



**CONNECTING RESOURCES: LOCAL, STATEWIDE, AND NATIONAL EFFORTS
TO REDUCE AND ELIMINATE COLORECTAL CANCER MORTALITY AND DISPARITIES
JUNE 16, 2008**

-SUMMARY REPORT-

Background and Purpose:

The National Colorectal Cancer Roundtable (NCCRT) is a national coalition of public, private, and voluntary organizations whose mission is to advance colorectal cancer control efforts by improving communication, coordination, and collaboration among health agencies, medical-professional organizations, and the public. The ultimate goal of the roundtable is to increase the use of proven colorectal cancer screening tests among the entire population for whom screening is appropriate. Through its collective efforts, the roundtable will:

- Strengthen the network of public and private organizations concerned with promoting colorectal cancer screening.
- Determine clinical and consumer barriers to screening through research.
- Assess current public awareness of and interest in screening.
- Develop and disseminate health messages.

The NCCRT visit to Boston follows the productive 2007 session held in Baltimore. Building upon that discussion, the NCCRT in collaboration with the Harvard School of Public Health-Division of Public Health Practice, the Dana Farber Cancer Institute, and the Boston Medical Center convened local, state, and national leaders to discuss Colorectal Cancer (CRC) programs in Massachusetts, and in particular those in Boston. This discussion aimed to support the NCCRT in gaining an understanding of local CRC issues and how they are being addressed in an effort to share lessons learned with NCCRT members.

This conference included a full day of activities. The morning session was hosted at the Harvard School of Public Health, Division of Public Health Practice. The session Co-Chairs were Howard K. Koh, MD, MPH, the Harvey V. Fineberg Professor of the Practice of Public Health, Associate Dean for Public Health Practice and Director, Division of Public Health Practice and Karen Emmons, Ph.D., Professor in the Department of Society, Human Development, and Health at the Harvard School of Public Health, faculty member in the Center for Community-Based Research at the

Dana-Farber Cancer Institute and Deputy Director of CCBR and Associate Director of The Initiative to Eliminate Cancer Disparities of Dana Farber Cancer Institute and Harvard Cancer Center. The afternoon session Chair was Paul Schroy, MD, MPH, Director of Clinical Research for the Section of Gastroenterology, Associate Professor of Medicine at Boston University School of Medicine and Associate Professor of Epidemiology/ Biostatistics at the Boston University School of Public Health. Ten presentations were given throughout the day. Most presentations included a PowerPoint presentation, which is available upon request. A summary of each follows.

Massachusetts Health Care Reform Overview presented by Nancy Turnbull:

Chapter 58, known as Health Care Reform, was passed by the Massachusetts state legislature and signed into law in April 2006. Health Care Reform is aimed at providing access to affordable, quality, and accountable health care for Massachusetts residents.

The primary goals of Health Care Reform include:

- Subsidize insurance for low and moderate income
- Reform the non-group/individual market
- Require individuals age 18+ to have health insurance
- Require employers w/ 11+ FTE-employees to make a “Fair Share” contribution
- Increase Medicaid reimbursement levels

Massachusetts Health Care Reform is built upon the premise that individuals and employers will share responsibility for providing coverage. As of July 1, 2007, all Massachusetts adult residents are required to have health insurance. Employers are required to make a “fair share contribution” to this coverage.

According to Urban Institute data for Fall 2006 and Fall 2007, Health Care Reform has: reduced the rates of un-insured among working-age adults by almost half; improved access to care; reduced out-of-pocket health care costs; and reduced medical debt. Overall, support for Health Care Reform remains high in Massachusetts.

MDPH Women’s Health Network presented by Mary Lou Woodford:

Women’s Health Network (WHN) Program began in 1992. The program began as the Breast and Cervical Cancer Initiative with screening for breast and cervical cancer beginning in 1993. To date more than 80,000 uninsured women have been screened, with more than 1,200 breast cancers, 2,400 cervical disorders, and 340 cervical cancers detected to date.

WHN funding is made available through the Centers for Disease Control and Prevention (CDC), National Breast and Cervical Cancer Early Detection Program, WISEWOMAN (Well-Integrated Screening and Evaluation for Woman Across the Nation), and the Massachusetts State Legislature.

As Healthcare Reform continues to shape the healthcare environment in Massachusetts, the Women’s Health Network has had to adapt its program services as well. Historically, the program has only provided services to the uninsured and

underinsured, however this new healthcare world has created opportunities to interact and help many more low income women in the Commonwealth. The new model of services delivery provides comprehensive care coordination to insured, underinsured and uninsured low income women statewide.

The Women's Health Network has also partnered with the Men's Health Partnership Program to extend services to low income men in the same age group. The new care coordination program provides patient navigation, case management, risk reduction education and valuable support services to ensure that appropriate screening, diagnostics and treatment are initiated in a timely manner. The program provides funding for services not covered by insurance or Health Safety Net. The program seeks to decrease disparities and support healthcare reform by increasing the use of preventive screening, follow up and treatment for breast cancer, cervical cancer, colon cancer, prostate cancer and heart disease. Currently the program has 17 contracts across the state and plans to coordinate care for 8,000 men and 27,000 women age 40 and over. All enrolled individuals will receive education and assistance to ensure appropriate screening is completed in a timely and effective manner. Patient navigation will be conducted by community health workers to assist in overcoming any barriers to completion of the recommended care plan.

The Care Coordination Model follows evidence based guidelines to assist providers and communities in maximizing eligibility, reach, and services. The model supports the essential components of the patient-centered medical home criteria. Projected short term outcomes of this new model include: increased knowledge about the importance of prevention, early detection and disease management, increased number of low income men and women who obtain preventive services, increased use of evidence-based prevention and disease management services, increased number of low income men and women that receive primary care, decreased disparities in utilization of evidenced based prevention and disease management service, increased culturally diversity in the healthcare workforce, increased case management workforce, and increased patient and provider satisfaction in the healthcare system.

In the long term, WHN hopes this the new model will decrease healthcare costs resulting from early identification; disease management and early initiation of treatment; decrease, pain and suffering resulting from chronic disease, including cardiovascular disease; and cancer and decrease mortality from chronic disease, including cardiovascular disease and cancer.

Colorectal cancer education, screening and follow up are part of the program's new agenda. Comprehensive patient and provider education should help to increase compliance with recommended CRC screening performance measures.

MassCONNECT presented by Howard Koh, MD, MPH:

The MassCONNECT is a 5-year \$2.5M Community Network Program (CNP) funded by the National Cancer Institute (NCI). It is one of 25 CNPs across the country that focuses on reducing cancer and cancer health disparities. It is one of four programs

that focus on low socioeconomic position populations. MassCONNECT serves Boston, Lawrence and Worcester.

MassCONNECT, a Community Based Participatory Research (CBPR) project, works closely with four leading Community Coalitions including: the Boston Alliance for Community Health, REACH US CEED in Boston; the City of Lawrence Mayor's Health Task Force and Common Pathways in Worcester.

MassCONNECT's major themes include: education, research, and training. The project goals include: sustaining a strong infrastructure and nurturing partnerships; connecting cancer control resources; conducting community based participatory research; and increasing the use and access to evidence-based cancer prevention and screening services. Additionally, the project seeks to impact policy and improve health communication through many outlets including the media.

MassCONNECT is currently conducting several Pilot Project Studies funded by NCI, including the following:

- Cancer Disparities in Context: Engaging Communities in Monitoring and Mapping (Mentoring Investigator, Nancy Kreiger: PhD and Project Leader: Jarvis Chen, ScD)

The aims of this study are to geocode 1999-2003 Massachusetts Cancer Incidence and Mortality data and link to 2000 U.S. Census tract poverty data and populations denominators to generate smooth, age-standardized cancer incidence and mortality rates for Boston, Lawrence, and Worcester. Results expected in Spring 2009.

- Project Impact: Massachusetts Health Care Reform and Mammography Screening (Mentoring Investigator: Howard Koh, MD, MPH and Project Leader: Sherrie Wallington, PhD)

The aim of this study is to evaluate the impact of the 2006 universal health care insurance law in Massachusetts (which requires all residents have health insurance) on mammography screening utilization for previously uninsured individuals at or below 100% federal poverty level. The study will also assess the barriers and facilitators of screening in light of insurance coverage. Results expected in Spring 2009.

- Challenges in Covering Cancer Disparities: A Study of Journalists (Mentoring Investigator Vish Viswanath: PhD and Project Leader: Sherrie Wallington, PhD)

The aims of this study are to understand how the local media portrays cancer disparities and also to identify barriers which impede reporting on cancer control issues, as well as to offer potential solutions. Results expected in Fall 2008.

- Communication Inequalities on HPV, Cervical Cancer, and the HPV Vaccine (Mentoring Investigator: Vish Viswanath, PhD and Project Leader: Cheryl Clark, MD, SD)

This study seeks to document the communication needs surrounding Human papillomaviruses (HPV) infection and vaccination among low-socioeconomic position black women who are primary caregivers of young women and girls aged 7-20. Results expected in Fall 2009.

-Improving the Process of Cancer Screening for Low-Income Diverse Population (Mentoring Investigator: Terry Field, ScD and Project Leader: Chyke Doubeni, MD, MPH)

This study seeks to examine key facets of colorectal cancer screening for disadvantaged patients in the two community health centers in Worcester. Project aims include: 1) examine patterns of screening among adults served in the community health center setting; 2) conduct qualitative interviews of health care providers involved in providing CRC screening services at the two health centers and area hospitals to identify barriers and opportunities for improving rates of screening and follow-up of abnormal screening; and 3) exploratory analyses to examine the follow-up of abnormal screening. Results expected in Fall 2009.

Other MassCONNECT leveraged large-scale research projects include:

- PLANET MassCONNECT, National Cancer Institute, \$3.5M (Vish Viswanath, PI)

In this project, Dr. Viswanath, in collaboration with Boston Alliance for Community Health, the Mayor's Health Task Force, and Common Pathways, is testing a Community Based Participatory Research (CBPR) model disseminating evidence-based cancer prevention interventions by combining a national resource, the Cancer Control P.L.A.N.E.T., and close collaborations with community partners of MassCONNECT. The project promotes an intervention called PLANET MassCONNECT, a web portal that adopts the national resource to local conditions. The study examines if providing three types of capital—human capital (community health educators serving as technical resources and workshops to train community members), social capital (communications among potential users leading to social capital), and financial capital (modest infrastructure support and pilot intervention grants)—will increase the organizational capacity to plan, adopt, and implement evidence-based cancer control interventions in communities of three different sizes and structures. The outcomes of interest are use, reach, and adoption of PLANET MassCONNECT.

- Community Health Center Screening Project, Centers for Disease Control and Prevention, \$4M (Karen Emmons, PI)

This study, in partnership with the Greater Lawrence Family Health Center, seeks to increase attendance at cancer screening visits by using a CBPR approach to improve cancer screening rates among low-income and minority populations. The randomized control trial will compare different approaches to using technology to facilitate cancer screening. This Lawrence-based study will be of value to the MassCONNECT coalitions, all of whom have prioritized effective use of cancer screening strategies.

- MassCONNECT 4Kids, National Center on Minority Health and Health Disparities, \$2.6M (Howard Koh, PI)

MassCONNECT 4 KIDS proposes a community-based participatory research initiative to compare the effectiveness of a motivational intervention (MI) program with usual best practices to reduce secondhand smoke (SHS) exposure to children. The study will develop a MI program in conjunction with community

partners, integrate it into a health department-sponsored home visiting program for high-risk children, and deliver it through trained community health workers. Potential outcomes include: increased knowledge, attitudes, beliefs about dangers of SHS in the home, in particular the health effects on nonsmokers and children; adoption of a voluntary smoke-free home policy; and evidence of effectiveness of a community-based, participatory, home-visiting intervention through development of new components, or enhancement of current components of an existing home visitation program.

- Women's Health Network Analysis, Massachusetts Department of Public Health, \$.5M (Howard Koh, PI, Rebecca Lobb, Co-PI)

MassCONNECT has recently leveraged funding to conduct a rigorous evaluation of a decade or more of statewide data regarding the Massachusetts Women's Health Network Program. The WHN Program, which provides free breast and cervical cancer early detection and follow-up services to eligible, low income, uninsured, or underinsured women, is now being formally evaluated by MassCONNECT. The program evaluation will document the demographic and clinical characteristics of at least 60,000 women in the program, their case management and health outcomes, and inform a better understanding of how underserved women currently utilize free breast and cervical cancer screening services. The research project will directly impact policy, given that the WHN Program has redesigned its services in response to the new universal health care insurance law in Massachusetts.

MA Colorectal Cancer Working Group presented by Paul Schroy, MD, MPH:

The Colorectal Cancer Working Group was created by the Massachusetts Department of Public Health in 1997 in an effort "to reduce the incidence, morbidity, and mortality of colorectal cancer through education, prevention, early detection, advocacy, policy and research."

The goals of the Colorectal Cancer Working Group are to develop a statewide colorectal cancer plan and provide technical advice to the Massachusetts Breast and Cervical Cancer Initiative Well Women Project's pilot CRC screening project.

The Working Group works with a statewide coalition of public, private, and voluntary organizations and dedicated individuals, including: Department of Public Health, American Cancer Society, Boston Public Health Commission, Massachusetts League of Community Health Centers, Academic centers: Boston University, Dana-Farber Cancer Institute, Tufts University, University of Massachusetts, community hospitals, medical insurers and health plans, professional societies, advocacy groups, and survivors.

The primary goals of the Working Group include: educating the public about lifestyle and risk factors, access and self-advocacy in a culturally and linguistically appropriate manner, eliminating language and cultural barriers to access screening and prevention services, increasing resources for community and workplace-based strategies, and increase the number of people screened.

To achieve these goals, the Working Group will use a variety of media outlets to encourage CRC prevention and screening, including statewide transit media campaigns, radio PSAs, patient information brochures, and develop culturally and linguistically appropriate public education strategies, programs, and materials around CRC prevention and screening.

In addition, the Working Group has developed tools to educate health care professionals about CRC, particularly around ways to increase institutional capacity for prevention and screening. The first statewide survey of beliefs and screening practices of primary care providers in Massachusetts was conducted in 1997. The survey was also repeated in 1999 and 2000.

The long term goals of the Working Group include: obtaining financial resources from federal and state sources for CRC activities, implementing policies improving access to prevention and screening services, mandating payer/managed care guidelines, promoting screening as a standard of quality, educating legislators on CRC, obtaining support for surveillance activities, and surveying health plans across state regarding CRC screening rates and coverage.

Open Doors to Health & Improving Screening through CHCs presented by Karen Emmons, PhD:

“Access” is a major issue in cancer disparities prevention. Some of the challenges in obtaining access include: having health insurance, having a regular health care provider, having systems/settings that implement evidence-based prevention and education strategies, developing interventions that recognize constraints & assets that population experiences, having social support/healthy social norms, and living in a safe, healthy environment.

To reduce CRC disparities though improving access, education programs have been planned with low income housing communities to draw from local leadership structure.

The conceptual model incorporating social context intervention development brings together participant observation and peer leaders to work within and across training sites. Targeted awareness, motivation, skills development, and behavior change and maintenance is promoted through events such as screening bingo, health fairs and cookouts, dancing, and walking.

Through these activities, the group has found that barriers to screening in CHCs center around issues of patient factors, lack of system flags for those due for screening, limited staff time for follow-up/reminders, and time wasted on tasks that could be automated.

CMS Demonstration Project presented by Palmira Santos, PhD:

The Colorectal Cancer Working Group is a partnership with MassPRO Doctor’s Office Quality - Information Technology (DOQ-IT) initiative to increase access and capacity by decreasing missed appointments.

The Primary Care QI Initiative partners with the MassPRO DOQ-IT team of physician advisors to operationalize key assessment, process and procedural steps outlined in “How to Increase CRC Screening Rates in Practice: A Primary Care Clinician’s Toolbox & Guide.” This tool aims to help the physician advisors on the DOQ-IT teams to work with practices on assessment and reengineering office systems. Pilot targeted medium to small practices, including 33 practices, developing 26 clinical measures including breast and CRC in fall/winter 2008.

The Pilot CMS Premier Hospital Quality Incentive Demonstration (HQID) Project trained team of DOQ-IT physician advisors developed a tool kit to bring to the practice, including a practice assessment, establishing policy goals, realign duties and responsibilities, and practice tool assessment.

Though this project, practices learned that their perceived CRC rates were considerably higher than the actual rates. Practices believed that patients did not want CRC screening when in fact the issue was more complex. Through goal setting, some practices did extremely well, doubling their rates with just two policy/process changes. Others however found it more difficult to proceed beyond the assessment. The DOQ-IT team believes that incentives are needed to engage more practices and make this a priority. The pilot folded into P4P demonstration and key focus in the CMS 9th scope of work Quality Improvement Organizations (QIOs) nationally.

Promoting Shared Decision-Making presented by Paul Schroy, MD, MPH:

Shared Decision-Making (SDM) is an interactive process involving information exchange, values clarification, and decision-making within the framework of a provider patient-relationship. The overall objective of this study is to conduct a three-arm randomized controlled trial to evaluate the impact of an interactive, web-based decision aid on shared decision-making and patient adherence to colorectal cancer screening recommendations.

Participants have been drawn from the General Internal Medicine ambulatory care clinics at Boston Medical Center and the South Boston Community Health Center. Inclusion criteria are: (1) Asymptomatic average-risk subjects 50-75 years of age; (2) Under the direct care of one of the staff (attending) physicians or physician extenders; (3) No prior screening other than FOBT; and (4) No major co-morbidities that preclude CRC screening by any method. Eligible subjects were identified and randomly allocated to one of three arms after stratification by site and provider. The three arms will include two intervention arms (decision aid alone versus decision aid plus personalized risk assessment with feedback) and one control arm. Participants randomized to the control arm viewed a generic website that discusses lifestyle changes that can reduce overall cancer risk. The intervention and control web-based interactions took place just prior to a pre-arranged office visit with their provider to discuss CRC screening.

All participants were asked to complete a pretest that assessed knowledge, beliefs, attitudes and behaviors related to colorectal cancer screening. Participants were also asked to complete a posttest after meeting with their provider. The posttest aims to

assess whether CRC screening was discussed, whether a screening strategy was chosen and whether patient felt satisfied with the process and/or screening decision; the posttest also reassessed knowledge, belief and attitudes related to CRC screening. Adherence has been monitored for up to 12 months utilizing computerized appointment schedules and laboratory or endoscopy tracking systems.

As of October 2008, study enrollment was over 700. The project plans to complete enrollment within the next six months and conduct follow-up in a year. The primary outcome of interest is patient adherence. Plans to upgrade the tool are underway. For example, it is currently DVD-based and will be modified to serve as a web-based tool. Additional revisions include expanding the implementation strategy and creating a Spanish language version.

Motivational Interviewing presented by John Wiecha, MD, MPH:

The Theory into Practice System (TiPS) is a project developed to help primary care providers utilize innovative technologies to promote health screening. The online course focuses on developing primary care providers with an understanding of health behavior change. The course will also help primary care providers to improve their communication to help patients choose, and undergo, the method of CRC screening most appropriate for them. By applying the principals learned in the course to critique video interviews, primary care providers have an opportunity to critique their own performance.

This program can help one achieve Pay-for-Performance incentives and possibly board recertification requirements and includes three training components/modules: 1) Improve colorectal cancer screening effectiveness, 2) Improve quality of care of patients with chronic illness and 3) Reduce malpractice risk and improve patient safety through improvements in office systems.

More information about this exciting program and a course demo is available at: <http://www.bu.edu/fammed/cmetips/>

DOTWELL Endoscopy Quality Improvement Project presented by Stephen Tringale, MD:

The DOTWELL Endoscopy QI Project focuses on colonoscopy performance improvement tracking at Codman Square Health Center and Dorchester House Multi-Service Center. Languages include: Vietnamese, Haitian Kreol, Spanish, and Portuguese. In addition, 70% are <200% poverty level.

The primary goal of the Colonoscopy Tracking Performance Improvement Project is to improve the screening colonoscopy rate. Method One includes: establishing a baseline colonoscopy rate, develop an EMR form uploading previous colonoscopy results developing tracking and reporting processes, simplifying referral and scheduling services, and educating providers. Method Two utilizes the rapid scheduling process, patient education (mailing, health center awareness campaign), patient survey, and sustainability.

Data has been compiled for one year and sorted into three groups: Group A (those who did not make an appointment), Group B (those who made appointment but did not attend), Group C (those who attended their appointment). The study found that Group A 29% did not make an appointment because they did not understand the reason for test, 29% did not make an appointment due to anxiety and 29% did not make an appointment due to procrastination. In Group B, 34% did not attend the appointment they scheduled because they did not understand the reason for the test, 55% did not attend the appointment they scheduled due to fear/anxiety, 55% did not attend the appointment they scheduled due to lack of an escort and 30% did not attend the appointment they scheduled because of a language barrier. Finally, Group C results show that 64% completed the colonoscopy because “doctor said so,” 45% cited GoLytely as hardest part, and 27% expressed anxiety.

Challenges to providing these services include limited IT resources, challenges in implementing new tracking process, developing skills, language barriers, and maintaining current contact information for patients.

In 2009, resources will be focused on True Navigation project, developing tools to address anxiety, promoting health benefits, developing education materials, expanding transportation options, and locating cultural and language appropriate resources.

Computerized Patient Reminder System presented by Jim Michaelson, PhD:

Developing an appointment making/reminding system for colorectal cancer screening is critical to increasing screening because a very large number of patients do not complete their appointments. Of the patients that schedule appointments but do not attend them, 40 percent nearly half eventually kept their appointment after follow-up calls.

More than 100 studies have shown that ordinary reminders (especially telephone reminders) will improve the use of breast cancer screening. An inexpensive and easy, technological fix can be found in automated computer generated telephone reminder messages. A decade of study of screening mammography has taught us that annual screening saves lives, particularly when screening begins early and done regularly.

An integrated reminder/tracking system for minimizing delay in the diagnosis and treatment of breast cancer is a useful model. The reminder/tracking system is on a server outside of an individual hospital, so that it can follow a woman wherever she seeks medical care. The reminder/tracking system is located on a server outside of an individual hospital, but it is still be fully secure and HIPAA compliant.

And example of the automated system includes the following message:

The Massachusetts General Hospital is calling with a medical appointment reminder for Ms [first name] [last name]. If this is your name, please press “1” now. Otherwise, press “2”. Nothing pressed – wait 3 seconds: This is an automated message from the Massachusetts General Hospital calling with a

medical appointment reminder for Ms. [first name] [last name]. To confirm the time and day of your upcoming appointment, you may call 617-726-0985 from 9 AM to 5 PM. Thank you. Goodbye.

The current goal is to build a similar program for colorectal cancer screening. Ideally, a comparable system would include a computer generated telephone reminder messages to help patients remember to attend screening visits and receive in-bound 800-number telephone calls for patients interested in screening, engage them in educational IVR conversations about screening, and sign them up for appointments for screening.

Patient Navigation for CRC Screening presented by Chava Chapman, MbBch, MPH:

The role of patient navigation for colorectal cancer prevention and control is important to reducing and eliminating cancer disparities because of the racial and socioeconomic differences in cancer incidence and mortality. Grounding interventions in a strong theoretical framework can help expand the patient navigation model into cancer control projects.

Despite advances in care in the past, men and women of low socio economic position and racial/ethnic minority suffer worse cancer outcomes. Patient navigation can assist in improving outcomes by providing culturally competent logistical and emotional support to patients.

The NCI pilot study suggests that patient navigation improves rates of timely follow-up for abnormal breast cancer screening among urban women in all subcategories. However, there remains a need for multi-center trial with continuous control group to determine if navigation will reduce time to definitive cancer diagnosis (or resolution of abnormality) after an abnormal screening, address 4 screenable cancers (colorectal, breast, cervical, prostate), reduce time to completion of definitive treatment, and improve patient satisfaction with health care services.

On July 1, 2008 a two year screening, risk reduction, education, and treatment program will start at Boston Medical Center and Dorchester House, enrolling women and men age 40-64. This project is aimed at utilizing patient navigators to assess and reduce barriers patients find in care.

Closing Thoughts:

This conference was an incredibly productive session that launched many ideas of potential collaborations beyond the day's activities. Some collaborative ideas were to include some items presented during the day in the CRC Clinician's Guide, utilizing some of the programs in Boston to increase public outreach through the creation of templates for use in other communities, and exploring funding opportunities for screening projects, particularly around what we can learn about colorectal cancer screening in the context of health care reform. Other positive follow-up stemming from the meeting include the launch of AGA's pilot physician volunteer colonoscopy screening program in Boston, applying to do a study on health reform's effect on CRC

screening rates, in collaboration with the Massachusetts Department of Public Health and MassCONNECT as it seeks to renew its grant with NCI. The Roundtable committed to sending a letter of support for the grant renewal and will explore the possibility of providing some modest funds. The conference was also effective in developing relationships between local, state, and national CRC leaders.