Exemplary Primary Care Practices
80% by 2018 “Mini” Webinar Series

November 10th, 2015
1:00pm EST
Purpose of Today’s Webinar

• Examine “best practices” that primary care providers and practices can undertake to advance colorectal cancer screening
• Hear from an expert in the field about what it’s like to implement these practices
• Learn about resources available to support your work
• Q&A
Presenters:

Mary Doroshenk, MA (Moderator)
NCCRT Director

Jason Crawford, MD, MPH
Chief Medical Officer
Community Health Alliance of Reno, Nevada
Enhancing Colorectal Cancer Screening Rates in Primary Care Practices

Jason P Crawford, MD, MPH

Tuesday, 11/10/15
Objectives

- Implementing a systems-based approach to enhancing CRC screening rates in your practice using the *Steps for Increasing Colorectal Cancer Screening Rates: A Manual for Community Health Centers.*
- Review the “Increasing Cancer Screening and Linkages in a Community Clinic Setting Project” joint collaborative grant with CHA and NCC
- To identify tactics essential to the success of a colon cancer screening system
- Review of local CRC collaborative in the Reno/Sparks area
Data Source: UDS data 2012.
Adults 50-75 years of age who have received any of the following: colonoscopy during reporting year or previous 9 years, flexible sigmoidoscopy conducted during reporting year or previous 4 years, or FOBT or FIT during reporting year.
Increasing Cancer Screening and Linkages in a Community Clinic Setting Project

- Federally Qualified Health Center with 6 clinic locations, 21 medical providers, serving approximately 23,000 patients in the Reno/Sparks area
- Grant project in conjunction with Nevada Cancer Coalition, January 2015 – July 2015
CHA-NCC grant details and goals

- **Statement of Purpose:**
  The *Increasing Cancer Screening and Linkages in a Community Clinic Setting* Project aimed to use evidence-based strategies in a community-based setting to improve colorectal cancer (CRC) screening rates and compliance with in the Community Health Alliance (CHA) patient population.

- **Project Timeline:** January 5, 2015 – June 31st, 2015

- **Population served:** Patients aged 50-75 years old at CHA

- **Grant Goals:** 1) Data mgmt, 2) Outreach/Education, 3) Patient Navigation
Steps for Increasing Colorectal Cancer Screening Rates:
A Manual for Community Health Centers
Steps for Increasing Screening Rates

1. Make a Plan
2. Assemble a Team
3. Get Patients Screened
4. Coordinate Care across the Continuum

COMMUNICATION
Step #1 Make A Plan

Determine Baseline Screening Rates
- Identify your patients due for screening
- Identify patients who received screening
- Calculate the baseline screening rate
- Improve the accuracy of the baseline screening rate

Design Your Practice's Screening Strategy
- Choose a screening method
- Use a high sensitivity stool-based test
- Understand insurance complexities.
- Calculate the clinic's need for colonoscopy
- Consider a direct endoscopy referral system

Step #2 Assemble A Team

Form An Internal CHC Leadership Team
- Identify an internal champion
- Define roles of internal champions
- Utilize patient navigators
- Define roles of patient navigators
- Agree on team tasks

Partner with Colonoscopists
- Identify a physician champion

Step #3 Get Patients Screened

Prepare The Clinic
- Conduct a risk assessment

Prepare The Patient
- Provide patient education materials

Make A Recommendation
- Convince reluctant patients to get screened

Ensure Quality Screening for Stool-Based Screening Program

Track Return Rates and Follow-Up

Measure and Improve Performance

Step #4 Coordinate Care Across The Continuum

Coordinate Follow-Up After Colonoscopy
- Establish a medical neighborhood
Step #1: Make a Plan - Baseline Screening Rates

2012 = 3.22% (ouch!!!)
2013 = 6.36%
Steps #1: Make a Plan - Design your practice’s screening strategy

- Educate providers and staff as part of your planning phase
- Convince them with evidence that screening works to improve health outcomes
Why Screen?

There are two aims of screening:

1. Prevention
   Find and remove polyps to prevent cancer

2. Early Detection
   Find cancer in the early stages, when best chance for a cure
Benefits of Screening

Survival Rates by Disease Stage*

- Local: 90.3%
- Regional: 70.4%
- Distant: 12.5%

Stage of Detection

5-yr Survival

*1996 - 2003
Steps #1: Make a Plan -  Design your practice’s screening strategy

There is no evidence from randomized controlled trials that one screening method is the “best”

Years of life saved through an annual high-quality stool blood screening program are COMPARABLE to a high-quality colonoscopy-based screening program when positive stool tests are followed by colonoscopy.
Trends in the Prevalence of Fecal Occult Blood Test* by Health Insurance Status, US, 2000-2010

* A fecal occult blood test in the past year among adults ≥ 50 years; estimates age-adjusted to the 2000 US standard population.
Source: National Health Interview Survey, National Center for Health Statistics, Centers for Disease Control and Prevention.
Accuracy of Fecal Immunochemical Tests for Colorectal Cancer

Systematic Review and Meta-analysis

Jeffrey K. Lee, MD, MAS; Elizabeth G. Liles, MD, MCR; Stephen Bent, MD; Theodore R. Levin, MD; and Douglas A. Corley, MD, PhD

Background: Performance characteristics of fecal immunochemical tests (FITs) to screen for colorectal cancer (CRC) have been inconsistent.

Purpose: To synthesize data about the diagnostic accuracy of FITs for CRC and identify factors affecting its performance characteristics.

Data Sources: Online databases, including MEDLINE and EMBASE, and bibliographies of included studies from 1996 to 2013.

Study Selection: All studies evaluating the diagnostic accuracy of FITs for CRC in asymptomatic, average-risk adults.

Data Extraction: Two reviewers independently extracted data and critiqued study quality.

Data Synthesis: Nineteen eligible studies were included and meta-analyzed. The pooled sensitivity, specificity, positive likelihood ratio, and negative likelihood ratio of FITs for CRC were 0.79 (95% CI, 0.69 to 0.86), 0.94 (CI, 0.92 to 0.95), 13.10 (CI, 10.49 to 16.35), 0.23 (CI, 0.15 to 0.33), respectively, with an overall diagnostic accuracy of 95% (CI, 93% to 97%). There was substantial heterogeneity between studies in both the pooled sensitivity and specificity estimates. Stratifying by cutoff value for a positive test result or removal of discontinued FIT brands resulted in homogeneous sensitivity estimates. Sensitivity for CRC improved with lower assay cutoff values for a positive test result (for example, 0.89 [CI, 0.80 to 0.95] at a cutoff value less than 20 µg/g vs. 0.70 [CI, 0.55 to 0.81] at cutoff values of 20 to 50 µg/g) but with a corresponding decrease in specificity. A single-sample FIT had similar sensitivity and specificity as several samples, independent of FIT brand.

Limitations: Only English-language articles were included. Lack of data prevented complete subgroup analyses by FIT brand.

Conclusion: Fecal immunochemical tests are moderately sensitive, are highly specific, and have high overall diagnostic accuracy for detecting CRC. Diagnostic performance of FITs depends on the cutoff value for a positive test result.

Primary Funding Source: National Institute of Diabetes and Digestive and Kidney Diseases and National Cancer Institute.

For author affiliations, see end of text.
Long-Term Mortality after Screening for Colorectal Cancer

Aasma Shaukat, M.D., M.P.H., Steven J. Mongin, M.S., Mindy S. Geisser, M.S., Frank A. Lederle, M.D., John H. Bond, M.D., Jack S. Mandel, Ph.D., M.P.H., and Timothy R. Church, Ph.D.

ABSTRACT

BACKGROUND
In randomized trials, fecal occult-blood testing reduces mortality from colorectal cancer. However, the duration of the benefit is unknown, as are the effects specific to age and sex.

METHODS
In the Minnesota Colon Cancer Control Study, 46,551 participants, 50 to 80 years of age, were randomly assigned to usual care (control) or to annual or biennial screening with fecal occult-blood testing. Screening was performed from 1976 through 1982 and from 1986 through 1992. We used the National Death Index to obtain updated information on the vital status of participants and to determine causes of death through 2008.
Evaluating Test Strategies for Colorectal Cancer Screening: A Decision Analysis for the U.S. Preventive Services Task Force

Ann G. Zauber, PhD; Iris Lansdorp-Vogelaar, MS; Amy B. Knudsen, PhD; Janneke Wilschut, MS; Marjolein van Ballegooijen, MD, PhD; and Karen M. Kuntz, ScD

Table 4. Outcomes for the Recommnedable Set of Efficient Screening Strategies

<table>
<thead>
<tr>
<th>Test, Age Begin–Age Stop, Interval*</th>
<th>Outcomes per 1000 Persons</th>
<th>Efficiency Ratio†</th>
<th>Incidence Reduction, %</th>
<th>Mortality Reduction, %</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>COL</td>
<td>Non-COL Tests</td>
<td>LYG</td>
<td></td>
</tr>
<tr>
<td>MISCAN</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>COL, 50–75, 10</td>
<td>4136</td>
<td>0</td>
<td>230</td>
<td>29.6</td>
</tr>
<tr>
<td>Hemoccult SENSA, 50–75, 1</td>
<td>3350</td>
<td>9541</td>
<td>230</td>
<td>30.9</td>
</tr>
<tr>
<td>FIT, 50–75, 1</td>
<td>2949</td>
<td>11 773</td>
<td>227</td>
<td>25.9</td>
</tr>
<tr>
<td>Hemoccult II, 50–75, 1</td>
<td>1982</td>
<td>16 232</td>
<td>194</td>
<td>14.3</td>
</tr>
<tr>
<td>FSIG, 50–75, 5</td>
<td>1911</td>
<td>4139</td>
<td>203</td>
<td>9.7</td>
</tr>
<tr>
<td>FSIG + SENSA, 50–75, 5, 3</td>
<td>2870</td>
<td>5822</td>
<td>230</td>
<td>16.3</td>
</tr>
<tr>
<td>SimCRC</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>COL, 50–75, 10</td>
<td>3756</td>
<td>0</td>
<td>271</td>
<td>34.7</td>
</tr>
<tr>
<td>Hemoccult SENSA, 50–75, 1</td>
<td>2654</td>
<td>9573</td>
<td>259</td>
<td>22.9</td>
</tr>
<tr>
<td>FIT, 50–75, 1</td>
<td>2295</td>
<td>11 830</td>
<td>256</td>
<td>19.7</td>
</tr>
<tr>
<td>Hemoccult II, 50–75, 1</td>
<td>1456</td>
<td>16 239</td>
<td>218</td>
<td>9.6</td>
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<tr>
<td>FSIG, 50–75, 5</td>
<td>995</td>
<td>4483</td>
<td>199</td>
<td>8.4</td>
</tr>
<tr>
<td>FSIG + SENSA, 50–75, 5, 3</td>
<td>1655</td>
<td>11 623</td>
<td>257</td>
<td>7.0</td>
</tr>
</tbody>
</table>
Sample FOBT Policy in Flow Chart Form

Give FOBT Kit to Patient
- Have patient self-address a reminder letter or fold-over postcard.
- File the postcard in a tickler box, sorted by month.
- Put patient’s name in FOBT follow-up log.

Patient returns FOBT kit in one month.

No
Send reminder letter or postcard. Record that it was sent.

Patient returns FOBT kit within a month.

No
Direct Contact Required

Yes
Record test result in patient’s chart. Notify patient of results.

Negative
Repeat in one year or offer FS or CS.

Positive
Schedule appointment for CS.

Patient complies

Action

No

Yes

Colonoscopy


This chart can be viewed at: http://www.cancer.org/acs/groups/content/documents/document/acspc-024588.pdf
STEP 2

1. Make a Plan
2. Assemble a Team
3. Get Patients Screened
4. Coordinate Care across the Continuum
Step #2: Assemble a team

- **Find your internal and external champions!**
- Your champions can help you establish links of care.
- Educate your team on the system and make sure it’s easy to follow
A+ tactic #1: Staff Involvement

- Key Point.....the clinicians cannot do it all!
- Time that patients spend with non-clinician staff is underutilized
- Standing orders can empower nurses, MAs, intake staff to distribute educational materials, schedule appointments, follow order sets, etc
- Involve staff in meetings to discuss progress in achieving office goals for improving the delivery of preventive services
A+ Tactic #2: Hire a Screening Care Coordinator/Patient Navigator

- The care coordinator is the organizational, clerical and customer service provider for the program.

- Educates patients on FIT test usage, serves as a sort of “health coach”.

- Follows up with patients to ensure screening compliance through phone calls, mail, etc.
Step #2: Assemble a team – Partner with local colonoscopists

- Vital to the linkage between primary care and endoscopic and specialty care
- Vital linkage to hospital networks
- Vital for linkage to ongoing care providers of those identified with CRC during the screening and diagnostic process:
  - Surgery
  - Anesthesia
  - Pathology
  - Hematology/Oncology
  - Radiation/Oncology

- START EARLY IN THE PROCESS!!!
STEP 3

1. Make a Plan
2. Assemble a Team
3. Get Patients Screened
4. Coordinate Care across the Continuum

COMMUNICATION
Step #3: Get patients screened – Conduct a risk assessment

Sample Screening Algorithm

Assess Risk: Personal & Family

Average risk = No family history of CRC or adenomatous polyp

- < 50 years: Do not screen
- ≥ 50 years: Screen

If positive, diagnosis by colonoscopy

Increased or high risk based on personal history

Adenoma

CRC

IBD

Surveillance Colonoscopy

High Risk: Germline Syndrome HNPCC or FAP

Adenoma or cancer

Screening colonoscopy, genetic testing, and other cancer screening as appropriate

Screen with colonoscopy 10 years before youngest relative or age 40

Options

Tests That Find Polyps and Cancer
- Flexible sigmoidoscopy every 5 years, or Colonoscopy every 10 years
- Double-contrast barium enema every 5 years, or CT colonography (virtual colonoscopy) every 5 years

Tests That Primarily Find Cancer
- Yearly fecal occult blood test (gFOBT), or Yearly fecal immunochemical test (FIT), or Stool DNA test (SDNA), interval uncertain

*The multiple stool take-home test should be used. One test done by the doctor in the office is not adequate for testing.

The tests that are designed to find both early cancer and polyps are preferred if these tests are available and the patient is willing to have one of these more invasive tests.
# Common Sense Colorectal Cancer Screening Recommendations at a Glance

<table>
<thead>
<tr>
<th>Risk Category</th>
<th>Age to Begin Screening</th>
<th>Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average risk</td>
<td>&lt; Age 50</td>
<td>No screening needed</td>
</tr>
<tr>
<td>No risk factors</td>
<td>≥ Age 50</td>
<td>Screen with any one of the following options:</td>
</tr>
<tr>
<td>No symptoms</td>
<td></td>
<td>* Tests That Find Polyps and Cancer</td>
</tr>
<tr>
<td></td>
<td></td>
<td>** FS q 5 yrs*</td>
</tr>
<tr>
<td></td>
<td></td>
<td>** CS q 10 yrs*</td>
</tr>
<tr>
<td></td>
<td></td>
<td>** DCBE q 5 yrs*</td>
</tr>
<tr>
<td></td>
<td></td>
<td>** CTC q 5 yrs*</td>
</tr>
<tr>
<td></td>
<td></td>
<td>OR</td>
</tr>
<tr>
<td></td>
<td></td>
<td>** Tests That Primarily Find Cancer</td>
</tr>
<tr>
<td></td>
<td></td>
<td>** gFOBT q 1 yr**</td>
</tr>
<tr>
<td></td>
<td></td>
<td>** FIT q 1 yr**</td>
</tr>
<tr>
<td></td>
<td></td>
<td>** sDNA**</td>
</tr>
<tr>
<td>Increased risk</td>
<td>Age 40 or 10 years younger than the earliest diagnosis in the family, whichever comes first</td>
<td>Colonoscopy*</td>
</tr>
<tr>
<td>CRC or adenomatous polyp in a first-degree relative</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Highest risk</td>
<td>Any age</td>
<td>Needs specialty evaluation and colonoscopy</td>
</tr>
<tr>
<td>Personal history for &gt; 8 years of Crohn’s disease or ulcerative colitis or a hereditary syndrome (HNPCC or, FAP, AFAP)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Step #3: Get patients screened – Prepare the patient

- Educational materials
- Offer options for screening (but have FIT as foundation)
- No screening is NOT an option!!!
- FIT-based videos and handouts that are culturally and linguistically appropriate
- Scripts for providers and staff to counsel and deliver consistent messages to staff
Patient Preferences

Inadomi, Arch Intern Med 2012
A+ Tactic #3: Clinical Decision Support Tools

- Use pre-planned scripts (available in the Manual)

- Videos or demonstrations of FIT kit usage

- Decision aid tools and visual aids

- Ensure cultural/language sensitivity
Step #3: Get Patients Screened – Make a recommendation

A recommendation from the provider is the most influential factor on patient screening behavior.
Why patients aren’t getting screened? (according to Physicians)

Table 4 Perceived barriers by primary care physicians in Arizona to ordering CRC screening tests

<table>
<thead>
<tr>
<th>Barriers</th>
<th>Ranked #1</th>
<th>Ranked #2</th>
<th>Ranked #3</th>
<th>Total votes (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient reluctance to undergo screening procedures</td>
<td>501</td>
<td>229</td>
<td>83</td>
<td>813 (83)</td>
</tr>
<tr>
<td>Patient fear of procedure or results</td>
<td>183</td>
<td>279</td>
<td>180</td>
<td>642 (65)</td>
</tr>
<tr>
<td>Patient lacks insurance coverage for screening procedure</td>
<td>188</td>
<td>147</td>
<td>173</td>
<td>508 (52)</td>
</tr>
<tr>
<td>Time constraints</td>
<td>42</td>
<td>55</td>
<td>107</td>
<td>204 (21)</td>
</tr>
<tr>
<td>Logistical problems for the patient</td>
<td>20</td>
<td>55</td>
<td>118</td>
<td>193 (20)</td>
</tr>
<tr>
<td>Lack of reimbursement for ordering or performing procedures</td>
<td>38</td>
<td>45</td>
<td>53</td>
<td>136 (14)</td>
</tr>
<tr>
<td>Decreased availability of screening tests</td>
<td>36</td>
<td>22</td>
<td>51</td>
<td>109 (11)</td>
</tr>
<tr>
<td>Other</td>
<td>27</td>
<td>7</td>
<td>17</td>
<td>51 (5)</td>
</tr>
<tr>
<td>Your familiarity with current guidelines</td>
<td>4</td>
<td>1</td>
<td>4</td>
<td>9 (1)</td>
</tr>
</tbody>
</table>

Cancer Causes Control., 2011
Why patients aren’t getting screened?
(according to Patients)

“My doctor never talked to me about it!”
Step #3: Get patients screened – Ensure quality screening for stool-based screening program
Stool Testing Quality Issues

- In-office FOBT is essentially **worthless** as a screening tool for CRC and **should never** be used.
- CRC screening by FOBT should be performed with **high-sensitivity** FOBT - either FIT or a highly sensitive gFOBT (such as Hemoccult SENSA).
  - Older, less sensitive guiaic tests (such as Hemoccult II) should not be used for CRC screening.
- Annual testing
- All positive screening tests should be evaluated by colonoscopy
Clinicians Reference: FOBT
One page document designed to educate clinicians about important elements of colorectal cancer screening using fecal occult blood tests (FOBT).

Provides state-of-the-science information about guaiac and immunochemical FOBT, test performance and characteristics of high quality screening programs.

Available at www.cancer.org/colonmd
A+ Tactic #4: Access to FIT Tests

- Seek out opportunities to secure free or discounted FIT kits
- Deliver the FIT kit at the time of care, rather than sending patients to a lab
- CLIA-waived testing kits are now available – can complete processing in house
A+ Tactic #5: Use Electronic Health Records

- Activate tracking capacities within the system
- Add patient flags and reminders for physicians
- Use templates to standardize your practice across the organization
- Run reports to assist with program evaluation
<table>
<thead>
<tr>
<th>Recommendations</th>
<th>Interval</th>
<th>Scheduled</th>
<th>Given</th>
<th>Next Due</th>
<th>Template</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bone Density/DEXA - Dual-energy X-ray absorptiometry (DXA)</td>
<td>Repeating schedule</td>
<td>1</td>
<td>0</td>
<td>11/24/2015</td>
<td>DEXA Bone Scan_02_2015</td>
</tr>
<tr>
<td>Colorectal Cancer Screening, Colonoscopy an Individual Not</td>
<td>Repeating schedule</td>
<td>1</td>
<td>0</td>
<td>11/24/1990</td>
<td>Colorectal CA screening, Colonoscopy</td>
</tr>
<tr>
<td>Colorectal Cancer Screening; Fecal-Occult Blood Test, Immur</td>
<td>Repeating schedule</td>
<td>2</td>
<td>1</td>
<td>6/5/2016</td>
<td>Colorectal CA screening, FIT or FOBT</td>
</tr>
<tr>
<td>Screening mammography, bilat (2 view film study, each breast</td>
<td>Repeating schedule</td>
<td>2</td>
<td>1</td>
<td>6/11/2016</td>
<td>Mammogram Screening_02_2015</td>
</tr>
</tbody>
</table>

4 Items

Last reviewed by Jason P. Crawford, MD [6/7/2015 8:02 pm]
A+ Tactic #5: Use Electronic Health Records
A+ Tactic #6: Leverage data to your advantage

- “Unblinded” data
- Allows for continuous quality improvement
- Track program success by clinic and by physician or team, and use benchmarks to reach and exceed goals
- Move beyond MARCH!
- Foster the team-based approach
2015 Pilot Project - Results

2013 baseline of patients up to date with screening

= 3.22%

1st quarter, 2015: overall 5-fold increase in patients up to date with screening

= 37.29%

1st quarter, 2015 screening incidence rate compared to 1st quarter, 2014:

10-FOLD INCREASE IN SCREENING RATES!!!

NEWEST DATA: 3rd QUARTER, 2015 = 37.37%
CRC screening data through 3rd qtr, 2015
Step #4: Coordinate Care

The creation of a medical neighborhood will be critical in coordinating the care of patients.
Step #4: Coordinate Care

- Identified 2 local GI champions from each of our 2 GI groups in town
- Each GI champion helped to champion the cause with the 3 local healthcare systems in a top-down approach
- Subsequent collaborative planning meetings underway
- Utilizing existing models with demonstrated success
A+ Tactic #7: Know your needs, translate to cost-savings

- Using manual’s calculations template, estimate your annualized needs for colonoscopies

- Have this data available to bring to your meetings with GI groups and local healthcare systems

- Work the numbers into a cost-savings proposal to show the value proposition and help with community impact and bottom line
### Colonoscopy needs worksheet

#### ESTIMATED NEEDS CALCULATIONS FOR # OF COLONOSCOPIES AND SUBSEQUENT CANCER CARE

<table>
<thead>
<tr>
<th>Description</th>
<th>Estimate</th>
</tr>
</thead>
<tbody>
<tr>
<td># of CHA patients, 40-75 year old (as of March 2015)</td>
<td>10,410</td>
</tr>
<tr>
<td># of CHA patients, 50-75 year old (as of March 2015)</td>
<td>6,961</td>
</tr>
</tbody>
</table>

15% of 40-75yo are increased risk, require direct colonoscopy:  
10,410 x 0.15 = 1,561

A: ANNUALIZED NEED FOR INCREASED RISK PATIENTS, 40-75yo, over 3 years  
1,561 / 3 years = 520

85% residual average - risk patients, 50-75 year old, 6,961 x 0.85 = 5,916

B: ANNUALIZED NEED FOR AVERAGE RISK PATIENTS, 50-75yo (estimated 5% positive FIT, needs colonoscopy)  
5,916 x 0.05 = 295

(A+B): ANNUAL TOTAL # OF COLONOSCOPIES FOR ALL PATIENTS FOR YEAR 1, 2, 3  
815

YEARS 1, 2, 3 -- ANNUAL ESTIMATE X 18% UNINSURED RATE (CHA estimate, no other funding source)  
815 x 0.18 = 146

Estimated 50% will qualify for Access to Healthcare Network to provide some discounts  
146 x 0.50 = 72

Estimated residual need for colonoscopies for patients w/o any funding source  
72

GI consultants offered 30, Digestive Health offered 30

Estimated 5.45% of FIT-positive patients with follow-up colonoscopy positive for colon cancer  
60 X 0.0545 = 3.27 estimate 3-4 patients/year requiring colorectal cancer treatment

#### COST OF CARE ESTIMATES BY COLORECTAL CANCER STAGE AT PRESENTATION

<table>
<thead>
<tr>
<th>Stage</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>STAGE I</td>
<td>$36,000</td>
</tr>
<tr>
<td>STAGE II</td>
<td>$54,900</td>
</tr>
<tr>
<td>STAGE III, IV</td>
<td>$62,800</td>
</tr>
</tbody>
</table>

Our program will detect at early stage when fully implemented.
A+ Tactic #7: Do not reinvent the wheel

- Excellent evidence-based programs and community collaboratives already underway in many communities
- Use these as a foundation
- Utilize local resources
  - Local ACS chapter
  - State-based non-profits targeting colon cancer: Nevada Cancer Coalition, Nevada Colon Cancer Partnership
- Use appendices in manual to help find them other resources
- Review “Links of Care” webinar from August, 2015: https://www.youtube.com/watch?v=uyQIWD0xoM0&feature=youtu.be
What We’ve Learned

1. Some tactics are more valuable and effective than others
2. There will always be challenges
3. Partnerships are key
4. You HAVE to have a champion
Web resources

- Manual for CHCs:

- ColonMD:
  http://www.cancer.org/healthy/informationforhealthcareprofessionals/colonmdclinicansinformationsource/index

- Clinician’s reference and toolkit:
  http://www.cancer.org/healthy/informationforhealthcareprofessionals/colonmdclinicansinformationsource/foryourclinicalpractice/index
Mary Doroshenk, MA
NCCRT Director
80% by 2018 Resources

• Backgrounder: What can primary care providers do to support 80% by 2018?
• Backgrounder: What can women’s health providers do to support 80% by 2018?– Coming Soon
• Primary Care and Community Health Center Toolkits
• CDC online course for providers
• 80% by 2018 Communications Guidebook
What can primary care providers do to support 80% by 2018?

nccrt.org/tools/80-percent-by-2018/

80% by 2018
Primary Care Physicians
working together to save lives

Colorectal cancer is the second leading cause of cancer death in the United States among men and women combined, yet it's one of the most preventable.

The number of colorectal cancer cases is dropping thanks to screening. We are helping save lives. We can save more.
Five things primary care providers can do...

1. Understand the power of the physician recommendation and recommend screening to all eligible patients regardless of the reason for the visit.
2. Measure the screening rate in your practice.
3. Use evidence-based practice changes to systematize screening in your office.
4. Understand screening test options and offer choices.
5. Make sure patients and staff understand health plan coverage for screening.
Primary Care and Community Health Center Toolkits

nccrt.org/about/provider-education/

CDC online course for providers
80% by 2018
Communications Guidebook

nccrt.org/tools/80-percent-by-2018/
Thank you!

You have the power to have a huge impact on screening rates in the communities you serve and to help reach the goal of 80% by 2018!

Visit cancer.org/colonmd or nccrt.org/tools to learn more about how to act on the preceding recommendations and be part of 80% by 2018.
Questions
Thank You!

- Jason Crawford, MD, MPH
- Community Health Alliance of Reno, Nevada

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Join us for the following upcoming webinar:

Thursday, December 10\textsuperscript{th}, 2:00pm EST – New York Citywide Colon Cancer Control Coalition (‘C5’) Lessons Learned
Save the Date – Registration not yet opened

Thursday, January 14\textsuperscript{th}, 1:00pm EST – An overview of the new Centers for Disease Control and Prevention Colorectal Cancer Control Program (DP15-1502)
Save the Date – Registration not yet opened

Stay tuned for our webinar schedule in 2016!
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