

80% by 2018 Strategy Meeting: Working with Hospitals to Improve Screening Delivery

WELCOME AND INTRODUCTORY REMARKS

Dr. Michael B. Potter, NCCRT Professional Education and Practice Task Group Co-Chair; Professor, Family and Community Medicine, and Associate Director for Practice Based Research, Community Engagement Program, Clinical and Translational Science Institute, University of California, San Francisco

Dr. Potter thanked meeting participants for their attendance, and explained that the primary goal of the meeting was to bring representatives from different organizations together to explore the strategic role that hospitals can play in the effort to achieve an 80% colorectal cancer screening rate by 2018.

He offered some introductory remarks about the National Colorectal Cancer Roundtable, explaining that it is a collection of organizations supported by the American Cancer Society and the Center for Disease Control and Prevention aimed at increasing colorectal cancer screening rates. He highlighted the fact that there has been considerable progress to date in achieving the goal, with nearly 500 organizations and 100 hospitals and cancer centers signed on to the 80% by 2018 pledge.

Dr. Potter outlined the meeting objectives for the day:

1. Document best colorectal cancer screening practices in hospitals.
2. Understand barriers to delivering quality CRC screening in hospitals.
3. Identify strategies to overcome barriers so that hospitals can achieve higher CRC screening rates.
4. Explore the important role hospital partners can play in increasing access to providers who can perform colonoscopies for the patients of community health centers.
5. Assess the need for a new NCCRT hospital subgroup.

AGENDA OVERVIEW

Dr. Steven N. Hochwald, Committee on Cancer Liaison, Commission on Cancer

Dr. Hochwald spoke briefly about his experiences as the Head of Gastroenterology Surgical Oncology at Roswell Park and stressed both missed opportunities for colorectal screening, as well as situations where screening resulted in successful early detection and treatment. He went on to say that there has been a 30% decline in colorectal cancer mortality in the last decade due, in large part, to screening.

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He provided a quick overview of the day and emphasized that the goal of 80% by 2018 is an achievable task but one that can only be achieved through asking difficult questions, engaging in debate and searching for solutions that might not be simple.

*Dr. Dorothy Lane, NCCRT Professional Education and Practice Task Group Co-Chair
Associate Dean for Continuing Medical Education, Vice Chair of the Department of Preventive
Medicine, Stony Brook University Medical Center*

Dr. Lane outlined the ground rules for the day and asked the participants to identify themselves before speaking, so that all comments could be fully recorded. The participants then briefly introduced themselves and noted their affiliations.

ACHIEVING 80% BY 2018: HOW HOSPITALS CAN HELP US GET THERE

Dr. Richard C. Wender, Chief Cancer Control Officer, American Cancer Society; NCCRT Chair

Dr. Wender provided an overview of the ten main components of the strategic plan to achieve 80% by 2018, with a focus on how he thinks hospitals can help to achieve that goal.

Achieving the Goal

- 1. *The 80% by 2018 campaign has gone viral.*** Dr. Wender highlighted several people who have been pivotal in achieving the goal, and pointed out that the key is not to merely design a pledge, but to actually own it. He thinks that people are increasingly doing that.
- 2. *We're not getting anywhere near 80% without relying on our nation's primary-care clinicians.*** He pointed out that it is impossible to separate primary care from hospitals, and emphasized that there is nothing more important than linking payment to achieving high screening goals and that being a part of a system that values screening can have a real impact on a primary-care physician's likelihood to recommend screening.
- 3. *Approaching this state-by-state has broad appeal.***
- 4. *Engaging health care plans is difficult, but critically important.*** Dr. Wender identified health plans as superstar players in the colon cancer world and entities that can make an enormous difference.
- 5. *Hospitals and cancer centers can be the difference between our reaching this goal or not.*** Dr. Wender spent some time speaking about how hospitals and cancer centers can

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really make a difference, and he identified seven steps to hospital leadership of 80% by 2018:

- *Recognize and overcome barriers to participation.* Many hospitals have never led a public health campaign before, so this is new territory for them. Many hospitals may even have difficulty in defining the population for whom they are responsible. The business case for hospital leadership involves new payment models that are linked to quality. This is an opportunity to bring together a multidisciplinary team that combines population management, outpatient primary specialty care, and facilities in hospital care, and that this is an outstanding preparation for the future of medicine.
 - *Identify a champion (or champions).* Virtually every high-performing colon cancer screening system has a champion; in some cases, the Commission on Cancer hospital liaison can be that champion.
 - *Publicly commit to achieving this goal.* Be public about signing the pledge.
 - *Assemble a team.* Patient navigators are now the standard of care, particularly for colonoscopy navigation. Teams include primary care, gastroenterologists, patient navigators, anesthesiologists, surgeons, insurers, employers, administrators, the leaders of the institutions, and all of their teams.
 - *Partner with ACS staff.* Since its consolidation, ACS staff are now organized to align with health systems, including primary care, hospitals and comprehensive cancer programs. The staff understand that 80% by 2018 is a priority and can help hospitals with this challenge, in part by connecting them to NCCRT and ACS leaders.
 - *Use the NCCRT resources.* There are tools available including research on barriers and key messages. One of the most important key messages is that there has to be options for screening.
 - *Implement 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.*** Dr. Wender noted several ways to reach the uninsured and underinsured including alternative screening methods, engaging as many colonoscopy centers as possible and providing navigation.
 8. ***Financial barriers persist as major obstacles to screening.***
 9. ***Finding the right set of complementary strategies is a key goal.***

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10. We must floor the accelerator right now and keep the pedal to the metal for the next four years. Dr. Wender noted that the group has already spent 18 years improving colon cancer screening rates and now is the time to push to the finish line. One way to keep the momentum going is by continuing to enlist new partners and creating new ways to convene. If screening rates can be maintained at 80% for the remainder of the century, close to a million colon cancer deaths can be prevented.

OPPORTUNITIES AND RESOURCES OF THE COMMISSION ON CANCER (CoC)

Dr. Mary J. Milroy, Chair, Committee on Cancer Liaison, Commission on Cancer

Dr. Milroy provided a brief history of the Commission on Cancer (CoC), describing the organizations functions, networks, and organizational structure. Presently, the CoC is a consortium of professional organizations dedicated to improving the survival and quality of life of cancer patients through standard setting, prevention, research, education, and monitoring of comprehensive quality care.

CoC as an accredited body has over 1600 hospitals throughout the country in its network that are also part of the 80% by 2018 effort. She noted that a message that the CoC is sending out to their State Chairs is to make colorectal screening a high priority. Towards this effort, CoC wants to monitor and report system-wide goals; develop tools, practices, and policies that maximize screenings; eliminate no-shows; educate about the importance of screening; and identify local barriers to screening.

General discussion:

- For patients of a certain age who have not yet been screened, encouraging hospitals to incorporate an EMR system that automatically enrolls these patients in screening will make a big difference.
- There is precedence to use registrars to register patients for CRC screening rather than the physician.

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UNDERSTANDING OPPORTUNITIES AND BARRIERS THAT HOSPITALS FACE IN SCREENING

Mary Doroshenk, MA, Director, NCCRT

Ms. Doroshenk summarized the themes that emerged from the pre-meeting survey. She reported that 24 participants responded to a 12-question online survey. The purpose of the survey was to explore the strategic role of hospitals in the 80% by 2018 effort.

Responses to the survey included:

What are the most important roles for hospitals in the delivery of quality CRC screening?
• A respected health leader in the community
• Help prioritize the delivery and care coordination of quality CRC screening
• Establish, disseminate, and monitor benchmark quality standards for programs and providers
• Lead the way in establishing partnerships with other stakeholders
• Lead the way to improve access to screening for the underserved
• Participate in quality registries, optimize use of EMRs, and make data available to providers and facilities
• Promote and prioritize screening by working with primary care networks
• Identify patients and provide timely referral to colonoscopy
• Establish programs to better engage the community in screening
• Provide education, outreach, and navigation to ensure timely screening
• Expand access by removing barriers
• Establish agreements with FQHCs and other providers
• Coordinate downstream processes post-screening

What are some of the best practices you have seen hospitals utilize?
• Serve as a source for colonoscopy by coordinating with primary care for underserved populations
• Remove barriers to screening by providing transportation, extended hours, and easy procedures
• Follow national guidelines (CO-RADS) for reporting results and recommending follow-up intervals.
• Conduct community needs assessment, participate in community outreach, integrate screening with primary care, conduct targeted campaigns to reach unscreened populations

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| <ul style="list-style-type: none"> • Provide leadership in the use of patient navigators and provide low-cost or no-cost care across the continuum |
| <ul style="list-style-type: none"> • Integrate screening in EMRs |

What are some of the biggest challenges hospitals face with respect to this role?

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| <ul style="list-style-type: none"> • Don't recognize their role as leaders |
| <ul style="list-style-type: none"> • Don't feel they can impact primary care |
| <ul style="list-style-type: none"> • Have business pressures that limit ability to offer services to underserved |
| <ul style="list-style-type: none"> • Fear not having the capacity to meet demand |
| <ul style="list-style-type: none"> • Not equipped to reach underinsured or uninsured patients and serve in a community-based organizational role |

What do you recommend to overcome these challenges?

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| <ul style="list-style-type: none"> • Leadership |
| <ul style="list-style-type: none"> • Communication between hospital management, ACS, community, and medical leaders |
| <ul style="list-style-type: none"> • Need champions to advocate for CRC screening |
| <ul style="list-style-type: none"> • Help hospitals understand their role in the screening continuum and disease prevention |
| <ul style="list-style-type: none"> • Help hospitals understand the economic benefit of serving the underserved |
| <ul style="list-style-type: none"> • Work with specialty societies to legitimize effort with local GIs |
| <ul style="list-style-type: none"> • Identify volume and capacity estimates to estimate ability to offer screening services |
| <ul style="list-style-type: none"> • Provide innovative programs such as Flu-FIT |
| <ul style="list-style-type: none"> • Set up screening programs in senior centers, food pantries, etc. |

What are the specific issues we need to address in hospitals serving rural and underserved communities?

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| <ul style="list-style-type: none"> • Financial challenges for patients |
| <ul style="list-style-type: none"> • Limited number of endoscopy facilities and staff |
| <ul style="list-style-type: none"> • Poor communication with FQHCs post follow up |

What do you recommend to help overcome challenges with serving rural and underserved communities?

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| <ul style="list-style-type: none"> • Use lower-cost testing regimen such as FIT for screening |
| <ul style="list-style-type: none"> • Enlist rural surgeons and other alternative providers in areas where there are not enough GIs |
| <ul style="list-style-type: none"> • Find ways to improve efficiency of endoscopy suites; work with local providers to serve local needs |
| <ul style="list-style-type: none"> • Coordinate closely with FQHCs on navigation protocols to overcome patient barriers |

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| <ul style="list-style-type: none"> Engage the community; educate community about the benefits of screening; conduct targeted campaigns to reach specific communities |
| <ul style="list-style-type: none"> Secure resources to address the needs of immigrant populations |
| <ul style="list-style-type: none"> Work with legislature to secure funding for diagnostic colonoscopy and treatment, and reimbursement for case management and patient |

What are some financial challenges hospitals face in supporting the delivery of quality CRC screening?

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| <ul style="list-style-type: none"> Treatment of disease (status quo) is more highly compensated than prevention or early detection |
| <ul style="list-style-type: none"> Difficult for large organizations to prioritize changes in CRC screening |
| <ul style="list-style-type: none"> Free-care application process can be challenging |
| <ul style="list-style-type: none"> Difficulty in recuperating costs from patients |
| <ul style="list-style-type: none"> No reimbursement for concrete needs: transportation, childcare, time off work |
| <ul style="list-style-type: none"> Dealing with third-party payers |

What are some ways hospitals have attempted to address these financial challenges?

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| <ul style="list-style-type: none"> Take short-term financial risk in lieu of long-term benefits by embracing population health strategies |
| <ul style="list-style-type: none"> Make sure everyone who is eligible signs up for Medicaid; assist patients with “free care” applications |
| <ul style="list-style-type: none"> Partner with Project Access, FQHCs, and other health access partners |
| <ul style="list-style-type: none"> Establish clearly defined commitments and protocols for engaging with partners for effective patient navigation to eliminate waste and no-shows |
| <ul style="list-style-type: none"> Seek grants or contracts from DOH for reimbursement for screening |
| <ul style="list-style-type: none"> Donate services or provide a sliding scale for services |
| <ul style="list-style-type: none"> Partner with drug companies to get reduced price or free tests (FIT/FOBT) |
| <ul style="list-style-type: none"> Incentivize employed physicians to provide the appropriate care to underserved populations |

Which essential partners should hospitals work with?

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| <ul style="list-style-type: none"> FQHCs |
| <ul style="list-style-type: none"> GIs, surgeons, primary care physicians, PAs, nurses |
| <ul style="list-style-type: none"> State cancer plans |
| <ul style="list-style-type: none"> Departments of health |
| <ul style="list-style-type: none"> CHCs, FQHCs |
| <ul style="list-style-type: none"> Professional organizations |
| <ul style="list-style-type: none"> ACS Health Systems staff |

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• Community-based organizations
• Churches
• Survivor groups
• Local policy makers
• Local media outlets

What should national leaders do to support hospitals efforts?
• Convene national partners and make clear this is a priority
• Improve coordination among national partners
• Develop and disseminate best practices and models that fit all types of hospitals
• Address barriers from a hospital point of view
• Develop action plans for hospitals to adopt
• Convene meeting of members to share successful models
• Identify a network of community resources
• CoC needs to expand their guidance documents for programs that plan screening initiatives to comply with the screening standards of accreditation.
• Develop and disseminate educational tools for providers and patients that follow current screening guidelines
• Work with the national hospital association; push members to get involved
• Coordinate efforts on policy issues; push for Medicaid expansion
• Increase awareness of CRC-screening benefits

What issues could benefit from a policy or legislative approach?
• Filling the gaps in coverage for all recommended modalities of CRC screening for the underinsured or uninsured; co-pays, anesthesia
• Strengthen the requirements for FIT and FOBT products to reduce clutter in the market
• Require employers to cover time off and paid time off for CRC screening
• Make CDC CRC funding available in each state
• Require hospitals that receive federal dollars to provide a certain amount of free and discounted care
• Provide malpractice liability relief or protection and tax benefits for physicians and facilities that provide services for underserved populations
• Enhance P4P programs for rural hospitals that are more dependent on government programs
• Apply pressure on state legislatures and governors from red states to expand Medicaid

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Other advice?

- Leverage the strong leadership of cancer centers and the strong relationships that cancer centers have with ACS to bring additional key players to the table
- Formulate an expert-approved change package
- Make a business case for CRC screening
- Get celebrities and high government officials to promote this
- Raise awareness that this is a preventable disease

THE LANDSCAPE—CASE STUDIES

Case #1: West Side Community Health Services/Hennepin County Medical Center

Dr. Richard Zera, Hennepin County Medical Center, CoC State Chair, Minnesota

In his presentation titled, “Tale of Two Cities,” Dr. Zera shared his experience of how West Side Community Health Services (WSCHS), an FQHC in St. Paul, and Hennepin County Medical Center (HCMC), a safety net hospital in Minneapolis, were addressing the 80% by 2018 effort.

The majority of patients at WSCHS are of color, with low incomes, and only 9% have private insurance (the majority of which are underinsured with high out-of-pocket deductibles). Only 25% are up to date with screening. In the population that EMR used to identify patients due for screening; colonoscopy is offered as first line. iFOB is offered when colonoscopy is refused. There is no program in place for an iFOB patient to receive a low- or no-cost colonoscopy.

The WSCHS/HCMC program a) has a physician champion; b) held a stakeholder meeting to engage relevant partners, including local providers and national leaders of high-performing models; c) partnered with the two largest GI/colorectal surgery groups to provide twelve diagnostic colonoscopies per month; and c) hired a navigator specifically for CRC screening and colonoscopy.

WSCHS has approached all major hospital systems in St. Paul regarding care for positively screened patients. Some of these hospitals have offered to increase its charity care, and others are looking to their foundations to provide financial support.

In HCMC, 53% of eligible patients are up to date with screening. However, barriers to increased screening at HCMC include underutilized EMR, low physician engagement, and high burden of comorbidities and low health-care literacy among the patient population. To overcome these barriers, the CEO has made 80% by 2018 a priority: primary care physicians have a champion,

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non-physicians are empowered to initiate screenings, and efforts are ongoing to broaden the group that performs colonoscopy to improve access and increase usage of iFOB.

Case #2: Rural Ohio Communities

Dr. Michael Sarap, South Eastern Ohio Regional Medical Center, CoC State Chair, Ohio

Dr. Sarap spoke from his role as a rural head surgeon about what they have been able to accomplish in rural communities in Ohio through concerted efforts to raise awareness among physicians and the public, offer free and reduced-cost endoscopies, and build partnerships with key stakeholders.

He highlighted the engagement of primary care physicians, EMRs in prompting screening-related questions, widespread public enthusiasm for helping raise awareness, and stakeholder engagement with providers, county health departments, ACS staff and others. Donation of time and services by hospital administration and staff, surgical endoscopists, and pathology departments have made possible 500 free or reduced-cost colonoscopies since 2006, and small grants have been used for educating the public and physicians about the benefits of early screening.

Case #3: Suffolk County Preventive Endoscopy

Dr. Dorothy Lane, Associate Dean for Continuing Medical Education, Vice Chair of the Department of Preventive Medicine, Stony Brook University Medical Center

Dr. Lane described the experience of the Suffolk County Preventive Endoscopy (SCOPE) demonstration project (Project SCOPE) at Stony Brook University Medical Center - a model for delivering colonoscopy screening to low-income populations to meet anticipated increasing demands.

Project SCOPE, based in the Department of Preventive Medicine, featured internal collaboration with the academic medical center's large gastroenterology practice and external collaboration with the Suffolk County Department of Health Services' network of community health centers. Research findings showed that health center patients had only half as high of a screening rate (28%) when compared to community patients (54%). There were also long delays in getting appointment for colonoscopy at the Medical Center, and there was a misconception among SBUMC endoscopists that health center patients were no-shows or poorly prepped.

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Patient navigators conducted pre-colonoscopy telephone visits instead of office visits to the gastroenterologist in virtually all patients. Telephone visits allowed the clinician to gather relevant information for making screening decisions. The patient navigator was instrumental in reducing barriers, including, but not limited to, scheduling, transportation, and physical navigation of the medical center on the day of colonoscopy.

Further, the effort offered a positive training experience to fellows and faculty, and also met many of the competency requirements of a teaching hospital.

Case #4: Key Issues

Dr. John I Allen, Immediate Past President of the American Gastroenterological Association, Clinical Chief of Digestive Diseases, Yale University

Dr. Allen joined the group by phone. He started his presentation emphasizing the role of navigation at each critical point in the continuum at primary care offices and at endoscopy suites. Citing an example, he noted that in Hennepin County, where there is navigation, the no-show rate at primary care facilities is very low when compared to the over 50% no-show rates in counties without navigators. Navigation is especially useful with the underserved (uninsured, underinsured, and undocumented immigrants) population, and this population will need to be addressed in order to reach the 80% screening rate.

Another issue he touched upon was the post-screening issues related to bills that patients have to deal with. They can get their bills waived or discounted (both arduous processes), or let their bills be turned over to collections.

To address these issues, he advocated for a) mapping the process and gaining consensus about how to bill, waive, and collect; b) establishing free access to care pathways that are culturally and financially sensitive to the needs of the populations; c) clarifying the pathways for screening versus diagnostic protocols; and d) including and providing access to undocumented immigrants under the 80% by 2018 plan.

Case #5: Engaging the Hospital C Suite

James Hotz, MD, Clinical Services Director, Albany Area Primary Health Care

In his presentation, Dr. Hotz made a case for upstream investment to provide the best community benefit for the least investment. He noted that for hospitals to be tax exempt under ACA, they have to prove their community benefit. Providing colorectal screening is one of the most efficient means of providing community benefit and a real return on investment when the numbers are added.

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To create an efficient program, he noted that leadership, navigation, and coordination of services are keys to success. He described Albany Area Primary Health Care to showcase program impacts, and attributed the rise in CRC screening rates from 26% in 2012 to 73% in 2014 to these measures. He noted the cost effectiveness of a collaborative model as a means to reach the target population and the need for champions.

In South Carolina, the Cancer Coalition collaborates with 17 FQHCs, rural health centers, and PCPs; GI practices and endoscopy centers, pathologists and lab services, surgeons, and cancer treatment services. Navigators are key to efficiency and effectiveness and are trusted intermediaries between the health care system and patient. Navigators can also play a major role in removing personal barriers to screening. He emphasized that care coordination across the continuum should be carefully planned and consistently executed to ensure timely, high-quality screening and follow-up care.

Case #6: The Flu-FIT Model

Dr. Michael B. Potter, Professor, Family and Community Medicine & Associate Director for Practice Based Research, Community Engagement Program, Clinical and Translational Science Institute, University of California, San Francisco

Dr. Potter described the FluFIT program (FluFIT.org) that helps clinical teams increase access to CRC screening by offering home tests to patients at the time of their annual flu shots. He encouraged folks to visit the website, which offered a complete suite of resources, training materials, and program details.

Successful FLU-FIT and FLU-FOBT programs have been implemented in public and private clinic settings as well as pilot tested in commercial pharmacies.

WHAT WE CAN LEARN FROM OUR PARTNERS

There was a 45-minute question and answer session with the panel members to discuss what could be learned from the presentations. The following questions and comments were raised.

What are the common themes with respect to the possible solutions?

The importance of navigation:

- The most successful navigation programs are those that are scientifically implemented and evidence based.
- Supporting navigation is important

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- Hospitals can pay for navigation by obviating costs incurred due to the no-shows and poor preps
- Navigators should be trained in understanding where the resources are and how to navigate through that.
- It is important to make the business case for navigation and CRC screening with hospitals

Utilizing partners:

- Identify the right leadership to make a case for CRC screening
- Use hospitals community needs assessment to conduct CRC screening needs assessment by adding a few cancer questions to the assessment
- Use EMRs to increase patient screening
- Identify critical partners and get to the table; work with ACS, CRRT to engage with multiple partners
- Use state roundtables to implement state strategy within a state cancer plan
- Roundtable has wide array of tools to help start these initiatives and carry them through, specifically a web-based resource for educating physicians about CRC screening
- Encourage hospitals to screen employees and their families

Other themes include CRC screening as an effective means to meet CoC requirements for reducing disparity, and having critical access hospitals who get federal funding allocate some funds for CRC screening programs.

DEFINING THE HOSPITAL'S LEADERSHIP ROLE

Participants identified some roles that the hospitals can play in reaching the 80% by 2018 goal as part of their vision. These included:

- Leveraging the status of the hospital systems as a respected health leader in the community to promote and advocate for screening
- Prioritizing delivering care coordination on quality CRC screening across the continuum including employees
- Establishing, disseminating, and monitoring benchmark quality standards for programs and providers
- Playing a leadership role in establishing partnerships with other stakeholders, particularly primary care
- Playing a leadership role in improving access of primary care setting with limited linkages to the hospital systems, especially those serving the underserved

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DEFINING HOSPITALS' NEEDS

Deliberating on what is most needed for hospitals to support the CRC screening efforts in addition to what was identified in the survey; participants identified the following as hospital needs:

- Identifying a clear business model in favor of screening
- Managing patient challenges like access to transportation
- Understanding how hospitals can impact primary care
- Linking EMRs
- Understanding the benefits of prevention or early detection as opposed to treatment of disease or status quo
- Playing a role in collaborative community based role
- Developing standards for quality of practice and care for the procedures and tests so everyone in the system and community is aware
- Developing standards for the patient navigation process

TAKING ACTION: RESPONSIBILITIES OF PARTNERS

The group identified hospitals and hospital organizations, CHCs and CHC organizations, state programs under CDC, the American Cancer Society, professional societies, the CoC, and the roundtable as key partners in the effort. Following a review of the action items identified in the survey, each stakeholder group was asked to identify what they thought were realistic action items. Listed below are the responses from each group.

Hospitals and hospital organizations

Reasonable hospital and hospital organization action items included:

- Increasing the percentage of those screened
- Developing the business case for screening
- Increasing access to procedure for screening
- Making 80% by 2018 CRC screening a quality initiative
- Piloting the effort with hospital employees
- Changing from FOB to FIT program
- Engaging people between ages the ages of 50 and 64 in the effort
- Establishing the 80% by 2018 screening effort as a model for accomplishing other public health problems

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American Hospital Association

AHA suggested the following action items:

- Providing a framework (already exists) for how health systems can engage with communities to accomplish something amazing
- Assisting and looking at a) existing successful best practices and b) which of these successful best practices can be replicated
- Providing tools, training, and education going forward that would help the hospitals and health systems make the case for engagement within their community
- Taking the existing framework and tailor it to address CRC screening in communities

Commission on Cancer

Given the amount of work to become a CoC accredited program, representatives felt reasonable actions included:

- Creating a toolkit specific for CRC screening in the context of CoC credentialing, and sharing it with hospitals
- Tapping into their networks of COPs and State Chairs and the Colorectal Committee of the American College of Surgeons, including their Rural Surgery Community
- Engaging with the ACS and helping smaller community hospitals conduct needs assessment
- Identifying the available tools what are suited for this purpose, and helping to disseminate it among hospitals

American Cancer Society

Reasonable ACS action items included:

- Putting together a resource on effective strategies and best practices based on experience of the work of our directors on 80% by 2018
- Offering our expertise on patient navigation to this roundtable (there is an ACS navigation toolkit)
- Strategically using ACS staff embedded in hospital systems, cancer centers, state roundtables, and community health systems to promote this effort
- Supporting policy initiatives with the help of ACS CAN

General Comments

General comments from participants included:

- Putting the CDC Resource Colorectal Cancer Control Program into circulation and use

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- Creating a roundtable business committee that would include those with a finance background to help create a compelling case/elevator speech for promoting the business case for CRC screening
- Encouraging hospitals to reach out to their primary care practices and promote the importance of screening
- Incentivizing state-wide programs to increase the outreach to hospitals to increase hospital participation/collaboration
- Making the right tools and resources available to hospitals to make it easy for them to engage in and implement strategies towards this effort
- Identifying champion(s) who can reach out to a CFO or CEO to make the business case
- Engaging with specialty societies and academy members in trying to implement some actions to increase screening
- More effectively engaging state-level roundtables to move this effort forward
- Having representation from various GI societies in this roundtable, and for them to get their members on board with this effort
- Working to engage societies and get greater commitment
- Exploring what ACOs can do for this effort