# Welcome to the CCAI Annual Meeting!


## Comprehensive Cancer Alliance for Idaho

Feb. 23rd, 2023 @ 9:00am -12:pm MST

*Through the pandemic and the other side:*
*Centering health equity in your work across the cancer continuum*

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HOSTED BY:

**BECKY CREIGHTION**

**Health Program Manager, IDHW**

**BRIE VELTRI, CHES**

**Health Program Specialist, IDHW**

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# Housekeeping:

- Help yourself to drinks (coffee, tea, water)
- Please silence phones. Please mute your microphone
- Restrooms are down the hall on the right
- Anything on your table is up for grabs - stickers, hand sani, pens
- There are pipe cleaners on your table for fidgety fingers
- Please feel free to stand up and stretch throughout
- Visit the exhibit tables and take any resources
- Networking lunch following the presentations

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# Why Are We Here?

**Think about your role and what you do individually, and collectively, to help prevent cancer or find it early through screening**

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# AGENDA

| Time | Session | Speaker |
|---|---|---|
| 9:00 AM | Welcome to the CCAI Annual Meeting! | Becky Creighton and Brie Veltri, IDHW Comp. Cancer Program |
| 9:10 AM | Idaho Statistics 2020 Update | Chris Johnson, Cancer Data Registry of Idaho, IHA |
| 9:40 AM | Data Trends and the Impact of COVID-19 | Bozena Morawski, Cancer Data Registry of Idaho, IHA |
| 9:55 AM | The Value and Integral Role of Healthy Equity in Public Health | Katie Lamansky, Get Healthy Idaho, Idaho Dept. of Health and Welfare |
| 10:15 AM | Break | |
| 10:30 AM | The Power of Partnering to Achieve Health Equity | Dr. Dave Wetter,PhD. Huntsman Cancer Institute, Director of the Center for (HOPE) |
| 11:00 AM | CRC 2023: Updates on Disease State and Screening options | Dr. Catherine Kouchakji, Ph.D. Medical Director Liaison, Exact Sciences |
| 11:30 AM | Health Equity Advocacy in Idaho and Nationwide | Erin Riley, American Cancer Society; Cancer Action Network |
| 11:45 AM | Call To Action | Becky Creighton and Brie Veltri, IDHW Comp. Cancer Program |
| 12:00 PM | Virtual: Close<br>In-Person: Networking and Lunch | |

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# 2021-2025
# Idaho Comprehensive Cancer Plan
## *Review of Data Measures*


**CHRIS JOHNSON**

**Epidemiologist, Cancer Data Registry of Idaho**

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# Acknowledgments and Disclaimer


- This project was funded in whole with Federal funds from the National Cancer Institute, National Institutes of Health, Department of Health and Human Services, under Contract No. HHSN261201800006I, and the Centers for Disease Control and Prevention, Department of Health and Human Services, under Cooperative Agreement NU58DP007160 to the Cancer Data Registry of Idaho, Idaho Hospital Association.


- The findings and conclusions in this presentation are those of the authors and do not necessarily represent the official position of the National Cancer Institute or the Centers for Disease Control and Prevention.

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# Strategic Plans

- Are important for any organization to establish and guide us to accomplish our mission:

***The mission of CCAI is to convene the cancer community, to ensure cancer data are accessible, and utilize our collective impact to address the cancer burden in Idaho.***

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# Outline

- CDRI
- Cancer burden in Idaho
- CCAI Strategic Plan Measures

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# Cancer Data Registry of Idaho

- CDRI is a statewide cancer registry that collects incidence and survival data on all cancer patients who reside in the state of Idaho and out-of-state residents who are diagnosed or treated for cancer in the state of Idaho.
- CDRI was established in 1969 and became population-based in 1971.
- Cancer is a reportable disease under state law, and operations of the registry are mandated by Idaho Code.
- Funding:
  - <1% of the Idaho tobacco tax, sole source contract from IDHW.
  - CDC – National Program of Cancer Registries
  - NCI – Surveillance, Epidemiology, and End Results
  - Grants & contracts
    - Post-marketing surveillance for monitoring drug safety
    - Special projects

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# Cancer Burden in Idaho

- Since 2008, #1 or #2 cause of death in Idaho each year
  - About 20% of deaths are from cancer
- In 2020 in Idaho:

  9,180 new invasive cases

  1,220 new in situ cases

  2,928 cancer deaths

~31% of those diagnosed this year will die of cancer within five years

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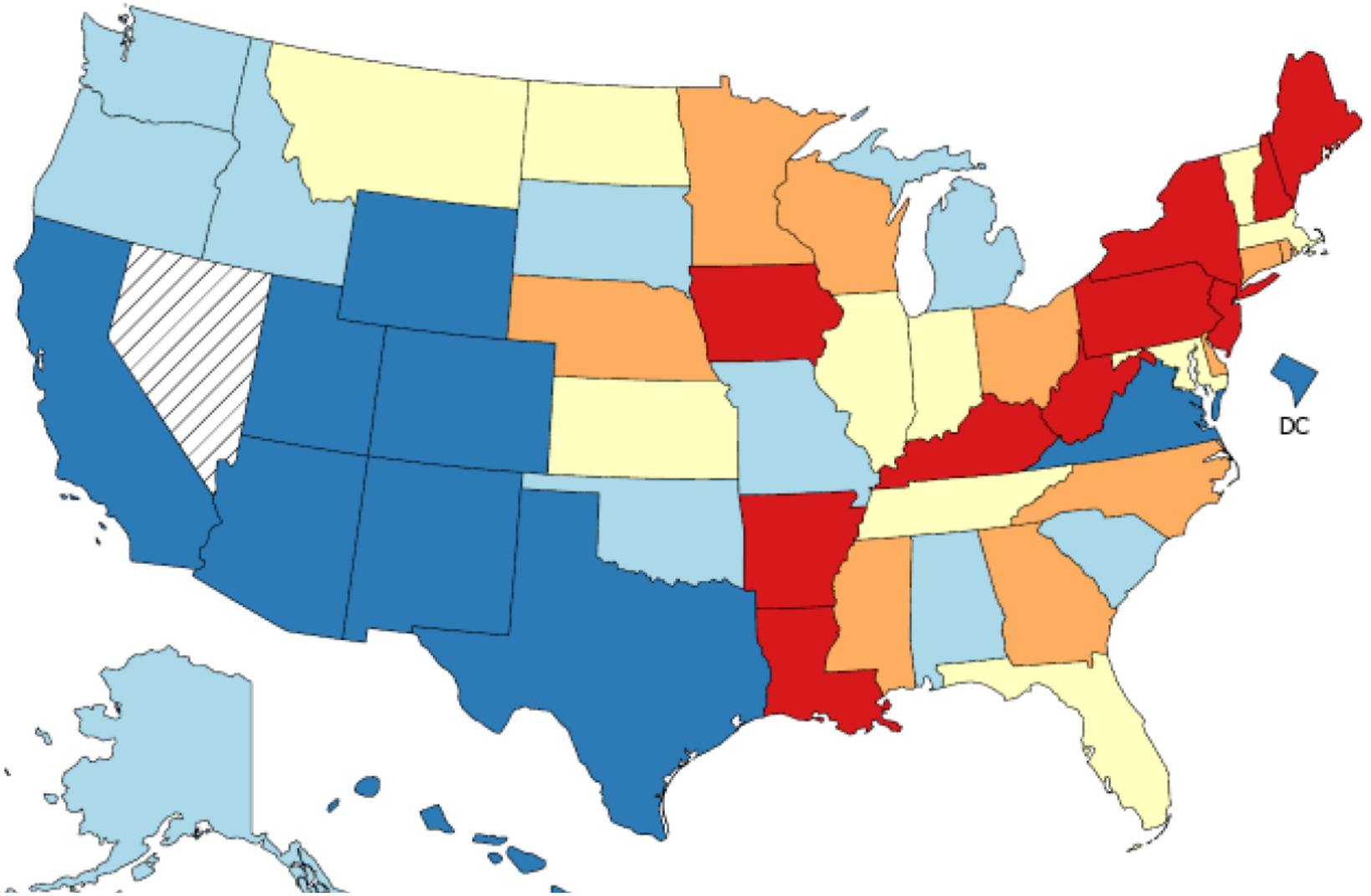
# Incidence Rates† for United States by State

## All Cancer Sites, 2015 - 2019

## All Races (includes Hispanic), Both Sexes, All Ages




Age-Adjusted

Annual Incidence Rate

(Cases per 100,000)

Quantile Interval

- 368.2 to 416.9
- > 416.9 to 453.2
- > 453.2 to 466.5
- > 466.5 to 476.2
- > 476.2 to 516.0
- Data Not Available ◇

US (SEER + NPCR)
Rate (95% C.I.)
449.4 (449.1 - 449.7)

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# Cancer Burden in Idaho

In 2020, Idaho ranked 9th lowest among states for lung cancer mortality, with #1 being lowest.

- This is tied to our relatively low smoking prevalence.

Idaho has among the lowest screening rates in the country (2020 data) for cancers of the:

- Colon and rectum (47th)
- Breast (48th)
- Cervix [Pap] (49th)

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# 2021-2025 Idaho Comprehensive Cancer Strategic Plan

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# 2021-2025
# Idaho Comprehensive Cancer Plan
# Update on Data Measures

Across the cancer continuum:

- Risk Factors
- Screening
- Incidence
- Treatment
- Quality of Life
- Survival
- Mortality

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# What is new – February 2023

- BRFSS 2021
- CDRI 2020 – incidence and survival
- BVRHS 2021 - mortality
- Clinical trial enrollment 2020

## Data Sources

- CDRI is the source for cancer incidence and survival data in Idaho.
- Cancer mortality, risk factor, and screening data come from the Division of Public Health, Idaho Department of Health and Welfare.

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# Scorecard

| Symbol | Meaning |
| --- | --- |
| ✓ | CCAI 2025 Target Achieved |
| ▲ | Progress towards Target |
| ■ | No Progress toward target |
| ● | Losing ground, moving in wrong direction |

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# Goal 1: Reduce incidence and mortality of tobacco-related cancers

| Indicator | Measure | Baseline 2020 | Update 2021 | Update 2022 | 2030 Target | Progress towards target | Target Met |
|---|---|---|---|---|---|---|---|
| 1.1 | Current use of any tobacco products by adults [at least 1 form of cigarettes; cigars, cigarillos, filtered little cigars; regular pipes, water pipes, hookah; e-cigarettes; and/or smokeless tobacco products every day or some days] (Age adjusted to the year 2000 standard population) | 27.2%<br>BRFSS 2019 | 24.6%<br>BRFSS 2020 | **22.3%**<br>**BRFSS 2021** | 16.2%<br>HP2030<br>TU-01 |  | ▲ |
| 1.2 | Current use of any tobacco products among adolescents [percent of students in grades 9 through 12 used cigarettes, e-cigarettes, cigars, smokeless tobacco, hookah, pipe tobacco, and/or bidis in the past 30 days] | 22.8%<br>YRBS 2019 | N/A | **18.5%**<br>**YRBS 2021** | 18.2%<br>CCAI (20%) |  | ▲ |

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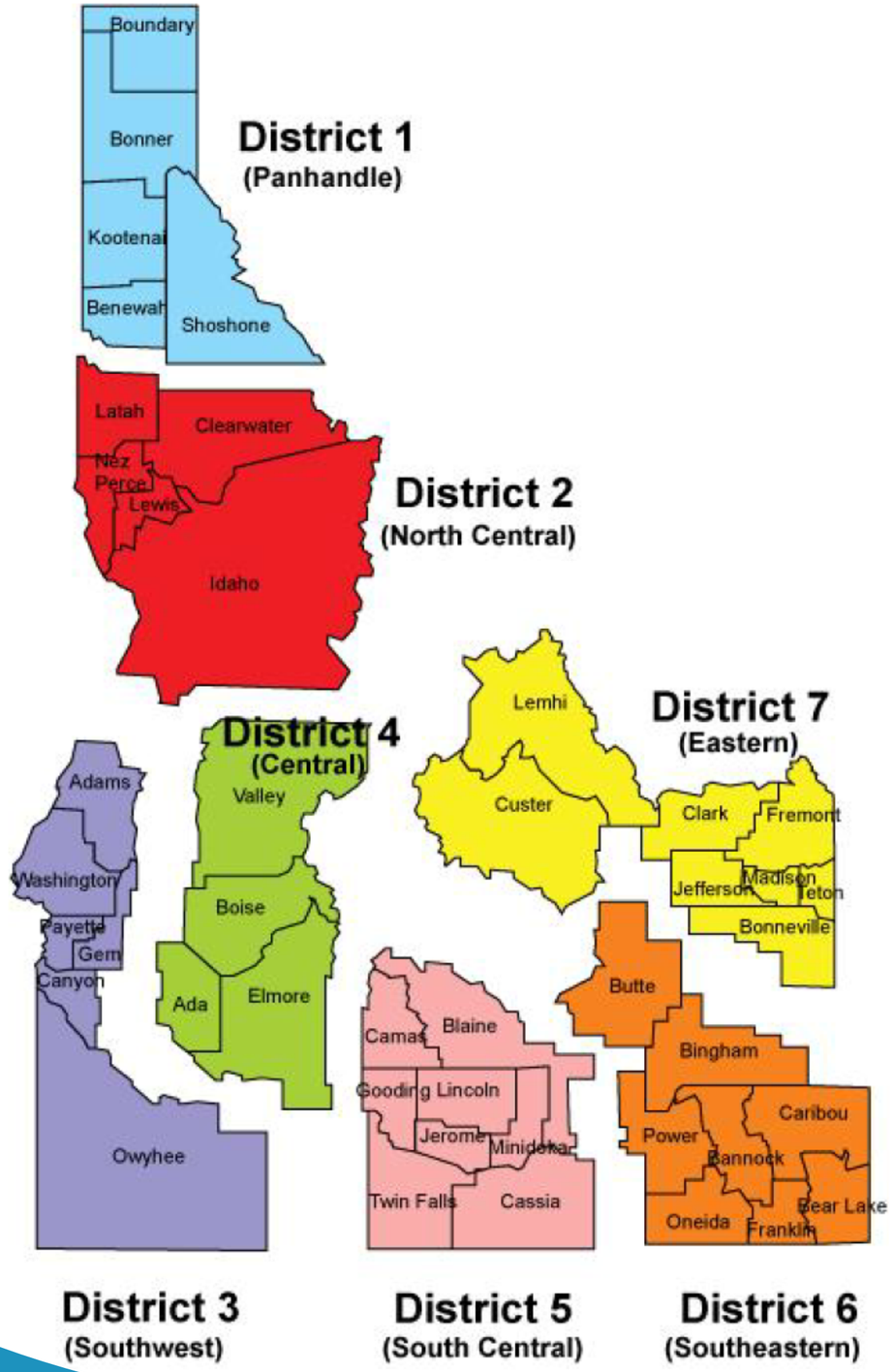
# Local Data

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# Goal 2: Increase access to healthy food options and opportunities for physical activity

| Indicator | Measure | Baseline 2020 | Update 2021 | Update 2022 | 2030 Target | Progress towards target | Target Met |
|---|---|---|---|---|---|---|---|
| 2.1 | Percentage of adults aged 18+ who do enough aerobic physical activity for substantial health benefits (age adjusted to the year 2000 standard population) | 34.5%<br>BRFSS 2019 | N/A | N/A | 59.2%<br>HP2030<br>PA-02 |  | |
| 2.2 | Percentage of adults aged 20+ who are at a healthy weight (BMI >= 18.5 and <= 25.0; age adjusted to the year 2000 standard population) | 33.4%<br>BRFSS 2019 | 31.0%<br>BRFSS 2020 | **30.0%**<br>**BRFSS 2021** | 40.1%<br>CCAI (20%) |  |  |
| 2.3 | Proportion of of students in grades 9 through 12 who were physically active for a total of at least 60 minutes per day on five or more of the past seven days | 47.6%<br>YRBS 2019 | N/A | **49.1%**<br>**YRBS 2021** | 57.1%<br>CCAI (20%) |  |  |

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# Goal 3: Increase protective behaviors from sun and other ultraviolet radiation exposure

| Indicator | Measure | Baseline 2020 | Update 2021 | Update 2022 | 2030 Target | Progress towards target | Target Met |
|---|---|---|---|---|---|---|---|
| 3.1 | Percentage of adolescents in grades 9 through 12 who report using artificial sources of ultraviolet light for tanning | 5.1%<br>YRBS 2019 | N/A | **5.0%**<br>**YRBS 2021** | 4.1%<br>CCAI (20%) |  |  |

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# Goal 4: Increase vaccination rate for vaccines shown to reduce the risk of cancer

| Indicator | Measure | Baseline 2020 | Update 2021 | Update 2022 | 2030 Target | Progress towards target | Target Met |
|---|---|---|---|---|---|---|---|
| 4.1 | Percentage of adolescent females aged 13-17 years who completed 3 doses of the HPV vaccine, or 2 doses 6 months apart if 1st dose before age 15 | 47.1%<br>IRIS 2020 | **49.4%**<br>**IRIS 2021** | | 80.0%<br>HP2030<br>IID-08 |  | |
| 4.2 | Percentage of adolescent males aged 13-17 years who completed 3 doses of the HPV vaccine, or 2 doses 6 months apart if 1st dose before age 15 | 43.1%<br>IRIS 2020 | **45.7%**<br>**IRIS 2021** | | 80.0%<br>HP2030<br>IID-08 |  | |
| 4.3 | Percentage of newborns receiving hepatitis B vaccine (Hepatitis B vaccine administered from birth through age 3 days) | 79.8%<br>IRIS 2020 | **78.6%**<br>**IRIS 2021** | | 95.8%<br>CCAI (20%) |  | |

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# Goal 5: Reduce cancer risk related to environmental carcinogens

| Indicator | Measure | Baseline 2020 | Update 2021 | Update 2022 | 2030 Target | Progress towards target | Target Met |
|---|---|---|---|---|---|---|---|
| 5.1 | Percentage of adults living in households ever been tested for radon (age adjusted to the year 2000 standard population) | 23.4%<br>BRFSS 2018 | **23.3%**<br>**BRFSS 2020** | N/A | 28.1%<br>CCAI (20%) |  |  |

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# Goal 6: Reduce breast cancer deaths and rate of late stage diagnosis through screening and early detection

| Indicator | Measure | Baseline 2020 | Update 2021 | Update 2022 | 2030 Target | Progress towards target | Target Met |
|---|---|---|---|---|---|---|---|
| 6.1 | Percentage of women aged 50 to 74 who had a mammogram within the past two years (age adjusted to the year 2000 standard population) | 67.8%<br>BRFSS 2018 | 71.3%<br>BRFSS 2020 | N/A | 77.1%<br>HP2030<br>C-05 |  |  |
| 6.2 | Age-adjusted rate per 100,000 females of breast cancer diagnoses at late stage (regional and distant) | 46.1<br>CDRI 2018 | 44.5<br>CDRI 2019 | **41.9**<br>**CDRI 2020** | 41.5<br>CCAI (10%) |  |  |
| 6.3 | Age-adjusted mortality rate, female breast cancer | 18.5<br>BVRHS 2019 | 16.8<br>BVRHS 2020 | **20.4**<br>**BVRHS 2021** | 15.3<br>HP2030<br>C-04 |  |  |

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# Goal 7: Reduce deaths and numbers of new cases of cervical cancer through screening and early detection

| Indicator | Measure | Baseline 2020 | Update 2021 | Update 2022 | 2030 Target | Progress towards target | Target Met |
|---|---|---|---|---|---|---|---|
| 7.1 | Percentage of women aged 21-65 who receive a cervical cancer screeing based on the most recent guidelines (age adjusted to the year 2000 standard population) | 72.8%<br>BRFSS 2018 (was 79.9% with previous criteria - see data notes) | 73.9%<br>BRFSS 2020 (see data notes for updated screening criteria) | N/A | 84.3%<br>HP2030 C-09 |  | ▲ |
| 7.2 | Age-adjusted rate per 100,000 females of invasive cervical cancer diagnoses | 8.3<br>CDRI 2018 | 8.0<br>CDRI 2019 | **4.9**<br>**CDRI 2020** | 6.6<br>CCAI (20%) |  | ✓ |
| 7.3 | Age-adjusted cervical cancer mortality rate per 100,000 females | 1.8<br>BVRHS 2019 | 2.0<br>BVRHS 2020 | **2.0**<br>**BVRHS 2021** | 1.4<br>CCAI (20%) |  | ■ |

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# Goal 8: Reduce the numbers of deaths and new cases of colorectal cancers through screening and early detection

**45 based on 2021 USPSTF Guideline**

| Indicator | Measure | Baseline 2020 | Update 2021 | Update 2022 | 2030 Target | Progress towards target | Target Met |
|---|---|---|---|---|---|---|---|
| 8.1 | Percentage of adults aged 50-75 who reported receiving a colorectal cancer screening based on the most recent guidelines (age adjusted to the year 2000 standard population) [*Baseline reflects FOBT, FIT, sigmoidoscopy, colonoscopy] | 66.2%<br>BRFSS 2018 | 66.5%<br>BRFSS 2020 | N/A | 74.4%<br>HP2030<br>C-07 |  |  |
| 8.2 | Age-adjusted rate per 100,000 of invasive colorectal cancer incidence | 36.7<br>CDRI 2018 | 35.0<br>CDRI 2019 | **32.3**<br>**CDRI 2020** | 29.4<br>CCAI (20%) |  |  |
| 8.3 | Age-adjusted mortality rate, colorectal cancer | 12.3<br>BVRHS 2019 | 11.0<br>BVRHS 2020 | **14.0**<br>**BVRHS 2021** | 8.9<br>HP2030<br>C-06 |  |  |

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# Goal 9: Reduce lung cancer deaths and rate of distant stage diagnosis through screening and early detection

| Indicator | Measure | Baseline 2020 | Update 2021 | Update 2022 | 2030 Target | Progress towards target | Target Met |
|---|---|---|---|---|---|---|---|
| 9.1 | Proportion of adults aged 55-80 who received a lung cancer screening based on the most recent guidelines (age adjusted to the year 2000 standard population) | 16.2%<br>BRFSS 2019 (see data notes) | N/A | N/A | 19.4%<br>CCAI (20%) |  | |
| 9.2 | Age-adjusted rate per 100,000 of lung cancer diagnoses at distant stage | 23.9<br>CDRI 2018 | 23.2<br>CDRI 2019 | **21.6**<br>**CDRI 2020** | 21.5<br>CCAI (10%) |  | ▲ |
| 9.3 | Age-adjusted mortality rate, lung cancer | 26.3<br>BVRHS 2019 | 25.7<br>BVRHS 2020 | **24.4**<br>**BVRHS 2021** | 25.1<br>HP2030 C-02 |  | ▲ |

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# Goal 10: Reduce prostate cancer deaths through close monitoring of early stage cases

| Indicator | Measure | Baseline 2020 | Update 2021 | Update 2022 | 2030 Target | Progress towards target | Target Met |
|---|---|---|---|---|---|---|---|
| 10.1 | Age-adjusted mortality rate, prostate cancer | 19.6<br>BVRHS 2019 | 20.4<br>BVRHS 2020 | **21.7**<br>**BVRHS 2021** | 16.9<br>HP2030<br>C-08 |  |  |

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# Goal 11: Monitor the development and implementation of screening and early detection methods for other cancers

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# Goal 12: Increase timely access to quality cancer diagnostic and treatment services for all Idahoans

| Indicator | Measure | Baseline 2020 | Update 2021 | Update 2022 | 2030 Target | Progress towards target | Target Met |
|---|---|---|---|---|---|---|---|
| 12.1 | Percentage of Idaho adults aged 18-64 with health care coverage (age adjusted to the year 2000 standard population) | 78.7%<br>BRFSS 2019 | 82.7%<br>BRFSS 2020 | **90.1%**<br>**BRFSS 2021** | 94.4%<br>CCAI (20%) |  | ▲ |
| 12.2 | Percentage of Idahoans who could not see a doctor due to cost sometime in past year (age adjusted to the year 2000 standard population) | 15.5%<br>BRFSS 2019 | 11.1%<br>BRFSS 2020 | **9.8%**<br>**BRFSS 2021** | 12.4%<br>CCAI (20%) |  | ✓ |
| 12.3 | 5-year relative survival ratio, adjusted for age and primary site mix (NAACCR cancer survival index) | 64.6<br>CDRI 10-16 | 64.3<br>CDRI 11-17 | **64.3**<br>**CDRI 12-18** | 66.2<br>HP2030<br>C-11 |  | ■ |

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# Goal 13: Increase opportunities to access and participate in cancer treatment clinical trials

| Indicator | Measure | Baseline 2020 | Update 2021 | Update 2022 | 2030 Target | Progress towards target | Target Met |
|---|---|---|---|---|---|---|---|
| 13.1 | Percentage of cancer patients who enroll in treatment-related clinical trials | 13.1%<br>Ages 0-19 | 3.2%<br>Ages 0-19 | **23.4%**<br>**Ages 0-19** | 50.0%<br>Ages 0-19 |  |  |
| | | 4.2%<br>Ages 20+<br>CDRI 2018 | 2.1%<br>Ages 20+<br>CDRI 2019 | **1.4%**<br>**Ages 20+**<br>**CDRI 2020** | 5.0%<br>Ages 20+<br>CCAI |  | |

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# Goal 14: Increase provider utilization of evidence-based treatment guidelines.

## Objectives

- Promote awareness, education and advocacy efforts aimed at increasing the number of patients who receive high quality care.
- Monitor Idaho performance on American College of Surgeons Commission on Cancer (CoC) standards for Cancer Program Practice Profile Report (CP3R) treatment standards.

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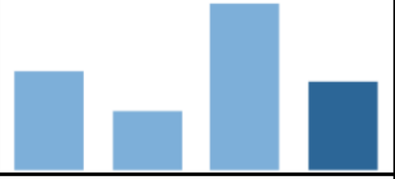
# Goal 15: Improve the physical and mental health of cancer survivors

| Indicator | Measure | Baseline 2020 | Update 2021 | Update 2022 | 2030 Target | Progress towards target | Target Met |
|---|---|---|---|---|---|---|---|
| 15.1 | Percentage of cancer survivors who report poor physical health 14+ of last 30 days (age adjusted to the year 2000 standard population) | 22.7% BRFSS 2018 | 16.3% BRFSS 2020 | **25.8%** **BRFSS 2021** | 20.4% CCAI (10%) |  | ● |
| 15.2 | Percentage of cancer survivors who report poor mental health 14+ of last 30 days (age adjusted to the year 2000 standard population) | 19.1% BRFSS 2018 | 11.5% BRFSS 2020 | **32.2%** **BRFSS 2021** | 17.2% CCAI (10%) |  | ● |
| 15.3 | Percentage of cancer survivors who are current smokers (age adjusted to the year 2000 standard population) | 26.2% BRFSS 2018 | 18.2% BRFSS 2020 | **21.6%** **BRFSS 2021** | 23.6% CCAI (10%) |  | ✓ |
| 15.4 | Percentage of cancer survivors who report no physical activity outside of work (age adjusted to the year 2000 standard population) | 25.7% BRFSS 2018 | 19.2% BRFSS 2020 | **27.9%** **BRFSS 2021** | 23.1% CCAI (10%) |  | ● |
| 15.5 | Percentage of cancer survivors who report consuming 5+ servings fruit and vegetables per day (age adjusted to the year 2000 standard population) | 13.4% BRFSS 2019 | N/A | **6.8%** **BRFSS 2021** | 14.7% CCAI (10%) |  | ● |



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# Goal 16: Improve access and referrals to palliative care services for cancer patients

| Indicator | Measure | Baseline 2020 | Update 2021 | Update 2022 | 2030 Target | Progress towards target | Target Met |
|---|---|---|---|---|---|---|---|
| 16.1 | Proportion of cancer patients aged 66+ at diagnosis who received hospice care in 12 months prior to death | 68.8%<br>SEER-CMS<br>2007-2018 cases died 2018 | N/A | Next update 2024 | 75.7%<br>CCAI (10%) |  | |

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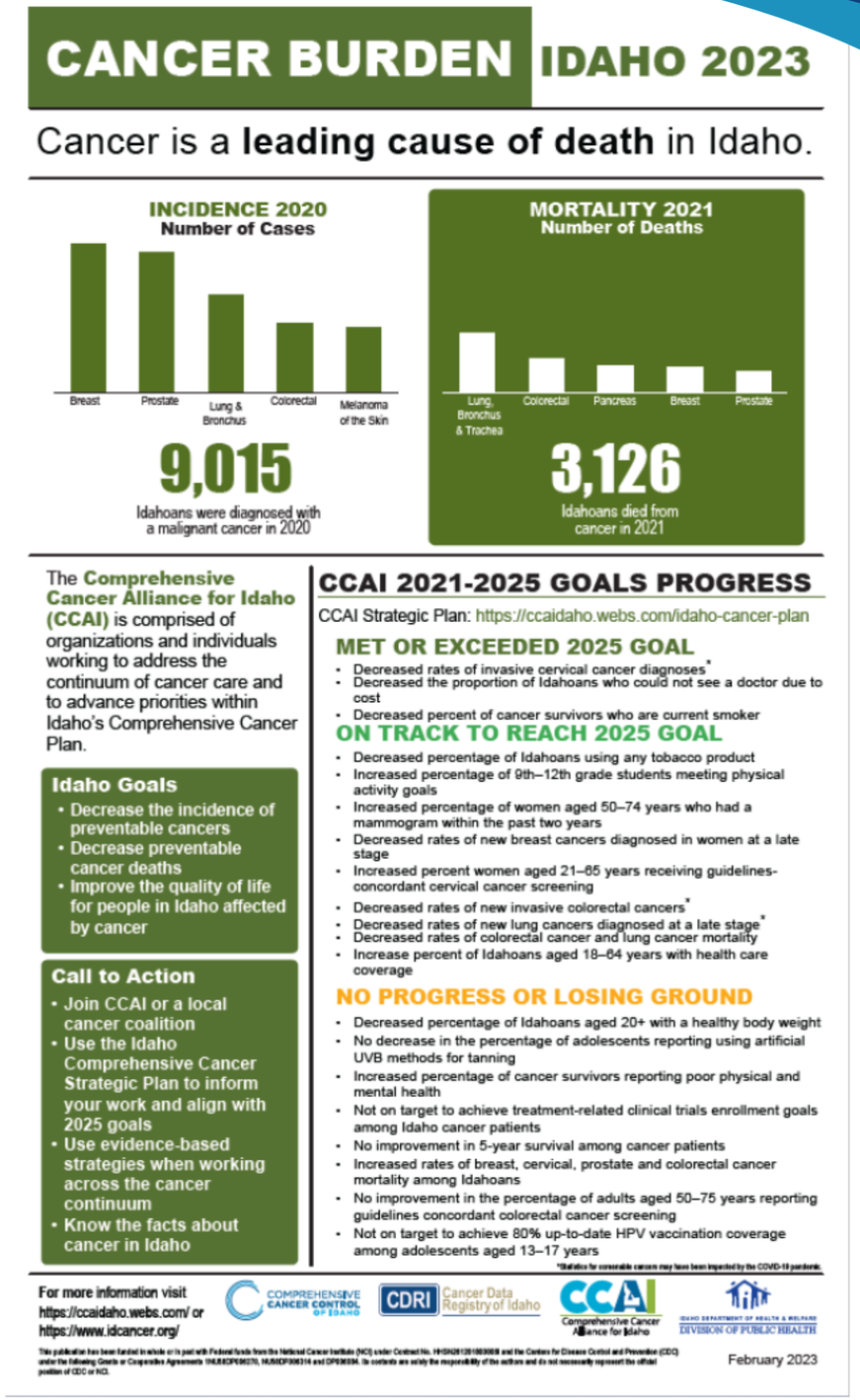
# Cancer Burden Fact Sheet



# Sources for Local-Level Data
# http://www.idcancer.org/statisticaldata

1. CDRI Annual Reports
2. Geographic Reports
3. Pediatric Cancer Reports
4. County Cancer Profiles

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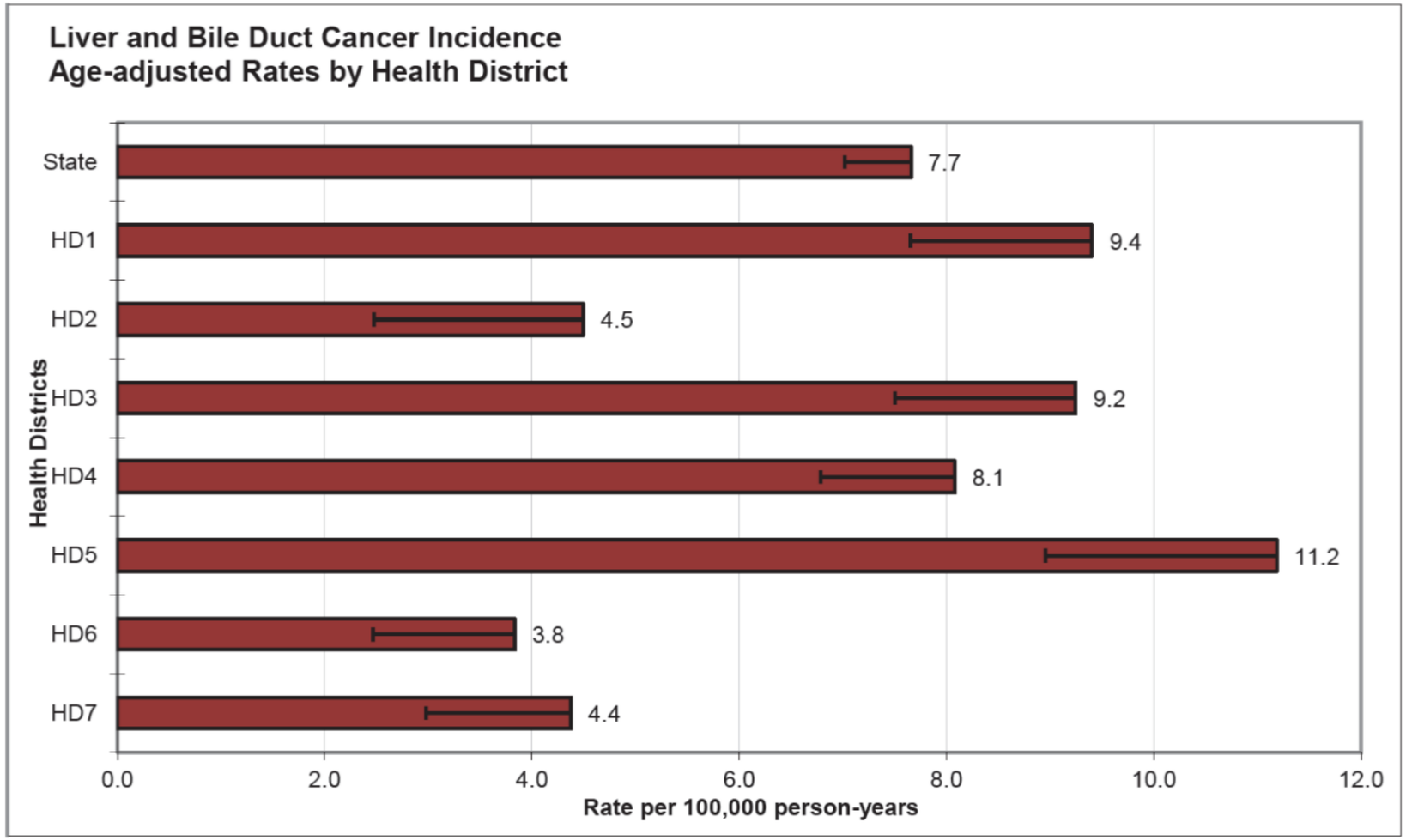
# CDRI Annual Reports

## http://www.idcancer.org/annualreports

## ** printed copies available here at meeting **



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# Geographic Reports

- “Incidence of Cancers Associated with Modifiable Risk Factors and Late Stage Diagnoses for Cancers Amenable to Screening”

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# Pediatric Cancer Reports

**PEDIATRIC CANCER IN IDAHO, 2010–2019**

**June 2022**

**A Publication of the**
**Cancer Data Registry of Idaho**

CDRI Cancer Data Registry of Idaho

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Idaho Hospital Association

IDAHO DEPARTMENT OF HEALTH & WELFARE

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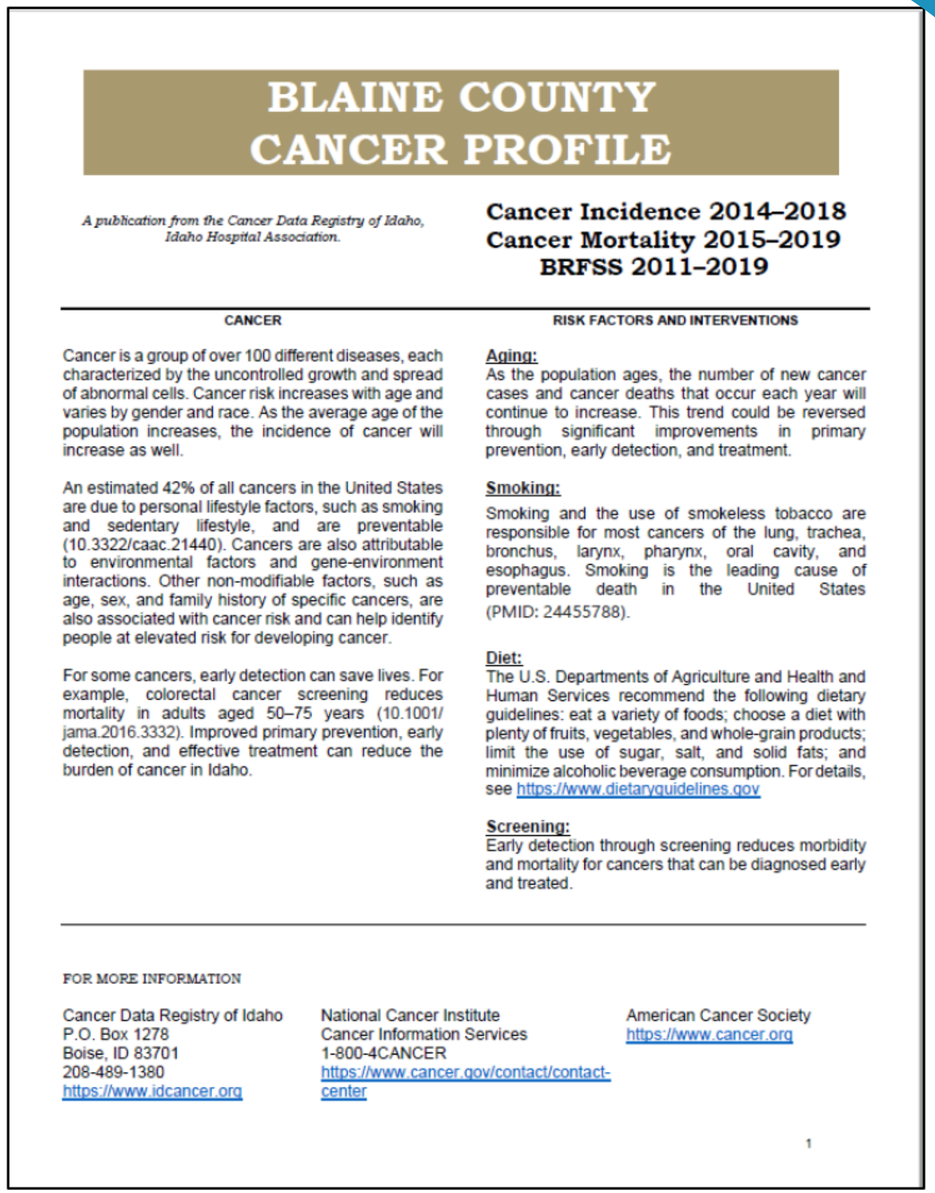
# CDRI County Cancer Profiles



## BLAINE COUNTY CANCER PROFILE

*A publication from the Cancer Data Registry of Idaho, Idaho Hospital Association.*

**Cancer Incidence 2014–2018**
**Cancer Mortality 2015–2019**
**BRFSS 2011–2019**

### CANCER

Cancer is a group of over 100 different diseases, each characterized by the uncontrolled growth and spread of abnormal cells. Cancer risk increases with age and varies by gender and race. As the average age of the population increases, the incidence of cancer will increase as well.

An estimated 42% of all cancers in the United States are due to personal lifestyle factors, such as smoking and sedentary lifestyle, and are preventable (10.3322/caac.21440). Cancers are also attributable to environmental factors and gene-environment interactions. Other non-modifiable factors, such as age, sex, and family history of specific cancers, are also associated with cancer risk and can help identify people at elevated risk for developing cancer.

For some cancers, early detection can save lives. For example, colorectal cancer screening reduces mortality in adults aged 50–75 years (10.1001/jama.2016.3332). Improved primary prevention, early detection, and effective treatment can reduce the burden of cancer in Idaho.

### RISK FACTORS AND INTERVENTIONS

**Aging:**
As the population ages, the number of new cancer cases and cancer deaths that occur each year will continue to increase. This trend could be reversed through significant improvements in primary prevention, early detection, and treatment.

**Smoking:**
Smoking and the use of smokeless tobacco are responsible for most cancers of the lung, trachea, bronchus, larynx, pharynx, oral cavity, and esophagus. Smoking is the leading cause of preventable death in the United States (PMID: 24455788).

**Diet:**
The U.S. Departments of Agriculture and Health and Human Services recommend the following dietary guidelines: eat a variety of foods; choose a diet with plenty of fruits, vegetables, and whole-grain products; limit the use of sugar, salt, and solid fats; and minimize alcoholic beverage consumption. For details, see https://www.dietaryguidelines.gov

**Screening:**
Early detection through screening reduces morbidity and mortality for cancers that can be diagnosed early and treated.

FOR MORE INFORMATION

Cancer Data Registry of Idaho
P.O. Box 1278
Boise, ID 83701
208-489-1380
https://www.idcancer.org

National Cancer Institute
Cancer Information Services
1-800-4CANCER
https://www.cancer.gov/contact/contact-center

American Cancer Society
https://www.cancer.org

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# Questions?

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# Trends in Idaho's Cancer Data and the Impact of COVID-19


## BOZENA MORAWSKI

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# Acknowledgments and Disclaimer


- This project was funded in whole with Federal funds from the National Cancer Institute, National Institutes of Health, Department of Health and Human Services, under Contract No. HHSN261201800006I, and the Centers for Disease Control and Prevention, Department of Health and Human Services, under Cooperative Agreement NU58DP006270 to the Cancer Data Registry of Idaho, Idaho Hospital Association.


- The findings and conclusions in this presentation are those of the authors and do not necessarily represent the official position of the National Cancer Institute or the Centers for Disease Control and Prevention.

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# Nota bene 1: 2020 Denominators

2020 population estimates are not informed by 2020 Census

2020 population estimates are bridged-race postcensal population estimates based on the 2010 census count

Come from U.S. Census via Population Estimates Branch, not the 2020 Census count

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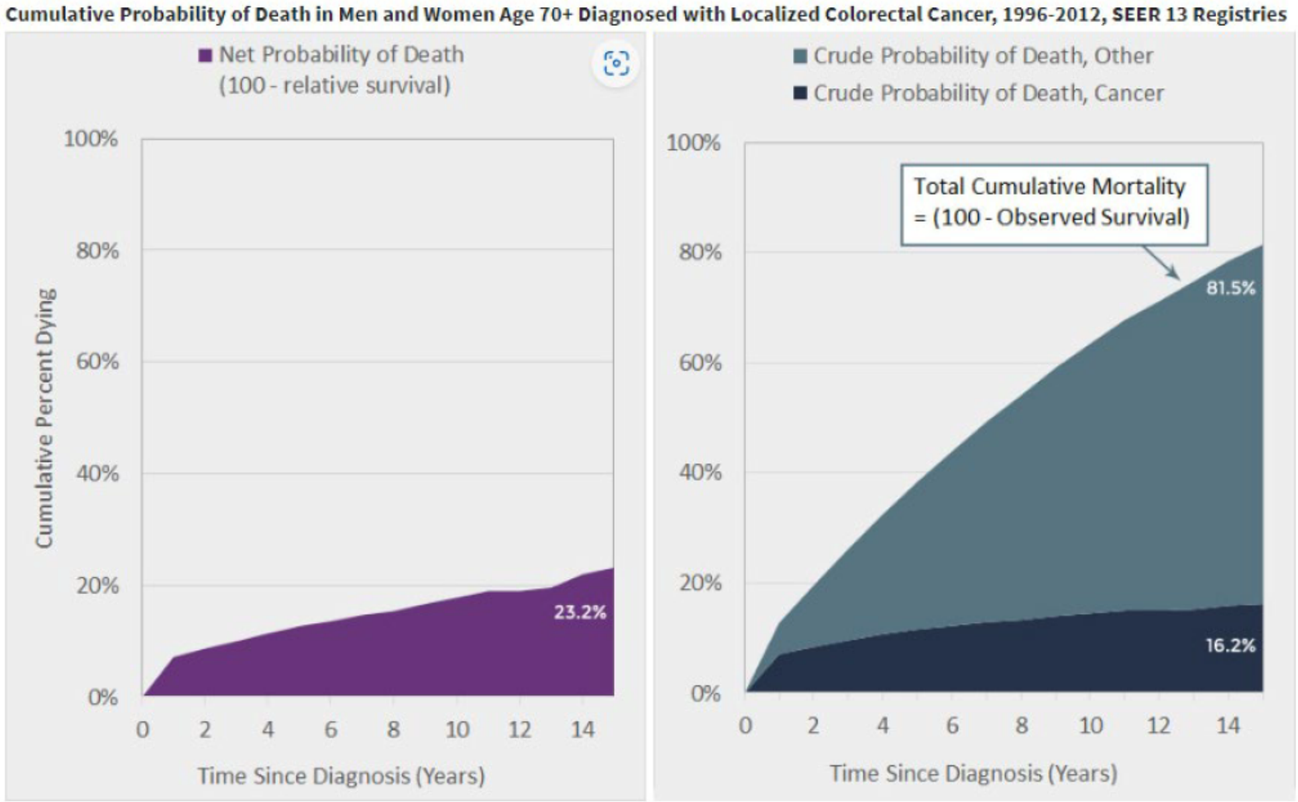
# Nota bene 2: Competing Risk

Nutshell version:

- Patient won't be diagnosed with cancer if they die of something else first (e.g., COVID-19) *(influencing incidence)*
- Person won't die of cancer if they die of something else first (e.g., car accident) *(influencing mortality, survival)*




https://surveillance.cancer.gov/survival/measures.html



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# COVID-19 Impacts on Cancer Burden

- *"Nearly immediately at the start of the COVID-19 pandemic, the clinical and public health cancer community voiced concerns over the disruption that the pandemic would have on the cancer care spectrum – including delaying cancer screenings or delaying, modifying or forgoing critical cancer care."*
  - Richards M, Anderson M, Carter P, Ebert BL, Mossialos E. The impact of the COVID-19 pandemic on cancer care. Nat Cancer 2020: 1-3.

- Screening and diagnostic procedures were down in Idaho in the beginning of 2020.

- Unknown impact of current Crisis Standards of Care. Non-emergency surgeries were on hold in some health systems.

- COVID-19 is a new, competing cause of death.
  - 1,357 COVID-19 deaths among Idaho residents in 2020. **[2,405 COVID-19 deaths among Idaho residents in 2021]**
  - ~400 additional excess deaths not directly attributable to COVID-19 in 2020.

# Medicaid Expansion (and Protection) During the COVID-19 Pandemic

- Medicaid Expansion took effect Jan. 2020
  - Benefits extended to 145,000 Idahoans as of Jan. 2023
- Under Federal Public Health Emergency, states not allowed to rescind Medicaid enrollment from anyone unless they moved out of the state, asked to be removed, or died

| Indicator | Measure | Baseline 2020 | Update 2021 | Update 2022 | 2030 Target | Progress towards target | Target Met |
|---|---|---|---|---|---|---|---|
| 12.1 | Percentage of Idaho adults aged 18-64 with health care coverage (age adjusted to the year 2000 standard population) | 78.7%<br>BRFSS 2019 | 82.7%<br>BRFSS 2020 | **90.1%**<br>**BRFSS 2021** | 94.4%<br>CCAI (20%) |  |  |
| 12.2 | Percentage of Idahoans who could not see a doctor due to cost sometime in past year (age adjusted to the year 2000 standard population) | 15.5%<br>BRFSS 2019 | 11.1%<br>BRFSS 2020 | **9.8%**<br>**BRFSS 2021** | 12.4%<br>CCAI (20%) |  |  |



https://healthandwelfare.idaho.gov/dhw-voice/faq-about-medicaid-expansion-and-continuous-enrollment

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# Immediate Decreases in Pathology Reports

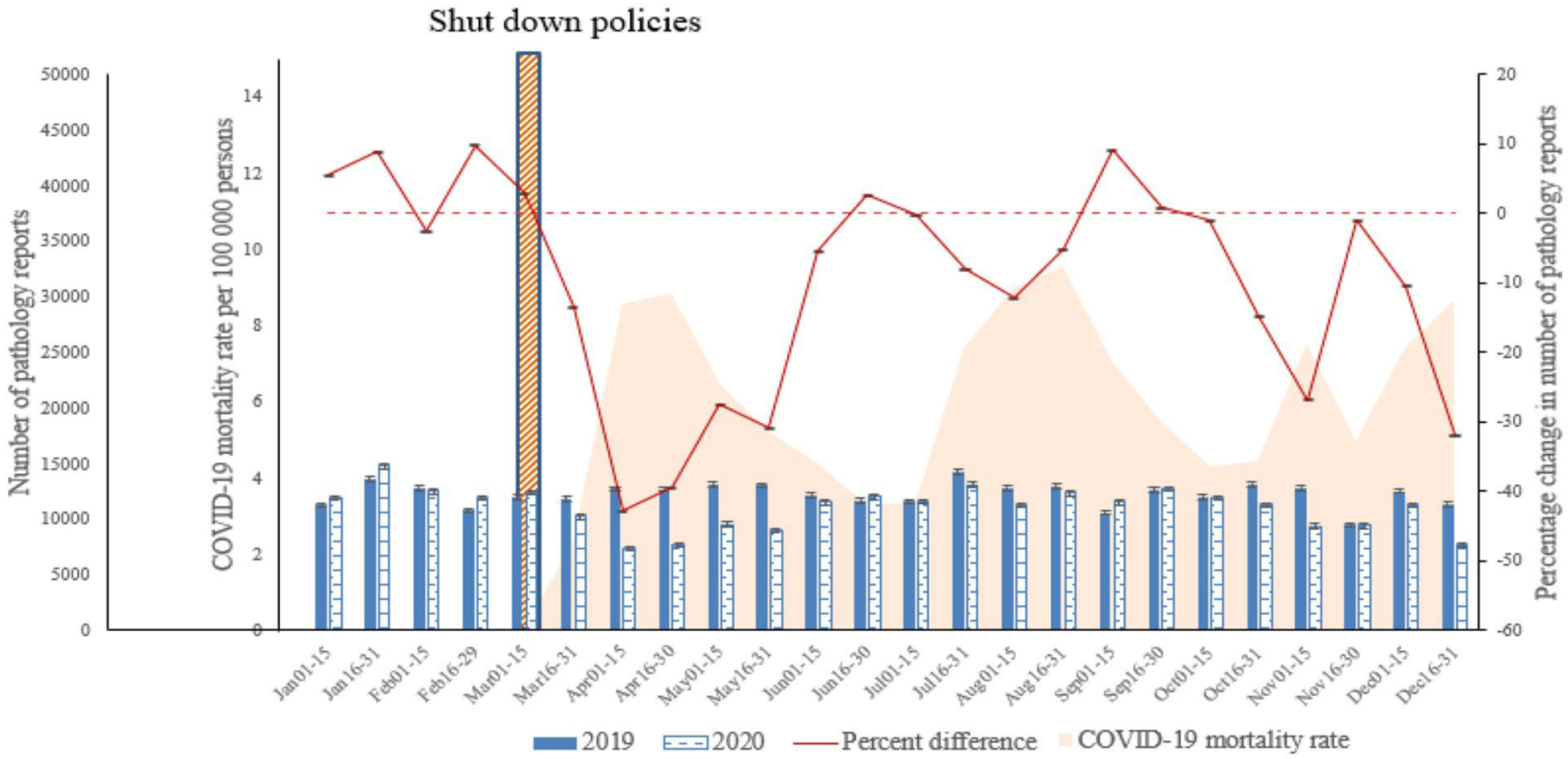


**Figure 1.** Cancer Pathology Reports: 2019 and 2020. Number of cancer pathology reports in Georgia and Louisiana in biweekly intervals to allow comparison of the same period in 2019 as in 2020. Numbers of pathology reports (blue bars) are shown with the primary y-axis, the coronavirus disease 2019 (COVID-19) mortality rate per 100 000 population in Georgia and Louisiana (light orange area) is shown with the secondary y-axis, and the percentage change in the number of pathology reports between 2019 and 2020 (red solid line) is shown with the tertiary y-axis. https://academic.oup.com/jnci/article/114/6/907/6307727



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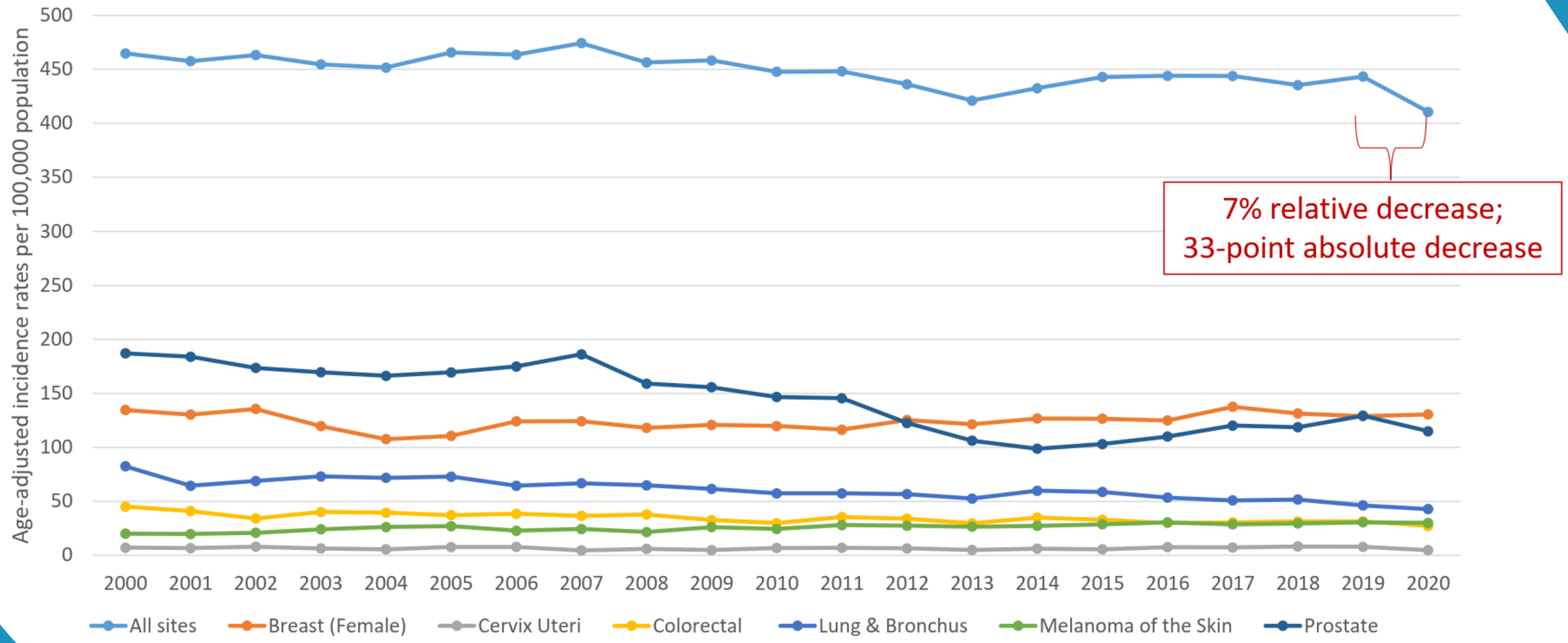
# Cancer Incidence 2000–2020

# Cancer Incidence Trends: 2000–2020

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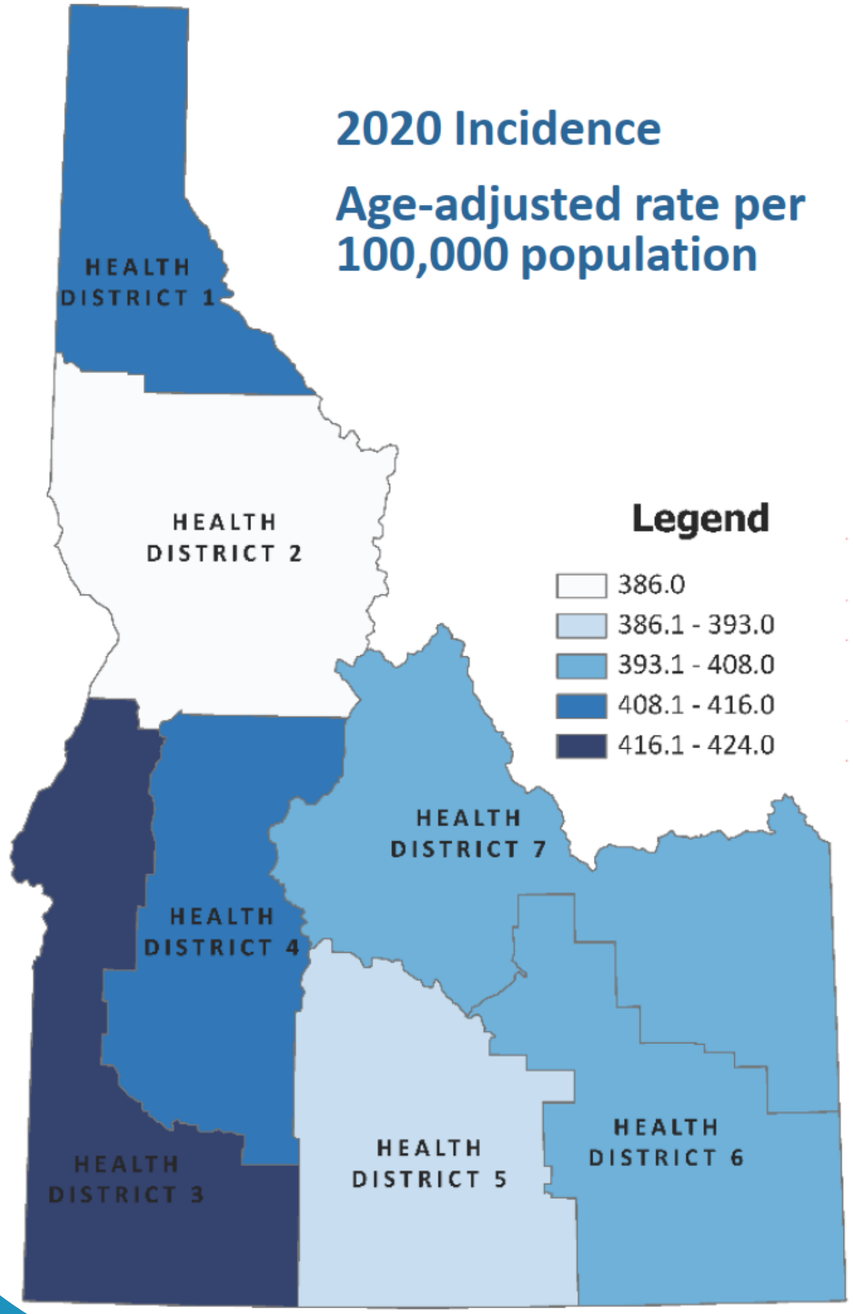
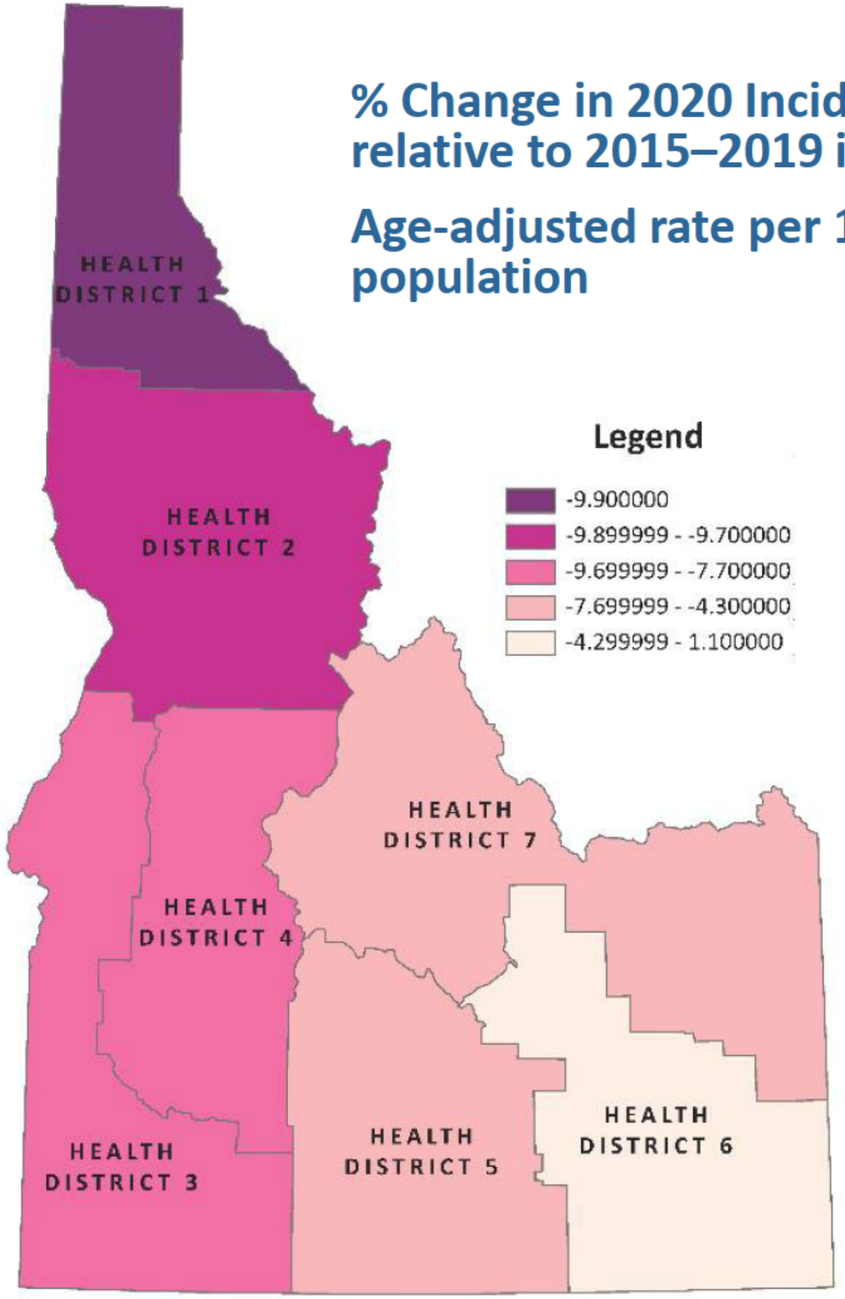
## 2020 Incidence

## Age-adjusted rate per 100,000 population




## % Change in 2020 Incidence relative to 2015–2019 incidence

## Age-adjusted rate per 100,000 population

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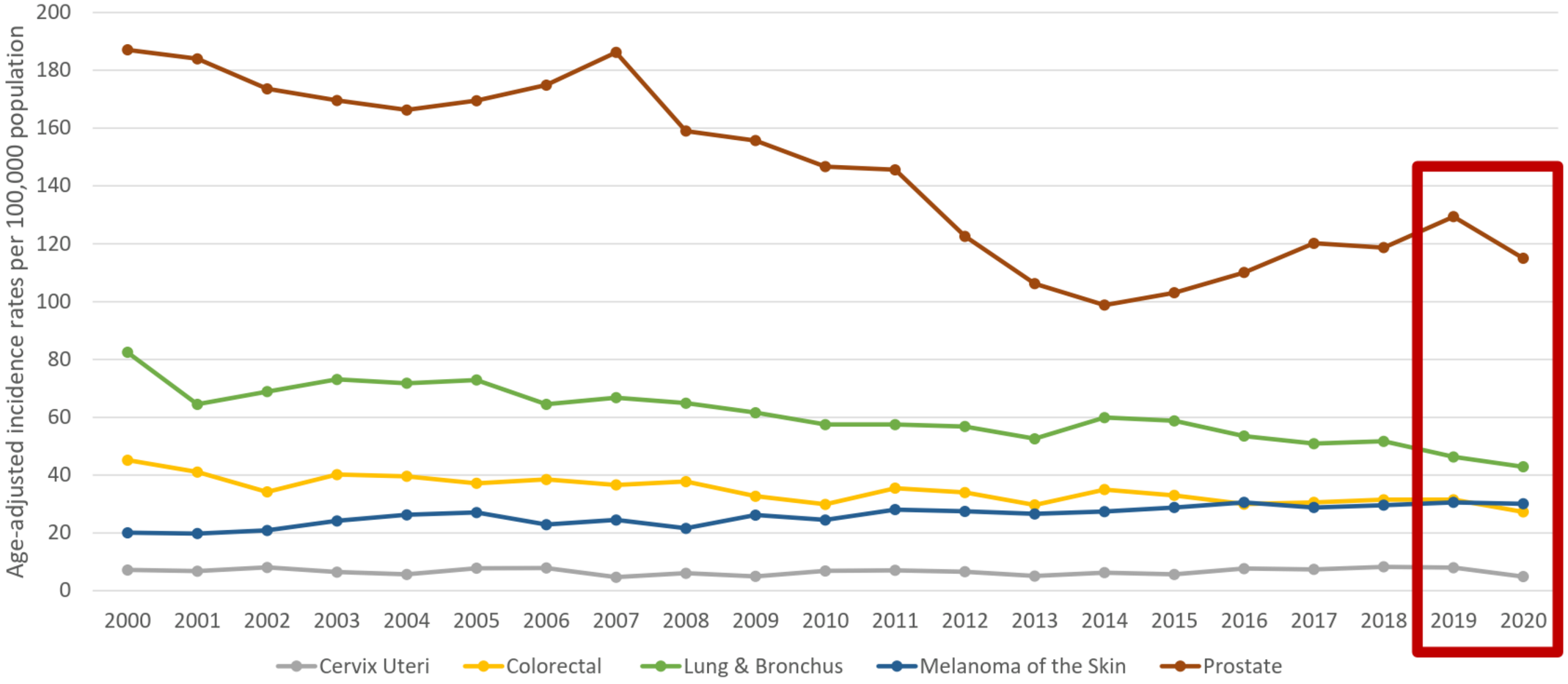
# Cancer Incidence Trends: 2000–2020

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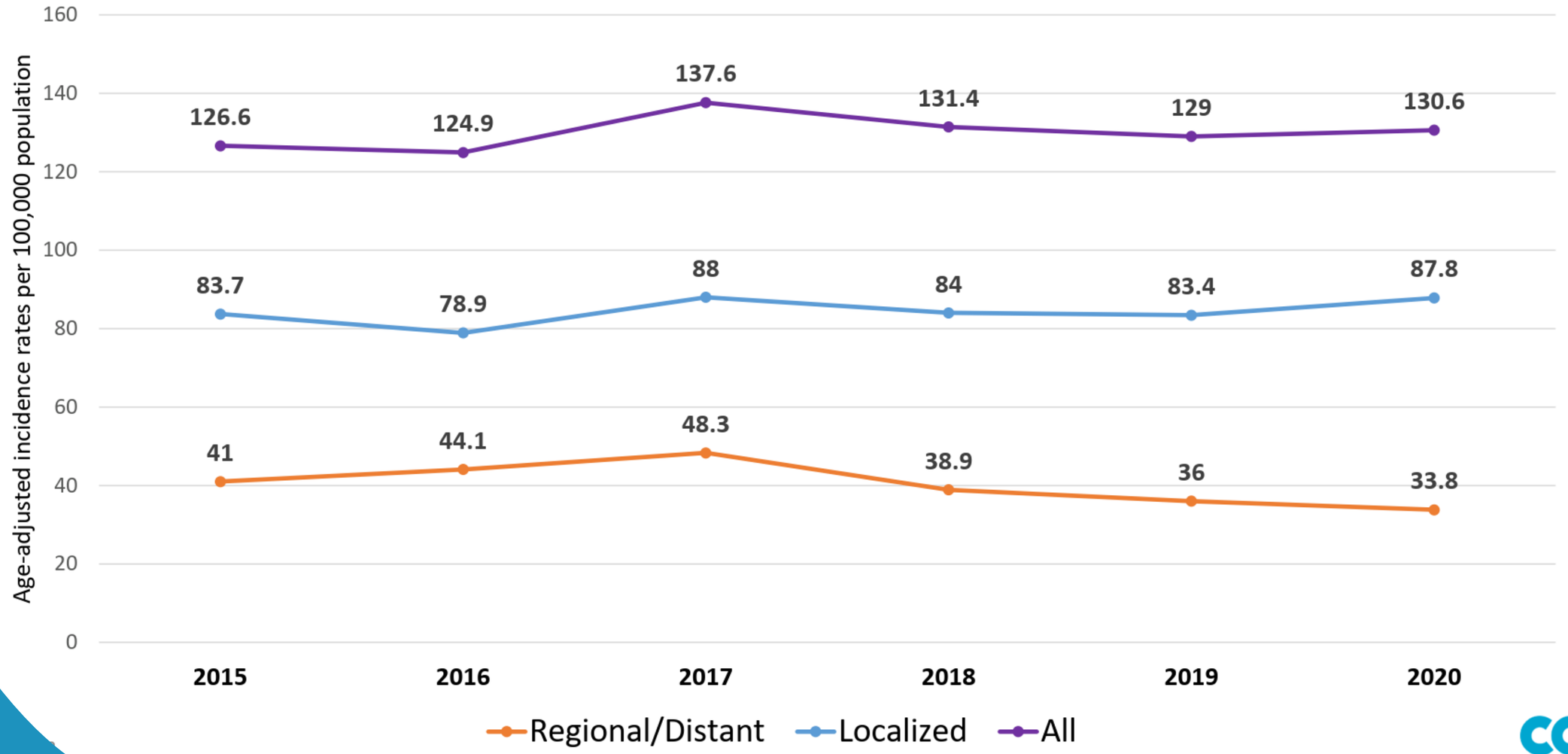
# Breast Cancer Incidence Trends: 2015–2020

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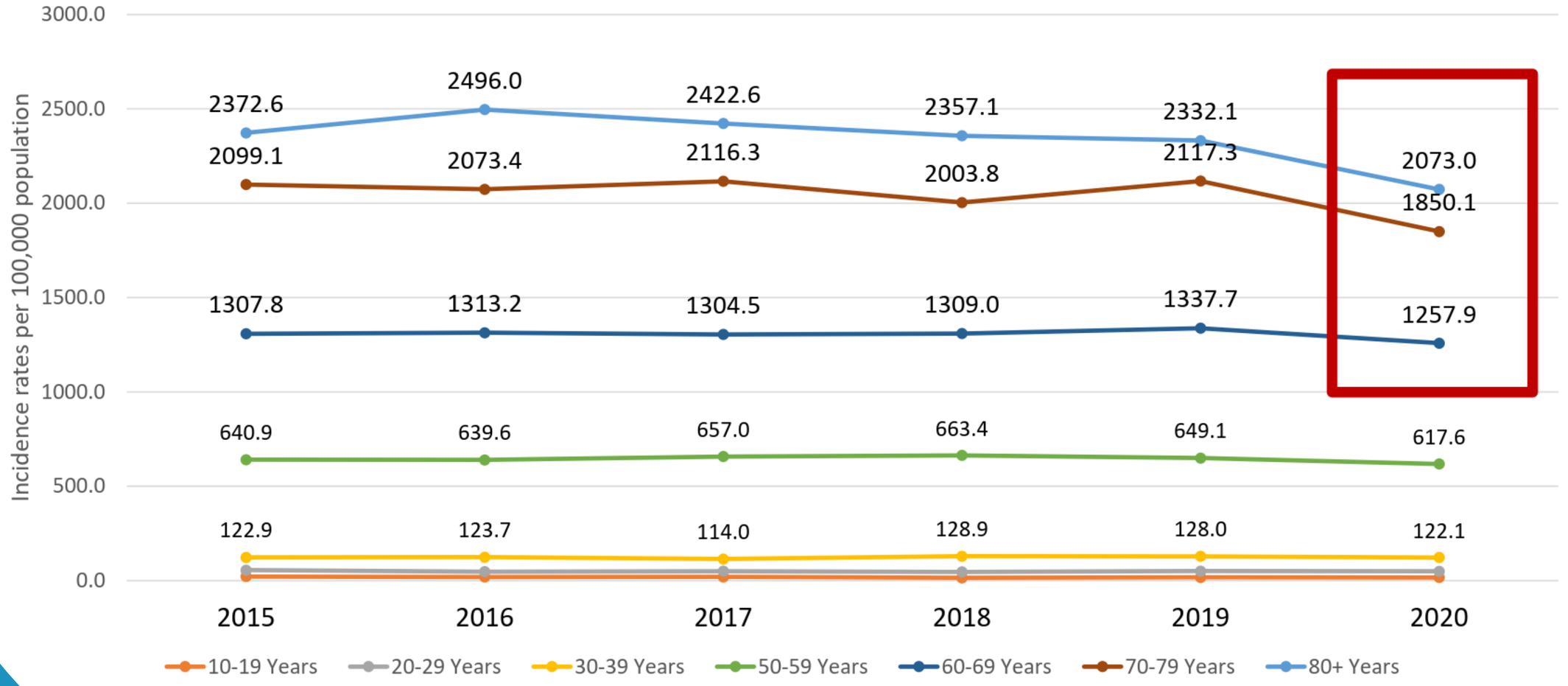
# Cancer Incidence Trends by Age: 2015–2020

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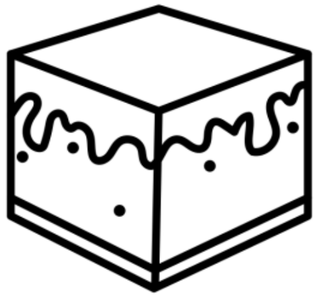
# Drilling down even further on decreases…

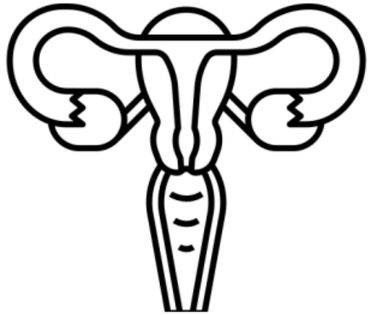
**Lung & Bronchus: Males & Females** — **70+ years**

**Colon & Rectum: Males & Females** — **60–79-year-old age groups**

**Prostate: Males** — **50+ years**

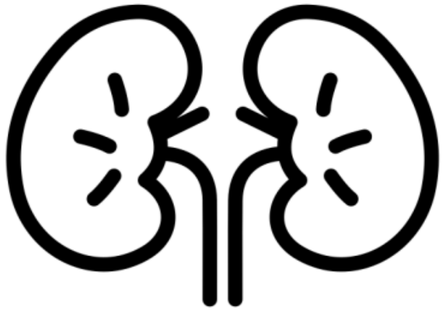


**Melanoma: Males & Females** — **50–59-year-old age group**



**Cervix: Females** — **30–39-year-old age group**

**Ovary: Female** — **70–79-year-old age group**



**Kidney & Renal Pelvis: Males & Females** — **60–69-year-old age group**



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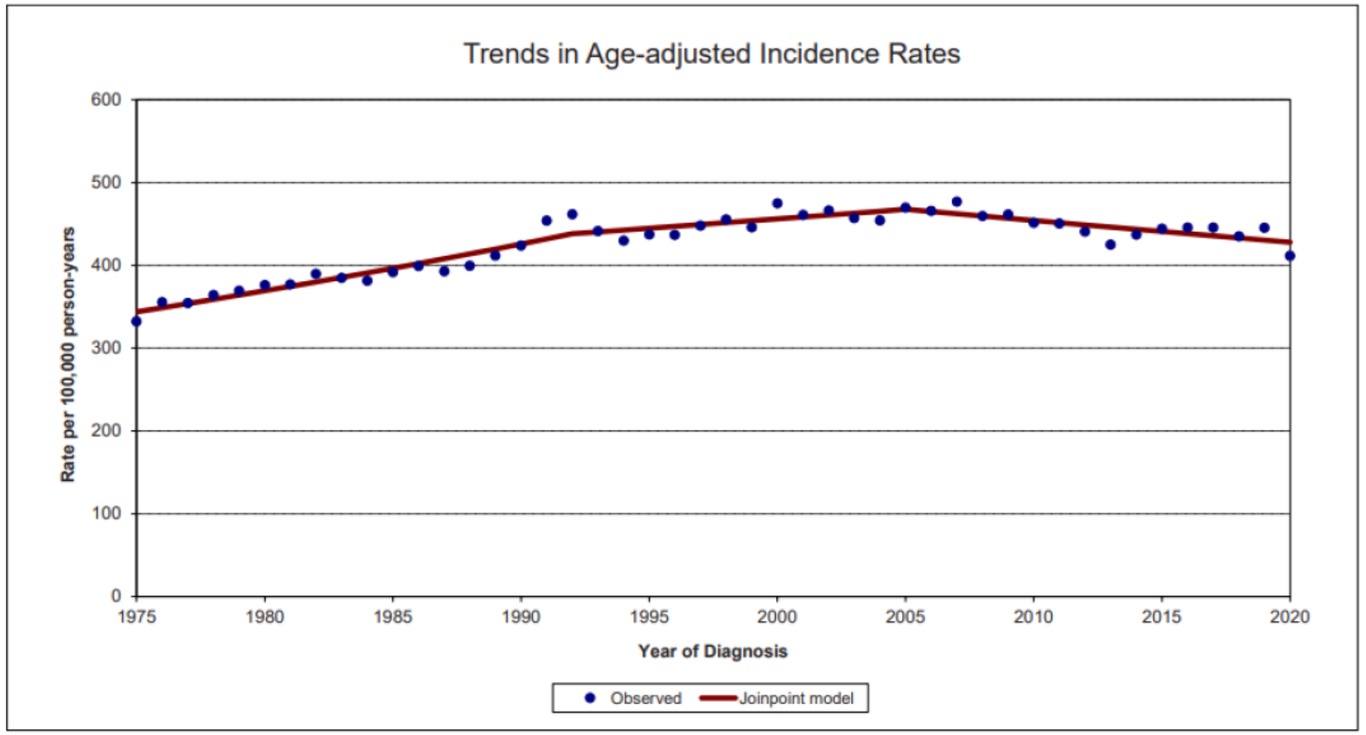
# Cancer Incidence Trends in 2021?

- We don't know yet (2021 data are "complete" in October 2023)
- Evidence that the increase that we have seen in (recent) cancer incidence rate increases may be slowing
- Why might this be?

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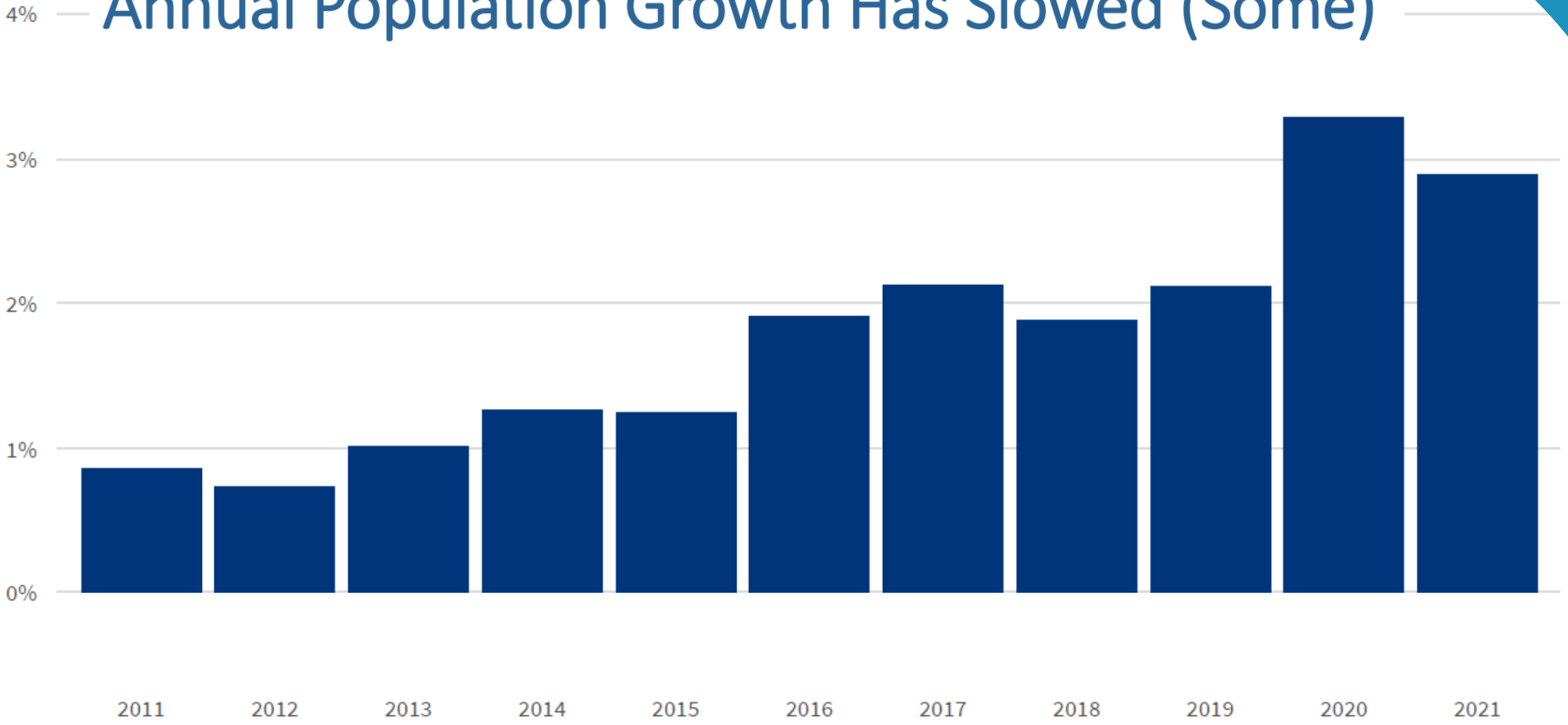
# Annual Population Growth Has Slowed (Some)






https://usafacts.org/data/topics/people-society/population-and-demographics/our-changing-population/state/idaho
(Source: U.S. Census)

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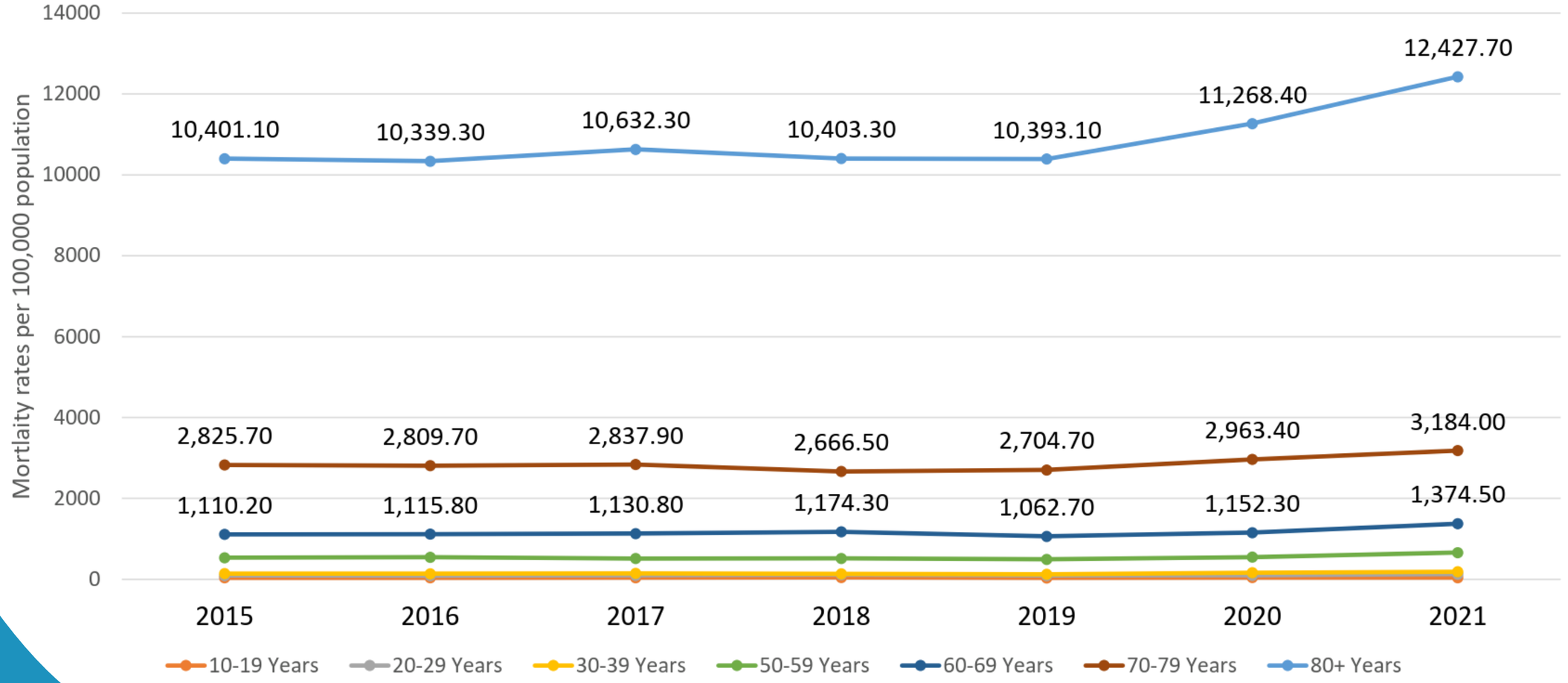
# Mortality Patterns Changed in 2020 and 2021 (Competing Risk)

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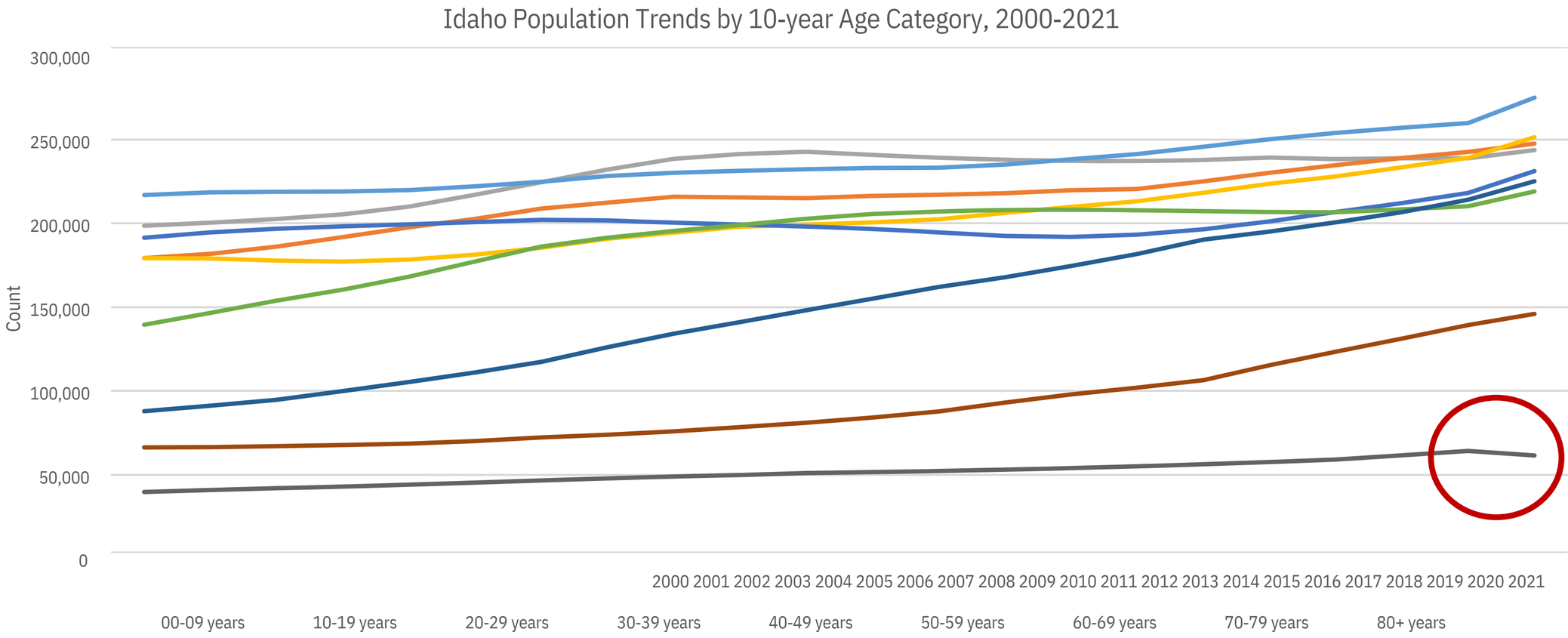
# Different Population Age Distribution in 2021



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# Cancer Mortality 2000–2021

Can mortality trends tell us anything about what we will see in 2021 for incidence?

# Death Certificate Certification Rules for COVID-19 (U07.1)

**Underlying Cause of Death (UCOD)**

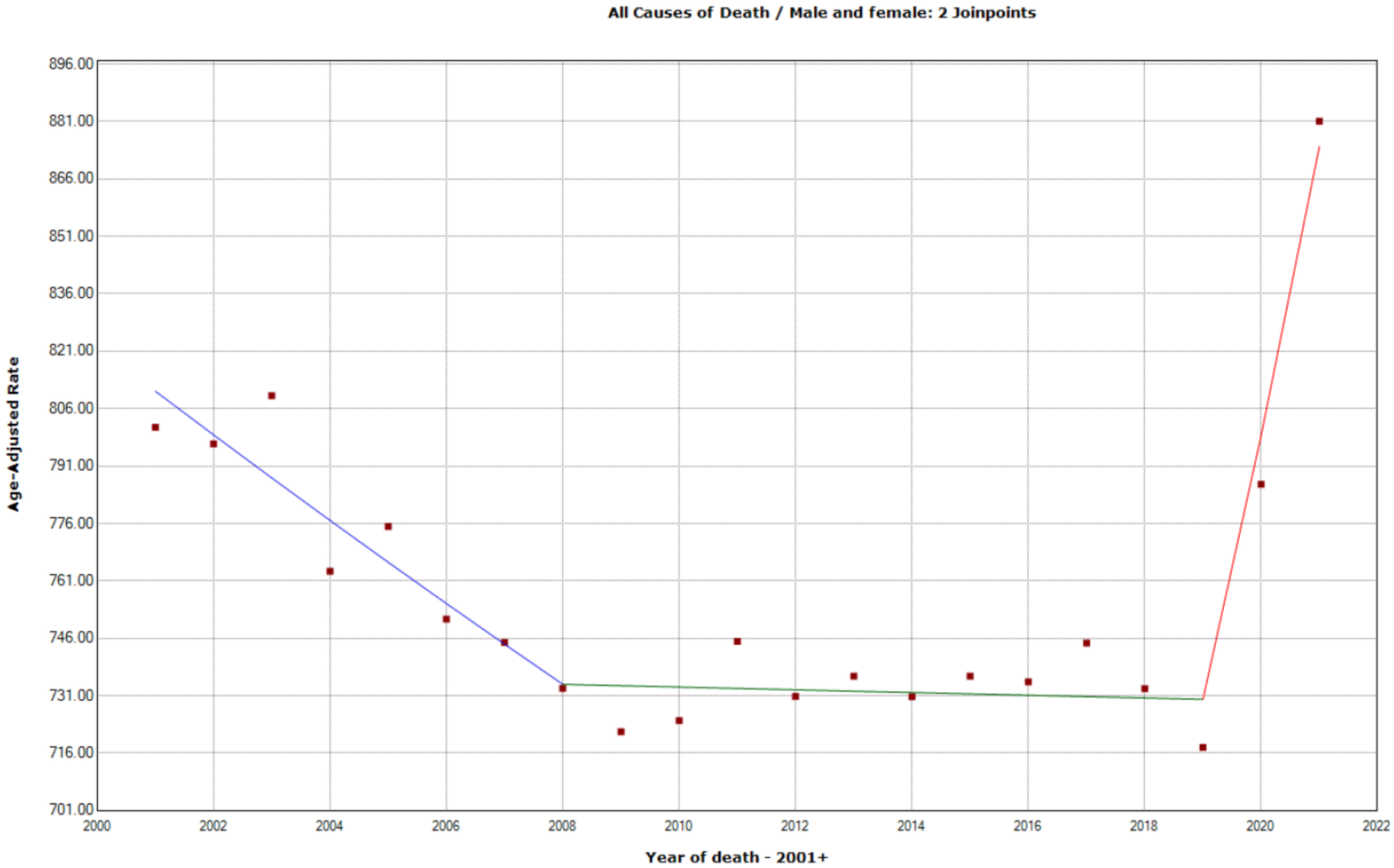
*"(a) the disease or injury which initiated the train of morbid events leading directly to death or (b) the circumstances of the accident or violence which produced the fatal injury"*

**UCOD is the primary field used to calculate mortality statistics in the United States**

**Vital Statistics Reporting Guidance**

**Certifying deaths due to COVID–19**

If COVID–19 played a role in the death, this condition should be specified on the death certificate. In many cases, it is likely that it will be the UCOD, as it can lead to various life-threatening conditions, such as pneumonia and acute respiratory distress syndrome (ARDS). In these cases, COVID–19 should be reported on the lowest line used in Part I with the other conditions to which it gave rise listed on the lines above it.




* = statistically significant trend

* Indicates that the Annual Percent Change (APC) is significantly different from zero at the alpha = 0.05 level
Final Selected Model: 2 Joinpoints.

# All causes of death

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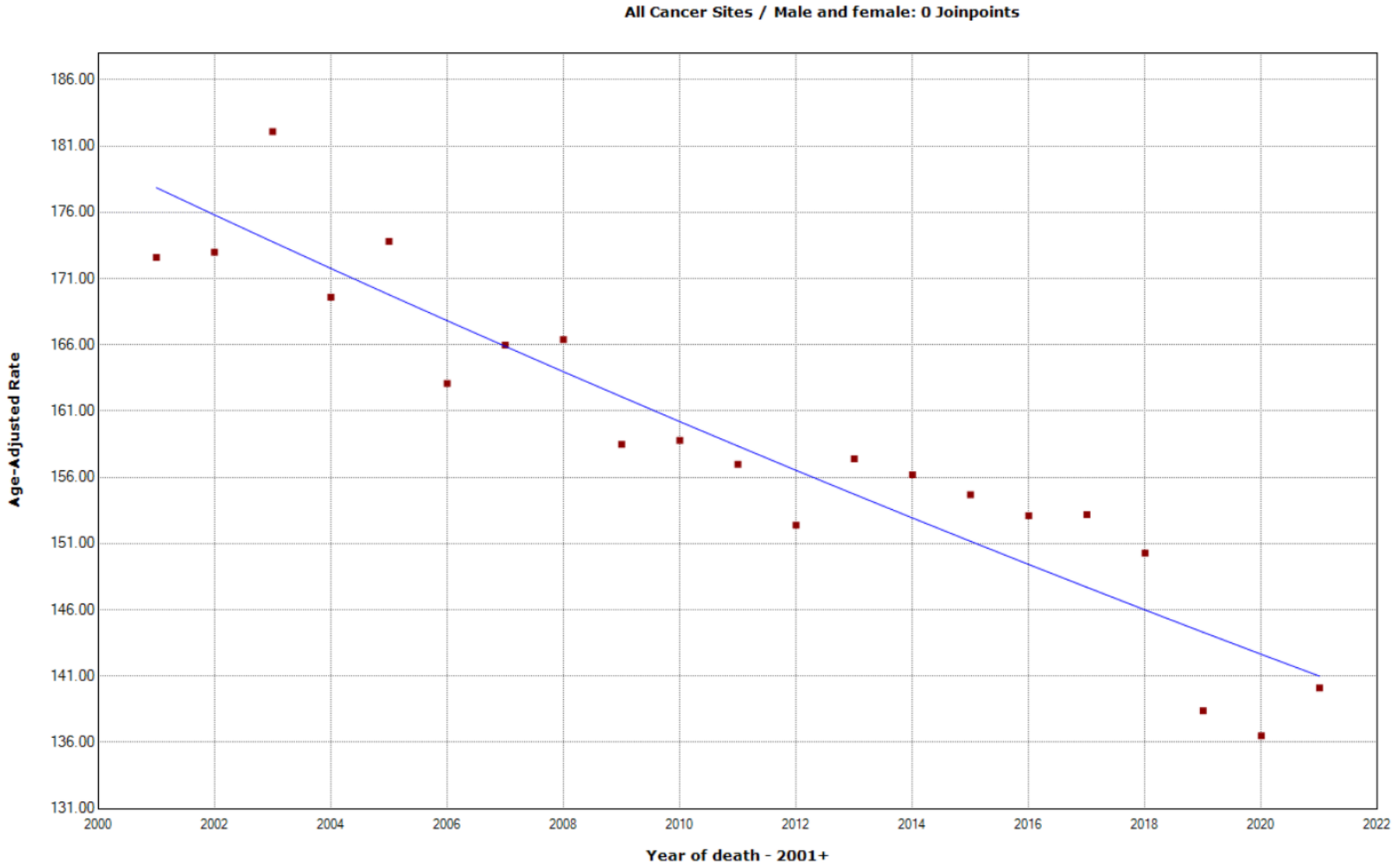


* Indicates that the Annual Percent Change (APC) is significantly different from zero at the alpha = 0.05 level
Final Selected Model: 0 Joinpoints.

# Cancer-related mortality: All primary sites

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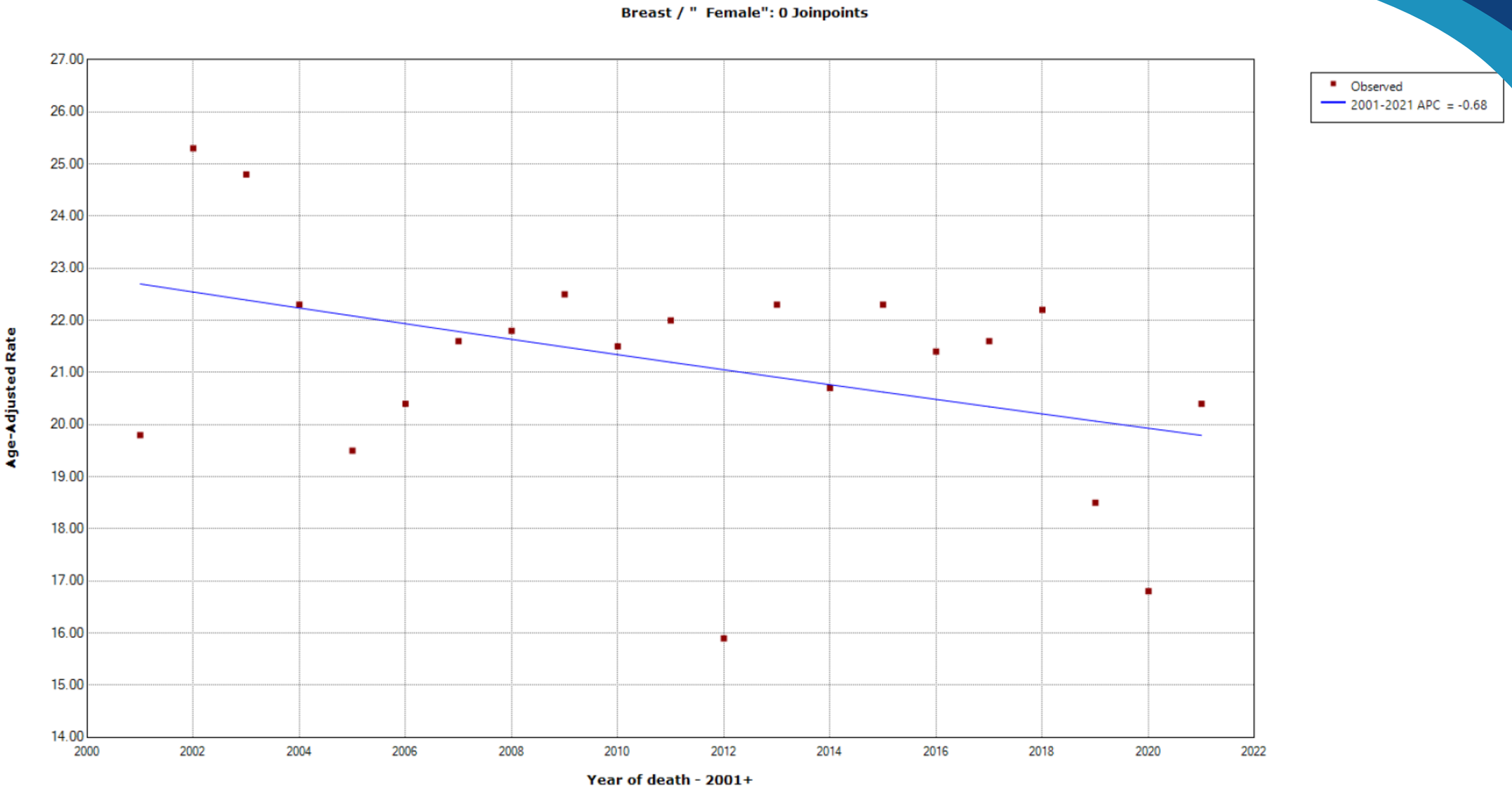


* Indicates that the Annual Percent Change (APC) is significantly different from zero at the alpha = 0.05 level
Final Selected Model: 0 Joinpoints.

# Cancer-related mortality: Female breast

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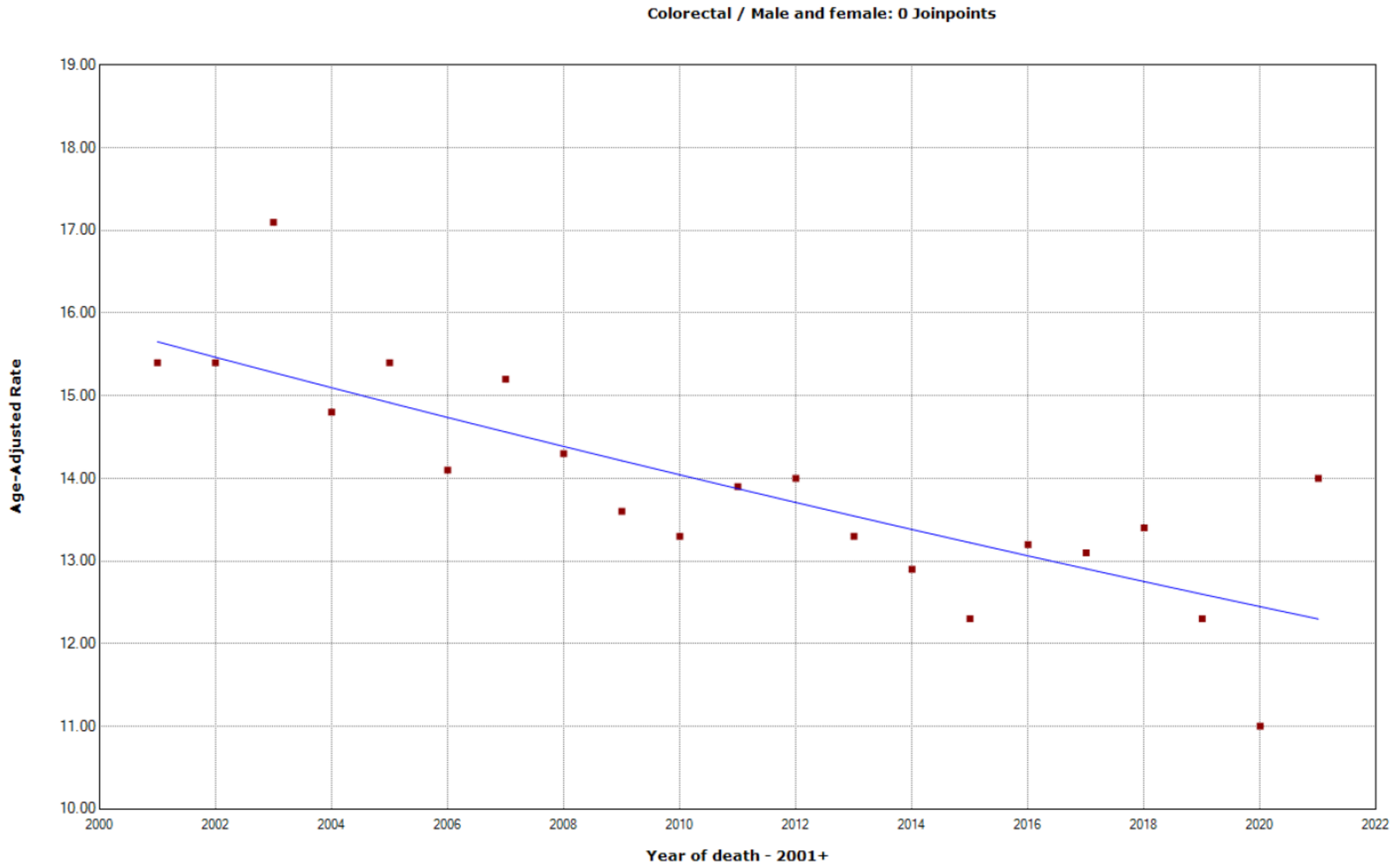


* Indicates that the Annual Percent Change (APC) is significantly different from zero at the alpha = 0.05 level
Final Selected Model: 0 Joinpoints.

# Cancer-related mortality: Colorectal

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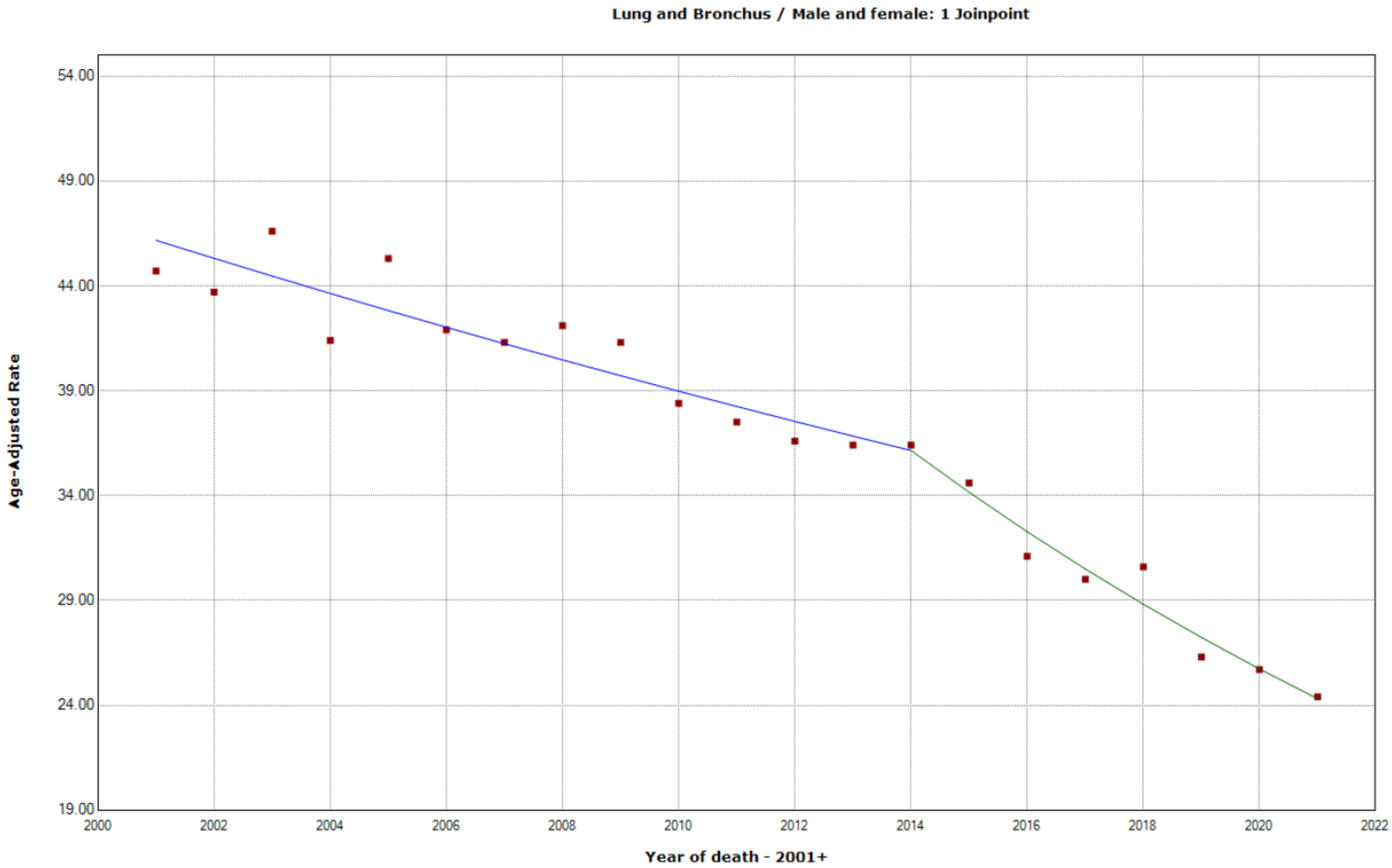


* Indicates that the Annual Percent Change (APC) is significantly different from zero at the alpha = 0.05 level
Final Selected Model: 1 Joinpoint.

# Cancer-related mortality: Lung & bronchus

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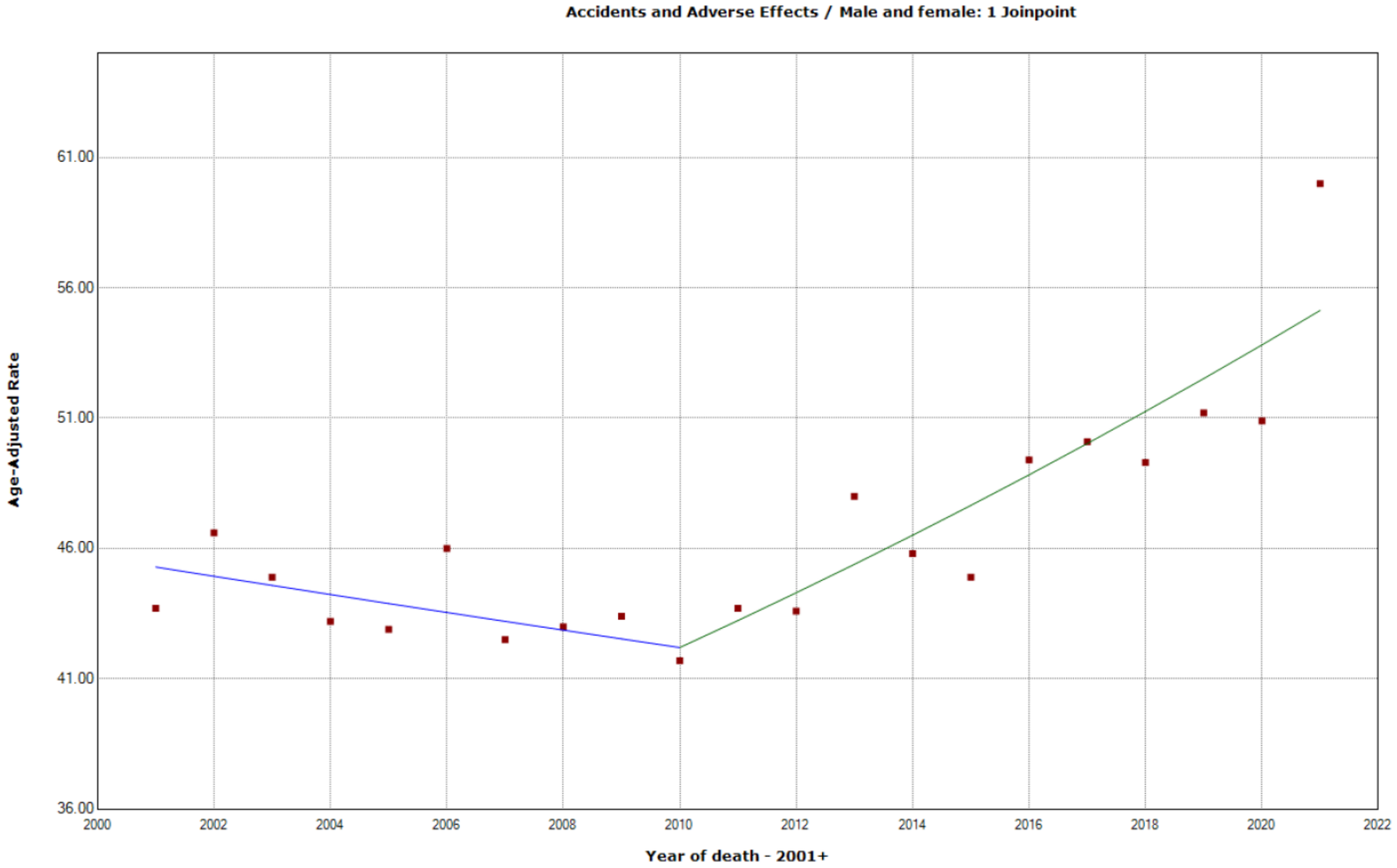
# Not cancer, but important when considering why cancer mortality rates went down

(competing risk again…)




* Indicates that the Annual Percent Change (APC) is significantly different from zero at the alpha = 0.05 level
Final Selected Model: 1 Joinpoint.

# Accidents and adverse effects

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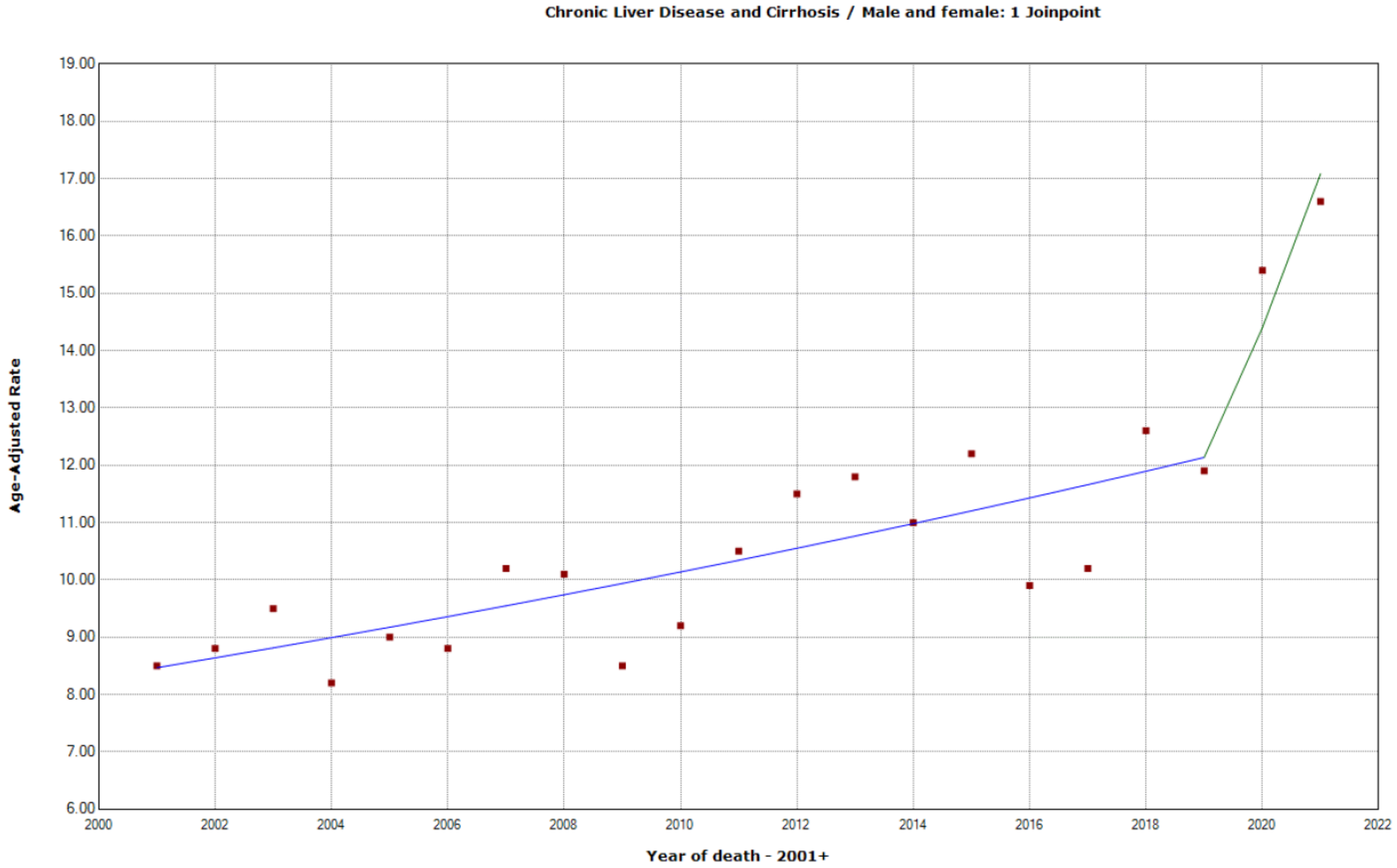


* Indicates that the Annual Percent Change (APC) is significantly different from zero at the alpha = 0.05 level
Final Selected Model: 1 Joinpoint.

# Chronic Liver Disease and Cirrhosis

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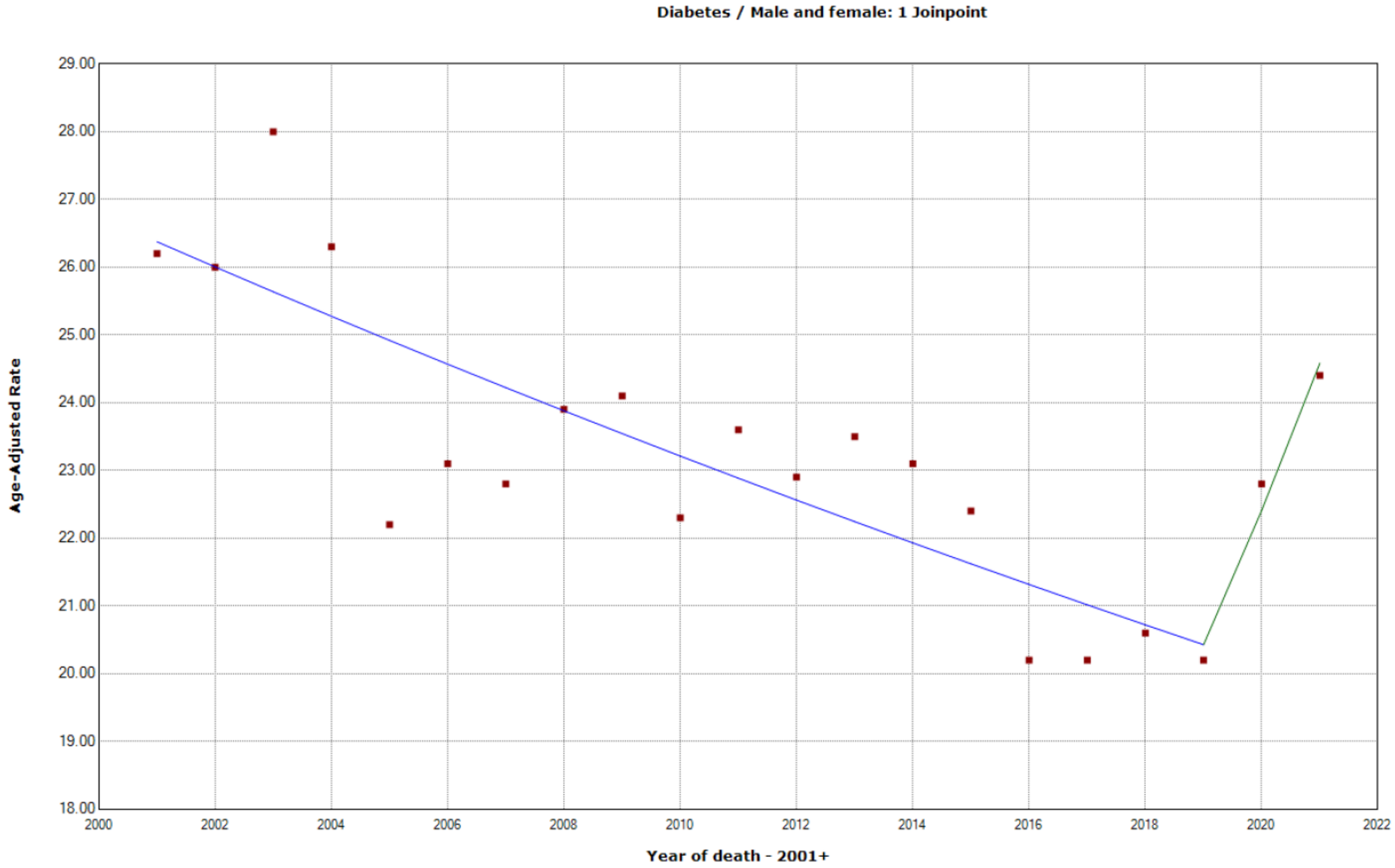


* Indicates that the Annual Percent Change (APC) is significantly different from zero at the alpha = 0.05 level
Final Selected Model: 1 Joinpoint.

# Diabetes-related mortality

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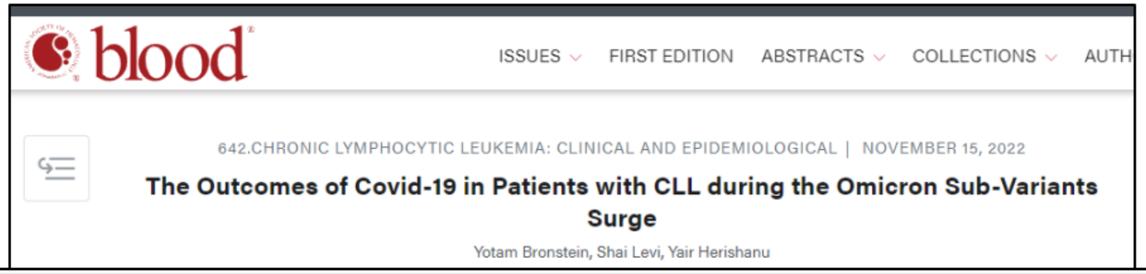
# Cancer Survival

Did patients diagnosed with cancer in 2020 have worse short-term outcomes than those diagnosed in 2015–2019?

# Did the pandemic impact outcomes among cancer survivors?



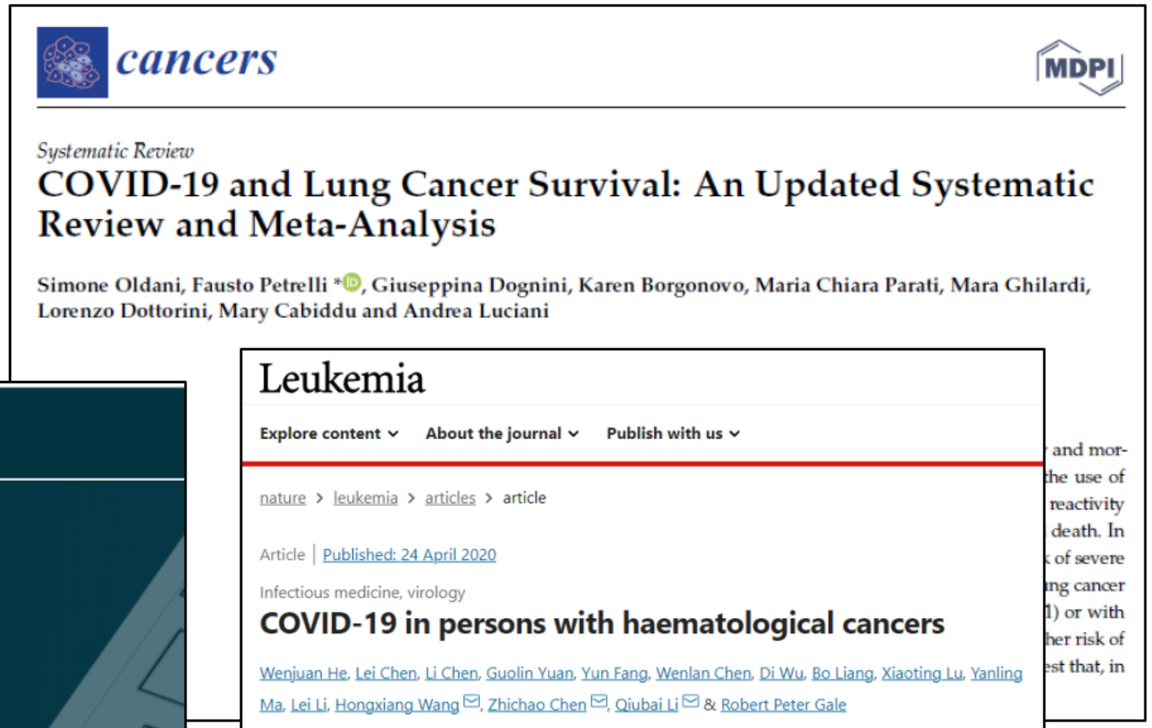
blood

ISSUES FIRST EDITION ABSTRACTS COLLECTIONS AUTH

642.CHRONIC LYMPHOCYTIC LEUKEMIA: CLINICAL AND EPIDEMIOLOGICAL | NOVEMBER 15, 2022

**The Outcomes of Covid-19 in Patients with CLL during the Omicron Sub-Variants Surge**

Yotam Bronstein, Shai Levi, Yair Herishanu



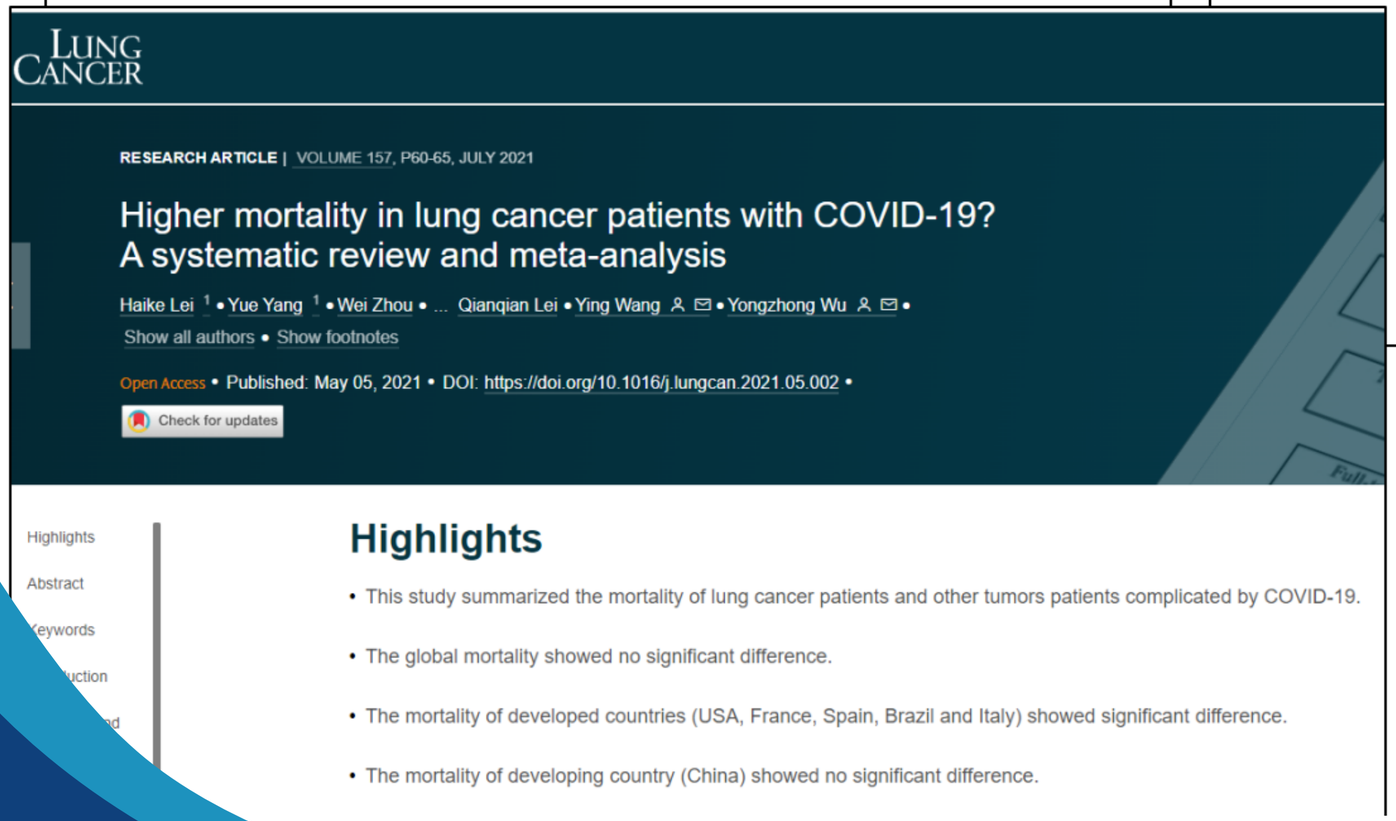
cancers

MDPI

*Systematic Review*

**COVID-19 and Lung Cancer Survival: An Updated Systematic Review and Meta-Analysis**

Simone Oldani, Fausto Petrelli *, Giuseppina Dognini, Karen Borgonovo, Maria Chiara Parati, Mara Ghilardi, Lorenzo Dottorini, Mary Cabiddu and Andrea Luciani



LUNG CANCER

RESEARCH ARTICLE | VOLUME 157, P60-65, JULY 2021

**Higher mortality in lung cancer patients with COVID-19? A systematic review and meta-analysis**

Haike Lei [1] • Yue Yang [1] • Wei Zhou • ... Qianqian Lei • Ying Wang • Yongzhong Wu •

Show all authors • Show footnotes

Open Access • Published: May 05, 2021 • DOI: https://doi.org/10.1016/j.lungcan.2021.05.002 •

Check for updates

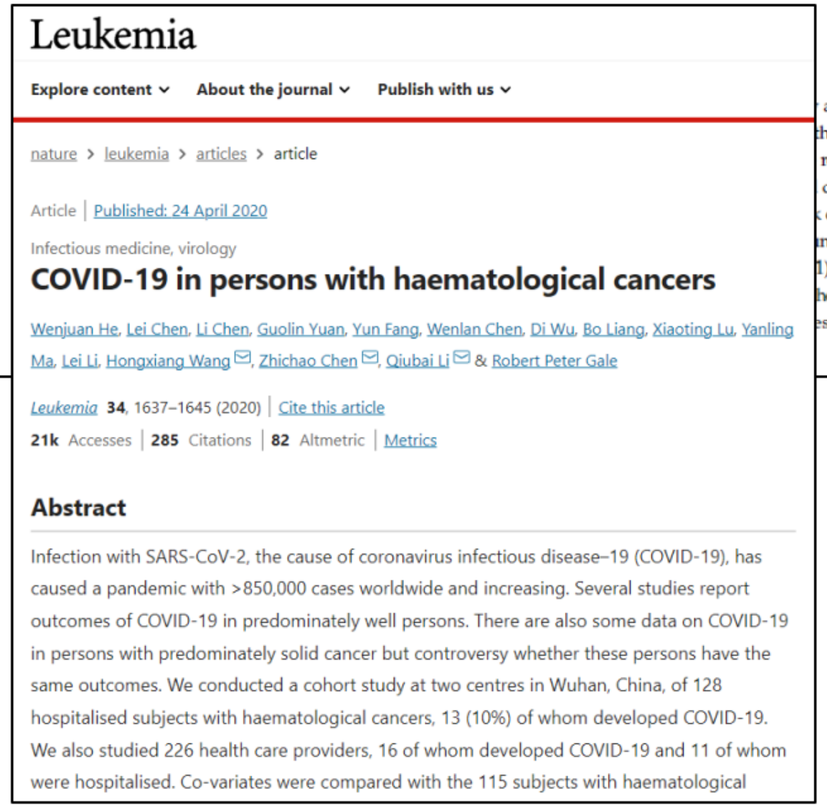
Highlights

Abstract

Keywords

## Highlights

- This study summarized the mortality of lung cancer patients and other tumors patients complicated by COVID-19.
- The global mortality showed no significant difference.
- The mortality of developed countries (USA, France, Spain, Brazil and Italy) showed significant difference.
- The mortality of developing country (China) showed no significant difference.



Leukemia

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nature › leukemia › articles › article

Article | Published: 24 April 2020

Infectious medicine, virology

**COVID-19 in persons with haematological cancers**

Wenjuan He, Lei Chen, Li Chen, Guolin Yuan, Yun Fang, Wenlan Chen, Di Wu, Bo Liang, Xiaoting Lu, Yanling Ma, Lei Li, Hongxiang Wang, Zhichao Chen, Qiubai Li & Robert Peter Gale

*Leukemia* **34**, 1637–1645 (2020) | Cite this article

**21k** Accesses | **285** Citations | **82** Altmetric | Metrics

### Abstract

Infection with SARS-CoV-2, the cause of coronavirus infectious disease–19 (COVID-19), has caused a pandemic with >850,000 cases worldwide and increasing. Several studies report outcomes of COVID-19 in predominately well persons. There are also some data on COVID-19 in persons with predominately solid cancer but controversy whether these persons have the same outcomes. We conducted a cohort study at two centres in Wuhan, China, of 128 hospitalised subjects with haematological cancers, 13 (10%) of whom developed COVID-19. We also studied 226 health care providers, 16 of whom developed COVID-19 and 11 of whom were hospitalised. Co-variates were compared with the 115 subjects with haematological

# COVID-19 and Cancer Burden Picture is Complex

- Increased health care coverage likely benefitted Idahoans
- Decreased access to care due to reduced capacity, fear of COVID-19, competing mortality risk may have impacted cancer incidence and survival

- Decreases in screenable (and other) cancers in 2020
- Large changes in population composition
- Decreases in cancer mortality for some sites in 2020, increases in 2021
- Survival impact remains unclear

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# Only time and more data will tell.

# Thank you.

Questions?

bmorawski@teamiha.org

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# The Value and Integral Role of Health Equity in Public Health


**KATIE LAMANSKY, CHES**

**Health Program Manager, Get Healthy Idaho, IDHW**

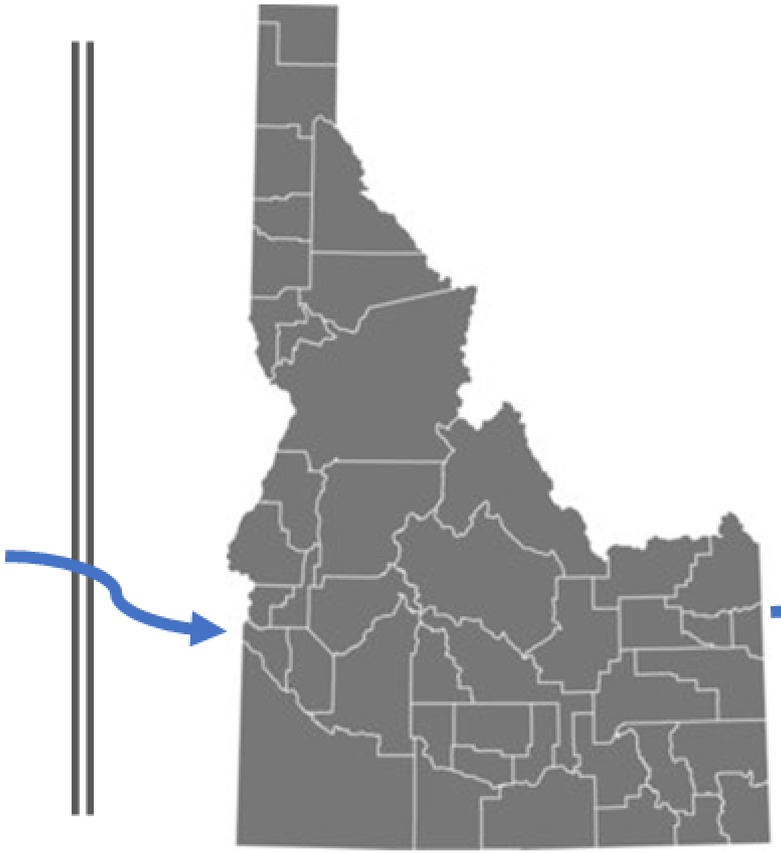
Comprehensive Cancer Alliance for Idaho

# The Value and Integral Role of Health Equity in Public Health

**Comprehensive Cancer Alliance For Idaho | Feb 23, 2023**
**Katie Lamansky, CHES, Health Program Manager**
*Bureau of Equity & Strategic Partnerships*
*Division of Public Health*
*Idaho Dept of Health & Welfare*

IDAHO DEPARTMENT OF HEALTH & WELFARE
DIVISION OF PUBLIC HEALTH

Last year, people moved to Idaho from ...


... and moved from Idaho to these states.

# Shifting Demographics

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# Public Health System

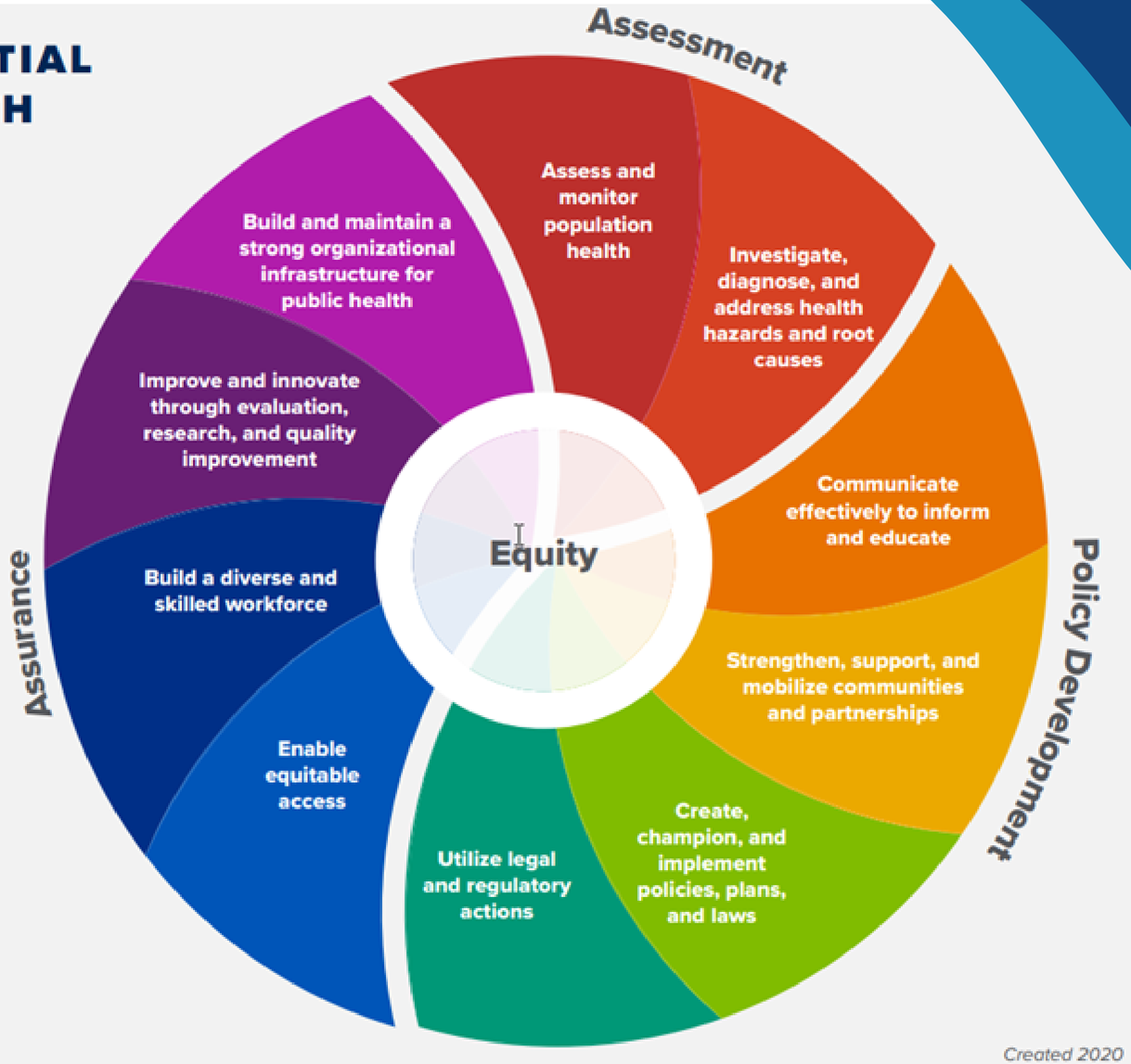
To promote, protect and preserve health for all

2/21/2023

## THE 10 ESSENTIAL PUBLIC HEALTH SERVICES

***To protect and promote the health of all people in all communities***

The 10 Essential Public Health Services provide a framework for public health to protect and promote the health of all people in all communities. To achieve optimal health for all, the Essential Public Health Services actively promote policies, systems, and services that enable good health and seek to remove obstacles and systemic and structural barriers, such as poverty, racism, gender discrimination, and other forms of oppression, that have resulted in health inequities. Everyone should have a fair and just opportunity to achieve good health and well-being.



# Health Equity

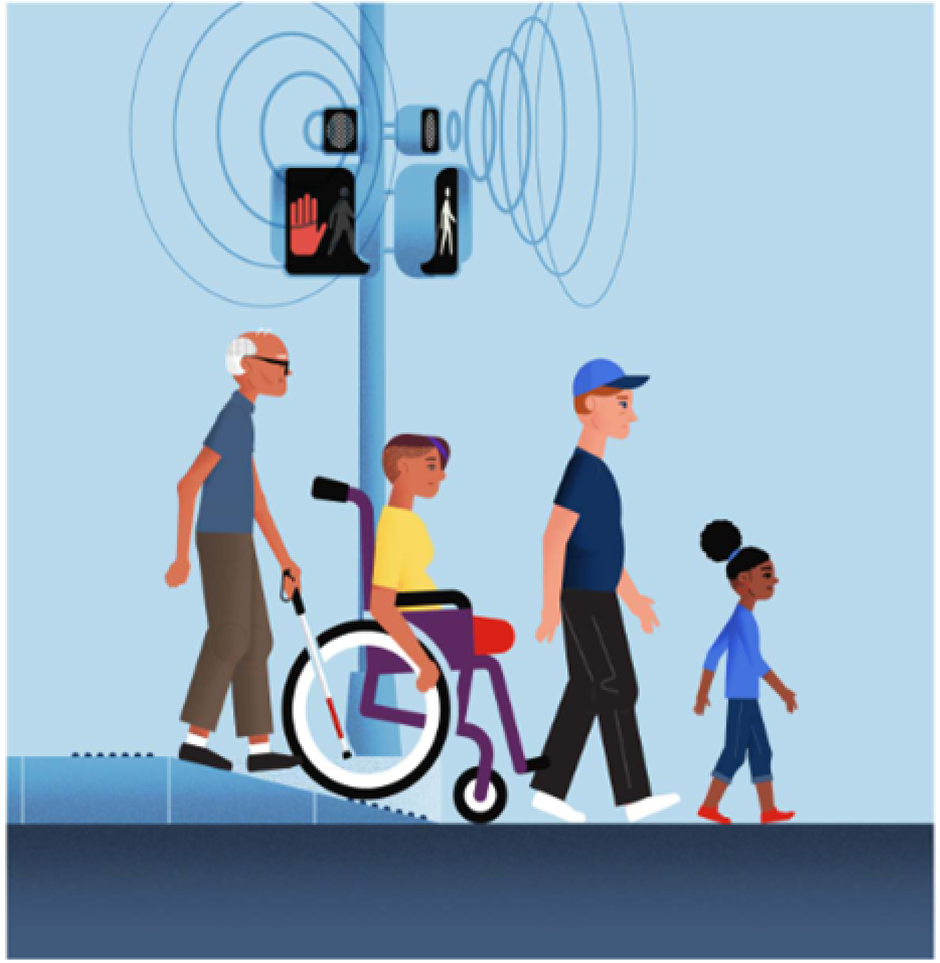
*Division of Public Health Definition:*

Everyone has a **fair and just opportunity** to be as healthy as possible. Health equity is the core principle that underscores a commitment to reduce and eliminate disparities in health and its determinants, including social determinants.

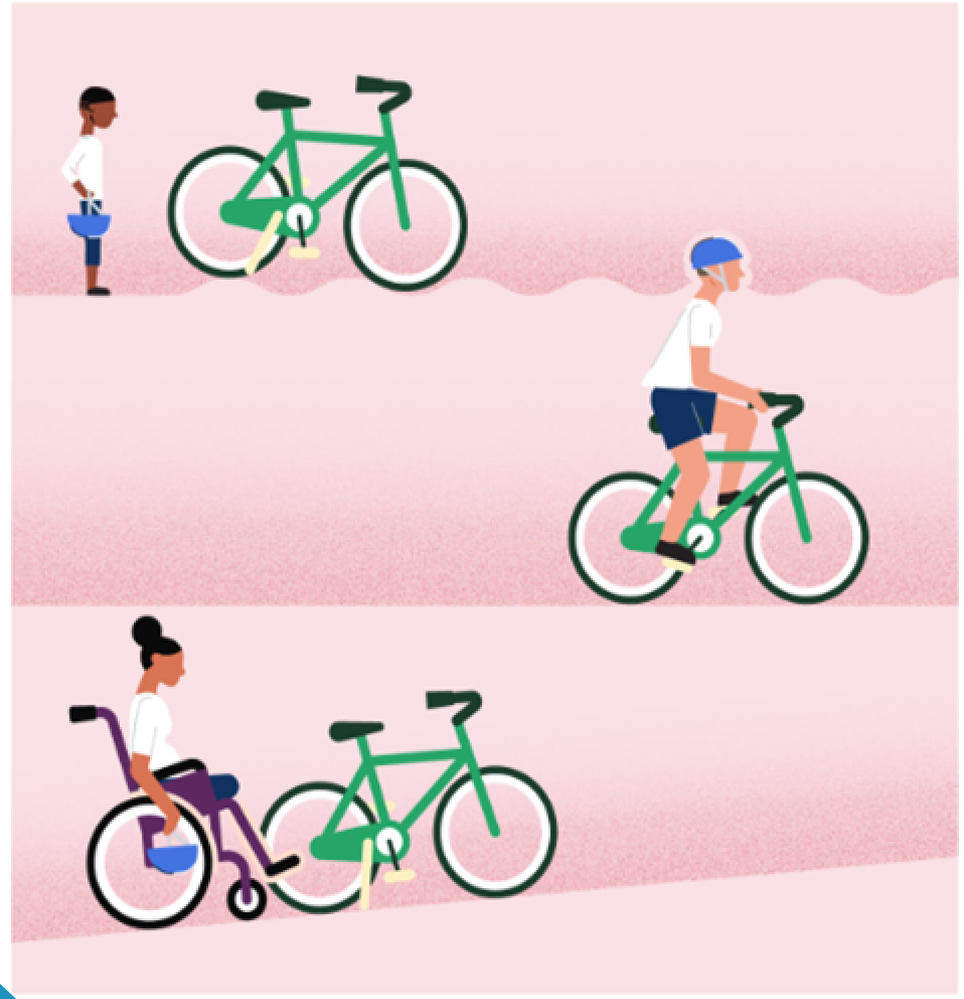
A commitment to health equity means striving for the highest possible standard of health for all and giving **priority attention to the needs of those at greatest risk of poor health**.

**EQUALITY:**
Everyone gets the same – regardless if it's needed or right for them.

**EQUITY:**
Everyone gets what they need – understanding the barriers, circumstances, and conditions.



**EQUALITY:**
Everyone gets the same–regardless if it's needed or right for them.



**EQUITY:**
Everyone gets what they need–understanding the barriers, circumstances, and conditions.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# Health Disparities

*Healthy People 2020 definition:*

"…a particular type of **health difference** that is closely linked with **economic, social, or environmental disadvantage**. Health disparities adversely affect groups of people who have **systematically experienced greater social or economic obstacles to health** based on their racial or ethnic group, religion, socioeconomic-status, gender, age, or mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion."

Source: HealthyPeople.gov. Disparities [cited 2012 Nov 20] Available from: URL:http://www.healthypeople.gov/2020/about/disparitiesAbout.aspx.

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# Example: Equity by Design

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# Equity is both the Ends & the Means

# Centering Equity in Organizational Practice

Organizational commitment to equity

Equip staff with training + tools

Use data to inform our work + influence change

Engage authentically with community

Share What We Know

Lean into and align with partners

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# Organizational Commitment to Equity

By prioritizing equity, diversity, and inclusion we are more likely to cultivate systems that benefit all people and communities

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# Equip Staff with Training + Tools

Ensure people have what they need to fully integrate and engage in this work

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# Use Data to Inform Solutions + Influence Change

Data – both qualitative and quantitative – tells a story.

It identifies barriers, informs solutions & influences action and change.

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# Engage Authentically with Community

Community members should have an **equal place** and **equal voice** wherever decisions are being made that will ultimately impact them



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