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

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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:

- 3%
- 11%
- 15%
- 25%

Year of death

Rate per 100,000


29.2 28.2 25.0 20.9 15.5
COLORECTAL CANCER SCREENING*
PREVALENCE AMONG ADULTS AGE 50 YEARS
AND OLDER BY STATE, 2012

*Either a fecal occult blood test within the past year or a sigmoidoscopy or colonoscopy within the past 10 years (includes diagnostic exams).
Source: Behavioral Risk Factor Surveillance System Public Use Data Tapes 2012, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention.
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

Data Source: National Center for Health Statistics (NCHS), Centers for Disease Control and Prevention, 2015
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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

FIT: Only good for one year
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.
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.
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:
    • ≥ 30% male screening patients
    • ≥ 20% female screening patients
ADR AND RISK OF INTERVAL CANCER
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
• 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.

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

Evaluating Test Strategies for Colorectal Cancer Screening: A Decision Analysis for the U.S. Preventive Services Task Force
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

<table>
<thead>
<tr>
<th>Method</th>
<th>Completion Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colonoscopy recommended</td>
<td>38% completed colonoscopy</td>
</tr>
<tr>
<td>FOBT recommended</td>
<td>67% completed FOBT</td>
</tr>
<tr>
<td>Colonoscopy or FOBT:</td>
<td>69% completed a test</td>
</tr>
</tbody>
</table>

Adherence to Colorectal Cancer Screening: A Randomized Clinical Trial of Competing Strategies
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 GUAIAC 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!
FIT WAS MORE EFFECTIVE FOR CRC SCREENING THAN FOBT

<table>
<thead>
<tr>
<th></th>
<th>FIT</th>
<th>FOBT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participation</td>
<td>6157 (60%)</td>
<td>4836 (47%)</td>
</tr>
<tr>
<td>Pos. rate</td>
<td>5.5%</td>
<td>2.4%</td>
</tr>
<tr>
<td>Polyps</td>
<td>679</td>
<td>220</td>
</tr>
<tr>
<td>Adv. Adenoma</td>
<td>145</td>
<td>57</td>
</tr>
<tr>
<td>Cancer</td>
<td>24</td>
<td>11</td>
</tr>
</tbody>
</table>

- 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

<table>
<thead>
<tr>
<th>Name</th>
<th>Manufacturer</th>
</tr>
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<tbody>
<tr>
<td>InSure</td>
<td>Enterix, Quest Company</td>
</tr>
<tr>
<td>Hemoccult-ICT</td>
<td>Beckman-Coulter</td>
</tr>
<tr>
<td>Instant-View</td>
<td>Alpha Scientific Designs</td>
</tr>
<tr>
<td>MonoHaem</td>
<td>Chemicon International</td>
</tr>
<tr>
<td>Clearview Ultra-FOB</td>
<td>Wampole Laboratory</td>
</tr>
<tr>
<td>Fit-Chek</td>
<td>Polymedco</td>
</tr>
<tr>
<td>Hemosure One Step</td>
<td>WHPM, Inc.</td>
</tr>
<tr>
<td>Magstream Hem Sp</td>
<td>Fujirebio, Inc.</td>
</tr>
</tbody>
</table>
Hemoccult ICT, HemeSelect, InSure, Fit-Chek, and MagStream 1000/Hem SP have been evaluated in large numbers.

Levi Z, Ann Intern Med. 2007; 146:244-55
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
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.
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

759 and counting!
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.
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

CT, DE, MD, NH, RI, VT, Washington, DC
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.
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
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 ANDCEOS 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.
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

<table>
<thead>
<tr>
<th>Factor</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>#4: Perceptions about the unpleasantness of the test</td>
<td>“I do not think it is a good idea to stick something where the sun don’t shine. The yellow Gatorade I cannot stomach.”</td>
</tr>
<tr>
<td>#5: Doctor did not recommend it</td>
<td>“I fear it will be uncomfortable. My doctor has never mentioned it to me, so I just let it go.”</td>
</tr>
<tr>
<td>#6: Priority of other health issues</td>
<td>“I just turned 50 and I am dealing with another health issue, so it’s on the back burner.”</td>
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</tbody>
</table>

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