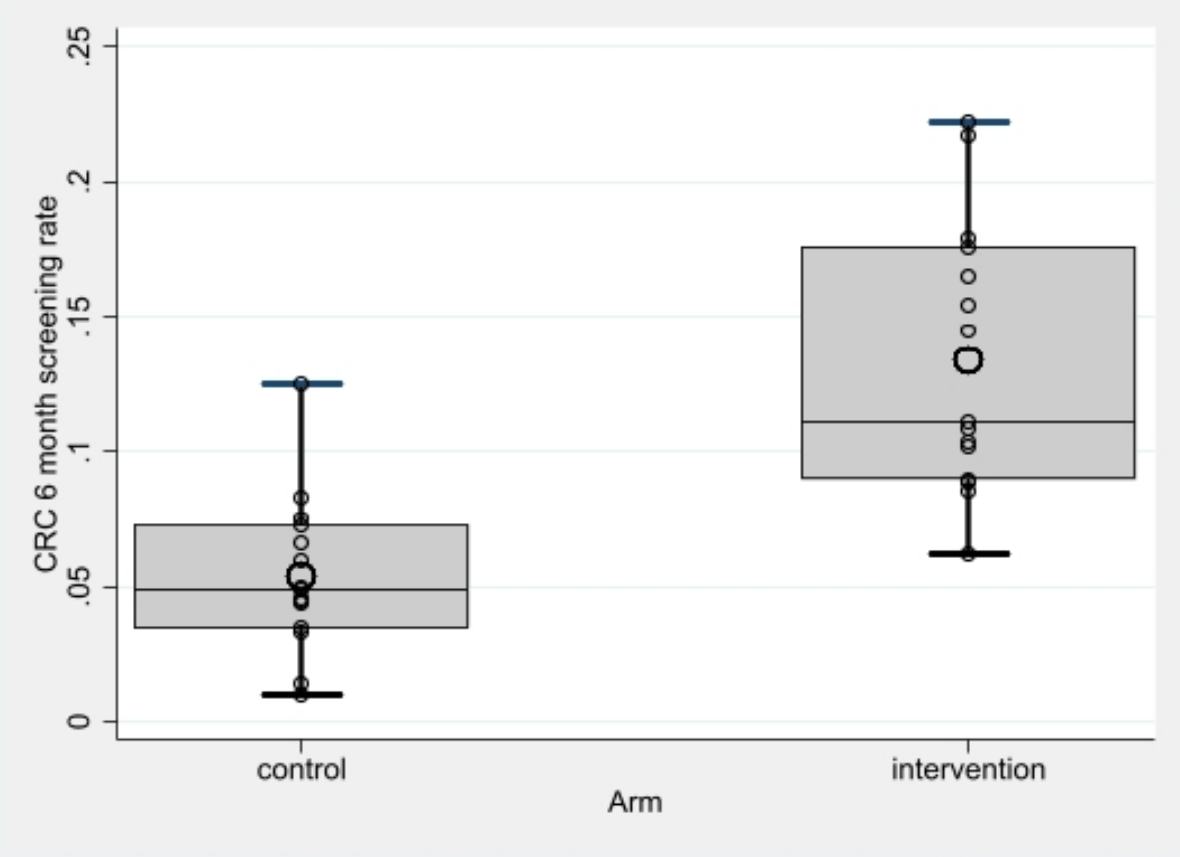
	Intervention	Usual Care	Difference		p value [a]
			Mean %	95% CI	
6 months					
No. eligible CRC screening	2613	3001			
Completed any CRC screening, % (claims data) [b]	11.8	4.5	**7.3**	5.4, 9.2	<.001
Completed FIT, % [b]	8.2	2.2	**6.3**	4.5, 8.2	<.001

[a] 2-sided significance level based on multilevel logistic regression adjusted for gender, age, CCO and intraclass correlation within clinic.

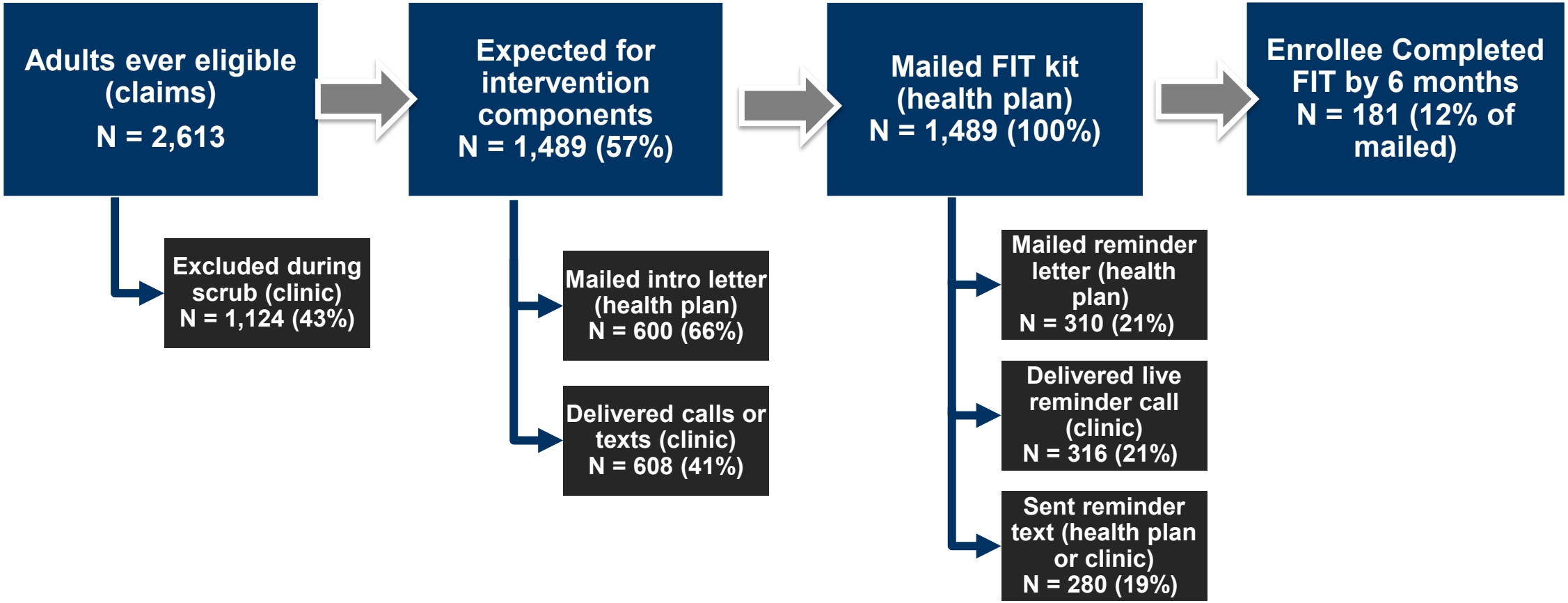
[b] adjusted proportions and differences based on same multilevel logistic regression

Any colorectal cancer screening, 6 months





Pragmatic Trial Implementation



Patient Navigation

- 26 patients needed navigation due to abnormal FIT results; 50% of eligible patients received navigation
  - Only 8 of the 14 intervention clinics (57%) had any patients for navigation
- Barriers included clinic staff turnover and shortages, limited availability for colonoscopies, extended referral waitlists, adequate technology for tracking

Qualitative Findings on Outreach Strategies

- Initial eligible patient list from CCOs did not match clinic eligibility list
- Delays in FIT mailing were disruptive, mail during best windows of time
- Outreach materials must communicate effectively—work with community partners & leverage provider relationships to lend legitimacy to outreach
- Make sure reception staff, lab staff, and clinic staff are all aware of program and procedures
- Staffing shortages were challenging, cross train staff

Scale-up Study

25 Total Organizations* & 47 Total Participants

Participants valued the ECHO activities (mean=3.8; 3.3-4.4) on 1 to 5 scale (least to most satisfied).

* These organizations represented over 350 affiliated clinics

Scale-up Study: Clinic Adoption

Clinic Adoption Activities:

- Hiring dedicated CRC screening staff, training staff
- Increasing clinic staff awareness
- New workflow processes
- Dedicating staff and resources, including patient navigation

Practice Change Activities:

- New patient outreach activities
- Educating patients and staff about CRC screening, mailed FIT
- Reducing patient barriers
- Securing sustainable funding for CRC screening outreach

"We are now doing a mailing FIT campaign. I don't know when that would've happened or if that would've happened anytime soon if we had not participated in this ECHO." ***- Program Participant***

Adoption Facilitators

- **Organizational Facilitators:**
  - Dedicated staff & FTE to support CRC screening
  - Processes & systems to track CRC screening
  - Leadership buy-in & support
  - CRC screening champion

- **Program Facilitators:**
  - Didactic presentations on CRC screening importance, mailed FIT, patient communication
  - Peer-to-peer sharing & expert support
  - Networking
  - Implementation tools *(i.e., outreach materials, resources, and workflow strategies)*

Summary

- Mailed FIT and phone-based models were effective in rural areas
  - Overcame challenges with **travel and access**, but more work to be done
- Collaborative model could reduce clinic burden with adaptations
  - Most consistent implementation was at health plan level, **economies of scale** helped small, rural clinics
  - **Eligible patient list** from health plans required a lot of back and forth
- **Patient navigation** requires buy-in for adoption, staffing, models, tracking adaptations
- Build long-term partnerships/trust increases effectiveness

Acknowledgements

- SMARTER CRC funding is from the National Cancer Institute: The Accelerating Colorectal Cancer Screening and Follow-up through Implementation Science (ACCSIS) Program is a Beau Biden Cancer Moonshot℠ Initiative.
- MPIs: Melinda Davis, Oregon Rural Practice-based Research Network & Gloria Coronado, University of Arizona
- Co-I: Amanda Petrik (Kaiser Permanente Center for Health Research), Erin Kenzie, Michael Leo, Raj Mummadi
- SMARTER CRC Team: Jennifer Coury, Brittany Badicke, Emily Myers, Maryan Carbuccia Abbott, Anders Herreid-O'Neill, Robert Durr, Mellodie Seater, Tiff Weekley, Jamie Thompson, Jen Rivelli, Jessica Currier, Anna Edelmann
- **Thank you to the CCOs, clinics, and scale-up organizational partners!**

Thank you!

Contact:
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smartercrc@ohsu.edu

Citations:

Badicke B, Coury J, et al. Effort required and lessons learned from recruiting health plans and rural primary care practices for a cancer screening outreach study. *Journal of Primary Care & Community Health*. 2024; 15. doi:10.1177/21501319241259915

Coury J, Coronado G, et al. Methods for scaling up an outreach intervention to increase colorectal cancer screening rates in rural areas. *Implementation Science Communications*. 2024 Jan 8;5(1):6. doi:10.1186/s43058-023-00540-1

Ramalingam N, Coury J,et al. Provision of Colonoscopy in Rural Settings: A Qualitative Assessment of Provider Context, Barriers, Facilitators, and Capacity. *The Journal of Rural Health*. Vol. 40, Issue 2, Mar 2024, pp 215-405. http://doi.org/10.1111/jrh.12793

Petrik AF, Coury J, et al. Data Challenges in Identifying Patients Due for Colorectal Cancer Screening in Rural Clinics. *The Journal of the American Board of Family Medicine* February 2023, 36 (1) 118-129; DOI: https://doi.org/10.3122/jabfm.2022.220216R1

Coronado GD, Leo MC, et al. Mailed fecal testing and patient navigation versus usual care to improve rates of colorectal cancer screening and follow-up colonoscopy in rural Medicaid enrollees: a cluster-randomized controlled trial. *Implement Sci Commun*. 2022 Apr 13;3(1):42. https://doi.org/10.1186/s43058-022-00285-3

Breakout Room Discussion

Questions

1. What are some topics, speakers, organizations and/or interventions would you like to include in future meetings?

2. What suggestions do you have for projects the Task Force could work on?

10 minutes in the breakout rooms, and then 5 minutes for report out.

Report out

Wrap up
What's Next?

- Plan our next project

- Continue Communication campaigns

- New Workgroups

Stay Connected:
Northwest CRC Task Force Website & ACS Teams Channel

Task Force Website:

- Northwest Colorectal Cancer Task Force | Healthier Washington Collaboration Portal

ACS Teams Channel

- Contact Char Raunio at Char.Raunio@cancer.org

Upcoming Events

- To post any events on the NW CRC Task Force website, contact Sahla.suman@doh.wa.gov

Next Meeting

- **Northwest CRC Task Force -** Next Meeting
  - October 7th, 2025 (Tuesday) 9:00 am- 11:00 am
  - Virtual on Zoom

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Thank you