Healthy People 2020: Who’s Leading the Leading Health Indicators?
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Public Health Analyst
Office of Disease Prevention and Health Promotion
U.S. Department of Health and Human Services
• Leading Health Indicators are:
  o Critical health issues that, if addressed appropriately, will dramatically reduce the leading causes of preventable deaths and illnesses
  o Linked to specific Healthy People objectives
  o Intended to motivate action to improve the health of the entire population

1200 Healthy People objectives
LHIs are a subset of Healthy People objectives
Who’s Leading the Leading Health Indicators?

Featured Speakers:

• **Carter Blakey** – Deputy Director, Office of Disease Prevention and Health Promotion, U.S. Department of Health and Human Services

• **Lisa Richardson, MD, MPH** – Director, Division of Cancer Prevention and Control, Centers for Disease Control and Prevention

• **Heather Dacus, DO, MPH** – Director, Bureau of Cancer Prevention and Control, New York State Department of Public Health
Clinical Preventive Services

• Clinical preventive services, such as routine disease screening and scheduled immunizations, are key to reducing death and disability and improving the Nation’s health.

• Evidence-based preventive services are effective in reducing:
  o Certain cancers, such as colorectal cancer, breast cancer, and cervical cancer
  o Chronic diseases, such as heart disease and diabetes
  o Infectious diseases, such as influenza, chicken pox, and pneumonia
  o Mental health conditions and substance abuse
  o Vision disorders
Clinical Preventive Services
Leading Health Indicators

- Adults receiving colorectal cancer screening based on the most recent guidelines (C-16)
- Adults with hypertension whose blood pressure is under control (HDS-12)
- Persons with diagnosed diabetes whose A1c value is greater than 9% (D-5.1)
- Children receiving the recommended doses of DTaP, polio, MMR, Hib, HepB, varicella and PCV vaccines by age 19–35 months (IID-8)
Colorectal Cancer and Screening

• Colorectal cancer is cancer that occurs in the colon or rectum.

• Sometimes abnormal growths, called polyps, form in the colon or rectum. Over time, some polyps may turn into cancer.

• Colorectal cancer screening strategies include:
  o Stool tests
  o Flexible Sigmoidoscopy
  o Colonoscopy
  o CT Colonography (Virtual Colonoscopy)

• The U.S. Preventive Services Task Force (USPSTF) recommends that adults age 50 to 75 be screened for colorectal cancer.
Colorectal Cancer and Risk Factors

• More than 90% of new cases of colorectal cancer occur in people who are 50 years old or older.

• Other risk factors include:
  o Personal or family history
  o Inflammatory bowel disease
  o Lack of regular physical activity
  o A diet low in fruits and vegetables
  o A low-fiber and high-fat diet
  o Overweight and obesity
  o Alcohol consumption
  o Tobacco use

• Overall, the most effective way to reduce your risk of colorectal cancer is to get screened for colorectal cancer routinely, beginning at age 50.
Recommended Colorectal Cancer Screening, Adults 50-75 Years, 2018

Notes: — is 95% confidence interval. Data are for persons aged 50 to 75 years who have had a blood stool test in the past year, sigmoidoscopy in the past 5 years and blood stool test in the past 3 years, or a colonoscopy in the past 10 years. Data (except those by health insurance status) are age adjusted to the 2000 U.S. standard population. Data by health insurance status are for persons age 50-64 years, and are not age adjusted.

Source: National Health Interview Survey (NHIS), CDC/NCHS.
Blood Pressure Control, Adults 18+ Years with Hypertension, 2013–2016

HP2020 Target: 61.2

Notes: — is 95% confidence interval. *2005–2008 Total = HP2020 baseline. Blood pressure control is defined as systolic blood pressure <140 mmHg and diastolic blood pressure <90 mmHg among adults with hypertension. Hypertension is defined among adults, excluding pregnant women, as systolic blood pressure ≥140 mmHg or diastolic blood pressure ≥90 mmHg or taking blood pressure lowering medication. Data (except those by insurance status) are for adults aged 18 years and over unless otherwise stated. Data by health insurance status are for adults aged 18–64 years. Data (except those by age group) are age adjusted to the 2000 standard population. Data by age group are not age adjusted. The categories Asian, black and white exclude persons of Hispanic origin. Persons of Hispanic origin may be of any race. Respondents were asked to select one or more races. Data for the single race categories are for persons who reported only one racial group. Target does not apply to age groups.

SOURCE: National Health and Nutrition Examination Survey (NHANES), CDC/NCHS.
### Poor Glycemic Control, Adults 18+ Years with Diagnosed Diabetes, 2013-2016

**Notes:** is 95% confidence interval. Poor glycemic control is defined as HbA1c greater than 9 percent. Diagnosed diabetes is defined as self-reported physician diagnosed diabetes. Women who only had diabetes while pregnant and persons with borderline diabetes are excluded. Women who were pregnant at the time of the exam are also excluded. The categories black and white exclude persons of Hispanic origin. Persons of Hispanic origin may be of any race. Respondents were asked to select one or more races. Data for the single race categories are for persons who reported only one racial group. Data (except those by insurance status) are for adults aged 18 years and over unless otherwise stated. Data by health insurance status are for adults aged 18-64 years. Data (except those by age group) are age adjusted to the 2000 standard population. Data by age group are not age adjusted. Target does not apply to age groups.

**Source:** National Health and Nutrition Examination Surveys (NHANES), CDC/NCHS.
### Recommended Vaccination Coverage, Children 19 to 35 Months, 2018

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<th>Education Attainment (of mother)</th>
<th>Percent Below HP2020 Target</th>
<th>Increase desired</th>
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<td>Total</td>
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<td>Advanced degree</td>
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<th>Family Income (percent poverty threshold)</th>
<th>Percent Below HP2020 Target</th>
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<th>Health Insurance Status</th>
<th>Percent Below HP2020 Target</th>
<th>Increase desired</th>
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<td>Public</td>
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<tr>
<td>Uninsured</td>
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**NOTES:** is 95% confidence interval. Recommended vaccine coverage for children aged 19 to 35 months includes at least four doses of diphtheria-tetanus-acellular pertussis (DTaP), at least three doses of polio, at least one dose of measles-mumps-rubella (MMR), at least three or four doses of Haemophilus influenzae B (Hib) depending on the brand used, at least three doses of hepatitis B antigens, at least one dose of varicella, and at least four doses of pneumococcal conjugate vaccine (PCV).

Data by educational attainment are for children of mothers aged 25 years and over.

**SOURCE:** National Immunization Survey (NIS), CDC/NCIRD.
A National Perspective on Colorectal Cancer Screening
Tracking Colorectal Cancer (CRC) Incidence and Death Rates

Rate per 100,000 (age adjusted)

Incidence

Mortality

HP2020 Target: 40.0

HP2020 Target: 14.5


NOTES: Colorectal cancer mortality (C-5) data are for ICD-10 codes C18-C21 and C26.0 reported as the underlying cause of death and are age adjusted to the 2000 standard population. Colorectal cancer incidence (C-9) data are for ICD-O-3 codes C18.0-C18.9, C19.9 and C20.9 and are age adjusted to the 2000 standard population.


C-9: National Program of Cancer Registries (NPCR), CDC/NCCDPHP; Surveillance, Epidemiology, and End Results Program (SEER), NIH/NCI; Bridged-race Population Estimates, CDC/NCHS and Census.

objs. C-5 & C-9
Decrease desired
Recommended CRC Screening by State, Adults 50–75 Years, BRFSS 2018

Percentage
- 55.0 - 59.9
- 60.0 - 64.9
- 65.0 - 69.9
- 70.0 - 74.9
- ≥75.0

* Up to date = fecal occult blood test (FOBT) within 1 year, or sigmoidoscopy within 5 years with FOBT within 3 years, or colonoscopy within 10 years.
Changes in CRC Screening by State, Adults 50–75 Years, BRFSS 2012-2018

* Up to date = fecal occult blood test (FOBT) within 1 year, or sigmoidoscopy within 5 years with FOBT within 3 years, or colonoscopy within 10 years.
Partnerships to Improve CRC Screening

NCCRT  CDC  American Cancer Society

NCI  Evidence is the Medium of Exchange  FQHCs

States  Health Systems

Insurers
CRC Screening

Increasing Population-level CRC Screening Rates

Colorectal Cancer Control Program (CRCCP)

• System-level integration into primary care systems
• Evidence-based strategies
• Continuous evaluation and improvement
How CRCCP Increases CRC Screening

Evidence-based Interventions (EBIs)*

- Patient reminders
- Provider reminders
- Provider assessment and feedback
- Reducing Structural barriers

Supporting Activities

- Small media
- Patient navigation
- Community health workers
- Provider education

*The Community Guide
https://www.thecommunityguide.org/topic/cancer
Tenets of the CRCCP Model

- Integrate public health and primary care
- Focus on defined, high-need populations
- Establish partnerships to support implementation
- Implement sustainable health system changes
- Use evidence-based strategies to maximize limited public health dollars
- Encourage innovation in adaptation of EBIs
- Use data for program improvement and performance management
CRCCP Awardees

Tribal Organizations:
- Great Plains Tribal Chairmen’s Health Board

Universities:
- Louisiana State University
- University of Chicago
- University of Puerto Rico (not shown)
- University of South Carolina
- University of Wisconsin
- West Virginia University
CRCCP Awardees Reach

240 Health systems

761 Clinics

6,039 Providers

1,240,336 Patients aged 50-75

Source: CRCCP Clinic data, April 2019 submission (Includes clinics recruited in Program Year (PY) 1, 2, 3 and through April 2019 of PY4)
A Closer Look at CRCCP Clinics

761 CRCCP Clinics

- 70% are Federally-Qualified Health Centers (FQHCs)
- 27% serve high percentages of uninsured patients (>20%)
- 50% use FOBT/FIT tests as the primary colorectal cancer screening test type

Abbreviations: FOBT=fecal occult blood test; FIT=fecal immunochemical test
Source: CRCCP clinic data, April 2019 submission (Includes clinics recruited in PY1, 2, 3 and through April 2019 of PY4)
CRC Screening Rates for Clinics Enrolled in PY 1

CRCCP Mean Weighted Screening Rate

Baseline

~260,351 screenings

Year 1

~294,397 screenings

51.7%

Year 2

~309,871 screenings

53.2%

Year 3

~316,315 screenings

Source: CRCCP Clinic Data, April 2019 data submission. PY1 Clinics only; Years 1-3.
Clinic CRC Screening Rates through PY3 Increase with Each Additional EBI Implemented

Source: CRCCP Clinic Data, April 2019 data submission. Year 1 Clinics only; Years 1-3.
Expanding the CRCCP’s Reach and Impact

New Notice of Funding Opportunity (NOFO)

- Initial call for proposals sent out last month
- Official NOFO expected to be posted late December 2019-early January 2020
- Updates available at grants.gov
Thank you!

Go to the official federal source of cancer prevention information:

www.cdc.gov/cancer
Addressing Colorectal Cancer in New York State

Heather Dacus, DO, MPH
Director, Bureau of Cancer Prevention and Control, NYSDOH
Bureau of Cancer Prevention and Control (BCPC)

- The New York State Department of Health BCPC, in conjunction with its key partners, works to reduce the burden of cancer for all NYers through the coordination and implementation of population- and evidence-based strategies.

- The BCPC tracks its progress on goals/indicators specified in the [NYS Prevention Agenda](#) and the [2018-2023 NYS Comprehensive Cancer Control Plan](#).
Colorectal Cancer in New York State

• About 9,000 men and women in NYS are diagnosed with colorectal cancer each year.

• Over 3,100 men and women die of colorectal cancer every year in NYS.

NYS Cancer Registry, 2011-2015
Figure 3  Trends in colorectal cancer incidence and mortality by race and ethnicity, New York State, 2001-2015

(A) Incidence

(B) Mortality

Rates are age adjusted to the 2000 U.S. standard population.
BCPC Colorectal Projects and Partnerships
Key CRC Screening Projects

**Direct Service Provision** - Reaching the uninsured

- NYS Cancer Services Program

**Working with health care systems to implement Evidence-Based Interventions** (Made possible through the CDC’s Colorectal Cancer Control Program)

- Patient navigation to reduce structural barriers
- Quality improvement learning collaboratives
- Academic Detailing/Practice Facilitation
- Exploring opportunities with NYS Medicaid Managed Care Plans
Key Partnerships

- State-funded Cancer Services Program contractors
- NYS Cancer Consortium / CRC Action Team
  - Members include the American Cancer Society and NYC Department of Health and Mental Hygiene, among many others
- Community Healthcare Association of NYS (State Primary Care Association)
  - Multiple Federally Qualified Health Centers across NYS
- NYC Department of Health and Citywide Colorectal Cancer Control Coalition (C5)
- NYS Medicaid
- NYS Partners that have taken the National Colorectal Cancer Roundtable’s 80% Pledge
What is the 80% Pledge?

A National Colorectal Cancer Roundtable initiative to achieve an 80% colorectal cancer screening rate among men and women ages 50 to 75 years.

Began in 2015 as ‘80% by 2018’

Renewed in 2019 as ‘80% in Every Community’
New York

• 14 Academic Institutions
• 14 Cancer Centers
• 18 State/City/County Health Departments
• 25 Community Organizations
• 14 Employers
• 20 FQHCs

Total Pledges

183

• 7 Health Plans
• 30 Hospitals/Health Systems
• 9 Primary Care Practices
• 11 Gastroenterology practices
• Primary Care Association, Quality Improvement Organization, Faith-Based Organization, among others
NYS Cancer Services Program
(Direct Screening Provision to the Uninsured)
NYS Cancer Services Program

• Contractors across NYS that:
  – Provide breast, cervical and colorectal cancer screening and diagnostic follow-up to uninsured
    • Partner with over 1,400 medical facilities and over 3,500 individual providers
    • Promote cancer screening in their regions
    • Public education and targeted outreach
  – Provide case management:
    • Follow up on results and coordinate with providers to schedule diagnostic services
    • Provide treatment referrals, as needed
      – 94% initiated treatment within 60 days
Colorectal Cancer Screening for the Uninsured through the NYS Cancer Services Program

Since 2007:

• Over 60,000 adults received CRC screening and/or diagnostic follow up.
• Most were average risk and screened using stool-based tests.
• Nearly 9,700 screening colonoscopies were performed for increased/high risk individuals.
• Over 5,500 diagnostic colonoscopies for either positive stool-based tests or who were symptomatic for CRC.
Implementing Evidence-Based Interventions in Health Care Systems (With CDC CRCCP funding)
Evidence-Based Interventions and Navigation in Federally Qualified Health Centers

• Project started: October 1, 2016
• Number of FQHCs: 4, working across 8 practice sites
• Tasked with:
  – Implementing EBIs to increase cancer screening rates at selected sites
  – Providing navigation services (as a supportive strategy)
    • Contacting patients in need of screening, assisting with scheduling appointments, addressing barriers to screening completion, follow up on abnormal screening, linking patients to cancer treatment (if needed)
  – Planning for sustainability beyond grant funds
    • Focus on perceived value of the EBIs and PN, monitoring and feedback to key partners, engaging leadership, and ensuring staff have the skills and resources need to continue the work
# Focus of Evaluation Efforts

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<tr>
<th>Evaluation Question</th>
<th>Measures</th>
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<tr>
<td>To what extent do practices adopt and implement EBIs to support cancer screening?</td>
<td>Number and type of EBIs and health systems changes adopted</td>
</tr>
<tr>
<td>What are facilitators and barriers to adopting and implementing EBIs?</td>
<td>Factors identified by project teams that facilitate or create barriers to EBI implementation</td>
</tr>
<tr>
<td>Do cancer screening rates increase from baseline?</td>
<td>% increase from baseline in the percent of target population screened</td>
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Implementation of Evidence-Based Interventions (EBIs)

Colorectal Cancer Screening

- Patient Education (8 sites)
- Provider Reminder Systems (8 sites)
- Patient Reminder Systems (8 sites)
- Reducing Structural Barriers (8 sites)
- Provider Assessment and Feedback (8 sites)
- Standing Orders (6 sites)

Barriers and Facilitators:

Colorectal Cancer Screening EBIs
- Provider test preference can be a barrier → promotion of different test options helps address patient barriers

Addressing Structural Barriers
- Transportation assistance
- Referrals for uninsured
- Providing information in multiple languages

Provider and Patient Reminder Systems
- Integration of patient navigator into the processes and workflow
- Considering provider and patient communication preferences

Navigation

<table>
<thead>
<tr>
<th>Patients Contacted &amp; in Need of Screening</th>
<th>Patients Received Cancer Screening</th>
<th>Patients Completed Follow-up Diagnostics</th>
<th>Patients Navigated to Cancer Treatment</th>
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<tr>
<td>9,991</td>
<td>2,016</td>
<td>198</td>
<td>48</td>
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Navigation and Evidence-Based Interventions in FQHCs
Average, Minimum, and Maximum Colorectal Cancer Screening Rates

TY Sept 2016
TY Mar 2017
TY Sept 2017
TY Mar 2018
TY Sept 2018
TY Mar 2019

7 sites
7 sites
8 sites
8 sites
8 sites
8 sites

Minimum
Average
Maximum

% screened
0%
10%
20%
30%
40%
50%
60%
70%
80%

TY Sept 2016 38.1%
TY Mar 2017 42.0%
TY Sept 2017 44.3%
TY Mar 2018 46.3%
TY Sept 2018 47.8%
TY Mar 2019 47.4%
Evidence-Based Interventions in NYS Medicaid Managed Care Plans

• Beginning in 2015, the NYSDOH BCPC began a project with three NYS Managed Care Plans in two Upstate regions of the State (Adirondack and Central New York)

• *Project Goal:* Improve CRC screening rates in the MMC population by implementing *evidence-based interventions*
New York State Medicaid

- One of the largest, most diverse Medicaid programs in the country
- As of January 2019, over 6.1 million New Yorkers covered
  - The majority (4.7 million) are enrolled in Medicaid managed care (MMC)
  - Health plans submit an encounter record every time an enrollee has a face-to-face visit with a Medicaid provider
    - These data are used to evaluate quality of care
CRC Screening in NYS Medicaid

• CRC screening is covered in the NYS Medicaid benefit package

• Over 600,000 MMC enrollees, between the ages of 50-75, are eligible for screening

• Statewide MMC CRC screening rates lag behind statewide commercial plan rates.

https://www.health.ny.gov/health_care/managed_care/reports/eqarr/
Priority Regions

Adirondack (ADK) counties: Jefferson, St. Lawrence, Franklin, Clinton, Hamilton, Essex, Warren, Saratoga, Fulton & Washington

Central NY (CNY) counties: Cayuga, Chenango, Lewis, Madison, Onondaga & Oswego
Evidence-Based Interventions Used

**Patient Reminders** (targeting members not up-to-date with screening):
- Mailing of Patient Reminder letters/educational brochures
- Tested offer of $25 incentive to subset of letter recipients (1st two rounds)
- Telephone calls to subset of letter recipients (added in 2nd round)

**Reducing Structural Barriers:**
- Promotion of Medicaid Transportation Benefit

**Provider Reminders and Education** (health plans conducted this work):
- Mailing of Provider Letters
- Promotion of Continuing Education Courses
- Education around Fecal Immunochemical Testing (FIT)
Refining Outreach Methods to Improve Screening Rates – Tracking Screening Among Intervention Cohorts

Screening Rates Over 6 Cycles by Method of Outreach

*CNY 3 is still in progress
### Annual Relative Change Among Regional Health Plan Screening Rates

#### Plan A ADK

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<td>5.15%</td>
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#### Plan B ADK

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#### Plan A CNY

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#### Plan B CNY

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#### Plan C CNY

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<td>8.32%</td>
<td>20.26%</td>
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So, How Are We Doing Across the State?
• A report highlighting progress on CRC screening across NYS

COLORECTAL CANCER SCREENING IN NEW YORK STATE

Progress towards 80% by 2018 and a Call to Action for 80% in Every Community

PROGRESS REPORT 2019

The NYS Colorectal Cancer Action Team is a subcommittee of the NYS Cancer Consortium, made up of members from the NYS State Department of Health, NYC Department of Health and Mental Hygiene, American Cancer Society, Mount Sinai Hospital, the Community Health Care Association of NYS, Capital District Physicians’ Health Plan, the Colon Cancer Foundation, St. Lawrence County Health Initiative, Northwell Health, Memorial Sloan Kettering Cancer Center, Columbia University Medical Center and Physician’s Endoscopy.
Colorectal cancer screening has increased over time, but, as a state, we’ve hit a plateau at 70.1% (we still have work to do to get to 80%!)

Rates vary across the state, with county-level rates ranging from 54% to 84%
Colorectal cancer screening* rates are lower among:

- Those ages 50 to 64 (66.3%) versus those ages 65 to 75 (77.9%)
- Those without a regular health care provider (32.9%) versus those with a regular health care provider (73.3%)
- Those without health insurance (50.9%) versus those with health insurance (71.5%)
- Men (69.0%) versus women (71.1%)

NYS Behavioral Risk Factor Surveillance System, 2017
Screening defined as FOBT/FIT within 1 year, colonoscopy every 10 years or sigmoidoscopy within 5 years with FOBT/FIT within 3 years
Colorectal cancer screening rates have been increasing among health plans in NYS, with variation seen among different insurance products.1

Data Source: NYS Managed Care Quality Reports
NYS FQHCs are making great progress, with a 41% increase in the percent screened from 2013 to 2018. NYS estimates of screening consistently exceed national estimates.²

Data Source: Uniform Data System, 2013-2018
Barriers and Challenges

- Continued focus on colonoscopy as the only test option
  - Need to continue to build public and provider awareness of importance of CRC screening and test options

- Competing priorities within busy health care systems
  - Staff turnover is common
  - Provider buy-in can change when clinic priorities change

- Workflow changes only sustainable when embedded into office policies/procedures/job descriptions

- Data quality must be an ongoing focus
Lessons Learned – Next Steps

Value of Collaboration and Partnerships

Use Tested Messaging and Proven Strategies

Promote All Test Options

Continued Resources Needed to Build on Success
Tens of thousands of lives could be saved in New York if colorectal cancer screening rates increased to 80% in Every Community.
Thank you!

Heather Dacus, DO, MPH
Heather.dacus@health.ny.gov
Roundtable Discussion
Stay Connected

- Visit healthypeople.gov to learn more about the Healthy People 2020 Leading Health Indicators

- To receive the latest information about Healthy People 2020 and related events, visit our website to:
  - Join the Healthy People 2020 Consortium
  - Share how your organization is working to achieve Healthy People goals

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