



ACHIEVING 80% BY 2018: *IMPROVING COLON CANCER SCREENING RATES IN ARIZONA*

RICHARD C. WENDER, MD
CHIEF CANCER CONTROL OFFICER
AMERICAN CANCER SOCIETY

Numerous events, accomplishments, and decisions have converged.

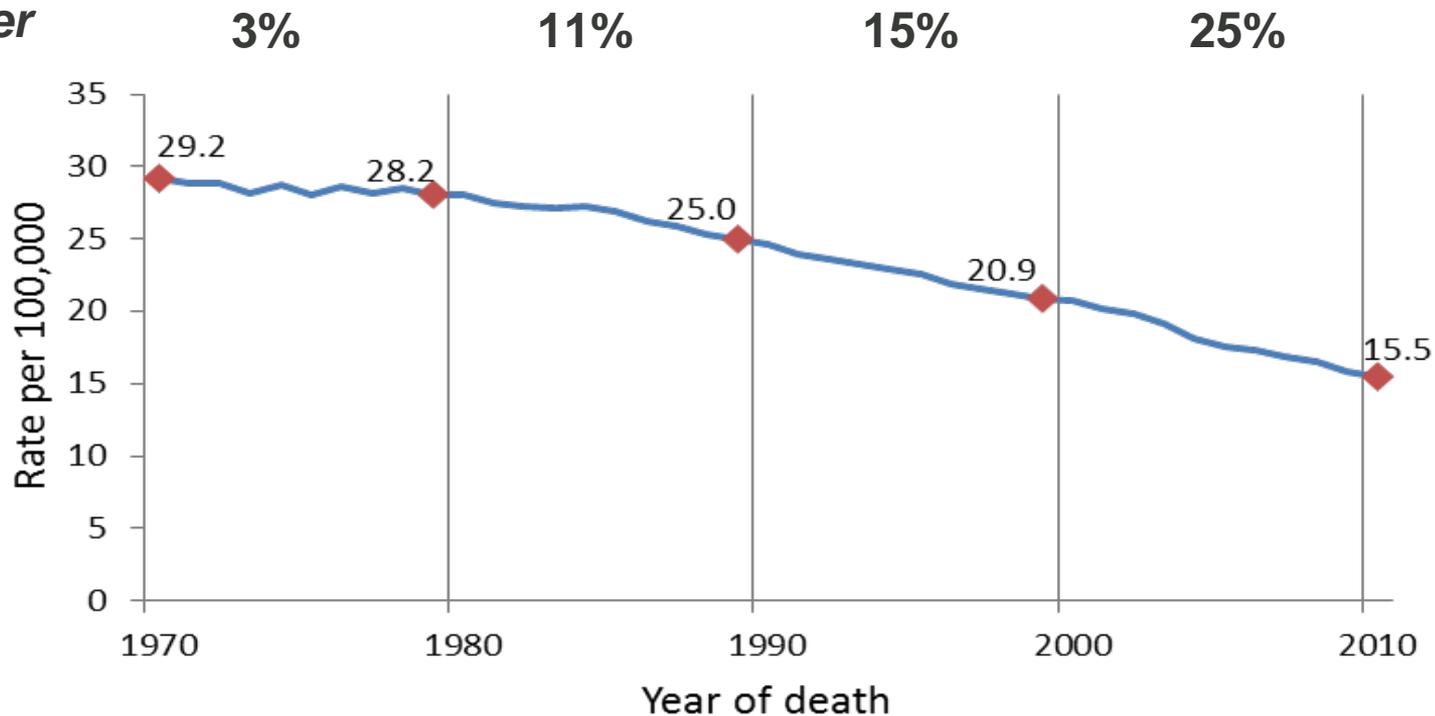


Together, they have created an extraordinary opportunity to achieve our goal of 80% colon cancer screening rate by 2018.

WE ARE MAKING PROGRESS

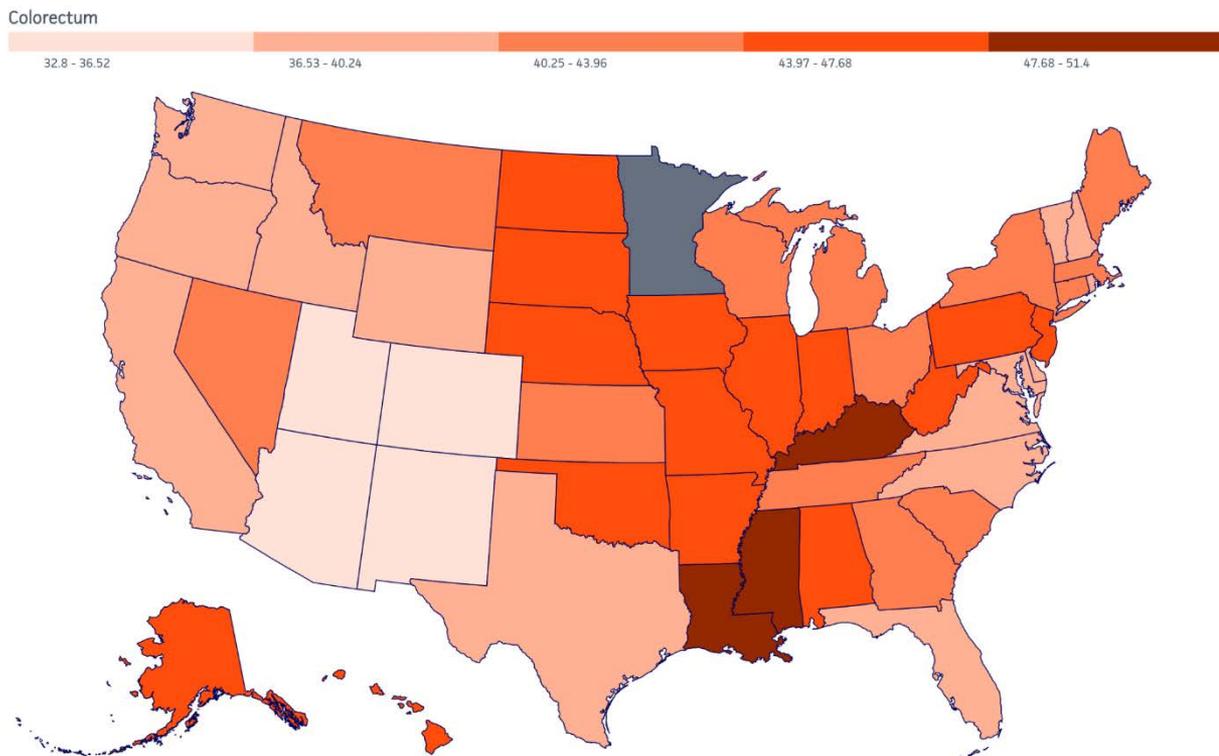
Increasing Decline in Colorectal Cancer Death Rates, 1970-2010

Decline per decade:



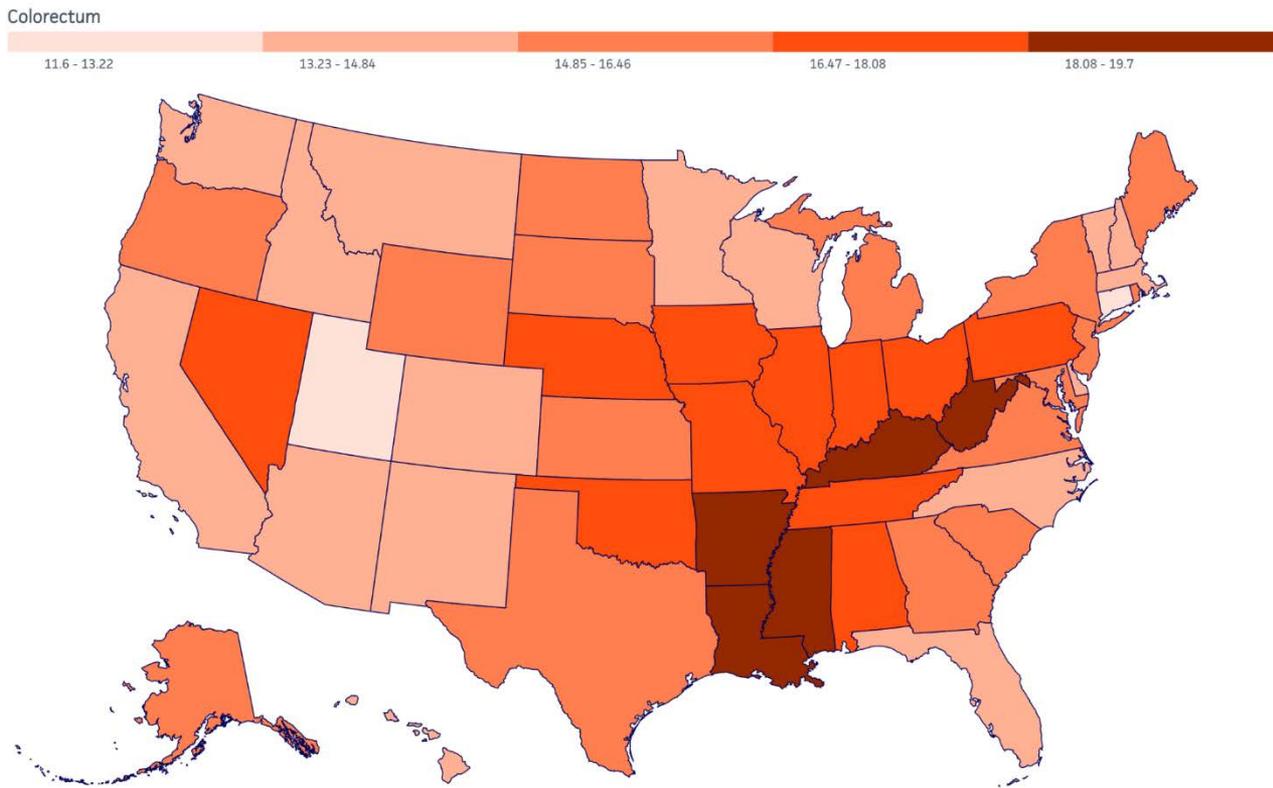
INCIDENCE RATES, 2008-2012

Per 100,000, age adjusted to the 2000 US standard population



DEATH RATES, 2008-2012

Per 100,000, age adjusted to the 2000 US standard population



The nation has become energized by the goal of 80% by 2018.

So what will it really take?



COLONOSCOPY AND STOOL TESTING ARE BOTH CRITICAL STRATEGIES

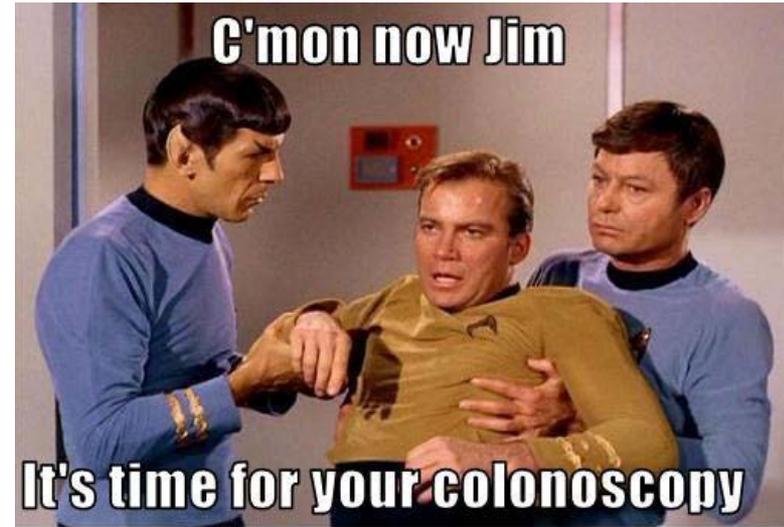
Every system achieving 80% is relying on stool testing as well as colonoscopy.

Both approaches are critical.



WE MUST MAKE HIGH QUALITY COLONOSCOPY AS WIDELY AVAILABLE AS POSSIBLE

- The increase in CRC screening rates between 2000 and 2010 resulted from a **36%** increase in colonoscopy rates.
- Getting to 80% demands that colonoscopy must be available to everyone.



COLONOSCOPY: Good for 10 years



TESTED

2016
NO TEST NEEDED

2017
NO TEST NEEDED

2018
NO TEST NEEDED

2019
NO TEST NEEDED

2020
NO TEST NEEDED

2021
NO TEST NEEDED

2022
NO TEST NEEDED

2023
NO TEST NEEDED

2024
NO TEST NEEDED



TESTED

FIT: Only good for one year



TESTED



TESTED



TESTED



TESTED



TESTED



TESTED



TESTED



TESTED



TESTED



TESTED



TESTED

IMPROVING COLONOSCOPY QUALITY

- Not all colonoscopies are created equal.
- Failure to achieve adequate polyp detection rates compromises the effectiveness of a screening program.



THREE KEY COMPONENTS OF COLONOSCOPY QUALITY

1. Screen the right patients at the right intervals.
2. Maximize bowel prep quality and patient show rates.
3. Monitor adenoma detection rate.

PATIENT NAVIGATION: THE KEY TO BETTER SHOW RATES AND BETTER BOWEL PREPS

- Navigators have been proven to significantly improve colonoscopy show rates and quality of bowel preps.
- Lynn Butterly, MD, in New Hampshire has proven that patient navigation can reduce no-show rate and inadequate bowel prep rate to essentially zero.

PATIENT NAVIGATION: THE KEY TO BETTER SHOW RATES AND BETTER BOWEL PREPS

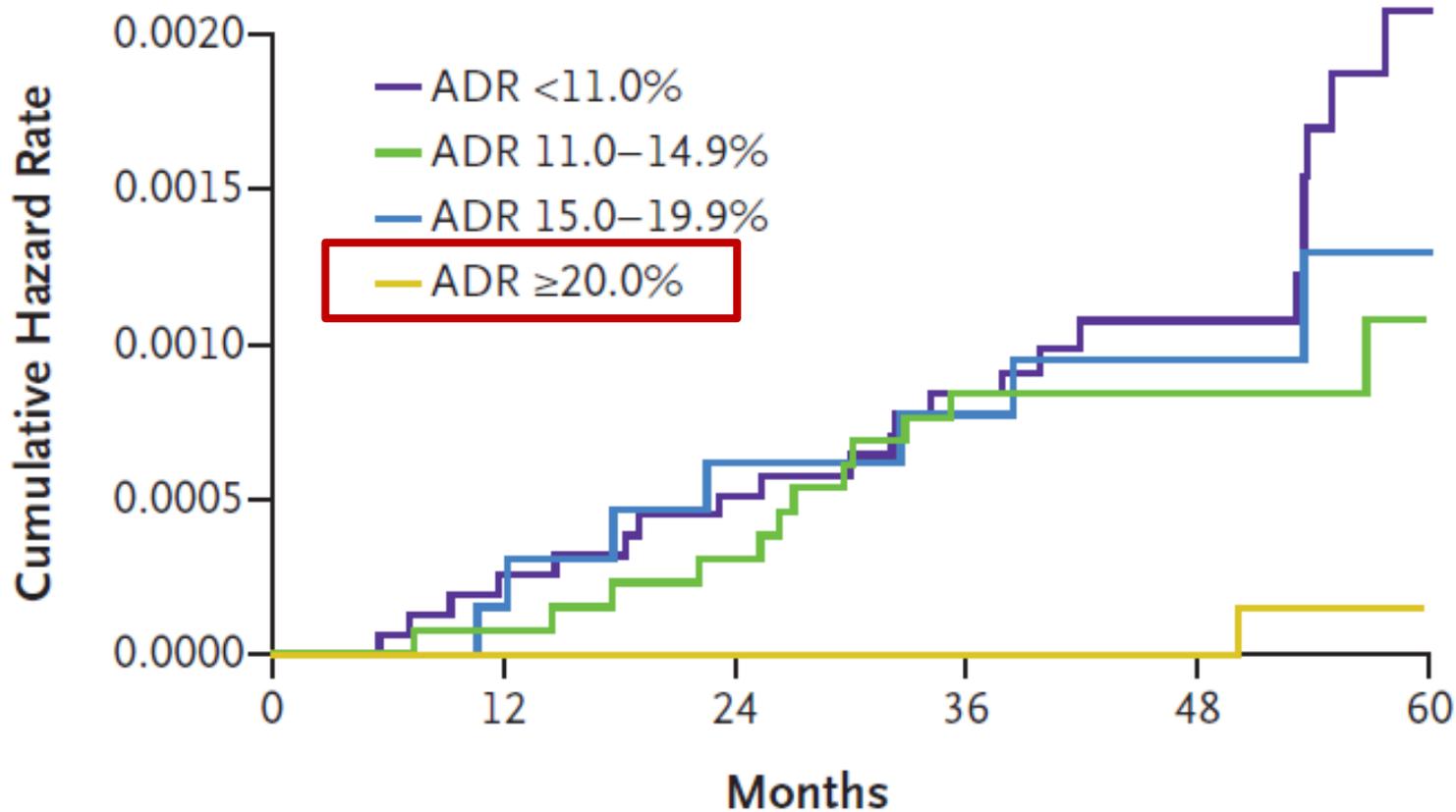
Colonoscopy navigation is now proven to be cost effective and should become a care standard.



THE MOST IMPORTANT MEASURE OF QUALITY COLONOSCOPY: ADENOMA DETECTION RATE

- Definition: The percent of screening exams with at least one adenoma detected
- Current Targets:
 - ADR should be:
 - $\geq 30\%$ male screening patients
 - $\geq 20\%$ female screening patients

ADR AND RISK OF INTERVAL CANCER



ADR AND OUTCOMES: KAISER

- Data from 314,872 colonoscopies performed between January 1, 1998 and December 31, 2010
- 136 gastroenterologists
 - To be included, GI had to have completed > 300 colonoscopies and 75 or more screening examinations during the study period.
- ADRs ranged from 7.4% to 52.5%.
- 8730 colorectal cancers diagnosed

EVERY HEALTH SYSTEM MUST COMMIT TO IMPROVING SYSTEM-WIDE ADR

- Every system must participate in a colonoscopy registry.
- Registries must monitor:
 - Show rates
 - Prep quality
 - Cecal intubation rates
 - ADR

STANDARDIZED COLONOSCOPY REPORTING AND DATA SYSTEM (CO-RADS)

SPECIAL REPORT

Standardized colonoscopy reporting and data system: report of the Quality Assurance Task Group of the National Colorectal Cancer Roundtable

David Lieberman, MD, Marion Nadel, PhD, Robert A. Smith, PhD, Wendy Atkin, PhD,
Subash B. Duggirala, MD, MPH, FAAFP, Robert Fletcher, MD, MSc, Seth N. Glick, MD,
C. Daniel Johnson, MD, Theodore R. Levin, MD, John B. Pope, MD, Michael B. Potter, MD,
David Ransohoff, MD, Douglas Rex, MD, Robert Schoen, MD, Paul Schroy, MD, Sidney Winawer, MD

Portland, Oregon, USA

WE MUST ALSO ENSURE THAT ANYONE CAN BE OFFERED A HOME STOOL BLOOD TEST

- Even if you recommend colonoscopy for all, some people won't get one, can't get one, or shouldn't get one.
- Using colonoscopy exclusively will, inevitably, lead to a screening gap.



STOOL BLOOD TESTING REMAINS IMPORTANT IN THE “AGE OF COLONOSCOPY”

- Colonoscopy is now the most frequently used screening test for CRC.
- However, when provided annually to average-risk patients with appropriate follow-up, stool occult blood testing with high-sensitivity tests can provide similar reductions in mortality compared to colonoscopy and some reduction in incidence.

ADVANTAGES OF STOOL BLOOD TESTING

- Stool blood testing:
 - Is less expensive.
 - Can be offered by any member of the health team.
 - Requires no bowel preparation.
 - Can be done in privacy at home.
 - Does not require time off work or assistance getting home after the procedure.
 - Is non-invasive and has no risk of causing pain, bleeding, bowel perforation, or other adverse outcomes.



Colonoscopy is required only if stool blood testing is abnormal.

MANY PATIENTS PREFER HOME STOOL TESTING

Colonoscopy recommended:

38% completed colonoscopy

FOBT recommended:

67% completed FOBT

Colonoscopy or FOBT:

69% completed a test

COLONOSCOPY FOR POSITIVE TEST IS CRITICAL

Patients who select stool blood testing must also be prepared to accept follow-up colonoscopy if the stool blood test is abnormal.



FECAL IMMUNOCHEMICAL TESTS (FITs) SHOULD REPLACE GUAIAAC FOBT

- FITs:
 - Demonstrate superior sensitivity and specificity.
 - Are specific for colon blood and are unaffected by diet or medications.
 - Some can be developed by automated readers.
 - Some improve patient participation in screening.

FECAL IMMUNOCHEMICAL TESTS (FIT)

- FIT tests are based on the immunochemical detection of human hemoglobin (Hb) as an indicator of blood in the stool.
- Immunochemical tests use a monoclonal or polyclonal antibody that reacts with the intact globin protein portion of human hemoglobin.
- More user friendly!

Stay **FIT**



FIT WAS MORE EFFECTIVE FOR CRC SCREENING THAN FOBT

	FIT	FOBT
Participation	6157(60%)	4836(47%)
Pos. rate	5.5%	2.4%
Polyps	679	220
Adv. Adenoma	145	57
Cancer	24	11

- Population based random sample of 20,623 individuals, 50-75 yrs (Netherlands)
- Tests and invitations were sent together
- 1 FIT (I-FOBT) vs. 3 G-FOBT samples

FITS AVAILABLE IN THE US

Name	Manufacturer
InSure	Enterix, Quest Company
Hemocult-ICT	Beckman-Coulter
Instant-View	Alpha Scientific Designs
MonoHaem	Chemicon International
Clearview Ultra-FOB	Wampole Laboratory
Fit-Chek	Polymedco
Hemosure One Step	WHPM, Inc.
Magstream Hem Sp	Fujirebio, Inc.

Hemocult ICT, HemeSelect, InSure, Fit-Chek, and MagStream 1000/Hem SP have been evaluated in large numbers.

OLDER GUAIAAC-BASED TESTS NOT RECOMMENDED

Hemoccult II and similar older guaiac tests should no longer be used for colorectal cancer screening.



REMEMBER: STOOL COLLECTION SHOULD BE DONE AT HOME!

- Stool collected on rectal exam may not be sufficient or sufficiently representative of stool collected from a complete bowel movement.
- There is **no evidence** that any type of stool blood testing is sufficiently sensitive when used on a stool sample collected during a rectal exam.
- Therefore, **HS-gFOBt and FIT should be completed by the patient at home, and NOT as an in-office test.**

**10 COMPONENTS OF THE
STRATEGIC PLAN TO ACHIEVE
80% BY 2018**

10 COMPONENTS OF THE 80% BY 2018 STRATEGIC PLAN

1. The 80% by 2018 campaign has gone viral.
2. We're not getting anywhere near 80% without relying on our nation's primary care clinicians.
3. Approaching this state-by-state has broad appeal.
4. Engaging health care plans is difficult but critically important.
5. Hospitals and Cancer Centers can be the difference between our reaching this goal or not.

10 COMPONENTS OF THE 80% BY 2018 STRATEGIC PLAN

6. Working with large employers and CEOs is a strategy worth exploring.

7. We need to use tailored messages to reach the unscreened.

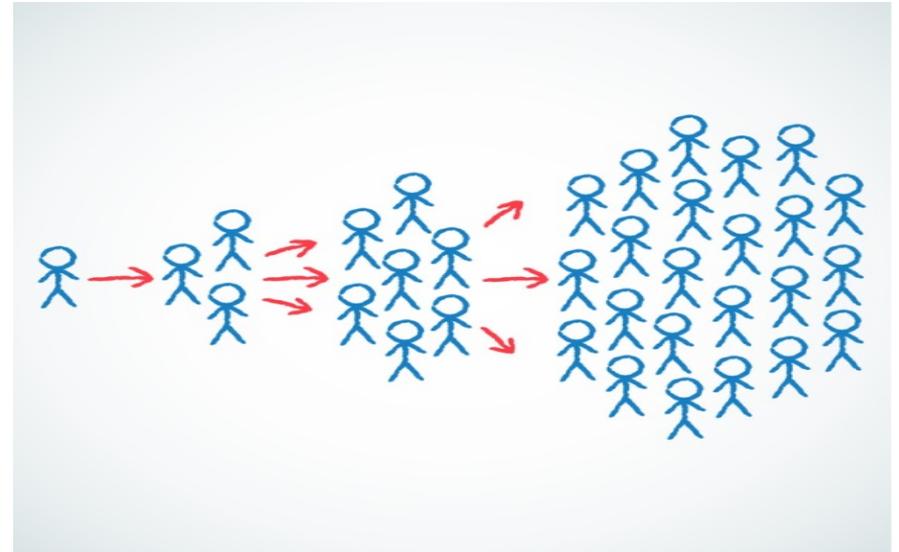
8. Financial barriers persist as major obstacles to screening.

9. Finding the right set of complementary strategies is a key goal.

10. We must floor the accelerator right now and keep pedal to the metal for the next four years.

1. THE 80% BY 2018 CAMPAIGN HAS GONE VIRAL

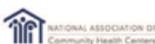
- The world loves a good goal. As public health stories go, this one works really well.
- Organizations are eager to pull together to get something important done.



MORE AND MORE ORGANIZATIONS ARE SIGNING THE PLEDGE



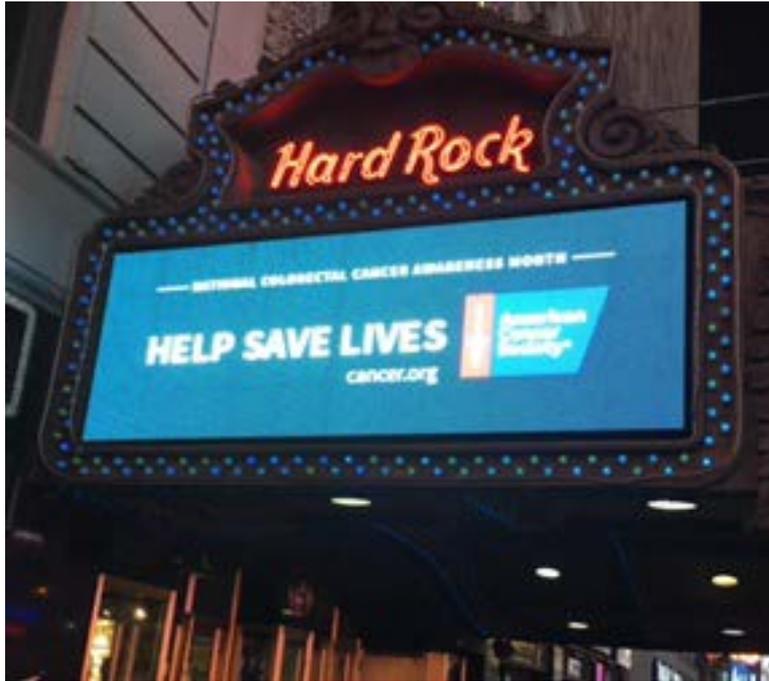
MORE ORGANIZATIONS ARE TAKING THE PLEDGE



MORE ORGANIZATIONS ARE TAKING THE PLEDGE



80% BY 2018 FEATURED ON BROADWAY



LITTLE ROCK'S JUNCTION BRIDGE WENT BLUE



UNPRECEDENTED MOMENTUM IN BUFFALO

- Every major hospital system and insurer in Buffalo united to sign the pledge.
- Buffalo's mayor is only the second mayor to sign the pledge



A nighttime photograph of the Columbus, Ohio skyline. The city's skyscrapers are illuminated with a vibrant blue light, creating a monochromatic glow. The lights from the buildings are reflected in the water of the river in the foreground. A dark bridge structure is visible in the middle ground, and the sky is a deep, dark blue with some light clouds. The overall atmosphere is serene and modern.

Columbus, Ohio Glowed Blue for a Night

80% BY 2018 LIGHTS UP CHICAGO

Health Care Service Corporation (Blue Cross Blue Shield of IL, TX, OK, NM, and MT) used its building lights in Chicago to promote 80% x 2018.



EVEN NIAGARA FALLS WENT BLUE!



21

Community health
centers are at 80%

Let's pledge to
maintain this momentum ...

... on the road to 2018.



2. WE'RE NOT GETTING TO 80% WITHOUT RELYING ON PRIMARY CARE

- The basics of screening have not changed:
 - Health insurance facilitates screening.
 - Everyone needs a primary care clinician.
 - The principal determinant of screening is whether or not a **primary care clinician recommends** screening.

But this is asking a lot.

WHAT MUST A PRIMARY CARE PRACTICE DO TO IMPROVE SCREENING RATES?

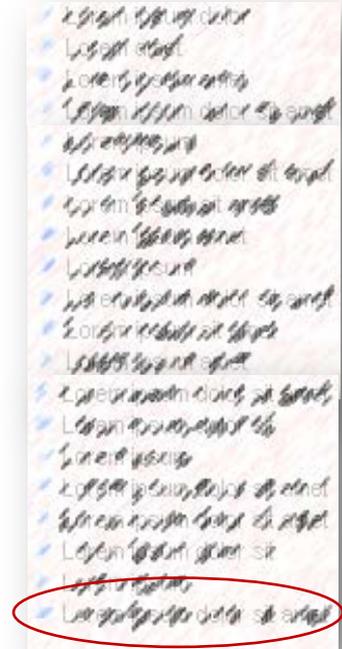
- Have strong leadership and champions.
- Have the capacity to measure and report screening rates in real time:
 - By practice
 - By clinician
 - By patient
- Have a system to contact patients who are out of date with screening and invite them to participate.

WHAT MUST A PRIMARY CARE PRACTICE DO TO IMPROVE SCREENING RATES?

- Identify a screening policy
 - Financial/insurance considerations
 - Availability of colonoscopy
- Provide some form of patient navigation
 - Ideally, navigation for colonoscopy should be provided by colonoscopy group
- Develop a reliable network of colonoscopists
 - Reliance on FOBT/FIT substantially reduces the number of colonoscopies

3. APPROACHING THIS STATE-BY-STATE HOLDS BROAD APPEAL

- Numerous states are in the process of forming state Colon Cancer Screening Roundtables or Coalitions.
- States **without** a history of NCCRT involvement are getting on board for the first time.
- Cities and states **love competition** – no one likes being at the bottom of the list.



MORE AND MORE STATE-LEVEL ENGAGEMENT



LET'S BE LITTLE LEAGUE: EVERYONE'S A WINNER

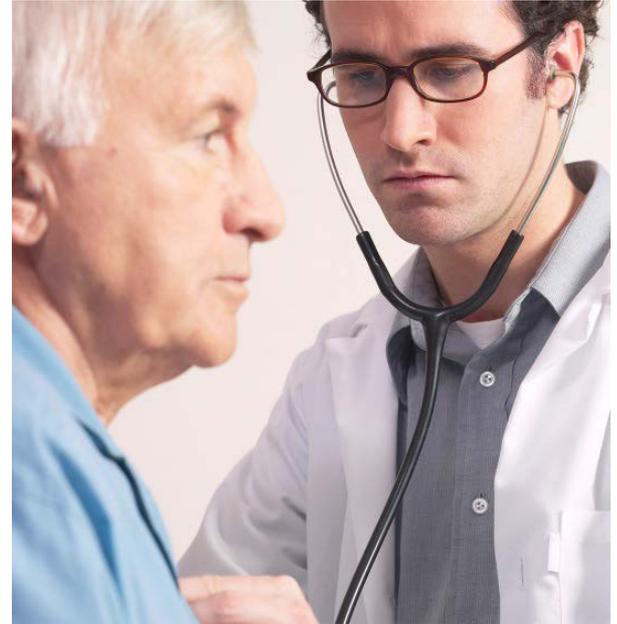
- Some states are out in front.
Some are far behind.
- But the playing field is not even.
- We will celebrate the first state to reach 80%

... but we will celebrate, with equal joy, every state that is working hard to get the nation closer to our 80% goal.



4. ENGAGING HEALTH CARE PLANS IS CRITICALLY IMPORTANT

- Health care plans have a broad agenda and many demands.
- Although improving HEDIS measures is a valued goal, controlling health care costs, reducing readmissions, and managing chronic illness may be viewed as more urgent goals.
- Competition with other plans may be intense.



39

Health plans
are at 80%

CHARACTERISTICS OF HIGH PERFORMING PLANS

- Leadership – a commitment to achieve very high screening rates
- A champion – or more than one
- A commitment to measurement and reporting of screening rates
- Implementation of population health management
- Reliance on both stool testing and colonoscopy
- Incentives and accountability for primary care providers
- Elimination of patient cost sharing

5. HOSPITALS AND CANCER CENTERS CAN MAKE THE DIFFERENCE

80% by 2018 offers a unique opportunities to build integrated systems that can prevent over **200,000 colon cancer deaths** by 2030.



FIVE STEPS TO HOSPITAL LEADERSHIP OF 80% BY 2018



1. Recognize and overcome barriers to participation.
2. Identify a champion (or champions).
3. Publicly commit to achieving this goal.
4. Assemble a team.
5. Implement the 80% by 2018 Strategic Plan.

6. ENGAGING LARGE EMPLOYERS AND CEOS IS A STRATEGY WORTH EXPLORING

- To more effectively impact health care plans, we will need to more effectively engage with their customers – **employers and CEOs.**
- Employers have a wonderful opportunity to help the nation achieve a critical public health goal.



ACHIEVING 80% BY 2018: THE ROLE OF EMPLOYERS

- Create a culture of wellness across the enterprise.
- Educate employees and their families about colon cancer risk.
- Make it easier for individuals to get screened.
- Create incentives.
- Serve as role models.

7. WE NEED TAILORED MESSAGES TO REACH THE UNSCREENED

- We have conducted market research with a large group of unscreened Americans.



*"A Colonoscopy with a friend
... Priceless"*

Long-time friends Judy Hagan and Cindy Blessing were riding in the car one day when both realized they were overdue for their colonoscopies. With family histories of colon cancer, both women understood the importance of the screening. Without delay, Judy grabbed her cell phone and called to make appointments for both of them on the same day. Read about their unique experience together at [\[redacted\]](#)

The Hansen Center 

BARRIERS TO CONSUMER SCREENING – FACTORS

#1: Affordability

- *“I do not have health insurance and would not be able to afford this test. I do not feel the need to have it done.”*

#2: Lack of symptoms

- *“Doctors are seen when the symptoms are evidently presumed, not before.”*

#3: No family history of colon cancer

- *“Never had any problems and my family had no problems, so felt it wasn't really necessary.”*

#1 reason among 50-64 year olds & Hispanics

Nearly ½ uninsured

#1 reason among 65+ year olds

BARRIERS TO CONSUMER SCREENING – FACTORS

#4: Perceptions about the unpleasantness of the test

- *“I do not think it is a good idea to stick something where the sun don’t shine. The yellow Gatorade I cannot stomach.”*

#5: Doctor did not recommend it

- *“I fear it will be uncomfortable. My doctor has never mentioned it to me, so I just let it go.”*

#6: Priority of other health issues

- *“I just turned 50 and I am dealing with another health issue, so it's on the back burner.”*

#1 reason among Black/African Americans;
#3 reason among Hispanics

ACTIVATING MESSAGES THAT MOTIVATE

There are several screening options available, including simple take home options. Talk to your doctor about getting screened.

Colon cancer is the second leading cause of cancer deaths in the U.S., when men and women are combined, yet it can be prevented or detected at an early stage.

Preventing colon cancer, or finding it early, doesn't have to be expensive. There are simple, affordable tests available. Get screened! Call your doctor today.

**Top Messages for
Unscreened Hispanic
Audiences**

“

IF YOU ARE 50 OR OLDER, YOU'RE AT A HIGHER RISK FOR COLON CANCER – EVEN IF YOU ARE HEALTHY. ASK YOUR DOCTOR FOR A SCREENING TEST. YOU CAN DO A SIMPLE TEST AT HOME.

“

YOU ARE SO IMPORTANT TO YOUR
FAMILY, DON'T LET THEM DOWN! DON'T
PROCRASTINATE ANY LONGER! GET
SCREENED FOR COLON CANCER TODAY!
IT COULD SAVE YOUR LIFE.

“

HI, MY NAME IS MARIA. I LOST MY FATHER TO COLON CANCER. HE WAS TOO STUBBORN TO GET SCREENED, BUT THE CANCER MIGHT HAVE BEEN PREVENTED IF HE DID. DON'T LET YOUR FAMILY LOSE YOU, TOO. GET SCREENED AND PREVENT COLON CANCER.

“

COLON CANCER IS THE SECOND-LEADING
CANCER KILLER IN THE U.S. AMONG HISPANICS,
BUT IT DOESN'T HAVE TO BE. COLON CANCER
CAN BE PREVENTED OR FOUND AT AN EARLY
STAGE. GETTING SCREENED IS ABSOLUTELY
NECESSARY! CALL A DOCTOR TODAY.

“

COLON CANCER STARTS WITH A POLYP IN THE
LARGE INTESTINE. POLYPS ARE VERY COMMON IN
PEOPLE AGE 50 AND OLDER, BUT THEY CAN BE
DETECTED AND REMOVED BEFORE THEY TURN INTO
CANCER. DON'T DIE OF CANCER. TALK TO YOUR
DOCTOR ABOUT COLON CANCER PREVENTION.

TOOLS ARE AVAILABLE ON WWW.NCCRT.ORG

- Wide range of tools available for download.



8. FINANCIAL BARRIERS PERSIST AS MAJOR OBSTACLES TO SCREENING

- To substantially increase screening rates, strategies to reach individuals without health insurance and on Medical Assistance must be developed.
- Federally Qualified Health Centers and academic primary care clinics serve as the safety net for many low income individuals.

9. FINDING THE RIGHT SET OF COMPLEMENTARY STRATEGIES IS A KEY GOAL

- Should we focus on working with primary care to implement population management?
- Or should we work on tailored messages to the unscreened?
- Or would it be better to focus on working with hospitals or health care plans?

Here's the painful truth:

There is nothing we can do to reach 80%
colon cancer screening rates by 2018

... except everything.

10. WE MUST FLOOR THE ACCELERATOR AND KEEP PEDAL TO THE METAL FOR THE NEXT THREE YEARS

- We have made the commitment to increase CRC screening rates by 15% in five years ... and we only have three years left to do it.
- Every member organization needs to participate in a national plan but also have their own plan to pursue the interventions that they are uniquely positioned to do.



Achieving 80% colon cancer screening rates by the end of 2018 will be very difficult.

Our goal is big ...

... but so the
potential impact.

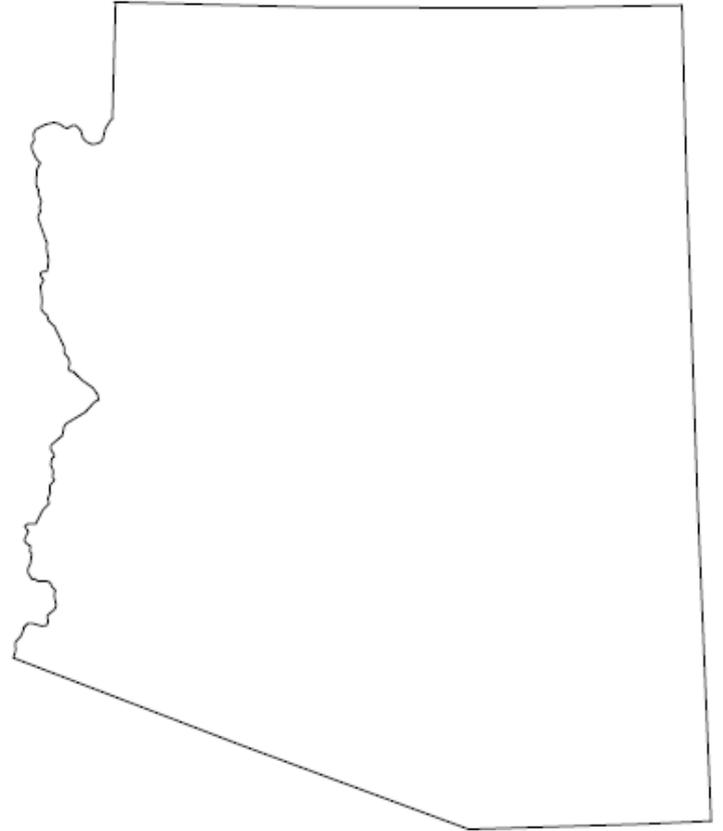


If we can achieve 80% by 2018,
277,000 cases and **203,000 colon
cancer deaths** would be
prevented ...

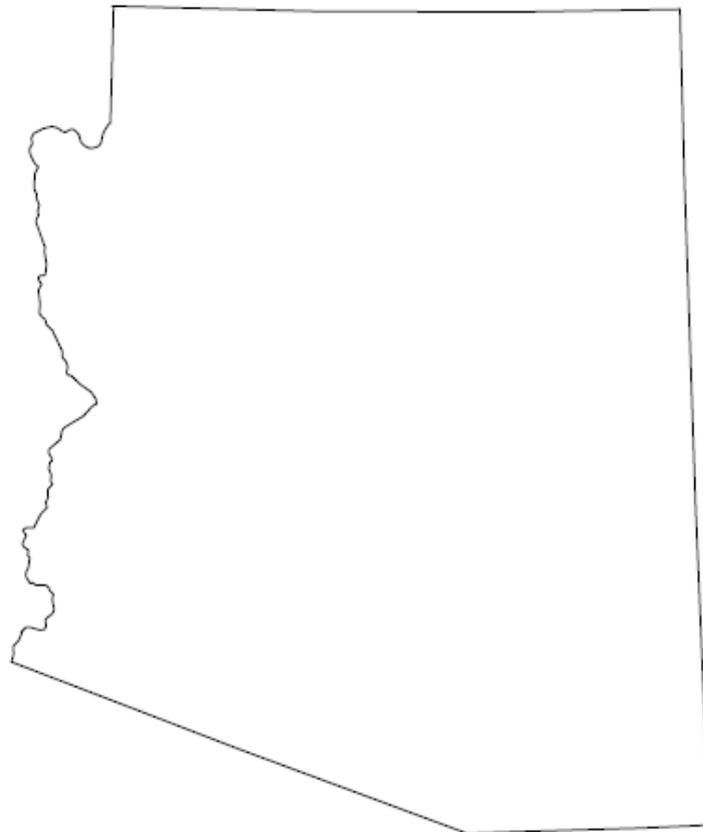
... by 2030.



In Arizona, **639,500**
people need to
be screened
to achieve 80%.



**But if we can achieve
80%, **7,263 cases**
and **5,322 deaths**
would be prevented by
2030.**



I **CAN** see it!





THANK YOU



 @RichWender